

**Joint Health Overview & Scrutiny
Committee (JHOSC)
to review
Consultation proposals from 'Healthcare
for London':
*"The Shape of Things to Come -
Developing New, High-quality Major
Trauma and Stroke Services for London"***

**A joint authority health scrutiny committee comprising all of
the London Boroughs and Essex County Council**

**Supplementary report of the Committee:
Minutes of 'Witness' Meetings
Written Submissions to the JHOSC**

June 2009

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Minutes of 'Witness' Meetings

4 February 2009

**R.B. Kensington and
Chelsea**

5 March 2009

L.B. Redbridge

23 March 2009

L.B. Lambeth

7 April 2009

L.B. Camden

24 April 2009

Westminster CC

7 May 2009

**L .B. Hammersmith and
Fulham**

**MEETING OF THE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW "SHAPING HEALTH SERVICES TOGETHER -
CONSULTATION ON DEVELOPING NEW, HIGH-QUALITY MAJOR
TRAUMA AND STROKE SERVICES IN LONDON"**

WEDNESDAY 4 FEBRUARY 2009

**Royal Borough of Kensington and Chelsea, Council Chamber,
Kensington Town Hall, Hornton Street, W8 7NX**

PRESENT:

Cllr Marie West - London Borough of Barking and Dagenham
Cllr Sachin Rajput - London Borough of Barnet
Cllr David Hurt – London Borough of Bexley
Cllr Carole Hubbard – London Borough of Bromley
Cllr John Bryant – London Borough of Camden
Cllr Ken Ayers - City of London
Cllr Greg Stafford - London Borough of Ealing
Cllr Vivien Giladi - London Borough of Enfield
Cllr Christopher Pond - Essex County Council
Cllr Janet Gillman - London Borough of Greenwich
Cllr Jonathan McShane – London Borough of Hackney (Vice-Chairman)
Cllr Peter Tobias – London Borough of Hammersmith and Fulham
Cllr Vina Mithani – London Borough of Harrow
Cllr Mary O'Connor - London Borough of Hillingdon
Cllr Jon Hardy - London Borough of Hounslow
Cllr Paul Convery - London Borough of Islington
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
(Chairman)
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Winston Vaughan - London Borough of Newham
Cllr Ralph Scott (substitute) – London Borough of Redbridge
Cllr Nicola Urquhart - London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Richard Sweden - London Borough of Waltham Forest
Cllr Susie Burbridge – City of Westminster

ALSO PRESENT:

Officers:

Paranjit Nijher - London Borough of Barking and Dagenham
Jeremy Williams – London Borough of Barnet
Louise Peek – London Borough of Bexley
Andrew Davies – London Borough of Brent
Philippa Stone - London Borough of Bromley
Shama Smith - London Borough of Camden
Simon Temerlies – City of London
Trevor Harness – London Borough of Croydon
Ade Adebola – London Borough of Greenwich
Tracey Anderson – London Borough of Hackney

Sue Perrin – London Borough of Hammersmith & Fulham
Rob Mack – London Borough of Haringey
Melanie Ponomarenko - London Borough of Haringey
Nahreen Matlib - London Borough of Harrow
Anthony Clements – London Borough of Havering
Guy Fiegehen – London Borough of Hillingdon
Deepa Patel – London Borough of Hounslow
Henry Bewley - Royal Borough of Kensington & Chelsea
Gavin Wilson – Royal Borough of Kensington & Chelsea
Joanne Tutt - London Borough of Lambeth
Barbara Jarvis - London Borough of Merton
Iain Griffin - London Borough of Newham
Jilly Mushington - London Borough of Redbridge
Julia Regan - London Borough of Redbridge
Bernadette Lee - London Borough of Richmond
Shanara Matin - London Borough of Tower Hamlets

Others:

Don Neame - Director of Communication, Healthcare for London,
Simon Robbins - Senior Responsible Officer for Major Trauma Project,
Healthcare for London
Richard Sumray - Chair, Joint Committee of London PCTs
Rachel Tyndall - Senior Responsible Officer for Stroke Project, Healthcare for
London
Michael Wilson - Project Manager for Stroke, Healthcare for London

1. APPOINTMENT OF CHAIRMAN

It was proposed by Cllr Peter Tobias (Hammersmith and Fulham),
seconded by Cllr Mary O'Connor (Hillingdon) and

RESOLVED:

**1) That Cllr Christopher Buckmaster (Kensington and
Chelsea) be appointed as Chairman of the JHOSC.**

2. APPOINTMENT OF VICE-CHAIRMEN

In the absence of any nominations, the Chairman referred to the
operational benefits of having Vice-Chairmen, and said that he would
speak informally to members of the JHOSC with the intention of
encouraging nominations.

3. APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Cllr Chris Leaman (Brent)
Cllr Graham Bass (Croydon)

Cllr Gideon Bull (Haringey)
Cllr Ted Eden (Havering)
Cllr Don Jordan (Kingston upon Thames)
Cllrs Sylvia Scott and Alan Hall (substitute) (Lewisham)
Cllr Gilli Lewis-Lavender (Merton)
Cllr Allan Burgess (Redbridge)
Cllr Stuart Gordon-Bullock (Sutton)

4. DECLARATIONS OF INTEREST

Cllr Carole Hubbard (Bromley) declared that she was an employee of Bromley PCT.

Cllr Jonathan McShane (Hackney) declared that he was an employee of the NHS in Southwark.

Cllr Vina Mithani (Harrow) declared that she was an employee of the Health Protection Agency.

Cllr Mary O'Connor (Hillingdon) declared that she was chairman of the London Health Commission.

5. PROPOSED TERMS OF REFERENCE

RESOLVED: That the proposed Terms of Reference be agreed.

6. PROPOSED OPERATIONAL ARRANGEMENTS

RESOLVED:

1) That a new paragraph 2 be added to the paper setting out the proposed operational arrangements, to read as below, and subsequent paragraphs renumbered:

2."MEMBERSHIP

2.1 This JHOSC is open to all Health Overview and Scrutiny Committees in London, plus those from adjoining areas."

2) That the model of a pan-London JHOSC looking at both acute stroke and major trauma be adopted.

Consideration was given to preferred arrangements for holding meetings. The Chairman read out a list of authorities which had kindly offered to host future meetings, and asked that if further councils were prepared to host a meeting, they contact the support officers.

The advantages and disadvantages were discussed of holding meetings at different times of the day, and on different days of the week. The suggestion was made that a meeting starting in the early afternoon and finishing by around 6 pm might supplement the 10 am - 4 pm model used for the former JHOSC set up in 2007.

The Chairman drew the meeting's attention to the list of possible witnesses and sources of evidence circulated with the agenda. He commented that it would be sensible for some of the witnesses to be invited to address both trauma and stroke at the same session. In some cases, seeking written evidence from those listed might be appropriate.

It was agreed that some of the hospitals which had been successful and some which had been unsuccessful under the stroke and major trauma bidding process should be asked whether they wished to submit their views, and also whether they wished to attend a meeting of the JHOSC to make a formal presentation.

It was agreed that it should be the intention to arrange a spread of witnesses to cover the respective care pathways for stroke and major trauma. A representative of Social Services should also be sought.

Organisations such as Age Concern, the Stroke Association, and the Heart Foundation (for stroke) and Headway (for major trauma) were suggested as organisations whose views might usefully be sought.

It was considered that up to one hour for a substantive witness was a reasonable time to take evidence and respond to Members' questions. However, in some cases, it might be desirable to take two witnesses together in a one-hour session. As regards the number of meetings to take evidence, the Chairman considered that between four and six meetings might be needed. The aim would be to hold the next meeting between 10 am and 4 pm, but to consider varying the time of the day of some of the subsequent meetings.

The Chairman suggested that he and the Vice-Chairman (if appointed) should meet as soon as possible with the support officers, in order to draft a programme of meetings and witnesses. Once developed, this would be circulated by email to all members of the JHOSC, and the full programme presented to the next meeting.

In response to the Chairman's enquiry regarding an extension of time beyond the public consultation period (which concluded on 8 May), for the JHOSC to submit its final report, Mr Neame said that he had already discussed this informally with the support officers, and considered that the timescale he had indicated previously (towards the latter part of June) should be possible.

The Chairman observed that the aim should be for the JHOSC to complete its evidence-gathering by the end of April, with the intention of arriving at a final draft report by the start of June.

RESOLVED:

3) That the proposed Rules of Procedure be agreed.

The JHOSC noted the officer support arrangements as set out in the report.

The Chairman reported that, since the start of the meeting, a nomination had been received for a position of Vice-Chairman.

It was proposed by Cllr Mary O'Connor (Hillingdon), seconded by Cllr Peter Tobias (Hammersmith and Fulham) and

RESOLVED:

4) That Cllr Jonathan McShane (Hackney) be appointed as a Vice-Chairman of the JHOSC.

7. THE CONSULTATION PAPER

a) Richard Sumray, Chair of Joint Committee of London PCTs

Mr Sumray referred to the 'Consulting the Capital' consultation from Healthcare for London (HfL) in 2007, which set out Professor Lord Darzi's vision for creating a world class healthcare system for London. The proposals for major trauma and stroke were among the first steps on a pan-London canvas to implement this vision. The co-ordinating JCPCT (composed of representatives of the thirty-one PCTs in London and SW Essex PCT) had held a number of meetings recently to finalise the consultation proposals. The JCPCT was likely to meet monthly until it reached its final decisions on the way forward at the end of July 2009, following the period of consultation.

b) Simon Robbins, HfL Senior Responsible Officer for Major Trauma (MT) Project

Mr Robbins delivered a powerpoint presentation on the Major Trauma Project (a copy of which is appended to these minutes). He drew attention to the MT Project's objective: "To design and implement an inclusive trauma system that assures the care of all injured patients and ensures that optimal care is provided at all stages of the patient journey."

He described the case for change, emphasising that currently the poorly co-ordinated pathway of care meant that the time which it took patients to get to the required specialist treatment was unacceptably long. In this context, he referred to examples of international experience and that of the Royal London Hospital, which demonstrated the improvements in patient care which were achievable. He also emphasised the critical role which the London Ambulance Service (LAS) had to play, and referred to the close working relationship which the JCPCT had forged with LAS in developing the consultation proposals.

He drew attention to the three phases of the MT Project (from August 2008 up until Summer 2009 and onwards), and indicated that by 2010/11, the hope was that all the intended benefits of the reconfigured services would be available to patients.

The benefits of the proposed system included improved patient outcomes, a reduction in the number of people suffering severe injury, and an increased capacity to respond to major incidents in London. The costs per life and per life-year saved were very low when considered against comparable medical interventions.

Mr Robbins described the forms of stakeholder engagement, factors used to differentiate between options, and the evaluation outcome of the bidding process. Three bids had demonstrated the ability to meet the required level of service by April 2010, and two by April 2012. He described the process by which the JCPCT had arrived at the three options for consultation, having ruled out the options for having two MT networks (unable to cope with demand), and five MT networks (significant risk of poorer patient outcomes). There was no definitive evidence in favour of a three-network system over a four-network system, and therefore the JCPCT had decided to consult on both options.

Concluding his presentation, he outlined the reasons for having arrived at a preference for a four-network system, based on the Royal London, King's College, St George's and St Mary's Hospitals. It was considered that this option provided the best coverage, major incident compatibility, and networks of a more sustainable size, with a greater proportion of London's population covered by the earlier implementation date (April 2010) than the other four-network option (which substituted the Royal Free Hospital for St Mary's Hospital).

Following the presentation, Mr Robbins responded to a number of questions from Members.

Questioned regarding the number of 1,600 major trauma cases per year in London, referred to in the consultation paper, Mr Robbins said that this was a best estimate, based on clinical experience, information from the London Ambulance Service, and international data.

As regards public confidence in the proposals, Mr Robbins drew attention to the important role of the present public consultation exercise (launched on 30 January) in explaining the proposals, and addressing questions and concerns.

Mr Robbins underlined the critical role which the LAS had to play in the initial triage at the scene of an accident/injury, in determining whether the person concerned was taken to a major trauma centre to receive specialist care (for a serious injury) or to the nearest trauma centre at

the A&E department of a local hospital (for less severe injuries). Care would be needed at strategic operational level to ensure that 'over-triage' (ie people being taken to receive specialist care when the seriousness of their injuries did not warrant this) did not occur.

Asked about the incidence of major trauma for different forms of crime (eg knife and gunshot wounds), Mr Robbins said that he would need to investigate whether this information was available; figures for the incidence of different forms of trauma were readily available, however, and would be provided to the JHOSC.

Discussions with PCTs outside London would continue regarding area boundaries and the destination of major trauma patients, as national proposals for improved major stroke pathways evolved, to ensure that care was provided on a clear and sound basis. It was proposed that hospitals outside London's M25 boundary would be able to designate themselves 'in' or 'out' of the London major trauma networks.

It was estimated that an additional £12 million would be required per year to deliver the proposed improvements in major trauma care, and this would come from London PCTs' ongoing investment expenditure.

Mr Neame clarified that the figure of 500 major trauma patients from outside London who would need to receive treatment at a London hospital (given in an earlier draft of the consultation paper) was incorrect, and the actual figure was 80. He confirmed that protocols would be agreed with ambulance services in adjoining areas.

Major incident planning would rely on the involvement of all London hospitals, and the proposals for major trauma would be aligned with this strategic process. The JCPCT had been in discussion with government at Londonwide level regarding arrangements required to respond effectively to a major incident such as a terrorist attack. Mr Robbins said that if the JHOSC wished to hear from a speaker on this subject, the JCPCT would be pleased to assist in identifying a suitable person.

With regard to meeting the needs of particular areas (eg SE London), Mr Robbins explained how it was anticipated that the proposed configuration of services would operate, and emphasised again the key role of the LAS in carrying out effective triage. Only hospitals which had demonstrated the capacity to meet the selection criteria by April 2010 (or, in two cases, to meet these criteria by April 2012) had been included in the consultation proposals, and HfL was confident that the locations of these hospitals best addressed the needs of the capital in terms of geographical coverage.

Mr Robbins recognised that the public consultation exercise provided an opportunity to explain the thinking behind HfL's proposals to the public. In particular, people might not readily understand the

importance of getting speedily to a specialist, rather than being taken to the A&E department at the nearest hospital. Further work might be needed to provide statistics which demonstrated how many people in local areas might be affected by the proposals. Also, further evidence might be needed to support the 45 minutes journey time by ambulance to a major trauma centre referred to in the consultation paper.

In terms of the proposed major trauma centres requiring additional clinical expertise, Mr Robbins referred to the limited number of specialists, but emphasised that it was not the intention to have to seek suitably qualified people from local general hospitals. However, it would be very important to increase the skills of existing specialists, and careful consideration would be needed to a long-term programme of education/training.

The Chairman thanked Mr Robbins for his presentation and for responding to Members' questions.

c) Rachel Tyndall, HfL Senior Responsible Officer for the Stroke Project

Ms Tyndall delivered a powerpoint presentation entitled, "Stroke Services for London" (a copy of which is appended to these minutes). She outlined the case for change, reminding Members that stroke was the second biggest killer in the UK, and the cause of around 2,200 deaths in London each year. It was estimated that treating stroke patients at a specialist centre, as was proposed, could save up to 400 lives each year in the capital. Eight hyper-acute stroke units (HASUs) (providing immediate specialist care), and twenty or more stroke units (providing post-HASU in-patient care) were proposed.

Ms Tyndall referred to the criteria on which the proposed reconfiguration of stroke services was founded, and said that every future provider of stroke services would have to meet demanding service specifications. An independent assessment of bids showed that at present there were no providers in London which met the required specification standards, and the JCPCT had a range of measures which were intended to ensure that quality service standards were met.

She referred to the critical role of a CT scan in determining whether thrombolysis was required. Speed of treatment where strokes were concerned was all-important, and the aim was to achieve a three hour 'window' from onset of symptoms to treatment, including a 30 minute journey by ambulance.

No configuration of HASUs that met the JCPCT's assessment requirements was presently capable of meeting the 30 minute travel time, however. In order to develop comprehensive coverage across the capital, in accordance with population needs, HASU services would therefore need to be commissioned in areas where no providers had

demonstrated that they were able to fully meet the requirements set. Three additional HASUs were therefore proposed - two in NE London and one in SE London.

Ms Tyndall reviewed the case for having eight HASUs, rather than more or less than this number. She went on to describe the advantages of co-locating HASUs and major trauma centres in major acute hospitals, which would help achieve strategic coherence, and sharing of equipment, and would inform choices that would be needed between service configurations.

She referred to the key issues taken into consideration in developing a preferred option for a configuration of eight HASUs to serve London, and indicated the location of the hospitals in question. A lot of modelling work had been carried out to calculate 30 minute travel times for the preferred sites, and she was confident that the best strategic mix of provision had been identified.

Ms Tyndall briefly described the role and function of Stroke Units, which would provide specialist treatment and rehabilitation following transfer from a HASU - either in the same hospital or closer to the patient's home. Transient ischaemic attack (TIA - 'mini strokes') services would provide rapid assessment and access to a specialist.

It was intended that all Stroke Units and TIA services that met the assessment requirement would be designated. In addition, the need had been identified to provide services at a number of locations where assessment requirements had not been met; major gaps in service provision existed in NE and SE London. These cases were considered to have very significant development needs, and consequently would require more support to develop their services.

Ms Tyndall drew attention to fact that stroke services in NE London were part of a wider review of acute services in that region. The proposed locations for Stroke Units and TIA services in NE London (except those located with HASUs) would therefore not be clear until the review was complete.

In some concluding remarks, Ms Tyndall referred to the need for more and better trained doctors, nurses and therapists in order to deliver the new stroke services. She also said that under the proposals, a small number of hospitals that currently treated stroke patients might not continue providing these services. She recognised the issue of travel time for friends and relatives visiting a patient recovering after a stroke, but pointed out that this should be seen in the wider context of securing a coherent network of provision.

Following the presentation, Ms Tyndall responded to a number of questions from Members.

For those returning home after hospital care, the changes should mean that there was a reduced dependence on social care provided by councils; however, some of those who had received treatment would live longer, which would be relevant in terms of the provision of elderly care services.

Ms Tyndall recognised that the arguments in favour of the proposed changes needed to be communicated effectively to members of the public, who might not readily understand the need for patients to be taken to units providing specialist care, as opposed to a more local hospital.

In order to ensure that HASUs and Stroke Units achieved the requisite standards, the JCPCT would be working very closely with these units, providing appropriate support. There would be financial incentives put in place, aimed at improving performance over time.

Ms Tyndall recognised the important role which the 'health promotion' agenda had to play in promoting healthier living, leading to a reduced incidence of conditions such as stroke. PCTs needed to give this area suitable priority, and work closely with colleagues in local authorities and other relevant organisations, to achieve effective prevention and early intervention measures.

Ms Tyndall clarified that Charing Cross Hospital was one of the eight designated HASUs. However, if St Mary's Hospital provided a major trauma centre (from 2012), a plan to develop co-location on the St Mary's site would be developed.

A number of members expressed reservations at the practicality of achieving a 30 minute ambulance journey time in particular areas of London. It was felt that data from HfL which underpinned this travel time would be helpful, and might assist in convincing members of the public, who might otherwise be sceptical of the claim.

A request was made for the statistics used in the scoring exercise for hospitals which had achieved designation status, and those which had been unsuccessful. Ms Tyndall indicated that this information was available on the HfL website. As regards the point at which a few hospitals would no longer provide stroke services, Ms Tyndall said that this would obviously be after the public consultation period had concluded, and would vary across London, depending on the capacity of other units to 'step up' provision to the standards required.

The Member for Waltham Forest expressed concern at the prospect of having to wait until July to learn the outcome of proposals for stroke services in NE London. He considered that the proposals should be made available for consideration, to allow input to the review process. In reply, Ms Tyndall said that she would pass on these comments to NHS colleagues involved with the review.

On the question of achieving a consistent level of care for stroke patients, Ms Tyndall recognised the importance of developing a care pathway that was strong throughout, from specialist consultants to auxiliary care.

As regards the additional workforce requirements implied by the proposals, Ms Tyndall said that there was an issue around the recruitment of additional appropriately skilled staff within the timescales proposed, and she recognised that this area required further consideration.

Ms Tyndall agreed that better education of GPs was needed in identifying stroke and TIA symptoms. She also referred to the benefits of improving public awareness in this respect (eg knowledge of the 'FAST' recognition test), and advised that there was to be a national publicity campaign to promote awareness.

The Chairman thanked Ms Tyndall for her presentation and for responding to Members' questions.

d) Don Neame, HfL Director of Communication

Mr Neame said that a copy of the final version of the consultation paper had been couriered the previous day to members of the JHOSC. The design copy would be sent to JHOSC Members as soon as it became available. He commented that the co-ordination of the consultation exercise by the JCPCT (consisting of 31 London PCTS and SW Essex PCT) would be along broadly similar lines to the earlier 'Consulting the Capital' consultation on Professor Lord Darzi's proposals. A summary of the consultation paper would also be produced. Health fairs would be held to publicise the proposals to the public and seek views.

Mr Neame encouraged Members of the JHOSC to engage with their local PCT in regard to the proposals in the consultation paper.

Health Impact Assessments had been commissioned to consider impacts in terms of health inequalities, and a preliminary report was expected roughly half-way through the consultation period. HfL would also be working with an organisation to obtain views from under-represented groups. These reports would be made available to the JHOSC.

Regarding the issue of travel times to receive treatment, HfL had a considerable amount of information, including a public presentation and video, which could be made available to the JHOSC. Mr Neame cautioned against focusing too much attention on whether the 30 and 45 minute travel times could always be met, since in the context of existing care, slightly exceeding these targets was not a critical factor

when balanced against a patient receiving the specialist care envisaged under the proposals.

In conclusion, Mr Neame said that he and colleagues from HfL would be pleased to come to a future meeting(s), and to receive the JHOSC's comments both on the consultation process and issues that arose as part of that process.

The Chairman thanked Mr Neame and his colleagues again for their presentations and indicated that it was very likely that the JHOSC would wish to invite them back towards the latter part of the consultation process.

It was agreed that it would be helpful if further questions submitted to the officer support group within a week of a JHOSC meeting, were forwarded to the relevant person/organisation, in order for a written response to be obtained, for circulation to all Members of the JHOSC.

The meeting finished at 1.21pm.

