MEETING OF THE
JOINT OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW HEALTHCARE FOR LONDON
FRIDAY 22nd February 2008

London Borough of Tower Hamlets, Council Chamber,
Mulberry Place, E14 2BG

PRESENT:
Cllr Marie West - London Borough of Barking and Dagenham
Cllr Richard Cornelius - London Borough of Barnet
Cllr Bass - London Borough of Croydon
Cllr Mark Reen – London borough of Ealing
Cllr Ann-Marie Pearce – London Borough of Enfield
Cllr Janet Gillman- London Borough of Greenwich
Cllr Gideon Bull - London Borough of Haringey
Cllr Ted Eden – London Borough of Havering
Cllr Vina Mithani – London Borough of Harrow
Cllr Mary O'Connor - London Borough of Hillingdon (Chairman)
Cllr Jon Hardy - London Borough of Hounslow
Cllr Meral Ece - London Borough of Islington (Vice Chairman)
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
Cllr Don Jordan – Royal Borough of Kingston upon Thames
Cllr Sylvia Scott – London Borough of Lewisham
Cllr Gilli Lewis-Lavender - London Borough of Merton
Cllr Megan Harris Mitchell - London Borough of Newham
Cllr Ralph Scott – London Borough of Redbridge
Cllr Nicola Urquart - London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Mark Francis – London Borough of Tower Hamlets

Cllr Richard Sweden - London Borough of Waltham Forest
Cllr Ian Hart – London Borough of Wandsworth
Cllr Barrie Taylor – London Borough of Westminster (Vice-Chairman)
Cllr Chris Pond - Essex County Council
Cllr Chris Pitt - Surrey County Council

ALSO PRESENT:

Cllr Ann Jackson – London Borough of Tower Hamlets (Mayor)

Officers:

Tim Pearce – LB Barking & Dagenham
Bathsheba Mall – LB Barnet
Louise Peek – LB Bexley
Graham Walton – LB Bromley
Shama Smith – LB Camden
Sureka Perera – Corporation of London
Helen Kearney – Corporation of London

Neal Hounsell – Corporation of London
Trevor Harness – LB Croydon
Nigel Spalding – LB Ealing
Alain Lodge – LB Greenwich
Sue Perrin – LB Hammersmith & Fulham
Nahreen Matlib – LB Harrow
Trevor Cripps – LB Haringey
Anthony Clements – LB Havering
Guy Fiegehen – LB Hillingdon
David Coombs – LB Hillingdon
Sunita Sharma – LB Hounslow
Deepa Patel – LB Hounslow
Peter Moore – LB Islington
Gavin Wilson – RB Kensington & Chelsea
Elaine Carter – LB Lambeth
Nike Shadiya – LB Lewisham
Barbara Jarvis – LB Merton
Greg Leahy – LB Newham
Jonathan Shaw – LB Newham
Jilly Mushington LB Redbridge
Rachael Knight – LB Southwark
Afazul Hoque – LB Tower Hamlets
Shanara Matin – LB Tower Hamlets
Hannah Bailey – LB Tower Hamlets
Kwekue Quagraine – LB Tower Hamlets
Phil Williams – LB Waltham Forest
Phillipa Stone – LB Westminster
Derek Cunningham – Surrey County Council

Speakers:

Dr Clare Gerada -Vice Chair, Royal College of GPs
Dr Tony Stanton - Joint Chief Executive, London – wide Local Medical Committees
Louise Silverton - Deputy General Secretary, Royal College of Midwives
Dr Simon Lenton - Vice President for Health Services, Royal College of Paediatrics and Child Health.
Dr David Jones - Council Member- Royal College of Surgeons

DATE AND VENUE FOR NEXT MEETING

14TH March 2008, London Borough of Ealing.

1. APOLOGIES FOR ABSENCE

Apologies for Absence were received from:
Cllr David Hurt – London Borough of Bexley
Cllr Kenneth Ayers- City of London
Cllr Helen O’Malley– London Borough of Lambeth

Cllr Mary Angell – Surrey County Council

Apologies for Lateness were received from:
Cllr Carole Hubbard – London Borough of Bromley

2. DECLARATIONS OF INTEREST

Cllr Carole Hubbard –London Borough of Bromley declared that she is an employee of Bromley PCT.

