Note of meeting with clinicians from surgical centres, 22 July 2013

In his introduction Bill McCarthy emphasised that NHS England wanted to achieve a lasting solution for every family in England who needs these services. This review should not be seen as a competition to find winners and losers; the aim was to get the best quality of care within the available resource, now and in the future. Quality included outcomes, safety, and patient experience. John Holden summarised the governance of the work.

The main points made during the meeting were as follows:

- professional relationships had been damaged, focus on "closures" has undermined network working (and communication between surgical centres) to the detriment of patient care. The last 5 years had been hugely disruptive - some could not face the prospect of "filling in yet another form" for the new review. There had been "hundreds of meetings". And yet at the same time there was much to commend the former process – a very large consultation exercise with a significant response rate. What could NHS England do differently to achieve a more lasting outcome, in less time? Would the prospect of "closure" be "taken off the table" – this would facilitate a different kind of debate (less confrontational, more honest about room for improvement).
- NHS England must not be complacent – instead must show it has listened, understood and will not repeat mistakes of previous approach. For example the Judicial Review was upheld not simply on a narrow technical point but a more fundamental rejection of JCPCT's decision. IRP had criticised the actions of CHF (national charity). There were fears that the new review would simply "repackage" Safe & Sustainable. NHS England's promise of transparency and use of evidence is nothing new, eg data on cardiac surgeons' mortality rates has been available for some time.
- some clinicians stated that there was a great danger in destabilising retrieval, PICU and other services by the cardiac review process and outcomes.
- the new review should be clear about "case for change" – needs to be current & relevant, eg reflective of latest mortality data, not the situation 25 years ago – a great deal has changed, survival rates are very good, and "natural selection" in the intervening period has meant that some UK centres already ceased to provide surgery – maybe those which remain provide the right balance? IRP recognised there is currently more than one model of provision – perhaps these best reflect different local circumstances?
- the new review needs to build up from standards; there has been extensive work on these with good clinical engagement (not just children's surgery but now cardiology centres and standards for adults services). But need to quality assure the standards; consider interface between adults' and children's standards; and be clear who signs them off.
- some of the new standards were "inclusive not aspirational" – ie set at a level which all current centres could meet. Was this sufficiently challenging and honest? Should the bar be raised? Co-location was "swept over" and not sufficiently specified. If very high aspirational standards were agreed, then this would have

clear consequences for current provision - eg what if a centre is not currently compliant?

- need to recognise that even if mortality has improved, questions remain about sustainability and resilience of surgical centres. This in turn links to debate about whether the "numbers" (eg 4 surgeons, minimum 400 cases per centre, etc) are right. The number is the "weakest [ie least evidenced] aspect" of the standards. Worldwide the best centres have grown out of small units, attracting more cases because of their reputation – so there is not necessarily a causal link which means big is always better. However some clinicians said they now looked overseas at the models which would predominate in the next decade and beyond, and this implied larger centres.
- clear differences of opinion about these numbers – eg IRP said relationship between volume of activity and outcomes was not sufficiently contextualised; some clinicians unconvinced about simple correlation given the high standards achieved in smaller units overseas. But others noted that sufficient volume per centre is essential, eg for training and research, and sufficient number of surgeons is essential to make the unit resilient to events.
- some clinicians stated that for surgeons to successfully attempt the most demanding and complex work on new born babies requires them to perform these most difficult procedures regularly – eg one per week (from which it is possible to extrapolate much larger numbers for the overall volume of activity required for each centre to be viable). This is "common sense". Arguably the "number should be 500 not 400".
- even if mortality rates across England have improved and are now uniformly good, there remain issues about morbidity (ie poor health of the patient after surgery) and patient experience. It is only the current lack of robust data on these issues which means they are not central to the debate about safety and optimal numbers of cases. In future they may be.
- others questioned whether all surgical centres would necessarily perform the full range of surgery in future, or whether the most complex cases should always be referred to fewer centres with particular expertise.
- recognising that some individuals would have "the best reputation", it was damaging that current data/discussion focused on the performance of the surgeon, when in fact it was the performance of the whole team which made the difference. Outcomes should be unit specific not surgeon specific. Key factors would include whether the antenatal service was poor? Was the transport and retrieval good? Was the PICU full?
- previous process did not listen closely enough to professional views; the review became a competition between centres for survival. Investment decisions were suspended due to uncertainty which in turn caused potential deterioration in service (or missed opportunity to improve) – vicious circle.
- undue focus on numbers could lead to potentially perverse consequences in terms of decisions to treat, and appropriate referrals between centres in the best interest of patient outcomes. As soon as a number (of cases required) is decided, it is bound to have an effect on behaviours – including whether or not patients are referred on to other centres. This could in some situations potentially compromise patient care.

- after two decades of improvement, of which we should be proud, services had effectively reached a plateau – to move up to the next level, over the next decade, it was argued the services would need to consolidate. This was not just about surgical capacity but also related services including PICU beds, and the highly skilled nursing staff who were in short supply. Further improvement required research, innovation and investment.
- effective antenatal diagnosis and adequate nurse staffing were at least as important to good outcomes as the precise number of surgical procedures undertaken.

Summing up Bill McCarthy noted that:

- there had evidently been a great deal of good work with extensive clinical involvement – for example the development of standards – and NHS England would seek to build on this
- engagement would be as wide as possible. We would not exclude any local or national stakeholder; nor would we give special access or influence to any group or individual
- alignment of children's and adults' standards would be an early priority for NHS England
- NHS England did not have a predetermined outcome in mind nor did we have an exact process (beyond the outline described in the Board paper). There was clearly a trade-off between the pace required to address concerns about "limbo", versus the necessary engagement to shape major change in the NHS
- there would inevitably be rumours but NHS England was committed to openness and transparency; there would be no side deals or unspoken agreements
- the aims of the project were to develop an appropriate programme of work in response to the findings of the IRP, and to commission high quality care not just for now but for the future.
- clinicians had emphasised the importance of considering morbidity as well as mortality; of looking at the whole patient pathway; and recognising that factors such as transport, PICU and nursing levels play a very significant part
- relationships had been damaged and NHS England must consider what it could do to help rebuild the trust which had been lost
- there was great value in regular discussion with a group of clinical representatives from every surgical centre
- some of the debate had touched on the risk of perverse behaviours, eg in the interests of preserving a unit's surgical status, linked to a breakdown in relationships between centres. Bill had heard elsewhere descriptions of "occasional practice". This felt like an extremely serious clinical governance issue for all Trusts – and in particular those attending today's meeting - to consider.