Chairman

**MEETING OF THE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW "SHAPING HEALTH SERVICES TOGETHER -
CONSULTATION ON DEVELOPING NEW, HIGH-QUALITY MAJOR
TRAUMA AND STROKE SERVICES IN LONDON"**

THURSDAY 5 MARCH 2009

**London Borough of Redbridge, Council Chamber,
128-142 High Road, Ilford IG1 2DD**

PRESENT:

Cllr Marie West - London Borough of Barking and Dagenham
Cllr Sachin Rajput - London Borough of Barnet
Cllr Carole Hubbard – London Borough of Bromley
Cllr Graham Bass - London Borough of Croydon
Cllr Greg Stafford - London Borough of Ealing
Cllr Ann-Marie Pearce - London Borough of Enfield
Cllr Christopher Pond - Essex County Council
Cllr Janet Gillman - London Borough of Greenwich
Cllr Robert Iggulden – London Borough of Hammersmith and Fulham
Cllr Vina Mithani – London Borough of Harrow
Cllr Ted Eden - London Borough of Havering
Cllr Mary O'Connor - London Borough of Hillingdon
Cllr Jon Hardy - London Borough of Hounslow
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
(Chairman)
Cllr Don Jordan – Royal Borough of Kingston Upon Thames
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Filly K. Maravala – London Borough of Redbridge
Cllr Nicola Urquhart - London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Richard Sweden - London Borough of Waltham Forest
Cllr Barrie Taylor - City of Westminster

ALSO PRESENT:

Officers:

Paranjit Nijher - London Borough of Barking and Dagenham
Jeremy Williams – London Borough of Barnet
Jacqueline Casson – London Borough of Brent
Shama Smith - London Borough of Camden
Simon Temerlies – City of London
Nigel Spalding - London Borough of Ealing
Tracey Anderson – London Borough of Hackney
Sue Perrin – London Borough of Hammersmith & Fulham
Rob Mack – London Borough of Haringey
Nahreen Matlib - London Borough of Harrow
Anthony Clements – London Borough of Havering
Deepa Patel – London Borough of Hounslow
Gavin Wilson – Royal Borough of Kensington & Chelsea
Joanne Tutt - London Borough of Lambeth

Julia Regan - London Borough of Merton
Iain Griffin - London Borough of Newham
Mike Emery - London Borough of Redbridge
Jilly Mushington - London Borough of Redbridge
Shanara Matin - London Borough of Tower Hamlets
Farhana Zia - London Borough of Waltham Forest

Others:

Rachel Barlow, Head of Operations for Surgery & Cancer, St Mary's Hospital
Prof. Peter Butler - Divisional Director, Trauma and Managed Networks,
Royal Free Hospital
Pamela Chesters - Chair, Royal Free Hospital
Edward Donald, Director of Operations & Performance, St Mary's Hospital
Gill Gaskin, Consultant & Clinical Director of Medicine, St Mary's Hospital
Dr Lionel Ginsberg - Consultant Neurologist, Royal Free Hospital
Candace Imison - Deputy Director of Policy, The King's Fund
Cllr Kieran McGregor, London Borough of Enfield
Nicholas Miller, Healthcare for London
Michael Scott, Chief Executive, Westminster PCT
Prof. Steve Smith, Principal of the Faculty of Medicine, Imperial College and
Chief Executive of Imperial College NHS Healthcare Trust
Andrew Way - Chief Executive, Royal Free Hospital

1. INTRODUCTORY REMARKS

Mr Mike Emery (Interim Head of Performance and Scrutiny, London Borough of Redbridge) welcomed everyone to the London Borough of Redbridge and made some 'housekeeping' announcements. He then led the meeting in a minute's silence to mark the recent death of Cllr Allan Burgess, who had been the London Borough of Redbridge's representative on the JHOSC.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Cllr John Bryant (Camden)
Cllr Ken Ayres (City of London)
Cllr Jonathan McShane (Hackney)
Cllrs Peter Tobias and Rory Vaughan (Hammersmith and Fulham)
Cllrs Gilli Lewis-Lavender and Sheila Knight (Merton)
Cllr Winston Vaughan (Newham)
Cllr Lufta Begum (Tower Hamlets)
Cllr Susie Burbridge (Westminster)

3. DECLARATIONS OF INTEREST

Cllr Carole Hubbard (Bromley) declared that she was an employee of Bromley PCT.
Cllr Greg Stafford (Ealing) declared that he was a member of the British College of Occupational Therapists.

Cllr Vina Mithani (Harrow) declared that she was an employee of the Health Protection Agency.

Cllr Mary O'Connor (Hillingdon) declared that she was chairman of the London Health Commission.

4. MINUTES

RESOLVED: That the minutes of the meeting held on 4 February 2009 be approved as a correct record, subject to the inclusion of Nigel Spalding (Ealing) among the list of officers present.

5. PROGRAMME OF WITNESS SESSIONS

The Chairman, Cllr Buckmaster, reported that the London Health Observatory, which had been approached to fill the first Witness slot on the day's programme, had advised at a late stage that they considered it inappropriate to attend to give evidence (although they would be prepared to provide data). Although the support officers had worked hard to find a replacement, this had not proved possible in the limited time available. Consequently, Cllr Buckmaster suggested that the first part of the morning might usefully be devoted to considering the Programme of Witness Sessions.

Cllr Buckmaster reported that the support officers had made every attempt to locate a venue at a south London local authority for the present meeting, but to no avail. However, the next meeting, on 23 March, would be held at the London Borough of Lambeth. He advised that he had been approached by a number of Members who were keen that future meetings be held in central locations, to the convenience of the majority. Following a short discussion, it was

RESOLVED: That (following the meeting on 23 March) future meetings be held in central locations, wherever possible.

Cllr Buckmaster said that he would discuss with the support officers the venue for the meeting on 7 April, provisional arrangements having been made to hold it at the London Borough of Merton.

Consideration was given to the Programme of Witness Sessions. The support officers provided a brief oral update of recent developments in securing speakers for the forthcoming meetings.

The following suggestions for additional Witnesses and topics were made:

The Allied Health Federation

Details of how the scoring of hospitals was carried out - to be put to Healthcare for London (at a future meeting)

Dr Simon Tanner, Regional Director of Public Health

British Association of Stroke Physicians

A speaker able to give an international perspective
Royal National Orthopaedic Hospital

Cllr Buckmaster said that further suggestions for Witnesses were welcome.

Cllr Jordan said that he would forward to the Chairman details of the case in their favour made by Kingston Hospital, one of the 'unsuccessful' HASU Stroke hospitals. Cllr Buckmaster said that he considered it would be useful for the JHOSC to hear from at least one such 'unsuccessful' hospital. Also, all 'unsuccessful' hospitals should be written to, asking whether they wished to submit written evidence.

Cllr Sweden referred to the unsatisfactory position concerning the plans for revisions to stroke services in NE London, and advised that all affected Boroughs had been invited to a meeting at LB Waltham Forest on 31 March to consider the way forward. He would be pleased to forward the minutes of this meeting to the JHOSC. The Chairman said that it would be useful for a councillor from one of the affected NE London councils to report formally back to a future meeting of the JHOSC.

6. FINAL REPORT

The Chairman advised that it was the intention for the minutes of each evidence-gathering meeting to provide a substantive record of key points, without the need for a separate summary of each meeting being produced. It was intended that the first draft of the final report would be drafted by officers from Kensington and Chelsea, and Gavin Wilson would attend each meeting and note the points made.

The meeting on 7 May would allow an opportunity for discussion of the final report; however, if further amendments were needed, a further meeting of the JHOSC could be held.

7. WITNESS SESSION: KING'S FUND

The meeting received a presentation from Candace Imison (Deputy Director of Policy), King's Fund.

Ms Imison opened her presentation by referring to the fact that, unlike the case with some other areas of Health Service provision, there was a clear evidence base to support the reconfiguration of services for both Stroke and Major Trauma, on the basis of achieving a critical mass (of patients) capable of generating effective clinical outcomes.

In the case of Stroke, there was strong evidence of poor outcomes linked to lack of rapid access to diagnostics and rehabilitation. Big

improvements to individuals' lives could be effected by rapid interventions and good rehabilitation.

The NHS was to be applauded for proposing what was intended to be a comprehensive and coherent framework of provision. Within this framework, hospitals would continue to operate as part of interdependent clinical networks.

Ms Imison underlined the importance of a good framework being put in place for the evaluation of the proposed changes. She also referred to the resource commitments underpinning the proposals, and suggested that it would be prudent to monitor their implementation.

The relationship between hospitals and the London Ambulance Service (LAS) was a key one, and the support of LAS in making the proposed changes work well would be critical. Feedback from the LAS on how new arrangements were working would be important.

Ms Imison said that her fundamental concern with the Stroke proposals was that the model proposed by Prof. Roger Boyle (National Clinical Director for Heart Disease) had not been adopted.

The model proposed in the consultation paper certainly provided rapid access to a scan (and thrombolysis if required), but it also involved transfer - within a short period of time - of a patient from a hyper-acute stroke unit (HASU) to another hospital (for continuing care and rehabilitation) in many cases. This transfer might have an adverse impact on the patient's condition, and she suggested strongly, therefore, that the proposed model be evaluated before it was introduced.

Effective protocols would be needed covering the transfer of patients between HASUs and Stroke Units at other hospitals, as potentially this could be an area of operational difficulties (e.g. HASU bed provision could become overloaded if transfer arrangements did not work smoothly, threatening the quality of patient care).

Ms Imison recommended, therefore, that the proposed model of Stroke provision be tested in one part of London before it was considered for implementation across the capital, and suggested that S.W. London (where St George's Hospital had been the centre of a Stroke network for a number of years) might be appropriate. However, this trialling should not delay the introduction of rapid access to scans, treatment and rehabilitation at other hospitals within existing service configurations. She also referred to the example of Surrey PCT, which encouraged all hospitals in its area to provide rapid access to scans and thrombolysis, (and trained a broader range of health professionals to provide thrombolysis), and suggested that the JHOSC might wish to investigate this further.

Following her presentation, Ms Imison responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

On the question of the removal of existing major Stroke services from a hospital, Ms Imison said that the loss of access for local people would need to be balanced against the improved quality of care received under the reconfiguration proposals in the consultation paper.

Good co-ordination of services across London's boundaries was likely to present challenges, but it would be very important to get this right. The LAS and ambulance services from surrounding out-of-London areas would need to co-operate closely. Ms Imison reiterated that the role of paramedics was a crucial one.

Reference was made to the increased number of ambulance journeys (from HASUs to Stroke units at other hospitals) and the implied need for additional vehicles and ambulance staff.

The likely organisational difficulties around bed availability arising from inter-hospital transfers were again noted, and the idea of 'ring-fenced' beds for Stroke patients was noted as likely to be impracticable.

Ms Imison envisaged that the deployment of staff within a Stroke network might be operated in a fairly flexible fashion, rather than having individuals necessarily attached to a particular hospital, and she referred to joint appointments as one such possibility. On the basis of her experience of the model of provision in S.W. London, she estimated that NHS London was not that far away from having adequate numbers of staff for the proposed eight HASUs.

Good integration of Stroke services provided by NHS and social care teams was clearly of considerable importance, and could offer significant benefits to patients. Ms Imison considered that, compared to other parts of the country, in London there had been a relative under-investment in intermediate and support care. However, continued rehabilitation in a community setting (with Stroke treatment relatively close to people's homes) was important.

The HASUs clearly had the potential to develop into powerful centres within the Health Service in London, and it might be appropriate to monitor their operation within a year or so of becoming operational.

As regards the impact of the Stroke proposals on relevant Health Service staff, Ms Imison considered that where hospitals lost thrombolysis, this could have a de-skilling effect. However, she did not consider that general stroke care (ie other than the initial period of rapid assessment/treatment) was likely to be taken away from district general hospitals. It would be important to ensure that existing professional skills in relation to Stroke were retained at these hospitals.

On the question of international examples of more effective Stroke treatment than presently existed in the UK, Ms Imison said that the consultation proposals should introduce comparable rapid diagnostic/treatment, which should deliver better outcomes in London.

As regards whether the proposals for Major Trauma could respond adequately to a major incident (e.g. terrorist attack), and could deliver on proposed ambulance transfer times (45 minutes), Ms Imosen said that she understood that the proposals for four Major Trauma networks had widespread clinical support. In practice, this model of provision had been practised in London for a number of years. She referred to the good record of NHS London in responding to major incidents, and did not feel that provision for a major incident ought to be a significant driver in determining the number of Major Trauma networks.

The Chairman thanked Ms Imison for her presentation and for responding to Members' questions. Ms Imison kindly agreed to respond to any further evidence-based questions from Members (sent to the Chairman, or Julia Regan or Gavin Wilson of the supporting officers).

8. ROYAL FREE HOSPITAL WITNESS SESSION

The meeting received a presentation from Andrew Way (Chief Executive), assisted by Pamela Chesters (Chair), Prof. Peter Butler (Divisional Director, Trauma and Managed Networks), and Dr Lionel Ginsberg (Consultant Neurologist), Royal Free Hospital (RFH).

Mr Way opened his presentation by welcoming the initiative taken by Healthcare for London in putting forward proposals intended to improve care for stroke and trauma patients in London. He pointed out that the RFH had been one of the first hospitals to operate a HASU (nearly two years previously). Also, being a 'trauma black spot' in London, the Trust had a lot of experience in responding to the needs of trauma patients.

It was important to realise that the RFH - as with other major hospital trusts in London - had a catchment for patients which extended outside the capital's boundaries (in the RFH's case, into Hertfordshire and part of Bedfordshire). In considering whether having eight HASUs and four MT centres was the appropriate level of provision, it was crucial, therefore, to consider the *actual* population which was presently covered, and to not de-stabilise unnecessarily existing service provision.

The RFH had long ago recognised the particular clinical strengths of UCLH, and had developed an alternate unique provider model based on one care pathway for heart attack and Stroke. This combined pathway provided outcomes of a high quality, but under the evaluation

criteria for the service reconfigurations proposed by Healthcare for London, the service would be lost.

Mr Way said that having to give priority to dealing with the considerable disruption caused by the inadequacies of the new Cerner IT system had affected the strength of RFH's bid.

Mr Way referred to the fact that the RFH had proposed an alternate catchment arrangement for four Major Trauma Centres (MTCs) that recognised the strength of the Royal London Hospital, but took account of the broader catchment of the RFH. However, this option had not been put forward by Healthcare for London for public consultation.

Although RFH's service proposal would be ready for implementation by the end of 2010, the consultation paper had chosen to show them (along with St Mary's) as ready by 2012, and the Trust felt that this portrayed their preparedness in an inaccurate manner.

The RFH had not been asked to submit any detailed financial appraisal, and on this basis (and assuming this was the case with other hospitals) Mr Way could not see how any realistic financial evaluation of the proposals was possible. However, it was surely essential to have a detailed picture of the financial costs and benefits for the proposed major changes in services.

Following his presentation, Mr Way and colleagues responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

On the question of whether the four MTCs proposed in the consultation paper represented the right level of provision, Prof. Butler said that if account was taken of the Home Counties catchment, he believed that five MTCs would be more appropriate.

On the optimum number of HASUs, Dr. Ginsberg referred to the need for a flexible approach, since although around eight HASUs might be a sensible level of provision in the short or medium-term, in time he could envisage that many district general hospitals could provide specialist Stroke care.

Based on population projections, Mr Way estimated that if patients from Home Counties were taken into account, the figure of 1,600 MT patients per year for London could rise to over 2,000 per year. He pointed out that under the consultation proposals, the RFH would no longer be able to operate with its existing catchment of MT patients.

Dr. Ginsberg confirmed that the hospital's decision to combine heart and Stroke treatment had been primarily due to the similarity in care pathways, rather than having been resource-driven. He was unable to say how many such combined heart/stroke centres would be needed to

cover London, since this modelling had not been done. The JHOSC agreed that it would be helpful for Healthcare for London to undertake this modelling, and advise the JHOSC of the results.

The JHOSC felt that it would be useful for details to be provided by Healthcare for London of the prevalence of Stroke in the 10-15 mile band outside London, to complement the information known for the capital. It also considered that a commentary from the RFH would be helpful on this sought information.

If the RFH was not chosen as the fourth MTC, Mr Way said that he would expect patients in certain parts of London (e.g. South Barnet) to be disadvantaged. However, overall, the proposals in the consultation paper should certainly be to the benefit of Londoners. Nevertheless, the view taken by the RFH was that in arriving at sensible final service reconfigurations, account must be taken not only of the best clinical pathways for patients living in London, but also for those in the immediate catchment area outside the city.

Reference was made to the very positive responses of the London Ambulance Service, and clinicians, to the RFH's combined heart/stroke care pathway. Given the time which it often took for evaluation of new services to be carried out in the NHS, the RFH believed that evaluation of their combined service should be undertaken, in order to see whether it might be a model that could be applied more widely.

In terms of the strength of its case over St Mary's to provide a fourth MTC, the RFH considered that it had all the necessary facilities (with the exception of a CT scanner) based on one site, with a very strong group of clinicians able to provide a 24/7 service by the end of 2010. However, some additional skills and personnel would be required, though these were likely to be small in number.

As regards an evaluation of the combined heart/stroke model, there was no model within the UK with which it could be compared. However, elements of the combined service (e.g. transfer time from accident to treatment) had been the subject of comparison with other leading hospitals.

Having eight HASUs was a proposal made by Healthcare for London based on achieving a 'critical mass' of patients per HASU, but would involve some de-commissioning of acute stroke services currently provided by some hospitals. This would have an impact in terms of longer transit times for some local patients, and under-utilisation of skills of staff affected. Most parts of London would have access to an 'inner' and an 'outer' HASU, except SW London (where St Georges would have a key role in provision) and N. Central London (where there was no 'outer' partner to UCLH).

With reference to a higher figure of up to fourteen HASUs, RFH recognised that, based on existing clinical expertise and capacity, eight was probably a realistic level of provision for the time being. However, in the longer-term, having a larger number was a possibility. The Trust had explored the model of some HASUs providing 24/7 provision, whilst some operated as daytime providers, and recognised that this was an alternative model which might address issues of local provision and travel.

In response to an enquiry from Ms Chesters regarding whether the JHOSC would consider Healthcare for London proposals to decommission a particular service, or whether this would be a matter for the local OSC concerned, Cllr Buckmaster referred to the specific terms of reference of the JHOSC in relation to responding to the present consultation exercise, launched in January. It would be for a local OSC to consider 'calling in' a particular subsequent proposal affecting service provision, although in terms of the role of a pan-London JHOSC in such circumstances, this was an area which had yet to be clarified.

In terms of the desirability of transferring an ill patient, after 72 hours' care in a HASU, to a Stroke Unit at a local hospital, this was a possibility under the model of provision proposed in the consultation paper, with a limited number of HASUs. In that context, delivering all treatment required for a Stroke patient in one hospital was clearly preferable. However, it was important to note that the consultation proposals referred to HASUs providing treatment "for the first 72 hours - or until a patient is stabilised".

From a logistical point of view, the administrative challenge of arranging transfers between HASUs and Stroke Units at a local hospital was recognised as an issue by the RFH, and a significant bed base would be required. Nevertheless, the advantages of a Stroke patient receiving expert care within the first critical 72 hours at a HASU should not be lost sight of.

In some concluding remarks, Ms Chesters referred again to the strengths of the RFH in terms of their capacity to provide a fourth MT centre, and underlined that the proposals for service reconfiguration should take account of the catchment from areas immediately outside London's boundaries. The overall cost of the proposals to the NHS and the areas where value for money would result from the proposed changes, were important areas for clarification. The RFH would be pleased to provide any further information which the JHOSC might require.

9. **ST MARY'S HOSPITAL WITNESS SESSION**
(see powerpoint slides appended to these minutes)

Witnesses were:

Prof. Steve Smith, Principal of the Faculty of Medicine, Imperial College and Chief Executive of Imperial College NHS Healthcare Trust
Michael Scott, Chief Executive, Westminster PCT
Gill Gaskin, Consultant & Clinical Director of Medicine
Edward Donald, Director of Operations & Performance
Rachel Barlow, Head of Operations for Surgery & Cancer

Members were informed that Imperial College NHS Healthcare Trust was the largest NHS Trust in England, with over a million patient contacts a year and an annual turnover of over £850 million. It was proud of its health outcomes and had the lowest hospital standardised mortality rates in the UK. It was also the UK's first academic health science centre.

The Trust had five hospitals, of which St Mary's was Healthcare for London's preferred option for the fourth MTC (in preference to the Royal Free). St Mary's had also been identified as one of the recommended hospitals to provide a Stroke Unit and transient ischaemic attack services.

Professor Smith and his colleagues made the following points in support of its bid to be designated a MTC:

- The Trust already had considerable experience and expertise in major trauma and was a national leader in resuscitation practice;
- The Trust had a patient pathway that aimed to stabilise the patient at the injury scene (specialists sent to site by car or helicopter) and then transfer them to the MTC or one of a network of trauma centres that was supported by the MTC ;
- St Mary's made geographical sense in relation to the location of the other proposed MTCs and its proximity to Whitehall and Heathrow (potential major incident targets);
- St Mary's was accessible from London's major transport arteries
- St Mary's was judged to be ahead of the Royal Free on five of the criteria (slide 6 refers);
- The Trust's highly regarded academic unit enabled them to keep at the forefront of medical developments.

In relation to the Trust's capacity to provide Stroke services, Professor Smith stressed the Trust's low stroke mortality rate and the high rating it was given in the Royal College of Physicians' organisation audit.

In response to a question about start dates, Professor Smith said that the Trust would be able to provide a fully functioning MTC by October 2010, and agreed that he had been puzzled by April 2012 having been set by Healthcare for London as an alternative to the April 2010 start date, given that the Trust could comply sooner.

In reply to questioning about Stroke services and the location of patients, the Trust witnesses stressed that their bid had been submitted

in partnership with a group of hospitals in North West London and that they would be working together to ensure that high quality was maintained 'across the patch'. Michael Scott, Chief Executive, Westminster PCT, added that the PCT was making a major investment in Stroke prevention, assessing and addressing underlying causes, and that the improved rehabilitation services should reduce the need for social care services for Stroke patients.

Witnesses were quizzed as to whether they thought the proposed number of MTCs and HASUs was right, and what the implications of opting for a different number would be:

- In relation to MTCs, the Trust witnesses replied that international experience suggested that a minimum of 400 cases annually per centre was needed for maintaining professional expertise. Therefore four centres would be right for London. The PCT witness said he was content with four MTCs, as it was best for doctors to have regular clinical experience of major trauma; also having five would be too expensive. It was suggested that the JHOSC should ask Healthcare for London if adding in patients from the Home Counties would justify the inclusion of a fifth MTC.
- In relation to Stroke services, witnesses said that increasing the number of HASUs from 8 to 16 would be too many to maintain clinical expertise – for example it would reduce the number of thrombolysis patients at St Mary's from 200 to 100, providing too low a number for any individual doctor.

In reply to a question about the patient welfare and bed availability concerns raised about moving patients from HASUs to Stroke Units, the witnesses explained that the 72 hours cited in the consultation document was an average based on clinical experience. Some patients would go straight home from HASUs; some would transfer to Stroke Units within 72 hours; and some would take longer to be stable enough for transfer. The Trust was working with its Stroke network to develop a transfer protocol, and would have a network stroke board to oversee the movement of patients and ensure that this happened at the "clinically correct time".

Further points were made in reply to specific questions:

- The Trust had considered combining Stroke and heart pathways in the way that the Royal Free Hospital had, and had ruled it out;
- In relation to the feasibility of some hospitals providing a 9-5 service for Strokes and some a 24-hour service, the Trust has done some modelling on this and had found that a minority of Strokes occurred between 9am and 5pm - so those hospitals would be unable to achieve a critical mass of experience;
- Trauma surgeons would develop a second speciality that they could practise, as well as looking after other surgical patients and emergency cases.

The Chairman thanked the St Mary's Hospital representatives for their presentation and for responding to Members' questions

The meeting finished at 4.32 pm.