3. CHAIRMAN'S WELCOME AND INTRODUCTION

The Mayor of Tower Hamlets Councillor Ann Jackson welcomed the Joint Committee to the borough. The Mayor gave members an overview of the history of the borough and famous landmarks. She further enlightened the Committee with a brief overview of the healthcare issues faced by residents of Tower Hamlets..

The Chairman thanked Mayor Councillor Ann Jackson for her address and thanked Tower Hamlets Council officers for accommodating the event. The Chairman went on to give the Committee an outline of the day's proceedings and noted that she had two items of other business , the final report and interim findings, which would be discussed at the appropriate agenda item.

The Committee were informed that the London Health Commission is holding a stakeholder workshop on the Health Inequalities and the Equalities Impact Assessments they are conducting for Healthcare for London on Wednesday 27th February 2008. Finally the Chairman explained to members that the scheduled JOSC meeting on the 14th March (due to take place in Ealing) would need to begin at 10am. She added that this was a result of the vast amount of evidence that is due to be considered at the meeting.

4. MINUTES

The minutes of the meeting held on 18th January 2008 were agreed subject to the following amendment:

That Cllr Gideon Bull of the London Borough of Haringey and Peter Tobias of the London Borough Hammersmith and Fulham, are stated as being present at the meeting.

That Cllr Peter Tobias' question to Hannah Miller on page 11 of the minutes be amended to reflect that the treatment of illness should be focused on prevention rather than cure.

5. PROJECT PLAN

The Project Plan was agreed.

6. SUBMISSIONS TO THE JOINT OVERVIEW AND SCRUTINY COMMITTEE

The Committee received the submissions from the Outer North East London Joint Health Overview and Scrutiny Committee and the mental health organisation Mind in response to Lord Darzi's review of the NHS.

Mind welcomed the opportunity to submit policy ideas to the Darzi review. They responded to a number of other priority areas that impact on mental health: acute care, maternity services, planned care and staying healthy. Mind explained that they were advocates of a much more holistic approach to mental health, advising effective support for people with mental health problems would need to include health, social care and third sector support.

The Outer North East London Joint Health Overview and Scrutiny Committee in relation to the actual document felt that the document was too simplistic and failed to deal with funding issues regarding the reshaping of services. They explained it only talked about positive aspects which made it difficult to disagree with the overall principles given the way in which they are worded.

The Committee stated that they were unconvinced by the prospect of GPs being open longer hours as several GP practices in London Borough of Redbridge have in fact been closed down by the relevant Primary Care Trust (PCT) in the last 18 months. In regards to the role of Primary Care Trusts yet the Committee felt that PCT's had not been reflecting the views of their communities. They further questioned the assumptions used in the document with regard to future population growth explaining they were unconvinced that the proposed reforms would deliver sufficient capacity for London's health needs.

It was further highlighted that the document did not give enough emphasis to the role of carers. They additionally expressed concerned to the partnership proposals, as they believe it will effect little improvement in the Health Sector's partnership working with Local Authorities. They finally highlighted the lack of consideration attributed to transport issues within the document.

7. WITNESS SESSION 1: Healthcare for London – the implications for primary care

Dr Clare Gerada Vice-Chair, Royal College of GPs and Dr Tony Stanton Joint Chief Executive, London-wide Local Medical Committees

The Chairman introduced Dr Clare Gerada and Dr Tony Stanton to the Committee. The following points were made during the presentation and ensuing discussion:

- The Royal College of General Practitioners represent 30,000 GPs around the United Kingdom. The College feels that the NHS works because of General Practice. The cost per year per patient of one GP is equivalent to one day of acute care.
- The main point of contact for people who use the NHS are GPs.