Chairman

**MEETING OF THE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW "SHAPING HEALTH SERVICES TOGETHER -
CONSULTATION ON DEVELOPING NEW, HIGH-QUALITY MAJOR
TRAUMA AND STROKE SERVICES IN LONDON"**

MONDAY 23 MARCH 2009

**London Borough of Lambeth, Council Chamber,
Brixton Hill, London SW2 1RW**

PRESENT:

Cllr Sachin Rajput - London Borough of Barnet
Cllr Chris Leaman - London Borough of Brent
Cllr Carole Hubbard – London Borough of Bromley
Cllr John Bryant - London Borough of Camden
Cllr Ken Ayers - City of London
Cllr Graham Bass - London Borough of Croydon
Cllr Greg Stafford - London Borough of Ealing
Cllr Ann-Marie Pearce - London Borough of Enfield
Cllr Christopher Pond - Essex County Council
Cllr Janet Gillman - London Borough of Greenwich
Cllr Jonathan McShane - London Borough of Hackney
Cllr Peter Tobias – London Borough of Hammersmith and Fulham
Cllr Margaret Davine – London Borough of Harrow
Cllr Ted Eden - London Borough of Havering
Cllr Mary O'Connor - London Borough of Hillingdon
Cllr Jon Hardy - London Borough of Hounslow
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
(Chairman)
Cllr Don Jordan - Royal Borough of Kingston upon Thames
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Sylvia Scott - London Borough of Lewisham
Cllr Gilli Lewis-Lavender - London Borough of Merton
Cllr Winston Vaughan - London Borough of Newham
Cllr Ralph Scott – London Borough of Redbridge
Cllr Nicola Urquhart - London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Richard Sweden - London Borough of Waltham Forest
Cllr Susie Burbridge - City of Westminster

ALSO PRESENT:

Officers:

Pat Brown - London Borough of Barking and Dagenham
Jeremy Williams – London Borough of Barnet
Andrew Davies – London Borough of Brent
Shama Smith - London Borough of Camden
Simon Temerlies – City of London
Nigel Spalding - London Borough of Ealing
Ade Adebola - London Borough of Greenwich

Tracey Anderson – London Borough of Hackney
Sue Perrin – London Borough of Hammersmith & Fulham
Rob Mack – London Borough of Haringey
Nahreen Matlib - London Borough of Harrow
Ian Buckmaster – London Borough of Havering
Deepa Patel – London Borough of Hounslow
Gavin Wilson – Royal Borough of Kensington & Chelsea
Joanne Tutt - London Borough of Lambeth
Nike Shadiya - London Borough of Lewisham
Barbara Jarvis - London Borough of Merton
Iain Griffin - London Borough of Newham
Hannah Bailey - London Borough of Tower Hamlets
Bernadette Lee - London Borough of Richmond

Others:

Prof. Karim Brohi - Professor of Trauma Sciences, Barts and the London NHS Trust
Bernell Bussue - Regional Director, Royal College of Nursing (RCN)
Annie Clacey - London Regional Co-ordinator, Headway
Gillian Cluckle - Clinical Nurse Specialist (RCN)
Alan Dobson - Adviser in Nursing Practice (RCN)
Norman Keen - Vice-Chair, Headway
Heather Jarman - Nurse Consultant, Emergency Department, St. George's Hospital NHS Trust (RCN)
Graham Simpson - Director of Strategy, Barts and the London NHS Trust
Valerie Solomon - London Councils
Rob Williams - Communications Team, Healthcare for London
Simon Williams - Association of Directors of Adult Social Services

1. INTRODUCTORY REMARKS

Cllr Helen O'Malley welcomed everyone to the London Borough of Lambeth and made some 'housekeeping' announcements.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Councillor Marie West (Barking and Dagenham)
Councillor David Hurt (Bexley)
Councillor Gideon Bull (Haringey)
Councillor Vina Mithani (Harrow)

3. DECLARATIONS OF INTEREST

Cllr Carole Hubbard (Bromley) declared that she was an employee of Bromley PCT and a member of the Royal College of Nursing.
Cllr Greg Stafford (Ealing) declared that he was a member of the British College of Occupational Therapists.

Cllr Jonathan McShane (Hackney) declared that he was an employee of Southwark PCT.

Cllr Vina Mithani (Harrow) declared that she was an employee of the Health Protection Agency.

Cllr Mary O'Connor (Hillingdon) declared that she was chairman of the London Health Commission and a member of the Royal College of Nursing.

4. MINUTES

RESOLVED: That the minutes of the meeting held on 5 March 2009 be approved as a correct record.

5. WITNESS PROGRAMME UPDATE

The Witness Programme update was noted.

6. WITNESS SESSION: ROYAL COLLEGE OF NURSING (RCN)

The meeting received a presentation from Bernell Bussue (Regional Director, RCN), Gillian Cluckie (Clinical Nurse Specialist, Stroke Care), Alan Dobson (RCN Adviser in Nursing Practice, Acute and Emergency Care) and Heather Jarman (Nurse Consultant, Emergency Department, St. George's Hospital NHS Trust).

Members were advised that in principle the RCN supported the direction of travel set out in the consultation paper - it was difficult to dispute the underlying logic that speedy access to specialised skills and services saved lives. Nevertheless, the RCN did have some concerns in relation to specific elements of the proposals.

Attention was drawn to the influential role of nurses throughout a patient's journey through care, in helping to deliver high-quality services. The RCN felt that this point had not been given sufficient emphasis throughout the consultation paper. The lack of a clear indication of anticipated patient numbers made difficult the consideration of workforce planning issues.

Excellent opportunities for specialists existed under the proposals, but there would clearly be impacts in other areas. Although the consultation paper referred to there being little impact on A&E staff, it was hard to see how this would be the case with major trauma, since A&E departments - and facilities for continuing care and rehabilitation - would need to be well-staffed with nurses and appropriate therapists. Over the last 10-20 years there had been no successful strategy to decrease A&E attendance.

The RCN considered that it was crucial for financial investment to be made available suitably in advance of implementation (which, in effect, meant now) for stroke departments and A&E's to recruit sufficient

numbers of skilled nursing staff. Ongoing funding was needed to support training and development needs, and staff retention. The evaluation of workforce initiatives after six months or a year was supported.

Whilst the consultation paper estimated that 600 additional nurses would be needed under the proposals for stroke, this vocational opportunity was not presently sufficiently appealing to attract the numbers required. It was likely that this would take some time to change. No nationally recognised stroke training existed for nurses. However, if the plans for implementation by April 2010 were not to be jeopardised, higher education bodies needed, without delay, to plan and offer suitable courses.

The points in relation to investment and training (above) applied also to gearing up in readiness for the changes affecting major trauma.

Whilst cardiac specialist networks had developed over five to ten years to become very successful, the five stroke networks in London were at an early stage of development, and it was difficult to see how they (and the major trauma networks) would be able to develop systems capable of delivering what was anticipated in the consultation paper by April 2010.

The work needed to devise effective systems for patient transfer should not be underestimated. Clear protocols - both clinical and administrative - were essential.

It was important that the delivery of the proposals for specialist stroke and major trauma should not be at the expense of providing the levels of care needed in other areas (e.g. chronic lung disease).

The RCN stressed that the consultation paper's welcome emphasis on providing specialist care at HASUs should not be at the expense of providing suitable investment in the development of transient ischaemic attack (TIA) services and preventative measures, and longer-term rehabilitation, including at home or in the community.

It was considered too early to say whether St Mary's Hospital or the Royal Free Hospital would represent the better fourth major trauma centre (MTC), although currently their preference was towards Option 1 (St Mary's). In terms of the proposed number of eight HASUs, it was possible that this might be too low a number.

The RCN was unclear whether the assessment of need used to underpin the consultation proposals had taken into account the higher incidence of stroke among certain groups, in particular BME. However, it was important to ascertain whether cultural and diversity issues and been taken fully into account.

Following the presentation, the RCN representatives responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

The need for an additional 600 nurses (the RCN was currently questioning this figure with Healthcare for London) was recognised as a very big challenge, given present numbers of nurses caring for stroke patients, and vacancy rates. Stroke care might become an attractive career choice for nurses, but this would not happen overnight. The movement of nursing staff to HASUs could have a destabilising effect on stroke units. Healthcare for London was, however, carrying out considerable work in order to plan for the workforce of the future, including a significant increase in the numbers of nurses in primary care services.

The transfer of stroke patients from a HASU after around 72 hours was recognised as a reasonable assumption, based on clinical need, but of course should only be carried out when a patient's condition was sufficiently stable. Of more concern were issues around 'repatriation' - whether beds were available in local hospitals to receive transferred patients. This was an important operational issue, and should not be underestimated.

The possibility that the development of MTCs might draw nurses away from District General Hospitals (DGHs) - thereby having a negative impact on local services - (as with HASUs having a similar effect on stroke units) was noted as an issue which would need to be monitored.

Regarding relationships with the London Ambulance Service (LAS), the RCN felt that LAS had been most efficient in introducing stroke recognition training for their staff, and had no concerns in relation to its provision for stroke patients. In relation to major trauma, it would be important to introduce additional training for LAS staff where required, and of course for this to be provided on an ongoing basis.

The RCN considered that Healthcare for London was taking a comprehensive view of factors affecting the future prevalence of stroke, and this was reflected in their projections. The RCN believed that measures in public health strategies were likely to reduce the rise in the number of strokes.

Although nurses had for some time delivered thrombolysis in cardiac care, the diagnosis of a stroke patient was considerably more complex, and training nurses to this level of expertise was a long way off, and could not be considered an easy 'fix'. However, currently only a consultant could request a scan, and it was considered that this system was inflexible and needed to be changed.

The RCN recognised that currently it undertook limited activity to encourage school leavers into nursing, and could do more to promote the opportunities of nursing as a career.

In terms of the greater prevalence of stroke among the generally older populations around the outer areas of London, and the concentration of stroke provision in the central area of the capital, RCN felt that the consultation proposals did provide a reasonable acceptance of the need to meet the health requirements of the 'outer London' areas. Some hospitals had been designated which currently did not meet the necessary standards, in order to provide comprehensive coverage. Also, some of the larger hospitals within the stroke networks should assist 'outer London' hospitals in meeting the necessary quality standards, although possibly not by the implementation date of April 2010.

The RCN did not believe that there was firm scientific evidence for determining a critical mass of the numbers of stroke (or major trauma) cases per year, on which to base the proposed number of specialist units. The proposed model had not been used elsewhere, so no ready comparison(s) existed.

Asked about what questions the JHOSC should consider putting to Healthcare for London/PCTs, the RCN advised as follows:

- The work done to determine the anticipated spend of the proposed new units should be queried - crucially, did the figures for additional investment (£9-12 million per year for major trauma; £23 million per year for stroke) in the consultation paper include the costs of rehabilitation and ongoing care?
- What number of additional nurses were needed under the proposals for major trauma?
- How would the workforce necessary to deliver the proposals be brought rapidly onstream, to allow effective implementation according to the timescale envisaged? The RCN considered that PCTs should by now be calculating predictive spend, particularly in respect of workforce recruitment. The projected number of nurses for stroke represented a doubling, or even tripling, of the existing workforce.
- How much work has been done in determining the spread of units in relation to stroke incidence in different locations?

The Chairman thanked the RCN representatives for their presentation and for responding to Members' questions.

7. WITNESS SESSION: THE ROYAL LONDON HOSPITAL TRAUMA CENTRE

The meeting received a presentation from Graham Simpson (Director of Strategy) and Professor Karim Brohi (Professor of Trauma Sciences), Barts and the London NHS Trust.

The Royal London had been designated a pilot centre for major trauma in 1988 and had developed its unique service since then. It had built up all the specialisms and facilities required to handle major trauma, and was equipped to deal with major incidents (as the events of 7/7 illustrated). The hospital had been designed to allow streamlined movement of major trauma patients.

A National Confidential Enquiry into Patient Outcome and Death (NCEPOD) report in 2007 had underlined the case for better care leading to a reduction in major trauma as a significant cause of death. It showed that less than 40% of major trauma patients received what could be considered 'good practice' care. Figures showed that there was a gulf between major trauma mortality rates in the U.S. and the U.K.

The key to improvement was to achieve a well-organised care network, which covered all aspects of the patient pathway.

Due to the nature of major trauma injuries, the time taken to get to the operating theatre was critical if there was to be a good chance of lives being saved. In London, currently around 70% of major trauma patients arrived at a local hospital's A&E department before receiving a secondary transfer to be operated upon. This process could typically take between six to ten hours. Consequently, too many people died (not in ambulances) but in an A&E department at a hospital which was unable to address their particular needs.

Mortality rates were as follows: No transfer - 12%; transfer in London - 19%; and from outside London - 95%.

Statistics showed that as the number of major trauma admissions increased, clinical outcomes improved.

The Royal London had a well-organised system to deliver specialist major trauma care, with Boards for trauma services, research, education, and regional systems, as well as peer review and governance. It handled around 1300 trauma patients a year, of which around 400 were major trauma cases. Its mortality rate (which compared with the average U.S. rate) was the result of continuing improvements, and was significantly better than those of other multi-speciality hospitals. There was a 28% higher survival rate for major trauma, and a 40% higher survival rate for *massive* trauma. Around 55 lives were saved and more than 220 people saved from permanent disability each year.

The Royal London was committed to strengthening partnerships with other hospitals, and sharing good practice. It worked with local schools, providing education about the causes of injuries.

Following the presentation, Mr Simpson and Prof. Brohi responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

The fundamental reason for the Royal London's better rates of mortality was its development over twenty years of the right clinical expertise and the right systems, whereas in other hospitals, major trauma had not been accorded this degree of priority. The hospital was keen to see its model of treatment extended, in order to end the present 'postcode lottery' of treatment.

Regarding the time it might take for other hospitals to achieve the same degree of success, there was good international evidence (U.S., Canada and Australia) to indicate that if the right systems were implemented, significant improvement could be achieved in around three to five years.

As regards the number of major trauma cases each year cited in the consultation paper (1,600), this had to be considered as being an educated estimate to some extent. Improved gathering of major trauma statistics was needed.

One significant factor to be taken into consideration for forward planning purposes in meeting London's needs was the likely development of trauma care outside London. This was largely an unknown factor, however - but the provision of facilities in, say, five to seven years' time would have an important bearing on the provision made in the capital.

Concerning cross-border issues, it was envisaged that the largely ad hoc arrangement in relation to the Royal London's catchment would become more formalised under the consultation proposals. It was likely that a national system would follow on from the changes in London, so existing arrangements were likely to change over time. The hospital had been in discussion with Ambulance Services outside London in relation to cross-border protocols.

It would be difficult for any of the other designated MTCs to improve to a level better than that achieved by the Royal London - the resources required for this would be considerable.

Prof. Brohi cautioned against making the mistake made in New York and Sydney, where far too many MTCs had been set up initially in relation to patient numbers, The result had been that insufficient critical mass existed to ensure specialists got the necessary clinical experience, and hospitals had been in competition for patients.

Prof. Brohi considered that at least two MTCs would be needed, particularly in view of the need to respond adequately to a major incident. Planning beyond that level would need to take account of

likely developments in trauma care in S.E. England. He considered that whether more than three MTCs were provided was essentially a matter of 'politics'.

It would be important to develop further network working between hospitals providing trauma care. Presently, the Royal London shared expertise and good working practices, and published protocols to assist other hospitals. Having a London-wide trauma system with defined pathways should allow more effective co-ordination in the event of a major incident, such as a terrorist attack. It was likely that the other (two or three) MTCs would struggle initially to achieve a full complement of the various specialists required. In this context, reference was made to trauma training for surgeons which was being set up.

If Charing Cross was chosen as an MTC, the journey time by blue-light ambulance should not be problematic - in the event of a major incident, the Police would free up roads for emergency service use.

Prof. Brohi confirmed that sufficient resources were devoted to stabilisation at the scene of an injury. The number of cases where radical treatment (e.g open-heart surgery) at scene was required in order to achieve a better outcome was extremely small. LAS staff were considered to be very well-trained, and capable of carrying out effective stabilisation at scene.

The Chairman thanked Prof. Brohi and Mr Simpson for their presentation and for responding to Members' questions.

8. HEADWAY (THE BRAIN INJURY ASSOCIATION) WITNESS SESSION

The meeting received a presentation from Annie Clacey (London Regional Director, Headway UK) and Norman Keen (Vice-Chair, Headway East London).

Ms Clacey provided background information on Headway and the work which it carried out as a national charity providing support to anyone affected by brain injury.

Its services included a helpline, and information resources (a website, booklets and factsheets). It had a network of local groups and branches, and provided support groups for survivors of injury, and carers. There were seven local Headway groups in London. Headway Centres helped survivors to regain skills and build confidence to help them adjust to their changed condition and re-integrate into society.

Brain injury could take several forms (i.e. acquired, traumatic, and non-traumatic) and could have significant, lasting effects on the individual and their family and carers.

Headway welcomed the consultation proposals, which it believed should increase the number of lives saved and improve initial outcomes for survivors. The intention should be to achieve an end to the 'postcode lottery' for receiving high-quality care.

However, following the more rapid life-saving treatment envisaged under the proposals, it was essential to have appropriate follow-on services - both for in-patient care, and rehabilitation and support in the community - if the effect of the treatment provided at the acute stage was not to be negated to some degree.

Headway was concerned that paramedics were well-trained and possessed all the necessary skills required to carry out effective triage at scene, since this was critical in ensuring that the injured person was taken directly to a centre offering the right treatment for their condition. The Glasgow Coma Scale (GCS - standard tool for assessing brain injuries) was not fool-proof, and neuro-trained personnel were needed who could spot if something was not right, despite a GCS reading.

Prompt diagnosis of traumatic brain injuries using a CT scan (available 24/7) was critical, and it was essential that the MTCs possessed adequate neuro expertise.

Coding of patients should allow for secondary coding where an initial assessment may not have picked up a brain injury, otherwise obtaining accurate statistics was difficult.

Once stable, patients needed to be discharged to wards where staff had relevant neuro training, to ensure good patient recovery. The consultation paper referred to the provision of high-quality ongoing treatment and rehabilitation, but the question was, how this would be achieved?

Trauma Centres must have the necessary diagnostic expertise, and scanning equipment, to enable them to identify where specialist interventions were needed. A clear system for transfer of patients to MTCs was also important. Sharing of knowledge and skills within the Trauma Networks would be important.

A&E departments must retain the diagnostic expertise to enable conditions to be identified which required rapid transfer to receive specialist treatment.

Headway had reservations about whether the extra £9-12 million quoted in the consultation paper for the major trauma proposals (and £23 million in respect of stroke) would be adequate.

Headway was concerned at any assumption that the provision of acute care might lessen the severity of disability and dependency in terms of

diminishing patients' long-term needs. It considered that currently there were severe shortages in the provision of rehabilitative care. Increased NHS and social care co-operation - and investment - was needed in this area.

Headway saw the need for further intensive neuro rehabilitation after initial care - for in-patients, day patients and in the community. A specialised neuro-rehabilitation consortium provided services across London through nine specialist providers. These services needed to be linked into the Trauma Networks. Whilst some PCTs provided local multi-specialist rehabilitation, others did not.

Good-quality information (symptoms, recognising danger signs, and details of organisations such as Headway) should be provided to patients who were discharged from all units within a Trauma Network.

Ms Clacey concluded by re-emphasising strongly the importance of Health and Social Care authorities investing in, and working together to provide, good-quality specialist rehabilitation and community support services. This would be essential in order to maximise the benefits of the proposed welcome 'front end' improvements to acute care.

Following the presentation, the Headway representatives responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

Headway received most of its funding from local authorities, but essentially operated on a 'shoe string' budget. It believed that it could do far more if it was better funded. They were able to identify what PCTs should be doing locally to provide suitable care for those recovering from brain injuries.

It was not clear from the consultation paper whether proposals for acute care or rehabilitation had been properly costed. What was clear was that the Health service and local authorities providing social care needed to work more closely in funding and delivering joined-up services.

Ms Clacey re-emphasised the need for A&E departments to possess general neuro expertise for diagnostic purposes. CT scanning was considered essential, and should happen at Trauma Centres as well as at MTCs. There was a danger that centralising services at MTCs could impact adversely on the facilities and service provided at units elsewhere in the Trauma Network.

The Chairman thanked Ms Clacey and Mr Keen for their presentation and for responding to Members' questions.

9. ASSOCIATION OF DIRECTORS OF ADULT SOCIAL SERVICES (ADASS) WITNESS SESSION

The meeting received a presentation from Simon Williams (ADASS, and Director of Community and Housing, L.B. Merton).

Essentially, the principles underpinning the achievement of good clinical outcomes were supported. If the right clinical interventions could be made at the front-end of a patient's care, this should result in less dependency later on services provided from Social Services budgets.

Whilst the consultation paper proposals were based upon the Darzi report's premise of 'centralise where necessary, localise where possible', in actuality the consultation focus was predominantly on specific pathways of providing acute care. It would be helpful for a similar level of detail on the longer-term, rehabilitation end of the care process. Mr Williams said that he understood that this information did exist, and emphasised that it needed to be made available to local authorities for consideration and comment.

The consultation proposals were in effect 'designing in' more transfers. Generally speaking, managing transfers successfully was not a strong point of the NHS or social care authorities, and there were various things that could go wrong. It would be important, therefore, to ask Healthcare for London what proposals it had to ensure that the transfer of patients went smoothly.

There was a need to change the service available for emergency and stroke care. A whole system re-design was needed for emergency care and social care, which incorporated the latest technology.

A shared understanding of the needs of patients and carers was needed. These groups needed to be aware of the signs of the onset of a stroke (using the 'FAST' check) and the need for speedy treatment

(the 'golden three hours' rule). Otherwise there was a risk that the person affected might seek treatment at a local hospital, rather than telephone for assistance, resulting in a speedy journey to receive specialist treatment at a HASU. An education campaign would be helpful to assist these groups.

It would have been helpful if further consultation had focused on design of a stroke network from a patient perspective, describing what treatment and care a patient could expect throughout their care pathway. The arguments were strong for providing specialist stroke treatment in the manner proposed. However, Mr Williams queried why 24-hour diagnostic care was not provided more widely by the NHS.

Mr Williams considered that the consultation paper made a good case generally for the changes proposed in relation to major trauma. However, in relation to the overall choices on offer for emergency and urgent care, it risked introducing a further degree of complication for patients. It would be important to ensure that new systems for getting patients to the right centre for the right treatment were described clearly, and understood by all concerned.

It was considered that the question of how a patient could access 'out of hours' assistance needed to be given more attention, and the system itself simplified. With, in effect, more ways to access emergency care under the consultation proposals, there was the possibility of some patients/carers becoming confused about who to contact or what action to take to get rapid treatment.

Referring in particular to the proposed Stroke Units at DGHs, Mr Williams stressed the need for integration between inpatient and community services, and gave examples of where patients could be required to be inpatients in order to get essential services. He believed that, in conjunction with social care providers, the NHS needed to re-

evaluate the delivery of effective rehabilitation and invest in high-quality rehabilitative care which was well-integrated with community services.

Following the presentation, Mr Williams responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

Since the publication in 2007 of the Darzi report, "Healthcare for London: A Framework for Action", Mr Williams believed that NHS London had made more attempts to involve social care authorities in its plans for improved healthcare for London. However, more needed to be done, and local authorities needed to work with NHS London to achieve the joined-up approach required.

For social care purposes, local authorities should not find it more difficult to deal with (three or) four MTCs, since patients would normally be transferred back to a local hospital for ongoing care. However, Mr Williams said that he would be more concerned if arrangements for rehabilitation had to be made direct with the MTCs or the proposed eight HASUs.

As regards whether the consultation proposals would draw resources away from less acute care, Mr Williams did not consider this likely to be the case with major trauma, although clearly there would be a level of new investment in the proposed HASUs. The important issue was to be clear about where investment was most needed in the care pathway. The clinical evidence cited in the consultation paper pointed to the initial three hours being critical in the case of stroke - but was this indisputably the case? Resources were also needed for recuperative care.

Mr Williams said that he was unaware of links in relation to the impact of the consultation proposals on children, which ADASS might have

established with local authority colleagues responsible for children's services, but he could investigate this.

Questioned about the possible greater demands on social care, and the need for individuals to be adequately rehabilitated before becoming the responsibility of the local authority, Mr Williams stressed the important role of intermediate care (perhaps of 8 - 10 weeks' duration). Systems should be devised with sufficient flexibility to ensure that the needs of the patient were put first. He considered that it was important for there to be suitable joint financial incentives in the system for the provision of health and social care.