- General practitioners work in small teams and provide personal care to a registered population. Their effectiveness is a result of the relationship formed with the population from ‘cradle to the grave’.
- The Royal College of General Practitioners are not in favour of the one-size fits all Polyclinic model but are supportive of joint working through a federated model. The RCGPs felt that one fit solution across London will not serve the needs of the London population on a whole; each GP practice serves different communities with different problems.
- One of the main issues London residents have with GP services are accessibility.
- Each PCT has a body of GPs which serve on a Local Medical Committee. Each of these committees is banded together centrally under the umbrella of London-Wide LMCs.
- There is clinical evidence in the Healthcare for London document on which ideas about hospital services are based. But the polyclinic idea does not appear to be based on evidence from the primary care sector and it is questionable whether such an evidence base exists.
- London-wide LMCs will be making its own full response to the healthcare for London consultation.
- Many proposals in HfL are welcomed by London Medical Committees. However there are considerable concerns over the Polyclinic model, which have dominated consultation discussions.
- There are 1,300 GP practices in London and the average practice has 6,000 patients.
- The main point of contact with the NHS for many people is their GP. Only 10% end up in a secondary care hospital setting. GPs are patient carer advocates for frequent users (the elderly, long term sick and young children). GPs excel in demand management and keeping people out of hospital,.
- A key concern of London-wide LMCs are polyclinics. The original definition suggested the single site polyclinic, which would serve an average of 50,000 patients. The average population in each Borough is 250,000, which would indicate an average of 5 single site polyclinics in each borough.
- GPs are not opposed to change but are pushing for the highest possible standards, with a view to stronger relationships with boroughs and more visible support of continuity of care.
- A better approach of General Practices working together rather than as collective Polyclinics should be administered. Polyclinics could put GP practices under threat from mini Hospitals.
- Rather than installing new diagnostic equipment in polyclinics, it may be more cost effective to use this money to improve access to hospital based equipment (eg longer operating hours).
- There is a shortfall in provision. Some practices in deprived areas across London are operating out of terraced housing resulting in a lack of accessibility for vulnerable and deprived groups. The Polyclinic model would benefit some areas of London.
- The best place to manage a patient is within a primary care setting.

Questions

.Q The Chairman enquired what would be the impact of maintaining the Status Quo and not implementing the proposals?

It was responded that it would be wise to accept the arguments for hospital reconfiguration. If not supported Hospital patients would not get the necessary care for their specific needs. However the use of Polyclinics should not be adopted throughout London. Rather an approach of General Practices working together would be the desired method.

Q The Councillor for Croydon asked about possible issues that may arise with a resident receiving care across boroughs?

It was noted that London traditionally provides specialist hospitals. Under the Picture of Health proposals in South East London, Lewisham hospital for example may not retain accident and emergency services. Consideration would need to be given as to the spill over affect in that sector.

Q There was a supplementary question about the hub and spoke polyclinic model and whether the speakers saw any merit in moving some services currently only available in district general hospitals into communities and what could be recommended for out of hours surgeries ?

It was reiterated that the speakers were not against Polyclinics if it was the model which best suited a specific local population. They added that they were also not against moving services from out of hospitals and putting them into GP practices, but would advise caution as there were risks. In relation to out of hours operation, the speakers were in favour of extended hours but stated that co-operatives working together in larger populations would be their desired model.

Q The Councillor from Waltham Forest questioned the speakers' views of specialism within a practice.

It was suggested that specialists located in community settings may find their role scaled down, with general cases being seen that might not require a specialist. GPs may not also see specialist cases (diabetes for example) and so they then lose that part of their knowledge base, which is difficult to claw back.

Q The Councillor for Wandsworth asked how the speakers would propose to support flexibility within the GP Service.

The speakers explained that the profession recognised that access to GPs, particularly for working people, has been a problem for the general population. The national negotiating team had developed a workable solution in the Autumn but this had been stopped. They reiterated the point that services should be tailored to the needs of the particular population. There was often a fixation about bricks and mortar but it was the team delivering a service that influenced the efficacy and outcomes of that service.

Q The Councillor for Richmond Upon Thames queried if primary care was able to deliver equality of access for long term illness as particular diseases are perceived to be getting more attention than others?