On the question of personal healthcare budgets, Mr Williams referred to evidence which showed that these could produce better outcomes for patients. Personalised budgets should be raised with the patient once they had recovered sufficiently from the immediate emergency situation for which they were admitted.

Regarding specialist diagnostic services, Mr Williams said that his personal view was that there might be some merit in these being provided by separate organisations, rather than being part of existing NHS Trusts.

The Chairman thanked Mr Williams for his presentation and for responding to Members' questions.

The meeting finished at 5.21 pm.

**MEETING OF THE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW "SHAPING HEALTH SERVICES TOGETHER -
CONSULTATION ON DEVELOPING NEW, HIGH-QUALITY MAJOR
TRAUMA AND STROKE SERVICES IN LONDON"**

TUESDAY 7 APRIL 2009

**London Borough of Camden, Council Chamber,
Judd Street, London WC1H 9JE**

PRESENT:

Cllr Marie West - London Borough of Barking and Dagenham
Cllr David Hurt - London Borough of Bexley
Cllr Carole Hubbard – London Borough of Bromley
Cllr John Bryant - London Borough of Camden
Cllr Graham Bass - London Borough of Croydon
Cllr Greg Stafford - London Borough of Ealing
Cllr Vivien Giladi - London Borough of Enfield
Cllr Mick Hayes - London Borough of Greenwich
Cllr Jonathan McShane - London Borough of Hackney (Vice-Chairman)
Cllr Belinda Donovan – London Borough of Hammersmith and Fulham
Cllr David Winskill – London Borough of Haringey
Cllr Margaret Davine – London Borough of Harrow
Cllr Ted Eden - London Borough of Havering
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
(Chairman)
Cllr Don Jordan - Royal Borough of Kingston upon Thames
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Nicola Urquhart – London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Richard Sweden - London Borough of Waltham Forest
Cllr Susie Burbridge - City of Westminster

ALSO PRESENT:

Officers:

Pat Brown - London Borough of Barking and Dagenham
Jeremy Williams – London Borough of Barnet
Louise Peek – London Borough of Bexley
Andrew Davies – London Borough of Brent
Philippa Stone – London Borough of Bromley
Mousumi Basu-Doyle – London Borough of Camden (and Camden PCT)
Samantha Kalarus – London Borough of Camden
Shama Smith - London Borough of Camden
Neal Hounsell – City of London
Nigel Spalding - London Borough of Ealing
Ade Adebola – London Borough of Greenwich
Tracey Anderson – London Borough of Hackney
Sue Perrin – London Borough of Hammersmith & Fulham
Rob Mack – London Borough of Haringey

Nahreen Matlib - London Borough of Harrow
Sean Cable – London Borough of Havering
Anthony Clements – London Borough of Havering
Deepa Patel – London Borough of Hounslow
Gavin Wilson – Royal Borough of Kensington & Chelsea
Joanne Tutt - London Borough of Lambeth
Julia Regan - London Borough of Merton
Iain Griffin - London Borough of Newham
Farhana Zia – London Borough of Waltham Forest

Others:

Dr Paddy Glackin, Londonwide Local Medical Committees
Dr Tony Grewal, Londonwide Local Medical Committees
Joe Korner, Director of Communications, the Stroke Association
Peter Rawlinson, Trustee, the Stroke Association
Valerie Solomon - London Councils
Lynn Strother, Lead on Policy and Voice for Age Concern London, and
Director of the Greater London Forum for Older People
Rob Williams - Communications Team, Healthcare for London

1. INTRODUCTORY REMARKS

Cllr John O'Bryant welcomed everyone to the London Borough of Camden and made some 'housekeeping' announcements.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Councillor Sachin Rajput (Barnet)
Councillor Chris Leaman (Brent)
Councillor Ken Ayres (City of London)
Councillor Ann-Marie Pearce (Enfield)
Councillor Chris Pond (Essex)
Councillors Peter Tobias and Rory Vaughan (Hammersmith and Fulham)
Councillor Gideon Bull (Haringey)
Councillor Vina Mithani (Harrow)
Councillor Mary O'Connor (Hillingdon)
Councillor Jon Hardy (Hounslow)
Councillors Gilli Lewis-Lavender and Sheila Knight (Merton)
Councillor Winston Vaughan (Newham)
Councillor Ian Hart (Wandsworth)

3. DECLARATIONS OF INTEREST

Cllr Carole Hubbard (Bromley) declared that she was an employee of Bromley PCT and a member of the Royal College of Nursing.

Cllr Greg Stafford (Ealing) declared that he was an employee of the British College of Occupational Therapists.

Cllr Jonathan McShane (Hackney) declared that he was an employee of Southwark PCT.

4. MINUTES

RESOLVED: That the minutes of the meeting held on 23 March 2009 be approved as a correct record, subject to the inclusion of Cllr Vivien Giladi (Enfield) in the list of those present, and the declaration of interest by Cllr Greg Stafford (Ealing) being in respect of his position as an employee of the British College of Occupational Therapists.

5. CHAIRMAN'S ANNOUNCEMENTS

Cllr Buckmaster proposed that the JHOSC hold an additional meeting to those scheduled previously, on Friday 22 May, to consider the draft report to be prepared by officers, based on the JHOSC's deliberations. He suggested that the question of whether a further meeting be then held (to agree a revised final report) be considered at the meeting on 22 May. The alternative would be for a revised report taking account of comments at the 22 May meeting to be emailed to all members of the JHOSC (to allow the opportunity for final comments), with the Chairman and Vice-Chairman authorised to agree the final report.

If members wished to identify what they considered to be key points for inclusion in the draft report, these could be sent to the Chairman, or Gavin Wilson or Julia Regan from the supporting officers.

Cllr Buckmaster referred to the desirability of reaching a final report built on consensus, but said that he recognised that there could be particular views expressed by an authority (ies) which might need to be contained in an appendix.

It was suggested that views of individual councils could be useful in helping to inform the JHOSC's final report, and such views received would be circulated by the supporting officers to all members of the JHOSC.

RESOLVED: That a meeting of the JHOSC be held on 22 May 2009 for the purpose of considering a draft report of its deliberations.

6. WITNESS PROGRAMME UPDATE

The Witness Programme update was noted.

7. WITNESS SESSION: THE STROKE ASSOCIATION

The meeting received a presentation from Mr Joe Korner (Director of Communications) and Mr Peter Rawlinson (Trustee) from the Stroke Association.

Mr Korner described briefly the work of the Stroke Association, which was respected by healthcare professionals and patients and carers as a trusted source of information on stroke-related matters. The Association funded research of at least £2 million a year. It played an important role in awareness-raising of stroke, and worked with a wide range of stakeholders in its campaign to improve stroke services.

It was important to be clear about the long-term nature of the care pathway for stroke, and for the providers of health and social care services to accord the post-acute intervention phase of care a greater priority, and work more closely together in delivering joined-up services. Having specialists (clinicians, nurses and therapists) working in one unit was important.

The Stroke Association had been involved in Healthcare for London's stakeholder discussions which had resulted in the current consultation proposals, and had confidence in the clinical evidence and criteria on which the proposals were based.

Eight hyper-acute stroke units (HASUs) were considered by the Association to be a minimum to deliver the level of service needed. It was possible, however, that one or two additional HASUs might be needed at some point in the future, based on presently unquantifiable factors.

The Stroke Association believed that the most pressing priority should be to achieve uniform access across all areas of London to quality hyper-acute and acute stroke care – and the present proposals for designating particular HASUs and stroke units should allow this.

It was important to note that three HASUs, five stroke units and four TIA units had been designated in areas of London in order to achieve comprehensive coverage across the capital. However, in these cases, a great deal of work needed to be done in order to achieve the required clinical criteria. What was needed in terms of staffing, training, commissioning and building up experience, should not be underestimated.

The Association supported the proposal that high-achieving hospitals should support the development of stroke services in those hospitals where rapid improvement was needed. It would be concerned if the development of the specialised units led a significant migration of skilled staff away from other hospitals.

Existing hospitals which currently provided high-quality services must not lose these until the new, designated units in other hospitals were

fully operational and meeting the clinical criteria. An eighteen-month period for implementation was proposed – but it might be necessary to consider extending this in order for the new proposals to operate successfully in the manner intended.

A public awareness campaign was recommended by the Association, focusing on parts of London where there would be the greatest change. This should cover: why the changes were happening; the clinical case for all Londoners having access to emergency stroke care; and the anticipated improved outcomes.

Mr Korner concluded the presentation by emphasising several points:

- a) the need to improve discharge planning and provide better community-based rehabilitation services – essential if acute stroke beds were not to get ‘blocked’;
- b) the need for adequate long-term support services – otherwise pressure on rehabilitation services would increase;
- c) the need for secondary prevention services – otherwise stroke and TIA survivors would remain at a very high risk of having a further stroke;
- d) the extra resources identified in the consultation paper were vital to its success. However, should it be necessary to achieve full implementation, further investment must be made available.

Following the presentation, Mr Korner and Mr Rawlinson responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

About 15% of strokes were haemorrhagic (i.e when a blood vessel burst), in which case thrombolysis was not appropriate, and indeed if administered, could lead to a patient’s death. This underlined the imperative for skilled diagnosis of a patient, using scan evidence. Also, thrombolysis should not be given in cases where the time of the onset of symptoms was not known - best practice was for it to be given within three hours of the first signs of stroke.

Of the approximately 85% patients who suffered an ischaemic stroke, only a small number could require thrombolysis, but nevertheless this percentage was significant in leading to improved outcomes – currently thrombolysis was not as widely available as it should be, but under the consultation proposals, this should change. The greater use of thrombolysis could therefore lead to fewer long-term demands on health and social care provision, and to a better quality of life for patients, family and carers.

There was considerable medical debate about the number of stroke patients who could benefit from thrombolysis. Nationally, the figure was around 10%, although in certain parts of other countries’ health systems, the figure could be as high as 20%.

A hospital which had not been designated as a HASU should not consider that it had been 'downgraded' – the provision of high-quality services in a well-run stroke unit were fundamental to the successful recovery of a patient. There had been much debate about the proposed number of HASUs, but time would tell whether eight was the right complement, and whether very large, specialist units were the best solution. However, it was important for clinicians to see enough patients to maintain their expertise as practitioners.

The Association recognised that under the proposals, some clinicians were likely to move from their existing hospitals to HASUs. Some would assist the training of other clinicians – and given the demanding implementation timescale, this would be an important role.

At present, there was no strategic plan or protocol(s) between the London Ambulance Service (LAS) and hospitals which would allow patients to be taken to the nearest hospital offering specialist stroke care. LAS had been involved very closely in the consultation proposals, and estimated travel times (maximum journey time from scene to hospital – 30 minutes) had been factored into the geographical spread of proposed units.

The Stroke Association was not prepared to comment on the case of individual hospitals no longer providing a stroke service, but believed that, under the proposals, no-one should be worse off in terms of the care they received, due to where they lived in London. There might, however, be transitional issues which needed to be resolved before the new service operated as intended.

The quality of rehabilitation and ongoing care, both within hospitals and after discharge, was crucial for stroke patients. Recovery from a stroke could take decades. In considering the consultation proposals, it was important to keep a focus on achieving quality care throughout the patient pathway, and not to concentrate inordinately on the initial intervention.

The Association re-emphasised that the present ad-hoc arrangements for taking some stroke patients directly to specialist treatment needed to be replaced by a properly co-ordinated, comprehensive system, as was proposed. Healthcare for London's (HfL) proposals should lead to a better level of stroke care in London than was available in most other countries.

The Association agreed to provide in writing details of key clinical criteria for the successful treatment of stroke.

The idea of having a pilot for the proposed model of delivery (suggested by the King's Fund at the JHOSC's meeting on 5 March) was not supported by the Association. The next phase of

HfL's Stroke Strategy for London was already drafted. The Association believed that HfL's plans would deliver as intended, and having a pilot would involve unnecessary delay. The model of having a limited number of hyper-acute centres and a larger number of stroke units had worked effectively in cities in other countries. There might be 'teething' problems once the new system went 'live' (e.g. travel, discharge issues), and these would need to be addressed, of course.

HASUs were likely to discharge most patients fairly quickly (often within 72 hours), but if patients needed to be kept for longer, this could have implications for bed availability. This did not appear to be an issue in Manchester (where a similar – though less complicated - model had been introduced relatively recently), but was something that would need to be monitored.

In response to a suggestion that a stroke patient might carry an encrypted card bearing details of their medication, Mr Korner said that this sort of aid could prove helpful to paramedics.

As regards instances where individuals might ask paramedics to take them to their local hospital for treatment, a public awareness-raising campaign should help to avoid such situations occurring

With an ageing population, rates of stroke could be expected to increase. The Association considered that presently TIA services available were "dire", and the proposals to improve preventative measures were very much to be welcomed. It would like to see HfL co-ordinate a public campaign aimed at increasing awareness among older people of the steps they could take to lessen their susceptibility to stroke (e.g. taking more exercise).

The Chairman thanked the Stroke Association's representatives for their presentation and for responding to Members' questions.

8. WITNESS SESSION: AGE CONCERN

The meeting received a presentation from Ms Lynn Strother (Lead on Policy and Voice for Age Concern London, and Director, Greater London Forum for Older People (GLF)).

Ms Strother explained that Age Concern London's main role was in policy affecting older Londoners. The Greater London Forum for Older People worked across London and had older people's forums in all London boroughs. Members of the forums worked within their communities in various ways (e.g. on committees with their local PCT, Local Authority, Police and other voluntary groups).

Ms Strother made the following points in her presentation:

- Age Concern London, GLF, forums (and other groups who had been contacted) all agreed on the principle of hyper-acute stroke

unit care, followed by a transfer to a local stroke unit for ongoing care and multi-therapy rehabilitation.

- There was concern that there was little mention of community rehabilitation. It was not clear how much rehabilitation would take place in the local stroke units and how much - if any - rehabilitation would take place on a domiciliary basis.
- There was no mention of increased preventative services.
- Older people contacted felt that it was difficult to answer in relation to which configuration of hospitals should be designated hyper-acute stroke units and which hospitals should provide the local stroke and Transient Ischaemic Attack (TIA) services.
- There appeared to be a lack of hyper-acute units in outer London – an area identified as being where most strokes occurred. This of course could be due to the fact that outside the Greater London area there would be hyper-acute units close to the borders, but which had not been shown in the consultation proposals. It would have been helpful if this information could have been provided.
- It was felt that figures of anticipated numbers of patients for the hyper-acute units - and particularly for the proposed networks - would have helped to provide an informed decision. Everyone wanted their local hospital to provide services for them; some figures as to the expected number of patients might have clarified why those particular hospitals were chosen, as some designated hospitals did not meet the new standards, and would need considerable input to reach and maintain the proposed standards - inevitably increasing the cost of the service.
- There was concern that all the units needed to increase standards – some to a considerable extent - and therefore regarding the costs this would incur.
- £23 million of new money was to be made available for the new structure – was the money specified for the upgrading of hospitals to standards, recruitment and training - or for the day-to-day running of the new services?
- Some of the hospitals identified for stroke units were in deficit – were the funds to be ring-fenced for the upgrade to meet the standard?
- How would the new procedures be assessed and monitored? Would this be solely on survival rates and quality of life criteria? How was 'quality of life' to be measured?

Recruitment, staffing and training

- 570 nurses, 200 therapists, 16 consultants and junior medical staff would need to be recruited. Were these people already available within the present system? If not, how far advanced was the recruitment process? How much interest was there by professionals in developing their careers through stroke speciality?
- Overall there was concern as to how successful the recruitment process would be - and particularly how new recruits would be trained by 2010. If not enough people were recruited or trained in time, would there be a 'plan B'?
- What would the staff/patient ratio be on the different types of stroke units?
- How much would agency nurses be used? What qualifications/training in relation to stroke care would be required? How would they be monitored/assessed in terms of maintaining high standards?
- Would staff be trained in treating people with dementia who had strokes?

Local Stroke Units

- In local hospitals, what impact would the proposals have in terms of bed management?
- Would there be a designated ward, or designated beds on a general ward? Would these be extra beds?
- If there were designated beds on a general ward, what steps would be taken to ensure that individuals did not get 'lost in the system' in terms of their specific care needs (e.g. would 'red tray' systems be in place for those with eating difficulties?) What staff support would there be to assist with special needs?
- There were times when hospitals 'have a run' on beds – if there was capacity in a stroke unit, or designated stroke beds – would these be used? In such instances, would stroke patients be sent to another hospital – perhaps out of their locality - or kept in the hyper-acute hospital, or placed on a general medical or geriatric ward where staff might not have been trained in stroke standards?
- Would patients be directly transferred from HASUs to local Stroke Units – or would they have to wait at home until a bed

became available - thereby delaying access to rehabilitation therapy?

- Was there a way of making better use of community hospitals in terms of rehabilitation?
- The incidence of stroke within the black African and black Caribbean population was estimated to be 60% greater than the white population. In talking to members of BME groups, many had said that they would prefer to go to a stroke unit in an area with a large ethnic population where there would be greater understanding of their specific needs - rather than go to a local unit; however, they did realise that it would be difficult to provide such facilities. As a compromise, those asked had requested that specific cultural, faith, gender and race issues be recognised, understood and catered for. Although all hospitals had policies on these areas, not all staff were either aware of, or understood, the different needs – especially important if the stroke patient has difficulty in communicating.
- Would discharge procedures be improved? Part of the delay in many cases related to the ordering of discharge medication in time, and the availability of hospital transport.

Rehabilitation

- Would patients be able to indicate which local hospital they wished to go to for rehabilitation? (People might want to choose a hospital which was a bit further away, but which had better transport links, with no change of bus/train.)
- Could hospital appointments be made for a time after 9.30 am for those who used the train, to allow their freedom pass to be used – particularly relevant for people in outer London.
- If a patient lived in one borough, but their GP was based in another borough, which borough would be responsible for rehabilitation, aids and/or social care packages?
- Would the provision of aids be fast-tracked?
- There was much confusion as to what, in rehabilitation terms, was free treatment from the NHS and what was social care at a cost. Was physiotherapy, occupational therapy, speech therapy, aids, and alarm systems free, or if carried out within the home – social care? This was considered to be very important for people who were just above the benefit threshold by a few pounds. They might feel that they could not afford the cost of rehabilitation or other services.

- Was there consultation with Transport for London to ensure that regular, reliable and frequent transport links to hospitals would be available?
- Would there be specific counselling services available – possibly in the community? For many patients, life was changed forever after a stroke – and a lot of confidence building and identifying new opportunities could be required, particularly for those suffering from depression.
- What support would there be for carers?
- Would patients be informed of access to benefits such as attendance allowance, which were not means-tested?

London Ambulance Service (LAS)

- Although the ambulance timings had worked well for journeys to the specialist units for heart attacks, had travel timings been conducted to the specific hyper-acute units?
- Presumably staff already had considerable training and experience in stroke diagnosis, in the course of their day to day work – Would there be specific LAS units called to stroke emergencies? Would appropriately trained paramedics be on board for stroke 999 calls?
- Would ambulance staff (including call centre staff) receive feedback as to how well patients recovered? (something LAS staff had requested).

Transition Period

- What plans were in place during the transition stage to 2010, including for hospitals until they reached the standard required?
- What standard of service would be available during the transition period?
- Would there be extra therapists available for stroke patients?
- Would patients automatically be taken to a unit with a scanner or would a 'postcode lottery' system operate?

Ms Strothers concluded her presentation by referring to the positive feedback from elderly people about the advertisement describing the symptoms of a stroke (the national 'FAST' campaign). It was felt to be clear and easy to remember, and it was considered that efforts should

be made for it to be available in schools, colleges, workplaces etc. in order to get the message across to the whole population.

Ms Strothers confirmed that Age Concern London was in favour of the principle in the consultation paper of care being provided initially in HASUs, followed by a transfer for ongoing care and rehabilitation to stroke facilities in a District General Hospital (DGH).

There was a concern that care in a DGH stroke unit and after discharge from hospital must match the quality of the initial care in a HASU. Currently, rehabilitative care was not always good, but it was absolutely critical to a patient's long-term recovery. There could be a long wait to receive therapeutic treatments, for example, and speech therapy was not available widely enough, or often provided for long enough, to individuals.

Ms Strothers was not aware of the number of stroke patients affected by dementia or other mental health conditions, but indicated that she could investigate this and hopefully provide the information.

As regards current TIA services, Ms Strothers was unable to comment directly on how well these performed, but cautioned that in many cases, those affected by TIA (the proverbial 'funny turn') – particularly the elderly – could feel that the attack was too small to bother a GP about. Also, they (or their carer) often felt they had been treated dismissively by healthcare professionals. This was not acceptable. Administrative procedures (e.g. for travel arrangements) should allow for a quality service to be provided to TIA patients, which did not leave them frustrated, tired, or upset.

Publicity campaigns from Age Concern and the NHS could usefully increase public awareness concerning strokes, including their contributory factors, prevention, and action to take on identifying initial signs. Importantly, this should include TIA, where quite slight symptoms might be experienced.

The Chairman thanked Ms Strothers for her presentation and for responding to Members' questions.

9. WITNESS SESSION: LONDONWIDE LOCAL MEDICAL COMMITTEES (LMCs)

The Chairman welcomed Dr Tony Grewal and Dr Paddy Glackin (both of whom were LMC Secretaries and practising GPs) to the meeting.

Dr Grewal referred to the fact that the vast majority of GPs consulted by Londonwide LMCs on Prof. Lord Darzi's 'Healthcare for London' proposals were hugely supportive – and remained so - of the plans to create specialist units for stroke and major trauma, and considered them to be an important factor in improving healthcare for Londoners.

Dr Grewal and Dr Glackin then responded to questions from Members.

The consultation paper proposals were focused principally on the delivery of hospital care, but it was recognised that the period of rehabilitation was of great importance, too. Achieving a seamless pathway of care was undoubtedly a big challenge. It would be important to explain the care pathway to patients (and family and carers), so that they understood the high-tech, short-term nature of the initial treatment, and that this would be followed by longer-term recuperative care provided closer to their home.

Dr Glackin expressed concern that the consultation paper had not addressed adequately the primary/secondary care interface. In particular, he referred to the numerous ways - in addition to dialling '999' – in which someone with stroke symptoms might seek assistance (e.g. by contacting/visiting a GP-led health centre, a 'walk-in' centre', an urgent care centre, an A&E department, an out-of-hours telephone line, or NHS Direct). This pointed to the need for training in stroke recognition to be provided far more widely than just to paramedics.

Dr Glackin referred to the access to rehabilitation for patients who had been treated at the specialist heart centres as being "patchy". This did not bode well for the proposals for stroke and major trauma. There were various reasons why rehabilitation services available might not be accessed (e.g. arrangements for making appointments and follow-up visits might not be clear, or a patient's first language might not be English). PCT budgets were related to the local borough population, but a patient's rehabilitation might take place in another borough.

On the question of TIAs, Dr Glackin agreed that often patients might be vague about their symptoms. His experience was that DGH neurology departments were generally resistant to seeing a patient referred by a GP within a week (the recommended period of treatment for a TIA). The alternative was for the GP to refer the person to a hospital out-patient appointment.

Dr Grewal's experience was that the quality of care for TIAs depended substantially on the local hospital in question. Some provided rapid access to treatment, whilst others did not. He suggested that pressure on hospital trusts from GPs, local authorities and others with an interest in securing access to rapid treatment could bear fruit. His view was that every DGH should have a facility for providing rapid treatment for a TIA.

Greater public awareness of TIA was needed, in order that those affected were clear about symptoms, what to do in the event of an attack, and the importance of getting quick treatment (within a week).

It was possible that in future some 'polyclinics' might provide certain hospital services (e.g. CT scans), but it was important to bear in mind that for clinicians to maintain their expertise, a critical mass of patients was needed. This was a key principle underlying the consultation proposals.

On the question of why those from BME backgrounds suffered higher rates of stroke, factors could include higher rates of hyper-tension, diabetes, and a poor response to some medication. However, further medical research into the reasons was needed. Other relevant considerations included historic under-funding by the NHS in inner city areas (which had a higher density of BME than the general population) and the fact that, since for some BME, English was not a first language, opportunities for advice and treatment might not be taken advantage of. Better publicity on stroke should assist, but for this to be successful, consideration would need to be given to some targeting of BME groups.

As regards the preferred location of the eight HASUs, the proposals were intended to deliver high-quality clinical outcomes, and this could not be achieved by spreading resources too thinly: geographical spread must remain a secondary consideration, given that LAS was confident that it could provide a maximum 30-minute journey time from scene to HASU. Hospitals which had failed to demonstrate acceptable levels of care could not expect to form part of the proposed stroke network.

Dr Glackin said that he understood that when a major incident occurred (perhaps involving just four or five people) the Royal London Hospital devoted its primary attention to dealing with the victims, and the more routine care provided in the hospital suffered as a result. If this was indeed the case, it clearly had serious potential implications for major trauma centres (MTCs) - and implications, too, for HASUs. He agreed to approach Londonwide LMC colleagues in Tower Hamlets in order to provide further information on this matter. Dr Grewal added that the key point was to identify what level of increased demand (due to a major incident) would cause a hospital's systems to become overloaded, leading to services suffering to other patients.

On the most appropriate number of MTCs, three or four was considered about right; if there were five, each would not receive enough patients to justify the concentration of clinical resource, or provide sufficient experience for individual clinicians.

As regards whether cost was an element in HfL's proposals for a certain number of specialist centres, Dr Glackin said that this had to be a consideration, given the cost of providing and running even one additional centre.

Traditionally, working relationships between GPs and social care professionals left something to be desired, as in cases involving child protection issues, and people with mental health difficulties. Non-coterminosity of healthcare/social care boundaries could pose a problem. Once a patient was discharged from hospital, the period of follow-up care was often critical, and professionals from all sides needed to co-operate to ensure that this went smoothly. A joined-up multi-disciplinary approach was needed if the proposals – particularly in relation to stroke – were to be translated into effective practice. In some cases (e.g. those without a carer) a period of intermediate care (e.g. community hospital) might be appropriate.

Whilst GPs tended to stay in one location for a considerable part of their working life, the career pathway of community health and social care professionals was typically very different, with individuals often moving on after a few years. This made considerably more difficult the development of good professional relationships with GPs. Dr Grewal emphasised the important role that the development of 'person to person' relationships could play in developing trust and a shared sense of working together across the traditional health/social care 'divide'.

Dr Grewal highlighted the disadvantage which faced those who were unable (e.g. elderly, restricted mobility) to travel to receive health treatment. He considered that making home visits was a very inefficient use of a GP's time, and the treatment that could be provided was limited, compared with what was available at a properly equipped medical facility.

The high number of single-person households was another area of concern, since often there was no-one on hand (e.g. a carer or family member) who could provide support. Policy makers often failed to take adequate account of such factors in developing their proposals. However, logistically and in resource terms, it would be difficult for local authorities to assist in such cases with social care support, given the number of individuals involved.

Reference was made by Dr Glackin to the model in the case of mental health patients of an allocated case manager who addressed a patient's needs and arranged appropriate support. This might be a model which could usefully be applied more widely, although resource implications could be significant.

Dr Glackin commented that currently stroke care in London was very poor compared with major international cities. If there was suitably increased investment in primary care in relation to stroke over a period of 10 – 20 years, however, he could foresee a diminished need for specialist stroke centres.

The Chairman thanked Dr Glackin and Dr Grewal for responding to Members' questions.

The meeting finished at 1.30 pm.

**MEETING OF THE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW "SHAPING HEALTH SERVICES TOGETHER -
CONSULTATION ON DEVELOPING NEW, HIGH-QUALITY MAJOR
TRAUMA AND STROKE SERVICES IN LONDON"**

FRIDAY 24 APRIL 2009

**City of Westminster, Council Chamber, Westminster Council House,
Marylebone Road, London NW1 5PT**

PRESENT:

Cllr Marie West - London Borough of Barking and Dagenham
Cllr David Hurt – London Borough of Bexley
Cllr Carole Hubbard – London Borough of Bromley
Cllr John Bryant - London Borough of Camden
Cllr Ken Ayers - City of London
Cllr Graham Bass - London Borough of Croydon
Cllr Greg Stafford - London Borough of Ealing
Cllr Christopher Pond – Essex County Council
Cllr Janet Gillman - London Borough of Greenwich
Cllr Jonathan McShane - London Borough of Hackney
Cllr Rory Vaughan – London Borough of Hammersmith and Fulham
Cllr Vina Mithani – London Borough of Harrow
Cllr Fred Osborn - London Borough of Havering
Cllr Jon Hardy - London Borough of Hounslow
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
(Chairman)
Cllr Don Jordan - Royal Borough of Kingston upon Thames
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Winston Vaughan - London Borough of Newham
Cllr Nicola Urquhart – London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Richard Sweden - London Borough of Waltham Forest
Cllr Susie Burbridge - City of Westminster

ALSO PRESENT:

Officers:

Pat Brown - London Borough of Barking and Dagenham
Ian Kaye – London Borough of Barnet
Jeremy Williams – London Borough of Barnet
Louise Peek – London Borough of Bexley
Andrew Davies – London Borough of Brent
Philippa Stone – London Borough of Bromley
Shama Smith - London Borough of Camden
Neal Hounsell – City of London
Nigel Spalding - London Borough of Ealing
Ade Adebola - London Borough of Greenwich
Tracey Anderson – London Borough of Hackney
Sue Perrin – London Borough of Hammersmith & Fulham

Rob Mack – London Borough of Haringey
Nahreen Matlib - London Borough of Harrow
Anthony Clements – London Borough of Havering
Deepa Patel – London Borough of Hounslow
Sunita Sharma – London Borough of Hounslow
Gavin Wilson – Royal Borough of Kensington & Chelsea
Joanne Tutt - London Borough of Lambeth
Julia Regan – London Borough of Merton
Iain Griffin - London Borough of Newham
Jilly Mushingon – London Borough of Redbridge
Hannah Bailey - London Borough of Tower Hamlets
Bernadette Lee - London Borough of Richmond
Farhana Zia – London Borough of Waltham forest
Jo Bevan-Taylor – City of Westminster

Others:

Bashir Arif – Impact Assessment Lead, Healthcare for London
Steve Black – Senior Analyst, Healthcare for London
Shaun Danielli, Project Manager (Trauma), Healthcare for London
Gail Engert – Chair, London TravelWatch Access to Transport Committee
Andrew Gonsalves – Transport Planner, Transport for London
Peter Gluckman – Public Health Action Support Team (PHAST)
Vishy Harihara – Barnet LINK
Nick Lawrance – Head of Policy, Evaluation and Development, London Ambulance Service
Prof. Hugh Markus – St George’s NHS Healthcare Trust
Julian Sanchez – Principal Transport Planner, Transport for London
Vincent Stops – London TravelWatch Officer
Cllr Peta Vaught – London Borough of Hounslow
Mark Whitbread – Clinical Practice Manager, London Ambulance Service
Michael Wilson – Project Manager (Stroke), Healthcare for London

1. INTRODUCTORY REMARKS

Cllr Susie Burbridge welcomed everyone to the City of Westminster and made some 'housekeeping' announcements.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Councillor Ann-Marie Pearce (Enfield)
Councillor Peter Tobias (Hammersmith and Fulham)
Councillor Gideon Bull (Haringey)
Councillor Ted Eden (Havering)
Councillor Ian Hart (Wandsworth)

3. DECLARATIONS OF INTEREST

Cllr Carole Hubbard (Bromley) declared that she was an employee of Bromley PCT and a member of the Royal College of Nursing.

Cllr Greg Stafford (Ealing) declared that he was a member of the British College of Occupational Therapists.

Cllr Jonathan McShane (Hackney) declared that he was an employee of Southwark PCT.

Cllr Vina Mithani (Harrow) declared that she was an employee of the Health Protection Agency.

4. MINUTES

RESOLVED: That the minutes of the meeting held on 7 April 2009 be approved as a correct record, subject to the addition of Cllr Chris Pond (Essex) to the list of those present, and the substitution of “Bryant” for “O’Bryant” under Item 1.

5. WITNESS PROGRAMME UPDATE

The Witness Programme update was noted.

6. CHAIRMAN’S ANNOUNCEMENTS

The Chairman reported that Healthcare for London had brought forward the date by which it wanted the JHOSC’s final report to be submitted, and had recently asked for the report by the end of May. Discussions were taking place with a view to agreeing a date in early to mid June.

Any responses from individual Councils to the consultation paper, and any comments on submissions received from Trusts should be forwarded by 8 May to the Chairman, or Gavin Wilson or Julia Regan of the supporting officers.

7. WITNESS SESSION: S.W. LONDON ‘HUB AND SPOKE’ STROKE CARE PILOT

The meeting received a presentation from Professor Hugh Markus (lead clinician for stroke services at St George’s NHS Healthcare Trust; and St George’s University of London) on the ‘hub and spoke’ thrombolysis model operated in S.W. London.

Prof Markus explained that the initiative had started around four years ago, but the provision of 24-hour thrombolysis at St George’s Hospital had only begun in September 2007. The ‘hub and spoke’ model had been introduced in February 2009 in order to provide daytime thrombolysis for patients at the following three District General Hospitals (DGHs) in the surrounding area: Mayday, St Helier, and

Kingston. Out of hours thrombolysis was provided by St Georges during the weekend, and between the hours of 5pm and 9am.

Over a period of one year, there had been a 10% increase in admissions. It was significant to note that somewhere between 15% to 20% of admissions were 'non-stroke'. This illustrated how difficult it was to diagnose stroke conditions. On this basis, Prof. Markus suggested that it was likely that up to 20% of those taken to a hyper-acute stroke unit (HASU) would be diagnosed as 'non-stroke'. This would need to be taken account of for planning purposes.

Significantly, only just over half (52%) of regional patients had been referred from the nominated three 'spoke' hospitals. This demonstrated clearly that people were inclined to present themselves, or be taken to, the best available centre of which they were aware. Without clear protocols, the same principle could be applied to the ambulance service. Again, this had clear implications in terms of planning for anticipated numbers of people arriving at HASUs.

It was noteworthy that since the Government's 'FAST' publicity campaign, numbers of people with strokes seeking treatment had increased quite dramatically.

Prof. Markus was impressed by the speed at which the London Ambulance service (LAS) delivered stroke patients to a central hospital location. However, the median 'door to needle' time for the pilot had been 55 minutes, and in this light he considered that, in most cases, the 30-minute target in the consultation paper was probably unrealistic, although it might be achieved in time. Interestingly, there was no significant difference in length of journey time for local or regional patients.

Based on the experience from the pilot, one issue which would need to be addressed under the consultation proposals was the smooth transfer of patients from a central location to a DGH. There had been some delays in patient 'repatriation' in the pilot, and this had obvious implications in terms of placing greater pressure on available beds in a HASU.

The following lessons could be drawn from the pilot:

- Overall, patients and carers were not concerned about where acute treatment was available – only that it was the best that was available;
- The additional travel caused by a patient's admission to the central ('hub') hospital did not appear to have caused problems for family and friends;
- It was very important for clear explanations to be given to patients of the care pathway they could expect, on admission;

- Transfer stages of the care pathway could be improved: patients and carers had concerns about lengthy waits on the day of transfer back to a DGH.
- Some patients had been taken to hospitals at times when they were not offering thrombolysis. This pointed to the adoption of a model whereby thrombolysis was available 24/7 – as was the case in the consultation paper’s proposals.

Prof. Markus identified the following conclusions from the pilot:

- ‘Hub and spoke’ had operated as a good interim model (pending the introduction of proposals in the consultation paper);
- Thrombolysis had been made more available than had previously been the case;
- Problems had occurred with splitting daytime and ‘out of hours’ service provision;
- The optimal configuration was to have thrombolysis available in 24/7 centres.

Following the presentation, Prof Markus responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

Prof. Markus underlined the need for centres providing 24/7 thrombolysis. In terms of whether there should be a ‘big bang’ implementation of the consultation proposals, or a more phased introduction, he suggested that as an interim measure, it would be possible to have 24/7 centres (HASUs), but to admit only those patients who were suitable for thrombolysis. This would reduce considerably the number of admissions.

Regarding whether eight HASUs was the right number, this was a matter for Healthcare for London to decide, taking realistic account of the anticipated number of stroke admissions (and allowing for a 15% - 20% of non-stroke admissions).

If a HASU saw more than 2,000 patients a year, this would be a matter for concern in terms of capacity. With reference to international experience (1,000 – 1,200 patients a year), Prof. Markus believed that between 1,200 – 1,500 patients a year would be about the right level for a HASU.

In the longer-term, HASU co-location with neurosurgery units made sense where feasible; however, this was unlikely to be possible for all areas of London.

There was no data from the stroke pilot to quantify numbers admitted to hospital for another condition, who were found to have a stroke. However, he reiterated the need to take account of the significant

number of people admitted who would be found *not* to be suffering a stroke.

Regarding the number of admissions (to the S.W. London pilot) for non-stroke reasons, this figure was unlikely to reduce over time with better training – even experienced consultants found accurate diagnosis difficult in some cases.

As regards the use of telemedicine for stroke patients, Prof. Markus said that its use in this context had been mainly in rural areas in other countries; he considered that the ‘hub and spoke’ model trialled in S.W London was a better one.

In terms of readiness for implementation in April 2010, whilst there was good ‘stroke’ training for doctors, there was a desperate need for integrated ‘stroke’ training for nurses. This was a UK-wide problem, and it would be a challenge to secure enough qualified nurses in time.

There was a possibility that HASUs could draw suitably qualified nurses away from DGHs. This would need to be addressed within each stroke network, and it was likely that more flexible working arrangements, allowing rotation between HASUs and stroke units at DGHs, could play a useful role.

Unlike the position with having enough suitably qualified stroke nurses, there was no such difficulty with the numbers of therapists needed to provide rehabilitative care.

The Chairman thanked Prof. Markus for his presentation and for responding to Members' questions.

8. WITNESS SESSION: LONDON AMBULANCE SERVICE

The meeting received a presentation from Mark Whitbread (Clinical Practice Manager) and Nick Lawrance (Head of Policy Evaluation and Development), London Ambulance Service.

LAS supported the consultation paper’s proposals for major trauma and stroke. It was confident that stroke patients could be delivered from scene to a HASU within 30 minutes, based on its experience of delivering patients to the (currently) eight heart attack centres (HACs), which had operated on a 24/7 basis since April 2006.

2007/08 data showed that 95% of journeys to HACs had been achieved within 30 minutes of leaving the scene, with a mean journey time of 15.57 minutes. There had been no instance of a patient death in an ambulance during conveyance to a HAC.

LAS met twice a year with the HACs to consider issues of mutual interest, with a view to ensuring that the best possible service was provided.

Given that the proposed geographical distribution of the eight HASUs provided a better coverage for London than existed in the case of the HACs, LAS believed that it would have no problem achieving the 30-minute target from scene to HASU.

In terms of readiness, all A&E ambulance crews were trained in FAST, and could already provide the service required under the consultation proposals. However, consideration was being given to training LAS staff in a slightly more complex test for stroke recognition (ROSIER). This went beyond FAST, in providing additional visual checks, together with a few other minor improvements. Using ROSIER, it was hoped that a further 10% of strokes could be identified initially.

No additional equipment would be required by LAS crews as a result of Healthcare for London's proposals.

Slightly increased journey times would require additional funding, in order to maintain performance in the areas from which the ambulances taking people to the specialist centres had come. LAS and PCTs were in discussion regarding additional resources for 2009/10 and beyond, and funding had already been set aside for the current financial year.

A new version of call prioritisation software had been implemented, and stroke patients with onset of symptoms within two hours were now categorised as 'Category A' (target response time = 8 minutes) as opposed to 'Category B' (target response time = 19 minutes).

There would be a communications exercise to brief staff concerning the HASU locations. A system for this purpose had already been introduced, and it was not envisaged that it would prove difficult to implement in respect of the HASUs and the major trauma centres (MTCs).

Regarding preparation specifically for the proposed MTCs, LAS had set up a group to consider what was required, and a considerable amount of work had been carried out to develop an effective triage tool for use on scene. LAS was confident that it could deliver accident victims from scene to MTC within the 45 minutes stated in the consultation paper.

Following the presentation, the LAS representatives responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

In terms of additional funding, LAS was bidding for around £500,000 from NHS London for the present financial year. This would be spent principally on extra overtime, although in the longer-term, funding

would be used to purchase the required resources. LAS was confident that the necessary funding would be approved.

Based on the experience of the HACs, LAS considered that a 24/7 specialist centre represented a better model of care than the 'hub and spoke' stroke model in S.W. London, which operated a mix of daytime and out of hours provision.

The scenario where a stroke or major trauma patient was kept in an ambulance waiting for a hospital bed at a HASU or MTC to become available would not occur, since there was a system in place to alert hospitals to the anticipated arrival of such patients.

Regarding a change in the age of people suffering strokes, LAS was not aware of any data that would support this. The collection of more detailed information on strokes would allow LAS to adapt their response as might be appropriate.

Questioned regarding arrangements across London's boundaries, Mr Whitbread referred to a 'pre-hospital' group which brought together LAS and representatives of relevant out-of-London ambulance services (East of England, South Coast, and South Central) to discuss arrangements in relation to major trauma. However, he also referred to discussions between LAS and out-of-London ambulance services in relation to HACs, where it had not always proved possible to reach agreement concerning arrangements for conveying patients to hospital.

Regarding what would be most useful in terms of maximising LAS's effectiveness, Mr Whitbread said that the most helpful thing would be if members of the public only called an ambulance in appropriate (ie emergency) circumstances.

Repatriation of patients from HASUs to stroke units at DGHs would involve a significant increase in journeys, but since these would fall outside the terms of LAS's A&E contract, there would be no impact on the services provided by LAS. There was a large number of private contractors who provided repatriation services.

The Chairman thanked Mr Lawrance and Mr Whitbread for their presentation and for responding to Members' questions.

9. WITNESS SESSION: HEALTHCARE FOR LONDON – HEALTH IMPACT ASSESSMENT RESULTS

The meeting received a presentation from Bashir Arif (Impact Assessment Lead) and Peter Gluckman (PHAST).

Fundamentally, there was a legal requirement to address equalities issues. However, as well as considering the needs of traditionally under-represented groups, the IA's focus would include deprived

communities, and would draw attention to any potential health inequalities. Thirdly, it would address the impact of travel access and the associated carbon footprint.

Mott MacDonald had been commissioned to undertake the IAs, working with the Public Health Action Support Team (PHAST). There was an active IA Stakeholder Steering Group, chaired by the Chair of the Greater London Assembly.

The second phase of the IA work would commence on 12 June, with the final report completed by the start of July. The IAs would ultimately be considered by the JCPCT as part of its decision-making, following the present period of public consultation.

There were four phases to an Integrated Health IA: scoping (emerging findings); assessment; decision making; and monitoring. Effective monitoring, in order to ensure that recommendations were being implemented, was crucial.

The IAs would not be considering paediatrics, burns, 'paired centre' combinations for acute stroke services, or detailed options for N.E. London. It was recognised, however, that adjustments might subsequently need to be made to the IA findings, in order to take account of the outcome of the proposals affecting N.E London.

Emerging findings identified the following groups as being significantly affected by the proposals for acute stroke services: women, older people, BME groups, people with mental health and learning disabilities, the socially deprived, those living in certain geographical areas, and 'late presenters' (ie those who did not present themselves to hospital immediately after having symptoms of an acute stroke).

Concerning the 60% greater incidence of stroke among black African and black Caribbean populations, this was something which needed to be explored in more detail in phase 2 of the work.

In respect of major trauma, emerging findings identified the following groups as being significantly affected: young men, BME groups, and those living in certain geographical areas.

Certain issues had been identified as having the potential to impact on both stroke and trauma proposals. These were:

- During and after care – transporting and discharge arrangements could be disorientating for some groups;
- Visitors, relatives and carers – increased travel times, particularly where public transport was used;
- Non-specialist centres – possible impact on the quality of care at these centres, due to a redistribution of resources (including ambulance provision);

- Commissioning – it would be crucial to achieve a smooth provision of services across patient pathways;
- Data availability – the lack of a systematic approach to data collection might cause difficulties in making definitive impact assessments, but good data was essential for effective monitoring

Next steps involved detailed planning work for the second phase, based upon the emerging findings. There would be further collection and analysis of qualitative and quantitative data. This would include stakeholder interviews with traditionally under-represented groups, and the development of transport and carbon models. There would be a focus on identifying strategies that would mitigate any negative impacts from the proposals.

Following the presentation, Mr Arif and Mr Gluckman responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

Mr Gluckman referred in more detail to the work proposed in phase 2 which should assist BME groups in London.

The IA brief did not include assessing the case for individual hospitals to play a particular role under Healthcare for London's proposals. However, to assist their work they would ask HfL for a plan which showed both the final designated centres and the small number of 'de-designated' centres.

Although the principal focus of the IAs would be on London's population, account would be taken of the cross-border transport/travel issues. However, getting robust data on which to base sound conclusions would be a challenge.

Regarding issues affecting N.W. London, with particular reference to the operation of one of the major trauma sites at a later date (2012) than the other three, Mr Arif referred to discussion later on the agenda concerning transport and travel modelling, which was likely to be of relevance. If, during the course of the work to develop IAs, data was found that suggested that some people would not be within the 30 and 45 minute 'scene to hospital' windows, this would be flagged up. However, the final IA report would not be available for the JHOSC to consider before it submitted its own report, since the timeframe set by HfL extended well beyond the JHOSC's (extended) timescale for comment to HfL.

Questioned on the extent to which the IA work appeared to duplicate work being done elsewhere to analyse the impact of the consultation proposals, Mr Gluckman referred to the statutory parameters within which IAs were produced, and to the slightly wider focus to take account of other relevant factors, as outlined earlier. He emphasised

that the IAs were produced entirely independently of HfL, and should allow HfL and PCTs to address particular areas of need and ensure that effective mitigation strategies were put in place. Where particular problems were identified during the course of the IA work, suggested solutions would be put forward.

There was a single contract covering all the phases of the IAs. A written response would be provided to the JHOSC concerning the cost involved.

The timescale set for the final IAs to be produced meant that it would unfortunately not prove possible to take account of the final outcome of the HfL proposals affecting N.E London. However, the IAs would make what comments were possible, on the information available. Matters which the IA was unable to comment upon in detail due to timescale considerations could be identified in its final report. Mott MacDonald/PHAST would consider key points in relation to N.E London which Cllr Sweden indicated he would produce, and would respond in writing to the JHOSC.

Any additional questions to Mott MacDonald/PHAST from members of the JHOSC could be sent to the Chairman, or Julia Regan of the supporting officers, for a written response to be made.

The Chairman thanked Mr Arif and Mr Gluckman for their presentation and for responding to Members' questions.

10. FEEDBACK FROM N.E. LONDON JHOSC

Cllr Richard Sweden reported back on the discussion which he had chaired at a meeting of a JHOSC of representatives of N.E London local authorities, held on 31 March 2009.

Attention was drawn to the main areas covered at the meeting, as set out in the minutes of the meeting, which had been circulated previously.

In particular, Cllr Sweden highlighted the concern that had been expressed at late public involvement in the development of proposals, and the fact that the third sector had not been engaged at a preparatory stage.