The speakers responded arguing that they did not think particular conditions were receiving more attention adding that there was no truth in the concept of a unilaterally morbid condition as there were many different elements to long term conditions. Steps were being taken to improve case management.

Q The Councillor for Hackney asked the views of the Royal College of General Practitioners on the Darzi proposals regarding polyclinics and whether they are motivated by GPs' self interest?

It was responded that GPs have a big commitment to their local communities, as they have a stakes in their businesses. It was further stated that there was no underlying theme of self interest prevalent amongst the General Practicing community.

Q The Councillor for Enfield stated that Polyclinics would be highly beneficial for deprived residents of her borough. She enquired if the Polyclinic model would be opposed in her local borough?

The speakers explained that they were not opposed to a better service for her constituents, but suggested that a one size fits all Polyclinic model should not be introduced wholesale across London. They fully understood the current situation in Enfield and could see the Polyclinic model being a good solution to the issue of accessibility to GPs in the borough.

Q The Councillor for Tower Hamlets enquired what the differences were to the Polyclinic models and how much of the current proposals the speakers would endorse? He further asked if it was likely that polyclinics would see a proliferation of private companies taking over GP practices?

It was explained that in the initial proposal, it was suggested that a polyclinic would have all services located on one site. This would mean that there would be a polyclinic on every hospital site and then four more in each borough, but this model may work in some places and may not in others. Others may better suit a hub and spoke or federated model. It was added that the privatisation of general practice might seem attractive at first but it would not be a step the speakers would not endorse.

Q The Councillor for Islington asked what was being done in relation to an ageing GP population, in particular to address the situations where single-handed GPs are retiring and are not being replaced?

In response it was noted that single handed GPs are often unfairly targeted about the level of care that they provide. Often they come out top in customer satisfaction surveys. Some PCTs had a policy of not replacing single GP

practices on retirement which leads to the displacement of patients and the loss of GP patient liaison.

Q. The Councillor for Richmond upon Thames queried how the speakers would strengthen Primary Care and asked if they consider the proposals as an attack on community based medicine? How involved had GPs been in developing the proposals?

It was noted that the Royal College of GPs is pushing for practice accreditation, which would set out standards on access and quality of care and would require practices to meet minimum standards. The speakers stated that they would recommend practitioner accreditation standards on quality and service. An investment in good buildings, Midwives, community nurses and more health visitors to support primary care was greatly needed as they were currently undervalued services. GPs had not been involved in developing the Darzi proposals.

Q The Councillor for Newham asked for the speakers' opinion on the idea of separating hospital diagnostics and General Practice diagnostics in a local setting. He further requested the links between Dentist and GPs as the current consensus amongst dentists was that they had been left out of the process.

It was explained that whilst it was feasible to move diagnostics such as ultrasound out of a hospital setting, this brought with it staffing, training and financial implications, and it was also important that polyclinics are not seen as a reinvention of local hospitals. The speakers welcomed a closer link with dentists in the reconfiguration process.

8. WITNESS SESSION 2: Healthcare for London - The implications for Maternity Care
Louise Silverton, Deputy General Secretary, Royal College of Midwives

The Chairman Cllr O'Connor introduced Mrs Louise Silverton to the Committee. The following points were made during her presentation and the ensuing discussion:

- Nearly 20% of all births were to women in London in 2006
- London has the fastest rising birth rate in England
- The number of women in London of childbearing age (15-44 years) is projected to increase by 11% by 2016, although these increases fluctuate across London
- A higher percentage of the population in London is young and significantly mobile. GP list turnover is between 20-40%
- Most maternity units in London do not have enough midwives to provide the level of one-to-one care that the Government has pledged to provide for women by 2009
- *Birthrate Plus* recommends a ratio of 1 midwife for every 28 deliveries for hospital births. This equates to approximately 36 midwives for every 1000

deliveries. Currently only Whittingham and Guy’s and St Thomas’ are the only hospitals to exceed the recommendation.