It was a matter of concern, too, that HfL was presently unable to be specific about what services would be affected by change. Cllr Sweden considered that there should be a separate consultation on the proposed number and location of stroke units.

The Chairman thanked Cllr Sweden for his comments, and said that continuing efforts by councillors representing N.E London authorities to elicit clearer proposals from HfL/local PCTs were to be supported.

RESOLVED: That the Chairman write to Healthcare for London, expressing the JHOSC's concern that the timescale prescribed for a) the outcome of proposals affecting N.E London b) the final report of the Impact Assessments, did not allow the JHOSC to address all matters upon which it might wish to comment.

11. WITNESS SESSION: LONDON TRAVELWATCH (LTW)

The meeting received a presentation from Gail Engert (Chair, Access to Transport Committee), London TravelWatch.

LTW was the operating name of London Transport Users' Committee (the statutory body set up to represent the interests of transport users in and around London). It was sponsored by, but independent of, the Greater London Assembly, and its remit extended across all modes of transport. It was represented on the Impact Assessment Steering Group set up to consider the consultation proposals.

LTW recognised that the duration of patient stays in specialist centres would be fairly short, and therefore the number of individual visits by friends and relatives would be small. Nevertheless, there would be issues which needed to be addressed.

LTW considered that the accessibility of any new or reconfigured hospital should be considered at the earliest possible planning stage. It recommended that every hospital should develop a travel plan which was audited independently for quality.

The appointment by every hospital trust and healthcare management board of a member as a 'travel planning champion' was considered to have considerable merit.

Hospitals needed to have strategies aimed at reducing demand for car parking, but which ensured that parking spaces (and dropping off facilities) were available for essential visits.

Information on public transport needed to be widely available, and provided for those planning a first visit – on websites, and by telephone – subsequent visits, and transfer to DGHs for further treatment.

A good hospital travel plan should comprise as a minimum: a) a staff, visitor and patient survey of travel mode and where the person had travelled from b) a site survey, and actions to improve accessibility for all modes of transport c) a survey of staff arrival times d) a car parking management plan e) details of the 'travel planning champion'. Also, an active representative group, working with local authorities and travel providers, was needed in order to monitor the travel plan.

Following the presentation, Ms Engert and Vincent Stops (London TravelWatch officer) responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

LTW had not considered travel in relation to the proposed specialist centres, and although there was a possibility that some attention in this area might be possible, it was likely that lack of resources would prove prohibitive.

LTW was keen to see hospitals allocate 'emergency' parking spaces for friends and relatives who were visiting. Reception staff should be able to direct visitors to nearby car parking, when hospital car parks were full.

It was recognised that some people would be making journeys into London from neighbouring areas, and some work was being done by LTW concerning bus journeys across London's boundaries.

Generally, hospitals did not accord travel planning matters a high enough priority, and having a Board member responsible for travel matters was very important.

At a visit to one of the proposed specialist centres (Royal Free Hospital), Mr Stops had observed cars unable to find a parking space; awkward routes from bus stops to the hospital; and no travel information on display on how to get to the hospital (despite Transport for London providing plenty of information).

The Chairman encouraged LTW to put pressure on hospitals to provide travel information as a matter of course – on their website, in hospital, and in appropriate literature.

Two hospitals which had good travel plans in place were Northwick Park and Great Ormond Street.

Reference was made to the difficulties which 'pay on entry' systems for hospital car parks could pose, particularly in an emergency or for those in a great hurry. It was noted that there were many different pay systems in place at hospitals, and it was therefore difficult to lobby for the same rules to be applied, London-wide. However, in all cases, systems of payment should be fair to visitors.

LTW agreed that patient transport should be addressed in hospitals' travel plans.

LTW's activity as an organisation concerned with travel and transport included lobbying, including at Ministerial level. It was able to bring pressure to bear on hospitals to publish travel plans, but other bodies – including local authorities – needed to do the same.

Regarding the issue, raised earlier, of considering transport in relation to the proposed HASUs and MTCs, LTW reiterated that resources prevented them looking at all these centres. However, they had looked at ten hospitals in detail, and had gained a good idea of the issues at stake. Basically, LTW's position was that good transport links should be planned where any new health facility was proposed, or where there was a significant expansion of an existing facility.

The Chairman thanked Ms Engert and Mr Stops for their presentation and for responding to Members' questions.

12. WITNESS SESSION: HEALTHCARE FOR LONDON - TRAVEL MODELLING

The meeting received a presentation from Michael Wilson (Project Manager, Stroke), Shaun Danielli (Project Manager, Trauma) and Steve Black (Senior Analyst) from Healthcare for London on the travel modelling that had been done to support proposals to provide specialist centres for major trauma and stroke.

Mr Wilson explained that data covering four years of London ambulance journeys had been used, including data from major incidents such as terrorist attacks. The dataset reflected current practice to take patients to the nearest available hospital bed, but contained insufficient journeys across London to the proposed major trauma and HASU sites.

Expected journey times from different parts of London to the proposed specialist sites were based on evidence that blue-light journeys took, on average, one third less time than regular journeys. London Ambulance Service supported their findings. Rush-hour was not found to have a significant impact on the length of blue-light journeys.

In response to questions, Healthcare for London agreed that it was sometimes clinically appropriate to stop the ambulance on route, in order to deliver life-saving treatment, in particular for a heart attack where a shock needed to be administered; LAS was skilled at doing this when the need arose. This was less likely to be an issue for stroke patients, but might apply to a minority of trauma cases. The need to carry out such action would be the case whatever the destination, so the implication for journey times would remain the same.

Occasionally, journeys took much longer than expected, but LAS used information about roadworks and congestion when planning their route. Large variations in travel time did not happen often and were not considered significant in planning the location of specialist centres.

Transport for London journey time modelling software had been used to estimate the time it would take to reach the hospitals on public

transport. Further investigation would be required to see to what extent the TfL model was able to adjust timings to provide average journey times for visitors with limited mobility, such as older relatives and partners of stroke victims. For this small minority of travellers, an accessible taxi might be more appropriate. The Health Impact Assessment would identify these issues.

The significant variation in travel times to account for rush-hour did not apply in the case of blue-light journeys - variation on blue-light journeys amounted to about three extra minutes for rush-hour.

The starting point for the travel-time models was Darzi's recommendation that certain services would be improved by having fewer specialist units. To make this effective, the number of units needed to be limited. Based on the number of proposed sites, a maximum journey time was set for ambulance services to be clinically effective, before considering the impact on visitors. The proposed sites were therefore selected on the basis that they met the required ambulance travel times. Previous consultation on the 'Healthcare for London' proposals showed that clinical effectiveness of the units was also a priority of users and carers.

The Chairman thanked the Healthcare for London representatives for their presentation and for responding to Members' questions.

13. WITNESS SESSION: TRANSPORT FOR LONDON

The meeting received a presentation from Mr Julian Sanchez (Principal Transport Planner) and Mr Andrew Gonsalves (Transport Planner) from Transport for London (TfL).

In his introductory remarks, Mr Sanchez explained that TfL's strategic objectives include promoting active lifestyles, sustainable transport and reducing health inequalities. TfL therefore welcomed partnership working with the NHS and with local councils. Around 1 million of the 18.2 million journeys taken in London every day were health-related and so TfL had been working closely with the NHS, with the aim of improving both organisations' understanding of the issues around access to healthcare.

Mr Sanchez drew the JHOSC's attention to forthcoming public consultation on the Mayor of London's Transport Strategy in autumn 2009, to be preceded by consultation with London councils during the summer.

TfL and NHS London had developed a health service travel analysis tool (known as HSTAT), launched at the end of 2008. HSTAT was available for use by Primary Care Trusts and would assist an understanding of the impact of future changes to location of health services. It was planned that boroughs would be able to run high-level

queries using the existing CAPITAL model on which HSTAT was based.

In terms of the current consultation, TfL considered the 30 minute and 45 minute travel times (for stroke and major trauma patients respectively) to be realistic. However, Mr Sanchez noted that the introduction of 20 mile per hour zones and “shared spaces”, intended to improve the streetscape and increase quality of life for local people, could slow down some journeys on residential streets. Traffic congestion was likely to continue to increase over the next twenty years, and this would also slow traffic down.

TfL had carried out an analysis of visitor access to each of the proposed Major Trauma Centres, HASUs and Stroke Units. The table below assigned a score to each hospital – (lowest score = 1 and highest = 6b):

List of sites and overview of accessibility Levels	
<ul style="list-style-type: none"> • Proposed Trauma Networks • Network 1 • Major Centre: St Mary's Hospital 6b • Minor Centres: Northwick Park (NW London) 3 • Central Middlesex (NW London) 3 • Hillingdon 2 • Ealing 0 • West Middlesex 3 • Charing Cross 6a • Chelsea & Westminster 3 • Network 2 • Major Centre: The Royal London Hospital 6a • Minor Centres: The Royal Free 4 • The Whittington 6a • Barnet 2 • Chase Farm 2 • North Middlesex 2 • Homerton 4 • Whipps Cross 3 • Queen's ? • Newham 1b • Network 3 • Major Centre: King's College Hospital 6a • Minor Centres: St Thomas' 5 • Queen Elizabeth ? • University Hospital Lewisham 4 • Queen Mary's Sidcup 2 • Princess Royal 2 • Network 4 • Major Centre: St George's Hospital 4 • Minor Centres: Mayday 3 • St Helier 2 • Kingston 3 	<ul style="list-style-type: none"> • Proposed Hyper-Acute Stroke Units • Northwick Park Hospital 3 • Queen's Hospital ? • University College London Hospital 6b • The Royal London Hospital 6a • King's College Hospital 6a • Charing Cross Hospital 6a • St George's Hospital 4 • The Princess Royal University Hospital 2 <p>Public Transport Accessibility Levels (PTALs) are used to measure the quality of access to the transport network. PTAL scores range from 1 – the poorest levels of accessibility, to 6b – the best. Levels of accessibility</p> <p>Presently TfL does not have PTAL scores for Queen's hospital in Romford, this is due to the fact that this is a relatively new hospital (opened late 2006), though Oldchurch Hospital, which Queen's replaced, and which was located a 5-10 min walk from Queen's had a score of 5</p> <p>TfL also does not have data on the Queen Elizabeth Hospital Woolwich at present either</p>

TfL would be responding in detail to the consultation once it had completed more detailed modelling of the proposed sites. Mr Sanchez undertook to send the JHOSC a copy of TfL's response.

Following the presentation, Mr Sanchez and Mr Gonsalves responded to a number of questions from Members. Additional or supplementary points to those covered earlier are set out below.

Cross-border needs and potential new services had not been considered as part of TfL's response to the consultation, but these issues could be raised at the sub-regional partnership meetings that TfL had with local councils.

Issues such as fare affordability, the location of bus stops for particular hospitals, and which tube stations should be prioritised for lift installation could be raised as part of the consultation on the Mayor's Transport Strategy.

Mr Sanchez undertook to report back to the JHOSC on how far the bus Countdown system had been rolled out.

In response to a question about tube and train capacity, Mr Sanchez replied that investment had been identified in TfL's business plan for a 30% increase in capacity.

The Chairman thanked Mr Sanchez and Mr Gonsalves for their presentation and for responding to Members' questions.

The meeting finished at 4.20 pm.

**MEETING OF THE
JOINT HEALTH OVERVIEW AND SCRUTINY COMMITTEE
TO REVIEW "SHAPING HEALTH SERVICES TOGETHER -
CONSULTATION ON DEVELOPING NEW, HIGH-QUALITY MAJOR
TRAUMA AND STROKE SERVICES IN LONDON"**

THURSDAY 7 MAY 2009

**Council Chamber, Hammersmith and Fulham Town Hall, King Street,
London W6 9JU**

PRESENT:

Cllr Marie West - London Borough of Barking and Dagenham
Cllr Sachin Rajput – London Borough of Barnet
Cllr Carole Hubbard – London Borough of Bromley
Cllr John Bryant - London Borough of Camden
Cllr Graham Bass - London Borough of Croydon
Cllr Greg Stafford - London Borough of Ealing
Cllr Anne Marie Pearce – London Borough of Enfield
Cllr Janet Gillman - London Borough of Greenwich
Cllr Peter Tobias – London Borough of Hammersmith and Fulham
Cllr Vina Mithani – London Borough of Harrow
Cllr Ted Eden - London Borough of Havering
Cllr Mary O'Connor - London Borough of Hillingdon
Cllr Jon Hardy - London Borough of Hounslow
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea
(Chairman)
Cllr Don Jordan - Royal Borough of Kingston upon Thames
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Winston Vaughan - London Borough of Newham
Cllr Ralph Scott - London Borough of Redbridge
Cllr Nicola Urquhart – London Borough of Richmond upon Thames
Cllr Adedokun Lasaki – London Borough of Southwark
Cllr Richard Sweden - London Borough of Waltham Forest

ALSO PRESENT:

Officers:

Glen Oldfield - London Borough of Barking and Dagenham
Jeremy Williams – London Borough of Barnet
Louise Peek - London Borough of Bexley
Andrew Davies – London Borough of Brent
Shama Smith - London Borough of Camden
Simon Temerlies – City of London
Nigel Spalding - London Borough of Ealing
Ade Adebola - London Borough of Greenwich
Tracey Anderson – London Borough of Hackney
Sue Perrin – London Borough of Hammersmith & Fulham
Nahreen Matlib - London Borough of Harrow
Anthony Clements – London Borough of Havering
Deepa Patel – London Borough of Hounslow

Sunita Sharma – London Borough of Hounslow
Gavin Wilson – Royal Borough of Kensington & Chelsea
Joanne Tutt - London Borough of Lambeth
Julia Regan – London Borough of Merton
Iain Griffin - London Borough of Newham
Jilly Mushington – London Borough of Redbridge
Bernadette Lee - London Borough of Richmond

Others:

Dr Tim Cassidy - British Association of Stroke Physicians
David Davis - S.E. Coast Ambulance Service
Felicity Dennis - Network Manager, Surrey Heart and Stroke Network
Vishy Harihara - Barnet/Camden LINK
Eddie Hunter - Longsight Consultancy
Carl Long - NHS Surrey
Kay Mackay - Director of Strategy and Service Delivery, NHS Surrey
Bhaskar Mandal - Ashford and St Peters Hospitals NHS Trust
Simon Milligan - Senior Finance Lead, Healthcare for London
Don Neame - Director of Communication, Healthcare for London
Helena Reeves - Communications Director, NHS Surrey
Jo Sheehan - Finance Lead, Healthcare for London
Valerie Solomon - London Councils
Dr Simon Tanner - Regional Director of Public Health
Rob Williams - Communications Team, Healthcare for London
Michael Wilson – Project Manager (Stroke), Healthcare for London
Jeffy Wong - Different Strokes

1. INTRODUCTORY REMARKS

Cllr Peter Tobias welcomed everyone to the London Borough of Hammersmith and Fulham, and made some 'housekeeping' announcements.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Councillor David Hurt (Bexley)
Councillor Chris Leaman (Brent)
Councillor Ken Ayers (City of London)
Councillor Chris Pond (Essex)
Councillor Jonathan McShane (Hackney)
Councillor Gilli Lewis-Lavender (Merton)

3. DECLARATIONS OF INTEREST

Cllr Carole Hubbard (Bromley) declared that she was an employee of Bromley PCT and a member of the Royal College of Nursing.

Cllr Greg Stafford (Ealing) declared that he was a member of the British College of Occupational Therapists.

Cllr Vina Mithani (Harrow) declared that she was an employee of the Health Protection Agency.

Cllr Mary O'Connor declared that she was chairman of the London Health Commission and a member of the Royal College of Nursing.

4. MINUTES

RESOLVED: That the minutes of the meeting held on 24 April 2009 be approved as a correct record.

5. ANNOUNCEMENTS

The Chairman reminded members that the next meeting, which would consider the draft response to the JCPCT, would be held at Kensington Town Hall on Friday 22 May, commencing at 10.00 am. The draft response would be circulated for consideration prior to the meeting.

A copy of the Chairman's letter to Healthcare for London concerning timescales for consultation with regard to proposals affecting N.E. London, and in relation to the Health Impact Assessments would be circulated shortly to all JHOSC members.

The Chairman reminded members that a copy of responses by individual Councils should be sent to himself or Julia Regan of the support officers by 8 May.

Cllr Bass reported that L.B. Croydon had passed a resolution the previous day supporting the submission made by Mayday Healthcare NHS Trust proposing the development of a HASU at Mayday.

6. WITNESS SESSION: SURREY PCT STROKE PILOT

The meeting received a powerpoint presentation from Kay Mackay (Director of Strategy and Service Delivery, NHS Surrey) and Dr Carl Long (NHS Surrey), supported by Bhaskar Mandal (Ashford and St Peters Hospitals NHS Trust), David Davis (S.E. Coast Ambulance Service), Felicity Dennis (Network Manager, Surrey Heart and Stroke Network), Helena Reeves (Communications Director, NHS Surrey) and Eddie Hunter (Longsight - Consultants to NHS Surrey).

Kay Mackay referred to the major engagement exercise in 2007 across Surrey (one of the largest NHS areas in the country), leading to six acute high-quality stroke units, with performance milestones built into their contracts.

There were a number of guiding principles underpinning the development:

- Consensus - clinician-led decisions throughout the care pathway, not just in relation to thrombolysis
- Equity of access to high-quality clinical outcomes
- Travel times
- Accessibility - care as close to home as possible, with robust links into local community and support services
- Quality of service was paramount
- Capacity - a recognition that no single unit would have delivered the desired outcomes
- Workforce and sustainability
- Building on what was already in place.

The fundamental challenge was to achieve high-quality stroke care, including 24/7 thrombolysis for all stroke victims, regardless of where they lived in Surrey. This was to be achieved principally by a) ensuring that all acute stroke units met national quality standards b) having specialist stroke teams c) developing knowledge, experience and competency.

It was recognised that there were not enough practising stroke clinicians in Surrey to provide 24/7 thrombolysis at all the sites. Consideration had therefore been given to the use of telemedicine for out of hours (beyond 9am - 5pm) and weekends and bank holidays. The aim was to have telemedicine at all six sites, operating on a network rota basis. Telemedicine also had a useful role to play as a training tool for stroke physicians.

Following the presentation, the NHS Surrey representatives and colleagues responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

The use of telemedicine - which was a different model to that proposed by Healthcare for London - took account of the geographical and demographic nature of Surrey, and was considered to be best-suited for Surrey's distribution of patients.

Being able to diagnose stroke effectively was, of course, critical, but a similar level of specialist care was important throughout the patient pathway. Speed of treatment was all-important, given the rate of loss of brain cells each minute for a stroke victim.

Ten minutes from scene to acute unit was the aim, although the primary attention in this respect was to the length of the 'job cycle' (i.e. the time taken to get to scene, assess a person, and transport them to a specialist unit). A 30-minute journey-time (which the HfL proposals were based on) had been a key determining factor in establishing the number of sites, and was considered the maximum journey length.

It was envisaged that the use of telemedicine should in time allow more patients to be assessed and treated. NHS Surrey was satisfied that radiologists and clinical consultants could rely on telemedicine for stroke diagnosis - there were no indications that the diagnosis by telemedicine was any less reliable than if done in person at situ. Telemedicine had been operating successfully at St Thomas's Hospital, since June 2007. King's Hospital was now linked up to this system for out-of-hours cases.

Reference was made to "Getting Better", published by the Stroke Association (February 2009), which endorsed the use of telemedicine in stroke care pathways.

The information given over the telephone to an ambulance control centre was critical in determining whether a Category 'A' (8 minutes), 'B' (19 minutes) or 'C' (60 minutes) response was delivered. This highlighted how important it was to increase the public's knowledge of stroke symptoms.

Mr Davis referred to there being a good deal of relevant stroke training available for paramedics. A multi-disciplinary training course (including A&E staff) was being piloted in the region. A pre-arrival stroke tool was being piloted in the S.E Coast region, using the 'FAST' test over the telephone; this was likely to be rolled out nationally.

With greater experience in the use of thrombolysis in the future, it could be that the '3 hour window' for treatment of stroke patients, which was presently recognised as the operating norm, could be reduced.

The Chairman thanked the speakers for the presentation and for responding to Members' questions.

7. WITNESS SESSION: BRITISH ASSOCIATION OF STROKE PHYSICIANS (BASP)

The meeting received a presentation from Dr Tim Cassidy.

The BASP was broadly supportive of the measures proposed by HfL, and supported the improvements for people with stroke. However, they had four main areas of concern:

a) The Transition Period

Moving to the establishment of eight HASUs could be traumatic - it often took years to build up a service, and some of the designated centres would be either starting from scratch or requiring support. The Stroke Strategy envisaged a six-month transition period. However, this could be a substantial underestimate, and BASP had significant concerns on the recruitment of staff required to achieve this. Failure to recruit in time would critically affect the ability of the new units to be

functioning in time. There was a risk that the decommissioned services would be blighted, but there was a need to allow them to continue. This would be particularly so for the South East sector.

b) Patient Flow & Repatriation

Maintaining bed availability in such large units would depend on repatriation arrangements. Even minor extensions from the predicted average 72 hour HASU stay could have serious consequences for bed availability. There were many reasons why the 72 hour stay might need to be extended. It was also very important that movements of patients were clinically safe.

c) Repatriation

Busy DGHs were running at 100% bed capacity - would they be able to take patients back? Patient selection could address some of the control of flow to HASUs. Up to 20% of patients had their diagnosis more than 24 hours after symptom onset; these cases could be redirected to their local SU. Approximately 25% of patients triaged as stroke would be 'negatives' and they would also need specific management.

d) Training

There was a concern that there would be a lack of training opportunities during the transition period. The changes would bring a requirement for training for all health professionals involved in stroke care. The existing units would no longer offer exposure to hyperacute care, and the developing units would be too inexperienced.

In response to Members' questions, the following points were noted.

It was very important that the acute stages of stroke were managed by a specialist stroke team. Approximately a third of patients would deteriorate further after admission, requiring more intervention.

Flexible lengths of stay were required, and this would be of concern to PCTs for commissioning purposes.

Changing demographics required an expansion of specialists. It would be an evolutionary change, and the training of all staff would have to expand.

Telemedicine had its role, and was being considered in NE England, but might be less useful for an urban area like London.

There was a recognised concern about a 'big bang' approach, and the transition period would be a time of challenge. Although the strategy was essentially sound, too quick an introduction could lead to a difficult transition.

The Chairman thanked Dr Cassidy for his presentation and for responding to Members' questions.

8. WITNESS SESSION: DIFFERENT STROKES

The meeting received a presentation from Jeffy Wong (Regional Co-ordinator for London, Different Strokes - a charity for and by young people who have been affected by stroke).

The presentation informed members of the impact of stroke on people under the age of sixty, who made up one quarter of stroke sufferers. One thousand strokes each year happened to people under the age of thirty years old.

Mr Wong highlighted the importance of a focus on ability rather than disability in considering recovery and rehabilitation for the younger stroke sufferer. While the consultation focused on the first 72 hours, after-care was also very important. Younger stroke patients should get a discharge pack with information on support and treatment. A multidisciplinary team should include physiotherapists, occupational therapists, speech and language therapists, and counselling for the patient and for their family.

Stroke for a young person meant reconsidering their employment and career, relationships and lifestyle changes if they required long term care. Families often required support from specialist stroke support networks if they were providing care to a young person affected by stroke. Families and carers needed to learn to provide support such as washing, cleaning and administering medication. Patients needed support to return to independence and the possibility of paid employment or another meaningful activity such as volunteering or structured daytime activities.

In response to questions, Mr Wong said that Different Strokes was in favour of the proposals to provide new clinical services for stroke. However it was also important to consider the care following the initial 72 hours. Personalised budgets, for example, could improve independence for young people to have more choice over their care and their daytime activities.