- London has the highest midwifery vacancy rates in England. The average vacancy rate in 2006/07 was 8.5%. Some hospitals have put a freeze on recruitment to address to some extent their deficits.
- During 2006/07 maternity services were suspended on 51 occasions and four related to medical/midwifery staffing.
- 18% of Midwives are working beyond the age of 55. 17.5% are in the position to retire now, 30% in 5 years and 53% in 10 years.
- 1.8% of births in London take place at home which is below the national average. Six units have home birth rates of less than 1%.
- London has a high rate of Caesarean section births – only eight NHS Trust achieved a rate below the national average of 23.5%.
- Midwives care for a woman during birth and sustain her past giving birth for a period of time. All women need a midwife, some need a doctor too. The number of visits a woman receives after going home varies across London. This is linked to the number of midwives per ‘000 of the population.
- The maternity sector is being starved of resources; with the current spend level reduced by 2% (equating to £55m).
- The size of maternity services in London and increases in child bearing ages of women are current challenges faced by the Royal College of Midwives.
- The rising number of complex births from women oversees has become an issue.
- Accessibility to housing is an issue for Midwives. Most Midwives who work in London do not actually live in London. They are also unable to qualify for the key worker housing scheme.

Questions

Q The Councillor for Wandsworth enquired if the speaker believed the Darzi report addressed midwifery issues and asked if she believed the NHS was up to the challenge of delivering a good service?

The speaker explained that the Darzi report did recognise some of the principles of maternity matters. However, free standing birth centres without obstetrics needed to be properly staffed and required clear protocols for transferring patients, and if these were in place then the Royal College could be more supportive of this proposal. She further remarked that the NHS was up to it, as resources are at their disposal and not everything is in need of being serviced. The NHS would need to be held accountable for the plans during the reconfiguration process.

Q The Councillor for Greenwich reported that at his Council’s last Health Scrutiny Panel meeting a positive picture had been presented by his local PCT in relation to the recruitment process. As a result he queried the reason for the disparity between the speaker's views and those of health professionals in his borough.

It was responded that the Councillor's local PCT may have not carried out their full projections for staff required at the time of their presentation. Students on placement may not have been included in their calculations as well as a scrutiny of the age profile of midwives.

Q The Councillor for Newham queried whether there were concerns that the proposals would not meet the need of deprived areas?

The speaker responded that if we were starting again from scratch, tertiary centres in areas of deprivation could be built. The Darzi report did look at health issues for deprived areas to a lesser extent, but this needs to become a focus or we will just perpetuate what we have now. More midwives need to be in the communities, with signs saying that if you are pregnant, this is where you can find your midwife. Every woman needs to be able to have a choice. For a number of women with complications or social needs, they need to be able to access doctor led units. But things like post natal care could be delivered in communities.

Q The Councillor for Merton queried of the seven London trusts that had vacancy rates in double figures, did the trusts also have the highest hospital deficits?

It was explained that the speaker did not have the information present, but would be able to supply the relevant information in more detail.

Q The Councillor for Islington asked if the Royal College of Midwives viewed the proposals in the Darzi report in relation to maternity care as adequate?

It was noted that there is not really much in the report that could be disagreed with, although exception could be taken to the consultation questions. The RCN agreed with the proposal of a set group of midwives who care for a specific number of the pregnant population. However concern was aimed at how the PCT's across London would administer it. The speaker added that providing community based care is where problems would arise, further stating that the Royal College of Midwives would be looking for a bigger lead from commissioners in commissioning the right type of care.

Q The Chairman enquired in response to the earlier mentioning of choice in the presentation, how the Royal College of Midwives managed expectations?

It was explained that the main restriction to choice is a lack of capacity, but to balance that, you did not want to much choice that you are wasting capacity. The speaker added that money was drastically needed for all aspects of Midwifery as a lack of choice could become a problem. Movement across Boroughs is also an issue, a Trust might provide antenatal and post-natal care, but they do not get the money for it. A host borough commissions based on the number of births it expects..

Q The Councillor for Essex County Council asked what provisions were being made for the estimated population growth in the sub M11 area, Thames Gateway and Hertfordshire?

The speaker explained that she was unaware of any new plans for hospitals in the areas as it was an issue of planning. Despite this she understood that dialogue was occurring with local authorities and local PCT into what the projected plans for these areas will be.

Q The Councillor for Haringey queried how the Royal College of Midwives dealt with people who did not have English as their first language?

It was explained that this was a huge challenge midwives faced. She explained it was deemed unacceptable to expect the partners, or family members to translate. It is important Midwives are culturally sensitive. She added that the Royal College of Midwives provided professional and trade union services, and could not provide translation services.

9. WITNESS SESSION 3: Healthcare for London – the implications for Paediatric Care and Child Health
Dr Simon Lenton, Vice-President for Health Services, Royal College of Paediatrics and Child Health

Councillor O'Connor introduced Dr Simon Lenton, Vice-President for Health Services, Royal College of Paediatrics and Child Health. During the presentation and ensuing discussion, the following key points were made:

- There are a number of factors signalling that reform of paediatric and child health services was needed, including the findings of UNICEF of children's health in the UK, rife inequalities in services and the view of the Healthcare Commission that acute services are poor;
- Current NHS reforms around elective and diagnostics fail to take into account that most children require care urgently or for long term conditions (LTC);
- Children are not mini-adults and have different needs and requirements in terms of their physiology, range of illnesses and the way in which we communicate with them;
- The need to take a holistic view of children's needs, from treatment itself to the environment this takes place in and the needs of the child's family, yet the fact that this did not always sit easily with a market-orientated approach to the provision of care;
- Whilst children are seen as the future, the Darzi report actually treats paediatrics and child services as something of an afterthought, with its piecemeal approach giving little focus to mental health services, disabled or disadvantaged children;
- The aspects of the Darzi report that the Royal College of Paediatrics and Child Health were in favour of was the proposed model of service delivery, with its focus on pathway thinking around a patient's journey, family friendly models of care and continuous improvement through feedback;

- The basic premise of the report that poor health with appropriate health care leads to better health was welcomed, but this needed to be broken down into the following steps – prevention – identification – assessment – short-term interventions – long-term support – palliation.
- Again, need for recognition of the differences in working with children was stressed. This was illustrated by the fact that targets set for adult care were not always suitable for children, in whom conditions developed in different ways;
- The Royal College weas of the opinion that children and their families should expect better care than that they currently receive, and this should be responsive to their needs and delivered in a range of appropriate settings, be this in the child's home, school, or local hospital;
- Clinical services needed to be delivered by teams working in integrated networks, with a focus on collaboration not competition. Whilst Dr Lenton expressed his view that there was not sufficient information about the vision for paediatrics and child health in the Darzi report, there was much scope to take these issues forward.

Questions

Q The Councillor from Hammersmith and Fulham enquired about the position of the models of excellence identified in the UNICEF report on child heath in the UK.

It was responded that foreign models were funded on a completely different basis. Whilst there were no simple solutions or single model proposed, there should be quality of care for children wherever it was delivered. Whilst there were current examples of patient-friendly care delivered according to the pathway model, but these needed to be expanded to be able to deliver on a larger scale.

Q The Councillor from Islington said that the importance of children growing up healthy should have been given far greater prominence in Darzi's vision. She asked how the model of holistic support could be developed over the next ten years and whether there was a role for local hospitals to provide care outside of centres of excellence.

It was responded that there were different ways of delivering treatment and these needed to be assessed on an individual basis. Broadly speaking however, there was a need to move away from traditional settings when caring for children and integrate services into their day-to-day lives, by providing care in homes and schools. Whilst it was inevitable that in some cases families would have to travel for specialist treatment at centres of excellence, this was often only one element of the process.

Q The Councillor from Westminster alluded to the report's views on the concentration of services on fewer sites and asked what Local Authorities could do to urge Darzi to take a more integrated approach to the provision of services.