In response to questions regarding strokes in children, Dr Cassidy (British Association of Stroke Physicians) explained that childhood strokes were extremely rare and sometimes a consequence of other conditions such as a genetic condition related to metabolism. Children required specialist treatment, and there was a role for hospitals such as Great Ormond Street Hospital for Children to treat these types of conditions. Mr Wong added that members of Different Strokes as young as nine had had strokes, sometimes related to a traumatic start in life. Families often struggled to cope with a child with these needs; the child lost friends following the stroke, and the family feared for his future. The support activities available were often insufficient to develop the full potential of the child.

Aftercare across London varied. Different Strokes provided a number of support groups for people affected by stroke and support for their families and carers. However due to the relatively small numbers, these groups were provided across groups of boroughs. There was a need for cross- borough collaboration to fund these projects. Support was very important for both patients and carers, to help them discuss and share experiences, frustrations and solutions around care and financial and social support. Some services offered a job club or exercise classes, followed by a social.

Sometimes young people could have two or three TIA's before suffering a stroke. It was important that GP's took TIA's seriously so that early interventions could be made, and having more TIA clinics was important. Young people also required more intensive therapy than older people, so rehabilitation was important to ensure ability rather than disability.

Dr Cassidy responded to a point that the cause of stroke in young people was often unknown. Sometimes it was related to an abnormality in a blood vessel leading to the brain, that might be aggravated by something else (for example, the hair-washing sink in a beauty parlour, or 'head-banging' style dancing). There were usually extensive investigations into the cause of a stroke in a young person, but in many cases the cause remained unknown.

Thrombolysis was licensed from the ages of 18-80. Some experienced consultants might administer drugs to someone over this age for those with otherwise robust health by enrolling them on the drugs trial for people over this age.

The Chairman thanked Mr Wong for his presentation and for responding to Members' questions.

9. WITNESS SESSION: DR SIMON TANNER, REGIONAL DIRECTOR OF PUBLIC HEALTH

The meeting received a presentation from Dr Simon Tanner (Regional Director of Public Health).

From a public health perspective, the test for the proposals in the consultation paper should be whether they: a) maximised outcomes for patients b) provided equity of services geographically, and in relation to particular groups e.g BME c) delivered value for money.

Dr Tanner considered that the proposals for HASUs should meet a) and b), and, on the available data, should prove cost-effective.

Dr Tanner believed that there was quite a convincing case in relation to the proposals for major trauma centres (MTCs). The slightly longer journey time to a MTC was considerably outweighed by the availability of multi-specialist treatment. He considered that the proposals should deliver value for money. Better initial specialist interventions, plus extensive rehabilitation, should lead to fewer people surviving with severe disabilities, with an obvious saving to society.

Following the presentation, Dr Tanner responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

On the question of co-location of a HASU and a MTC, Dr Tanner considered that the specialised treatment of stroke and major trauma had clinical adjacencies, and although not absolutely necessary, it was therefore sensible, where practical, to allow for co-location.

As to whether eight was the right number of HASUs, the 'critical mass' of patients (numbers seen by a specialist) and accessibility were key factors. Dr Tanner considered that in this context, eight HASUs was a reasonable number.

As regards the fact that criteria and methodology for the evaluation of St Mary's or the Royal Free Hospital as the fourth MTC had not been made available, Dr Tanner said that this was a matter which should be raised with Healthcare for London. Similarly, he felt unable to comment on why particular hospitals had not been designated under the consultation proposals.

On the question of whether, from a public health perspective, telemedicine might have a role to play, Dr Tanner said that he would have concerns at its introduction in relation to the model proposed in the consultation paper, since its 'hub and spoke' model would seem to

conflict with what was proposed. However, he professed to not being acquainted with the detail of telemedicine and its application.

Dr Tanner queried which witnesses had expressed concern at the potential difficulty of recruiting sufficient numbers of additional trained staff as part of the proposals. He referred to the fact that centralisation of expertise within the health service usually served to attract staff to that area.

Dr Tanner referred to the benefits in terms of better rates of mortality and morbidity that could be expected from the proposals.

He also drew attention to stroke being a preventable condition to some degree, through practising healthy lifestyle advice, for example. With both stroke and major trauma, the consultation proposals would only be truly successful if good-quality preventative advice/actions tackled the root causes. In the case of major trauma, reckless behaviour of young men was often a causative factor. Work in conjunction with the Police could help to address issues underlying knife crime and alcohol abuse.

Dr Tanner acknowledged that, historically, GPs tended not to have taken TIAs as seriously as they might. However, there was no justification for this to continue.

In terms of capitalising on the recent 'FAST' stroke campaign on television, Dr Tanner referred to a series of initiatives (e.g. "Go London" advertisements) as part of a strategic approach that was being developed. Social marketing would increasingly be used to encourage Londoners to lead a more healthy lifestyle.

The Chairman thanked Dr Tanner for his presentation and for responding to Members' questions.

10. WITNESS SESSION: NHS LONDON

The meeting received a powerpoint presentation from Jo Sheehan (Finance Lead, Healthcare for London) and Simon Milligan (Senior Finance Lead, Healthcare for London). A copy of this presentation is appended to these minutes.

An overview was given of the project objective, scope, key background issues, calculation of financial implications, cost/benefit considerations, and transitional issues.

Following the presentation, the HfL representatives responded to a number of questions from Members.

The JHOSC noted that a request had been made previously to HfL for an estimate of additional numbers of patients per HASU.

Regarding the 72-hours model for treatment of a patient at a HASU, it was explained that calculations had been made on the basis of an average of 3.8 days spent in a HASU. This information was awaited with interest.

There was a high cost to making early specialist interventions, including a significantly increased staff/patient ratio. However, in time, with better prevention and particularly rehabilitation, the overall cost of the stroke care pathway might be expected to change. There had been a number of international studies on the cost analysis of spending required to save a life, and these had been considered by HfL; independent research and analysis of this area was beyond their resource.

As regards the funding underpinning the proposals, good allocations under the comprehensive spending review had been received for 2009/10 and 2010/11, and PCTs had been prioritising their investments for the coming two financial years, and reflecting the proposals in their longer-term financial planning. It was recognised that, at the level of detail, correct clinical coding would be important.

On the question of whether the possible fourth MTC providers (St Mary's and the Royal Free hospitals) could have been operational before April 2012, the JHOSC was advised that it was only subsequently that these hospitals had indicated that they could meet the required clinical standards before that date. There was no question of NHS London planning to operate with only three MTCs, given the less certain financial climate beyond 2011. If the fourth site was able to start operating earlier than April 2012, this would be welcomed.

Jo Sheehan agreed to investigate the question of the methodology and the nine criteria used in relation to the decision on a fourth MTC, and advise the JHOSC accordingly.

The Chairman thanked the speakers for their presentation and for responding to Members' questions.

The meeting finished at 5.46 pm.

Written Submissions to JHOSC

STROKE

The Supporting the Vulnerable in our Community Overview & Scrutiny Committee (hereinafter referred to as the Committee) after having heard evidence from the relevant Cabinet Member, Councillor Helena Hart, and indeed from having heard evidence earlier in the same meeting in relation to ambulance times and in considering the demographics of the London Borough of Barnet (both present and future) including but not limited to expected growth and increased life expectancy, strongly consider the best option for the residents of the London Borough of Barnet and those in neighbouring Boroughs so affected by the relevant Healthcare for London proposals to be such that the Hyper Acute Stroke Units ought to be located at both the Royal Free Hospital and the Barnet Hospital respectively. The Committee advises Healthcare for London that should the above recommendation not be implemented, the residents of the London Borough of Barnet and those of relevant neighbouring Boroughs so affected will be adversely affected as a result of the same.

MAJOR TRAUMA

The Committee having heard evidence in the same manner as that stipulated in the response provided for stroke services hereinabove, consider the option of the current Healthcare for London proposals which include the Royal Free Hospital as a Major Trauma Centre as being the best option for both the residents of the London Borough of Barnet and neighbouring Boroughs likewise affected by the said proposals. In formulating its opinion the Committee consider certain factors to add weight to its opinion which include but are not limited to the fact that the London Borough of Barnet is a major transport hub with the M1, A1 and M25 within its locality, whilst having a large shopping centre namely Brent Cross and given its extremely ethnically diverse population with probably the largest Jewish population of any United Kingdom Borough and most significantly from reportedly being the second most religiously diverse Borough in the United Kingdom. The Committee also consider the potential threat of terrorism to be an influencing factor in forming its opinion given past acts of terrorism and most significantly given the rich ethnic diversity within the London Borough of Barnet and the potential for carnage as a result of the aforesaid transport links.

The Committee notes the excellent skills and abilities possessed by the relevant staff at the Royal Free Hospital and is concerned at the potential loss of those skills should the Royal Free Hospital not be considered as an option for Major Trauma services.

The Committee, being unbiased, have considered the perceived benefits of St. Mary's Hospital being included within the current proposals in light of the argument of potential problems at Heathrow Airport be that by perceived act of terrorism or otherwise. The Committee further note that if St. Mary's Hospital was considered a favourable option by Healthcare for London based on the assertion that it would benefit Heathrow Airport as stated above, then Healthcare for London ought to consider the benefit of the Royal Free Hospital as the preferred option in light of potential acts of terrorism or otherwise stemming from both Stanstead Airport and Luton Airport in light of the same and further and most specifically in relation to the entirety of the reasoning stated within the Committees opinion for the Royal Free Hospital to be included in the preferred option.

The Committee therefore consider that the benefit of having the Royal Free Hospital within the preferred option would be most favourable for the residents of the London Borough of Barnet and those of relevant neighbouring Boroughs for the reasons given above and further to the fact that the Committee are sceptical and indeed concerned about the travel times provided by the Ambulance Service in relation to the current proposed option by Healthcare for London.

In conclusion, the Committee considers four Major Trauma Centres including the Royal Free Hospital to be the most plausible option to take. The Committee recommends that if Healthcare for London believe they can make a strong enough case for St. Mary's Hospital in light of the argument concerning its benefits as a direct result of Heathrow Airport, that Healthcare for London reconsiders its position and also considers the impact on trauma services based on the potential ramifications of issues at all London airports and those within its Region including

Luton and Stanstead Airports. In light of the above should Healthcare for London still consider the potential benefit of St. Mary's Hospital to be favourable the Committee consider Healthcare for London could consider St. Mary's Hospital as a fifth Major Trauma Centre but not at the expense of the Royal Free Hospital.

Brent Council's Response to the Healthcare for London consultation on major trauma and stroke services in London

Introduction

Members and officers at the London Borough of Brent are grateful for the opportunity to comment on the proposals for major trauma and stroke services in London. The reconfiguration of these services will affect people in Brent and so it is important that the local authority is given an opportunity to express its view on these service changes. This paper sets out the authority's comments on both major trauma and stroke services.

Major Trauma Services

We have considered the clinical arguments for the consolidation of major trauma services into three or four major trauma units in London and on balance accept that there is a need to reconfigure services. It is of particular concern that death rates for severely injured patients who are alive when they reach hospital with a major trauma injury are 40% higher in the UK than in some parts of the USA, where they are running effective trauma systems. This inequality should not exist in a country with a health service as developed as the UK's.

Given that the council is in favour of service reconfiguration, we have considered whether three or four major trauma units best serves the people of London, and of course, Brent. Looking at the evidence available, we have come to the conclusion that four major trauma units would be best for the city. Furthermore, assuming that the Royal London, St George's and King's College Hospital will be the site of three of the trauma centres, we think the fourth trauma unit should be located at St Mary's Hospital, Paddington rather than the Royal Free in Hampstead. There are a number of reasons for this:

- We are satisfied that a four centre system will provide each centre with enough patients to develop the expertise needed to improve outcomes for trauma patients. Four centres will also provide the system with enough resilience to cope with a major incident (or series of major incidents) or any unforeseen circumstances.
- Given the Royal London has hosted a major trauma centre for the past 20 years, it makes sense for it to take patients from a larger geographical area than the three other trauma centres. It already has the expertise and experience needed to deal with major trauma. But, if the Royal Free is commissioned to provide major trauma services, its location will affect patient flows to the Royal London. Indeed, the Royal Free would manage the largest trauma network in London. As the Royal Free will not meet clinical standards until April 2012 (compared to April 2010 for the others), this makes no sense. Therefore, St Mary's is a better option because of its location in relation to the Royal London. St Mary's will be the lead centre in a smaller network which will give it time to focus on reaching the required clinical standards. This configuration also makes best use of the experience and expertise at the Royal London.
- North West London, with its proximity to Heathrow Airport, the M4, M40, M25 and M1 needs to be served by a major trauma centre. St Mary's is better placed to do this than the Royal Free because of its proximity to the sites that could be the location of a major incident and also to central London, where most major trauma currently occurs. Convincing members of the public of the need for change is a challenge facing the NHS in London. For Brent, the location of a major trauma unit, close to our borough boundary in Paddington, in a hospital already used by a significant proportion of our residents will make this easier to sell to residents. This is despite time to definitive care being far more important than journey time to hospital.

The council also hopes that as well as investing in major trauma centres, investment occurs in local trauma centres which will continue to deal with the majority of trauma injuries in London. For Brent, this would mean investment in Northwick Park and Central Middlesex Hospitals. One of the benefits of a four network system is the improved standards and performance management the major centre will bring to local trauma units. We hope that as well as improved management, investment goes into the local trauma centres so that the system is balanced and not unfairly weighted towards the major trauma centres, at the expense of local services.

Stroke Services

We have considered the clinical arguments in relation to the reconfiguration of stroke services and agree that they would be better provided in a networked system with a small number of hyper acute stroke units and a series of local stroke units and Transient Ischaemic Attack services. The small number of eligible patients (less than 10%) currently being offered thrombolysis is a reflection of current services and a firm indication that change is needed.

Brent Council supports the Joint Committee of PCTs preferred option to locate a hyper acute stroke unit at Northwick Park Hospital. Northwick Park Hospital is in Brent, but is on the border with Harrow and is obviously well placed to serve client groups from both boroughs, as well as the rest of north-west London. If Barnet Hospital (the alternative choice to Northwick Park) was selected as a HASU we are concerned that parts of north-west London including Brent, Harrow, Hillingdon and Ealing will be some distance from the nearest HASU. This is a worry given the time critical nature of effective stroke treatment.

Parts of north-west London including Brent, have significant black and minority ethnic populations. According to the 2001 census, BME groups account for 55% of Brent's population and this figure is expected to rise significantly at the next census in 2011. The biggest ethnic groups in Brent are:

- Indian – 18.5% of Brent's population
- Black / Black British Caribbean – 10.5% of Brent's population
- Black / Black African – 7.8% of Brent's population

Harrow also has a significant BME population. Over 41% of Harrow's population is from ethnic minority groups. The Asian community (consisting of Indian, Pakistani, Bangladeshi and other Asians) makes up 30% of the borough's total population, of which Indians comprise 21%. There are smaller black Caribbean and black African populations. The most recent arrivals to Harrow are from Africa, such as Somalis. The majority of population growth in Harrow up to 2020 is expected to be in the BME population.

The large, local BME population is relevant because people from BME communities are disproportionately affected by stroke. There is a 60% greater incidence rate of stroke within black Caribbean and black African populations and at a considerably younger age (up to 10 years younger)¹.

Circulatory disease, including heart disease and stroke is one of the two biggest causes of death in Brent. The stroke consultation document states² that the location of Northwick Park Hospital reflects likely patient flows. The document also contains a map showing that large

¹ Stroke Strategy for London, 2008

² The shape of things to come – Developing new, high quality major trauma and stroke services for London – page 38

parts of Brent and parts of Harrow are areas with high stroke prevalence³. Hospital admissions due to stroke from NHS Brent patients increased by 40% between 2003/04 and 2006/07 (from 225 to 325)⁴. There are a number of reasons why this might be the case, including increased survival after a stroke, increasing numbers of stroke events (increase in incidence) per year, or increased proportion of acute stroke patients admitted. Overall mortality from stroke in Brent is similar to that in London.

Twenty two per cent of all households in Harrow are older people households. Although the overall proportion of people over 65 is not as high as the national average, it is higher than the London average⁵. In Harrow the proportion of over 60's is due to increase by approximately one third by 2023, so that this group will then comprise almost one quarter of the total population. Most deaths of people aged 65+ in Harrow are caused by stroke or respiratory disease. On the basis that Brent and Harrow have significant BME populations and that Harrow has an above average number of older residents we believe it makes sense to locate a hyper acute stroke unit, stroke unit and TIA services in Northwick Park hospital, close to large numbers of people who are statistically more likely to suffer from stroke.

Because of the older population in suburban areas, more strokes occur in outer London than inner London. Northwick Park is one of three proposed hyper acute stroke units in outer London (the others being Queen's Hospital, Romford and The Princess Royal University Hospital). The other proposed stroke units are in and around central London. The Joint Committee of PCTs might wish to consider the merits of having more hyper acute stroke units in outer London to better serve people more likely to have a stroke.

We are pleased that investment is to be put into acute stroke care. As the clinical evidence for the reconfiguration shows, this is long overdue. One issue that is of concern to us is that appropriate investment is put into rehabilitation services. If outcomes are improved for stroke patients then rehabilitation will be crucial and we're concerned that once hospital treatment has ended additional stress will be placed on social care budgets to provide ongoing care in the home or residential care. We want to ensure that investment in rehabilitation services matches that put into acute care so patients receive a complete package of care.

³ The shape of things to come – Developing new, high quality major trauma and stroke services for London – page 26

⁴ Brent Joint Strategic Needs Assessment – page 78

⁵ Audit Commission

**Chief Executive's Department
Democratic Services**

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y/r Dial
date 6 May 2009

The person dealing with this matter is Louise Peek
Louise.Peek@bexley.gov.uk

**Freepost RSAE – RCET – ATJY
Healthcare for London
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HA1 2QG**

Email - hfl@ipsos.com

**Copy to – Councillor Christopher Buckmaster, Chairman, Joint Health
Overview and Scrutiny Committee**

Dear Sir or Madam,

**Healthcare for London Consultation on Major Trauma and Stroke
Services – Response from London Borough of Bexley's Health and
Adult Social Care Overview and Scrutiny Committee.**

Thank you for the opportunity to comment on the major trauma and stroke services for London consultation. We welcome any proposals to improve services provided to Bexley residents. Overall we consider that the proposed models of care for stroke and trauma services, if carefully implemented and delivered as outlined in the consultation, have the potential to realise considerable improvements to clinical outcomes and patient care.

However, we are very disappointed that the well regarded and we consider *vital* stroke services currently provided at our local hospital, Queen Mary's Sidcup (QMS), will no longer be provided in future and we feel that this will be a very real loss to our residents. We also have a number of more general concerns which we feel should be considered and addressed to ensure that the proposals can indeed deliver the many benefits that are anticipated.

We note that this is a pan-London consultation for pan-London service delivery. Consultation proposals have been developed to ensure that stroke and trauma services are delivered to the highest standards *across* the capital. The development of care networks for both trauma and stroke services will therefore necessitate greater joint working across the NHS and social care services. We would like to understand how services will be jointly commissioned across these networks and how similar investment, quality systems and service standards across London will ensure that a patient receives the same standard of care wherever they live and whichever care network they access.

We assume the configuration of the proposed care networks is in part based on existing patient flows, current incidences of stroke/major trauma episodes and PCT commissioning plans. If there are significant over-performances on projections we would like to know whether planned services could cope, where patients may be diverted if there is simply no space in their local network and what effect this might have on ambulance journey times?

During the recent Picture of Health consultation in South East London, we received many letters from our residents concerned about the accessibility of services and increased travel times when services are consolidated on fewer sites. In particular, residents were concerned that projected ambulance journey times were over optimistic, given major congestion that can occur at peak times.

The stroke and trauma consultation tells us that major trauma units will be accessible to all Londoners within a 45 minute ambulance journey and a hyper-acute stroke unit will be accessible within 30 minutes. We would like to understand how these estimated journey times have been developed and whether they are based on a journey time at a specific time of day or whether they represent an average figure, the latter suggesting that at some times of day, journeys may take considerably longer.

We hope that the estimated journey times are realistic as travel times have proven to be one of the most important considerations for residents. If they are not achievable we feel that this may undermine public confidence in the proposals. We understand that evidence is available to support the estimates and think that this could usefully be made available at public consultation events as any proposals are taken forward so that reassurance can be provided to residents.

We also note that ambulances are likely to be engaged for longer periods as they take patients to fewer, specialised sites and will also potentially undertake more journeys transferring patients between the different levels of care offered at hospitals within the care networks. We would like clarification of how many additional ambulances are required to meet this extra need and how transfer of patients between sites will be managed.

We feel that there will be more pressure on ambulance staff to make the right decision about where a patient should go to receive the best level of care. This will be fundamental to the success of the new care networks proposed. We would like to know what training will be required so that ambulance staff feel confident in making those decisions for trauma and suspected stroke patients and seek assurance that this can be delivered in time for planned implementation of the proposals.

Whilst the above issues express our more general concerns, we set out below our detailed responses to the separate trauma and stroke elements of the consultation.

Major Trauma Services

The three options for trauma networks propose King's College Hospital as the major trauma centre for South East London. We acknowledge that most major trauma incidents happen towards the centre of London. Princess Royal (PRUH), Queen Elizabeth (QEH), Queen Mary's Sidcup (QMS) and University Hospital Lewisham (UHL) are identified as local trauma centres. None of the options present any variant for South East London. Therefore in terms of the three options presented to us, we support the preferred option 1.

However, we note the maps setting out the three proposed trauma network configurations at pages 8 to 10 of the compact consultation document. On all three maps, QMS has the same status (in terms of offering a local trauma unit) as PRUH, QEH, and UHL. Although at the time of writing we are awaiting the outcome of the Independent Reconfiguration Panel's review of A Picture of Health (APoH), if that reconfiguration proceeds unaltered, QMS will lose its existing A&E services and will offer an urgent care centre only. This will therefore add a third tier of 'trauma' service, which does not appear to have been reflected in the proposed trauma networks. UHL may also see a differentiated emergency surgery intake if APoH proceeds.

The text on page 8 of the compact consultation document states that *"if current or future local consultations result in changes to trauma services provided at hospitals, the proposed trauma networks will be amended"*. We therefore seek clarification as to whether the SE London trauma network will be amended in light of APoH and what affects changes to local A&E provision might have on the proposed network.

Looking at the trauma services consultation as a whole, we note that the Royal London Hospital, King's College Hospital and St George's hospital can all start providing services to Londoners by April 2010. St Mary's Hospital or the Royal Free Hospital may provide a fourth trauma network, but these hospitals will require more time and support, up to April 2012, to meet the required clinical standards. We would like further information on what will happen over that two year period – where will patients in West London go for major trauma care and will other sites cope with added patients in the interim period?

Stroke Services

The consultation identified the PRUH as the preferred option for a hyper acute stroke unit to serve residents of outer South East London. King's College Hospital is also identified as the preferred location for a hyper acute stroke unit, but this would tend to serve residents of inner South East London. A suggested variant is St Thomas' Hospital. It is also proposed to develop local stroke units and TIA services at QEH and UHL. In terms of where Bexley residents will go to access stroke care, only one care network is proposed. In future they will access local stroke units and TIA services at either PRUH or QEH and will use the hyper-acute unit at PRUH.

We support the proposed model of care for stroke services in the future, but are concerned that proposed services in SE London have the capacity to

manage the number of strokes which are particularly prevalent amongst the population of this sub-region of London. Looking at the proposed configuration of local stroke units and TIA services, it appears that a significant swathe of outer South East London, namely Bexley borough, will be without local stroke services.