It was responded that as there were not enough paediatricians to keep all units open at present, consideration needed to be given to the reconfiguration of services. There was a real need to proactively plan for the future and work realistically with the resources that were available. There was no single solution yet there was tacit acceptance that it was not efficient to continue in the same manner and the situation needed to change. However it was often small changes that could have the biggest impact – Dr Lenton drew Members' attention to the need for more paediatric nurses, which could be as important as the need for more paediatricians. In terms of the role of Local Authorities, Members were urged to consider a range of interventions, from looking at PSA targets and working more closely with the PCT, to reducing speed limits in residential areas to cut down on the numbers of children injured in road traffic accidents.

Q The Councillor from Harrow asked if Healthcare for London could lead to more immunisations amongst children

It was responded that there were often specific issues around immunisation in the capital due to the transient nature of the population. There was a definite need to upgrade computer systems in some boroughs to be able to keep an accurate track of children's records. Much work also needed to be done to educate parents around the benefits of immunisation.It was also important to ensure that health professionals provided consistent messages, particularly around MMR. Whilst there were always increases in the number of immunisations following an outbreak, it was not sufficient to rely on this' to meet the immunisation requirements of London's children

10. WITNESS SESSION 4: Healthcare for London – the implications for Specialist Care, Complex Emergency Surgery and Planned Surgery Mr David Jones, Council Member, The Royal College of Surgeons.

Councillor O'Connor introduced Mr David Jones, Council Member, The Royal College of Surgeons. During the presentation and ensuing discussion, the following key points were made:

- The Royal College of Surgeons (RCS) exist to enable surgeons to achieve and maintain the highest standards of surgical practice and patient care. In practice this meant training the surgeons of the future and handing on skills from one generation to the next;
- The College's Patient Liaison Group (PLG) are a part of the College Council and exists to keep the College's 'feet on the ground'. The PLG lobby for continuity of care and named doctors throughout a patient's care;
- The RCS felt that standards and indicators should be used to measure performance and underpin standards as opposed to targets;
- A service delivery model based around networks of care was advocated, with an agreement on provision of specialist and general care within a network which was funded appropriately;
- It was stressed that there were already good examples of networking in practice around children's surgical services and trauma care, but these needed to be further developed to cover all services;

- It was felt reasonable to create a handful of major trauma centres to deal with the most severe cases, and the RCS welcomed the recommendation in the Darzi report to create three such centres in London;
- However, alongside these major specialist centres there was still a role for local district hospitals in providing care for the majority of more minor injuries such as fractures;
- In terms of funding, the RCS felt that it was necessary to reward quality and safety rather than activity. Similarly, when commissioning, equal regard should be given for routine services alongside more specialist services;
- Any reconfiguration of services should have a sound clinical and evidence based and must not be based on a drive for financial, political or managerial expediency;
- In terms of the Darzi report, the RCS main concerns centred around access, safety, continuity of care, training and the need to consider specialties;
- Surgical care ideally needed to be delivered via defined networks, for those requiring specialised care this would be in a specialised centre, however for more routine procedures care could be delivered locally, where this was considered safe and possible;
- In conclusion, the RCS felt that the JOSC had a role to play in ensuring that the Darzi report had fully considered the most appropriate method of service delivery for trauma and children's care in the future.

Questions

Q The Councillor from Barnet enquired as to what was meant by the reference to 'dilution of care' amongst surgeons and asked whether the RCS felt that the Darzi report would improve surgical services or if it was a money-saving exercise?

It was explained that as surgery was a craft, practice was essential, particularly for newly-qualified surgeons. However, due to the European Working Time Directive (EWTD), surgeons' hours were reduced and they were not always able to gain sufficient levels of skill through practice. For this reason the RCS was opposed to the EWTD and often referred to the 'dilution' of skills due to this restriction. The view was expressed that Lord Darzi was a political appointment as well as a surgeon, and there was therefore a political angle to the report. The RCS felt that simple steps were needed to improve the UK healthcare system.

Q The Councillor from Richmond Upon Thames asked whether the London Ambulance Service would need any further training in order to be able to recognise major trauma and direct patients to the most appropriate centre for their needs.

It was responded that London Ambulance were already skilled in this area and also had to contend with traffic congestion in the capital as part of their decision making processes when referring cases to hospitals. There were very few hospitals in the UK that had the expertise and equipment to deal with all trauma cases at present, and only one of these was in the capital at

present, so more specialised centres of excellence were welcomed by the RCS.

Q The Councillor from Newham asked whether the RCS felt that payment by safety and quality would lead to a drop in those having surgery and possibly lead to longer waiting times

It was responded that surgeons were used to high volumes of work but this could often be affected by other issues, such as nurse shortages, infections and the ‘target culture’. It was felt that the correct resources needed to be put into place to allow surgeons to deal with these issues; however the RCS resented being told what to do by the government.

Q The Councillor from Sutton asked whether there were sufficient resources in place to enable the training and accreditation of courses, trainers and professionals to take place

It was responded that at present young surgeons didn’t have enough time to be trained to excellence; instead the RCS was settling for competence. Training was clearly a costly issue and there were no guidelines at present as to how it was proposed to revalidate senior professionals.

Q The Councillor from Waltham Forest asked for the opinion of the RCS on where the line should be drawn between general hospitals and specialist centres, particularly in terms of which services should be kept within district hospitals

It was responded that in broad terms, accident units, children’s units, fragility fractures and limb injuries could remain within a district hospital setting, with some allowance for some specialist areas. Within present networks, there was recognition of the skills of certain specialists and the need to sometimes refer a patient to a particular doctor outside of their own local area.

Q The Chairman asked for the opinion of the RCS on the impact of not implementing the recommendations made by Darzi but keeping the status quo

It was responded that the RCS felt that many aspects of the report made practical sense, however much of the detail still needed to be expanded upon. Equity of care, irrespective of which part of London someone lived in, needed to be achieved

Q The Councillor from Croydon commented that in some scenarios (for example fracture surgery), the speaker seemed to be promoting networks of individual specialist surgeons across hospitals, rather than specialist hospital sites and asked what the RCS felt about the idea of publishing the performance statistics of individual consultants

It was responded that it was felt that performance statistics would come as part of the accreditation process, however it was often difficult to balance outcomes. For example, a skilled heart surgeon may have a much higher rate

of mortality amongst patients than a surgeon performing more routine operations.

Q The Councillor from Richmond Upon Thames asked what contact had been made with the Department of Health regarding last year's training issues?

It was responded that the situation regarding training was still in crisis, with a huge number of young people competing for a small number of places. There was an argument that training should be restructured to operate as it had done in the past to address this situation.

Q The Councillor from Harrow asked whether given current staff shortages, surgeons would be prepared to move to larger sites such as major trauma centres

It was responded that this was a major concern of the RCS and again came to down to the need to thrash out the detail of the Darzi report. Decisions such as this were for local negotiation and this was an instance when networks could come into play.

11. ANY OTHER BUSINESS

I. Interim Findings

Members were reminded that the deadline for submission of comments from individual boroughs was Friday 29th February. The Chairman indicated that a copy of the interim findings of the JOSC had been circulated to all Members and invited any initial comments. The following key points were raised:

- The need to address the issue of historic under-funding in some areas of East London in the final response;
- The adequacy of the entire consultation process;

There was discussion as to whether there would be any opportunity to follow-up on any of the responses received from NHS London? It was noted that the officer support group would follow this up should any Member indicate a specific issue. It was also agreed that the officer support group would forward to the witnesses any outstanding questions that Members had not had the opportunity to ask. .

Following discussions it was agreed by Members that the interim findings report could be shared with OSC at individual boroughs, but that the draft status of the report was to be stressed.

II. Format of the final response

The Chairman sought Members views on the format of the final response of the JOSC. It was proposed that an electronic copy be produced which boroughs could then decide to reproduce in hard copy if required. This was agreed by Members.

III. Further meetings

The Chairman notified Members of a number of forthcoming meetings once the JOSC's final report had been agreed:

- 6th May – MORI to respond to consultation outcomes (venue yet to be confirmed);
- 20th – 23rd May – PCTs to hold a series of public meetings;
- 12th June – Joint Committee of PCTs to agree consultation response.

12. CHAIRMAN'S CLOSING REMARKS

The Chairman thanked all those in attendance for their contribution to the meeting.