We would like to understand arrangements for day and out of hours services and whether 24 hour services will be provided at each of the hospitals identified as providing stroke services in South East London. We were concerned about the experience of the South West London Stroke Care Pilot, where there were incidences where patients were taken to a hospital to receive thrombolysis outside of the times this treatment was available, potentially leading to delays within the crucial 3-hour treatment window. The importance of communication cannot be understated.

We are very disappointed that stroke services will no longer be provided at our local hospital, QMS. We have visited the stroke unit at QMS and were very impressed by the services provided and the dedication of all staff. For a Borough such as Bexley, which has the fourth highest incidence of stroke in London, this will be a very real loss to our residents. Vital services will be moved further away and will be more difficult for both the patient and their friends and family to access. It is important to note that boroughs with similarly high incidences of stroke will all retain their local stroke units.

The Picture of Health consultation, which we have already mentioned in this response, proposes that QMS will operate as Borough Hospital providing a range of diagnostic and rehabilitative services. It will be a tertiary centre, where people will go for ongoing care once they have received acute care at a specialist unit.

Therefore we are extremely disappointed that QMS is not identified as a local stroke unit as we think that stroke rehabilitation fits within the service model for QMS as a Borough hospital, as would the assessment and diagnosis of TIAs. Indeed a vision for our local hospital presented to us in December 2008 specifically highlights such a role for QMS. We are therefore very concerned that this consultation continues the slow erosion of services from our local hospital.

We request clarity as to the role that QMS will have in stroke care in the future - what services it will provide, where it will fit within the proposed network of care and how will this be supported by community teams? What rehabilitative services will be available locally?

We would like to know how patient transfers will work and be managed between hyper acute stroke services in one borough, then rehabilitation/monitoring in a stroke unit in another borough, then transfer back to a patients' home borough for further rehabilitation and support. We have already noted that QMS may only offer an urgent care centre instead of a full A&E unit in the future. We would also like to be assured that if a person presents with a suspected stroke, skilled clinicians will be on site to treat the patient whilst waiting for an ambulance transfer to the appropriate location.

More generally, we request clarification of the actual geographical coverage for stroke services. A map included as part of a presentation to the Joint Health Overview and Scrutiny Committee suggested that the 30 minute ambulance journey 'gold standard' included areas outside the London boundary. We would like further detail on this to be provided as we are unclear whether and how these patients from outside London have been factored into the capacity modelling undertaken when the proposed care networks were developed. We are concerned that there may be a financial risk if PCTs outside London decide to fund care elsewhere - will this undermine the viability of the networks?

We are keen that residents' confidence in the proposals are not undermined by a failure to deliver. We note from evidence we have received at the Joint Health Overview and Scrutiny Committee that 570 nurses, 200 therapists, 16 consultants and junior medical staff would need to be recruited. We would like to know whether these staff are already working within the NHS and if not, how far advanced the recruitment process is and whether new recruits will be trained by 2010?

We would like further information on the 'significant development and more support' required to develop the hyper-acute unit at PRUH and the local stroke units and TIA services at PRUH and QEH. Is the JCPCT confident that these hospitals can reach the required standards in the required timescales, and that local PCTs will deliver the investment needed? When is it expected that these hospitals will reach the required standards and what will happen to existing services whilst new ones are developed? It is important that aspiration is met with delivery.

Summary

You will see that we support the proposed structures for the delivery of major trauma and stroke services in the future, although we would prefer our local stroke services at Queen Mary's Hospital to remain as we believe these deliver vital care and support to our residents.

We hope that you find our comments useful. If you require additional detail or clarification of the points we raise above, please do not hesitate to contact me.

Yours faithfully,



Councillor David Hurt
Chairman

Joint Committee of PCTs
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Dear Sir/Madam,

Date: 7th May 2009

Re: Consultation on new stroke and trauma services for London

This response is from the Camden Council Executive Member-*Adult Social Care and Health*, the Camden Stroke Local Implementation Team and the Camden Council Health Scrutiny Committee. The Camden Stroke LIT is a multi-agency group with the responsibility of overseeing the local implementation of the National Strategy for Stroke. Membership of the group is attached. NHS Camden presented this consultation to the Camden Health Scrutiny Committee for discussion which was also attended by the Executive Member.

Stroke

Our joint response is focused on the operational implications of delivering the new proposed emergency response model to strokes. We have grouped our thoughts under key topics for consideration.

Seamless transfer of care

Patient and carer perspective on the success of the new stroke hyper-acute service model will be dependent not only on clinical outcome but their experience during the transfer of care from HASUs to Stroke Units in local hospitals.

Excellent co-ordination of activities and information-sharing when stroke patients transfer from one type of care to another is essential. This will require highly skilled stroke co-ordinators and allocated discharge co-ordinators with excellent communication skills at the HASUs and Stroke Units. They will need to be accessible 24/7, have access to appropriate resources (including beds) and have personal qualities to influence organisational barriers.

It should be noted that HASUs must have access to interpreters on site to explain the next steps of the patient's journey to patient's and carers where English is not their first language. This is especially important given the higher prevalence of strokes in some BME groups and that some patients revert back to their mother tongue.

It will be vital that patient and carer involvement takes place from time of acute presentation and continues until the patient is settled back into the community. This means throughout the pathway

multi-disciplinary skilled staff having the means to access accurate information and provide consistent advice and support (this should include voluntary and community support presence also). This suggests having the means to share the stroke patient register and care plans safely with key care co-ordinators working in various organisations across the pathway.

Copies of discharge summaries, information literature and therapy reports should be given to patients as well as the GP, Social Worker and other key care co-ordinators identified.

It may be advisable to develop a London-wide stroke hyper-acute and acute discharge criteria with protocols with clear timescales and evaluation tools.

It should be noted that not all stroke conveyances will be via the London Ambulance Service. It should be anticipated that some stroke patients will present to their local hospitals via private transportation. Further, analysis of stroke incidence shows a number of strokes take place in non-stroke in-patient departments. It is not clear from the consultation document Healthcare for London's proposal for these scenarios. Should some resources be allocated to ensure all A&E staff and acute wards in local hospitals have adequate skills and equipment to identify and treat strokes presenting to local hospitals?

Acute stroke beds may get blocked without improved discharge planning arrangements. Healthcare for London should consider developing a London wide discharge planning protocol for stroke care as part of the implementation stages of this model.

Long term care and support

The document offers a clear London-wide pathway for acute response to strokes. It would have been helpful to have alongside this an agreed London-wide pathway for rehabilitation, longer term care and end of life care.

Specialist care at HASUs should not be at the expense of providing suitable investment in development of TIA services, prevention services and longer term care and rehabilitation, and savings arising from successful reduction in-patient stay should be re-invested to other parts in the pathway.

To improve the independence of clients, it is suggested that all care provided to stroke patients in London are delivered by staff trained and skilled to work in an enabling way. This model of care would commence on hyper-acute and stroke unit wards and follow into the community –including new ways of assessing and caring by social workers, district nurses and home care staff. Dedicated resources are required deliver enabling training and evaluate its clinical, independence and well-being outcomes.

JCPCT is asked to consider that without adequate long term support services, pressure on rehabilitation and community support services will increase. It is not clear from the consultation paper whether the £23m a year earmarked for stroke includes costs for rehabilitation and ongoing care.

TIA's and secondary prevention

We welcome the new vascular check guidelines, however a TIA and Stroke specific national guideline and resources for GPs and other key community partners to deliver effective secondary prevention and holistic long term care management is required. Otherwise Stroke and TIA rates will remain at the same level.

Evaluation

There is a need for ongoing evaluation of the effectiveness of the HASUs not only in respect to morbidity and mortality rates but also of local practices to deliver smooth transfer of care throughout the care pathway, and patient and carer involvement and education. It is suggested Healthcare for London consider how it will measure patient outcomes, service quality, clinical practice and transfer

processes, and assess how savings in acute care could be reinvested into TIA, secondary prevention and care management.

Timescale

The logistics of 'repatriation' to local stroke units should not be underestimated. Identifying clear points of access for referral, availability of beds and supporting the family and carers along the way takes dedicated time and effort. Healthcare for London should consider extending the deadline for full roll out until learning from early pilots are shared.

Additional comments on stroke from the Health Scrutiny Committee

The Health Scrutiny Committee is not convinced that eight HASU's will be sufficient for London considering the ageing population and an ageing population of BME groups where there is a higher prevalence of stroke. The development of new techniques in these specialist centres might also lead to a greater number of interventions being offered by the HASU's which in turn could require greater capacity. Healthcare for London might consider extending this to ten HASU's in future. Camden residents will be well served by the collaborative partnership between UCLH and Royal Free to provide excellent stroke services.

It is important that all staff -at both the HASU and other stroke services-are trained and able to deal sensitively with the specific needs of people who have had a stroke. Cases where stroke patients with side paralysis lose weight because food provided on the paralysed side of their body and then removed uneaten (due to lack of effective communication amongst all ward staff -including porters- and lack of specialist care) should never happen under these new arrangements.

The smooth transfer between hospital services and into adult social care services for further care is of particular concern to stroke patients and needs to be co-ordinated with ambulance or passenger transport service and communicated to the patient and their carers. Waiting for passenger transport following a stroke can be a cause of distress to patients and it is important that this is properly co-ordinated between the HASU's and their partner hospitals, and on discharge to community or outpatient based rehabilitation services.

Investment into adult social care and rehabilitation services for stroke sufferers to assist them with the transition back into the community and adjusting to any changes in their lives is essential to help stroke patients and their carers to cope following a stroke.

Major trauma

The Health Scrutiny Committee and the Executive Member for Adult Social Care and Health would like to comment on the location of the major trauma centres for Camden residents. The Stroke LIT have no comments to make on location.

Overall proposals

Members are in favour of having new high quality major trauma sites in London to reduce mortality rates for major trauma victims from 40% to a level comparable to the 28% achieved at Royal London Hospital, and similar survival rates achieved in specialist major trauma centres in the USA. The evidence from the Royal London Hospital shows the improvements that can be achieved for major trauma cases by having the right staff, with the right equipment ready to go from the site of the accident straight into the operating theatre.

Number of sites

Members are in favour of at least four major trauma sites to ensure equitable distribution of services across the capital as this would better achieve a balance between the clinical need to centralise services, and keeping services reasonably located for concerned relatives to visit. While London Ambulance Service has demonstrated that the major trauma sites can be achieved by blue light in

good time, having only three sites would mean relatives from the North London would have a considerable distance to travel to attend their family in life threatening situations.

The NHS Trusts in and near to Camden that serve our local residents have rising standards and all provide excellent services. The consultation document provided insufficient information for a judgement to be made between St Mary's and Royal Free to provide the major trauma centre. The methodology for making the judgements on the nine criteria listed in the consultation document has not been made public, and after enquiry it is not known by the hospital trusts either, and there is no explanation why the nine criteria listed are equally weighted.

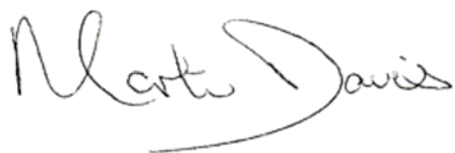
Members do think there may be a case for five major trauma sites. The consultation is based on the estimate that there will be 1600 cases per year in London, however the Royal London Hospital already treat major trauma cases from outside of London. If the major trauma cases outside of the GLA boundary are taken into consideration there would be a case for both Royal Free and St Mary's to be selected to serve the population in the Northern home counties. The consultation only considers people within the GLA boundary yet existing hospital intake demonstrates that London hospitals already provide specialist care to the home-counties . This arrangement would cover the airports and motorways to the North and to the West of London and the centre of London where most major trauma occurs.

Workforce

London ambulance service are key to ensuring that cases are accurately diagnosed and transferred to either the major trauma centre or to accident and emergency which will require significant training and preparation of paramedics. We would endorse proposals to have a low threshold for entry to the trauma centre to avoid cases being unnecessarily transferred from accident and emergency to a trauma centre.

With the development of these additional services there is a concern that there might be a drift of skilled staff to the new major trauma centres. It will be important to develop additional skilled staff within the work force to meet the demand from these new services. The expertise developed in these centres should also be used to drive service improvement and help trauma specialists to gain expertise to take to take back to accident and emergency departments in hospitals across the capital as is already happening with the Royal London hospital and in specialist trauma hospitals abroad.

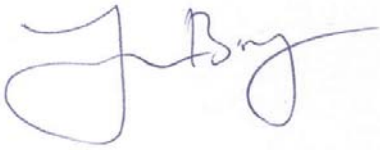
Yours sincerely,



Cllr Martin Davies
Executive Member – Adult Social Care and Health



Mousumi Basu-Doyle
Strategic Commissioner, on behalf of the Camden Stroke LIT



Councillor John Bryant
Chair of Camden Health Scrutiny Committee, on behalf of the Camden Health Scrutiny Committee

c.c. Camden Stroke LIT members
Rob Larkman, Chief Executive NHS Camden
Councillor Christopher Buckmaster, Chair of the Joint Overview and Scrutiny Committee to review new services for trauma and stroke, RBKC

Deputy Chairman Community & Children's Services
Kenneth Ayers CC

Healthcare For London
Harrow
HA1 2QG

Email kenneth.ayers
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Our ref NH/RS/006

Date 14 May 2009

Dear Sir/Madam,

I am pleased to send you the City of London Corporation (CoLC) response to the Healthcare for London consultation on major trauma and stroke services for London. The City of London Corporation has remained engaged with the process by:

- 1) Discussing the report at our own Health Scrutiny sub committee throughout the consultation period. This has included a presentation from the Chief Executive of City and Hackney PCT to consider our comments on the proposals.
- 2) Participating in the London Boroughs Joint Health Overview and Scrutiny Committee (JHOSC). The City of London Corporation has been represented by either Officers or Members at all meetings of the JHOSC.

In general the CoLC welcomes the proposals for major trauma and stroke outlined in your consultation documents. In particular we agree with:

- Your preferred option for the number and location of major trauma units
- The principle that no Londoner should be more than 30 minutes travel time from a hyper-acute stroke unit and that hyper-acute stroke units should be located with major trauma units wherever possible
- Your proposal on how you provide stroke care in the future.

We agree that there should be a minimum of eight hyper-acute stroke units in London but suggest that in planning the transitional arrangements to reach this arrangement you allow longer than you currently anticipate for the transition and build in sufficient flexibility so that a maximum of two further hyper-acute stroke units can be brought on stream if required. We believe that the transition will create significant pressure on your staffing resources, particularly in periods where existing and new services are running in parallel and this will need to be carefully planned for.

Of the specific concerns and suggestions that we have already fed into the JHOSC through our questions we would like to specifically highlight:

1. **The longer-term stroke pathway** – The consultation does not currently cover the impact of the proposals on prevention and rehabilitation services in the community. This is symptomatic of the lack of progress of the integration of Health and Social Care services in London. In order for the improvements in stroke care to be effective there needs to be further consultation on setting consistent standards across London for the whole stroke pathway to avoid significant variations in care.
2. **The co-ordination of ambulance and hospital services** - Although we have been impressed with the approach of the London Ambulance Service to the proposals, we still believe that further evidence is needed to show how hospitals and the ambulance service will work together to co-ordinate both the initial admission of stroke patients and the repatriation of patients between hyper-acute stroke units and local hospitals.

Thank you for giving us the opportunity to comment on the strategy and proposals. We await the outcome of the consultation process with interest and look forward to the positive impact of your proposals on the lives of the residents and workers in and around the City of London.

Yours sincerely,

Kenneth Ayers CC
Deputy Chairman Community & Children's Services
Health Scrutiny Sub Committee & JHOSC Representative

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Please ask for/reply: Mike Fisher

Your Ref
Our Ref: MF/maf
Date: 8 May 2009

Dear Healthcare for London,

Consultation – The shape of things to come: developing new, high quality, major trauma and stroke services for London

We are writing to set out Croydon Council's response to the consultation on stroke and major trauma services for London.

Trauma services

Croydon Council highly values the emergency healthcare services that the NHS provides. We wish to ensure that local people receive the very best in treatment and care. We therefore support the principles underlying the proposals for major trauma with St Georges as the major trauma centre and Mayday, Epsom and St Helier as networked trauma centres for south west London.

Stroke services

Our concerns relate to the proposals for stroke services. We have considered the information presented in the consultation and related documents and would like to make the following points.

We recognise that standards of stroke care for Londoners are not acceptable and need to improve. We believe that the case for change is clear and that the clinical model proposed is based on best evidence. We therefore support the clinical model as set out in the consultation document of Hyper Acute Stroke Unit, Stroke Unit and Transient Ischaemic Attack services.

Croydon Council members have carefully considered the consultation document and supporting materials. Councillors have listened to presentations from Croydon PCT and Mayday Hospital. A number of Councillors have attended pan-London meetings to discuss the proposals, including the Joint Overview and Scrutiny Committee on 24 April 2009. As an authority we also considered the outcome of several meetings of the Scrutiny Sub Committee for Health and Social Care that concluded that currently, standards in the quality of stroke care vary widely and it is recognised that people in outer London have the most limited access to high quality stroke services.

The outcome of our considerations is that we do not support the proposed configuration of services. We believe that there is a strong case for two Hyper Acute Stroke Units in south west London. We set out our reasons for this below.

Croydon is the most populous London borough. We have a higher proportion of older people than some other London boroughs, with many living in the south of the borough. We also have large black African, black Caribbean and south Asian communities concentrated mainly in the north of the borough. We have high levels of deprivation in some areas. All of this means that our population contains a significant number of people who are at a higher risk of stroke. We believe that our residents would be best served by a HASU within the borough.

We have seen the data on ambulance travel times in the briefing document accompanying the consultation. We are still not convinced that journey times to the nearest Hyper Acute Stroke Unit from certain parts of Croydon would be achievable. Evidence presented at the Joint Overview and Scrutiny Committee on 24 April by Professor Markus of St George's indicated that the median 'door to needle' time for the south west London network pilot had been 55 minutes.

The proposals also need to be considered in a context of growing congestion in many parts of London and more frequent disruption. The travel time data presented looks backward but there is no attempt to model future scenarios.

We think that insufficient consideration is given in the proposals to the impact on family and carers. Family members can provide physical and cognitive assistance to stroke victims from a very early stage. Times for non-blue light journeys to the nearest hyper acute stroke unit are very much longer and pose a particular problem for Croydon residents if travelling to St George's. The congestion and parking difficulties in the vicinity of that hospital are well known and are unlikely to improve. Journey times are high and journeys are complex by public transport from many parts of Croydon to St Georges, further compounding the difficulties for family and carers.

We understand that the stroke network pilot with Mayday in partnership with St George's has been favourably evaluated. We also understand that Mayday Hospital presented a strong clinical case as a site for a Hyper Acute Stroke Unit. Their proposal was discussed with and supported by St Georges and Epsom and St Helier hospitals. The proposals will mean that the current level of service offered at Mayday would be reduced. The proposals would also significantly increase the number of stroke patients attending St George's. We do not believe that increasing capacity on a single site in south west London makes the best use of two existing sites which already provide high quality stroke services, both of which could be developed to deliver the clinical model of a Hyper Acute Stroke Unit.

We believe it noteworthy that the Royal College of Physicians also supports a joint bid with St George's, noting that Mayday is on the 90th percentile of stroke units in the UK.

St George's itself says that it would not be able to cope with all of Croydon patients along with those from St George's and Epsom St Helier. It is certainly concerned that it does not have the capacity to deal with the predicted increase in stroke patients. This is understandable because if St George's was the only hyper acute stroke unit for SW London, we understand that it would become the largest in the world dealing with in excess of 2000 stroke patients a year.

We understand that some of the Croydon flow of patients could be routed to the Princess Royal University Hospital in Bromley. However, we would find it strange that a hospital that did not meet the evaluation criteria for a hyper-acute facility would be prioritised over a hospital that did meet the criteria.

In conclusion we believe that Croydon residents would be disadvantaged by the recommended option presented in the consultation document. Developing a Hyper Acute Stroke Unit at Mayday, possibly in partnership with St George's would, by contrast, provide the very best treatment and care for local people, guarantee that travel times can be met, and ensure that services across south west London are able to meet demand.

Therefore, the following resolution was passed at an Extraordinary Council meeting on 6 May 2009, which expresses the Council's position with respect of a HASU at Mayday Healthcare Trust:

"This Council supports the submission made by Mayday Healthcare NHS Trust to Healthcare for London that proposes the development of a hyper acute stroke unit (HASU) at Mayday. Such a development reflects the original joint bid made with St Georges for two HASUs providing specialist service capacity for the population of Croydon, South West London and surrounding areas".

In short, we have two centres in South West London both of a quality to provide a 24/7 hyper acute stroke service, both centres want this to happen - a two site approach makes sense.

We hope that you will take Croydon Council's seriously considered views into account when assessing the feedback on this important consultation document.

Yours faithfully

A handwritten signature in black ink that reads "Mike Fisher". The signature is written in a cursive style and is positioned above a long, horizontal, slightly curved line that serves as a decorative underline.

Mike Fisher
Leader of the Council

**‘The shape of things to come – developing new, high-quality major
trauma and stroke services for London’
- The views of Ealing Council’s Scrutiny Panel**

1. Background

Ealing’s Health, Housing and Adult Social Services Scrutiny Panel considered the proposals set out in ‘The shape of things to come – developing new, high-quality major trauma and stroke services for London’ at a special meeting held on 8th April 2009. The Panel invited the following bodies to provide evidence to this meeting, including:

- Healthcare for London – Project Lead for Stroke
- NHS Ealing – Chief Executive and Director Quality, Clinical Governance and Clinical Practice
- Ealing Hospital – Chief Executive and Consultant Neurologists
- NW London Stroke Network

2. Overall Views

The Scrutiny Panel supports the proposed framework outlined in the summary page of the consultation document, ie the

- development of new networks based around new major trauma centres
- establishment of hyper-acute stroke units for initial treatment and assessment
- the designation of certain hospitals to provide stroke units and TIA services

3. Major Trauma

The Scrutiny Panel favours the establishment of four new major trauma centres including St Mary’s Hospital (Option 1 in the consultation document).

4. Stroke

The Scrutiny Panel notes that Ealing Hospital did not bid to be designated as a hyper-acute stroke unit (HASU) and recognises and accepts that under the current proposals people suffering a stroke in LB Ealing will be taken to a HASU at Charing Cross Hospital or Northwick Park Hospital. The Scrutiny Panel also recognises that – according to a report provided by NHS Ealing - these hospitals are already the primary destination for 22% and 10%, respectively, of Ealing residents who suffer a stroke.

However, the Panel strongly opposes the proposal that the existing stroke services at Ealing Hospital be de-commissioned.

Two justifications for de-commissioning Ealing Hospital’s existing stroke services are given in the consultation document:

“These sites would need significant support to meet future standards, and extra capacity is not required in this area.”

The Scrutiny Panel does not believe that either of these justifications stand up to close consideration:

4.1 “Significant support” needed

- 4.1.1 Even if it were true that Ealing Hospital required significant support to meet future standards (which is disputed - see following sections), the case for ruling out Ealing Hospital as a stroke unit location is somewhat undermined by the inclusion of 5 other hospitals (out of the total of 21 proposed) which were *“shown to have significant development needs and would require more support to develop their services”* for the provision of a stroke unit. Similarly, the document states that West Middlesex *“will be supported to develop new standards”* in order to provide a TIA service; yet Ealing is not being offered such support.
- 4.1.2 However, the Scrutiny Panel is not persuaded that the process for assessing Ealing Hospital’s bid has been fair and transparent. The Panel noted that some of the hospital’s own self-assessment scores were significantly downgraded by the independent expert panel. Healthcare for London has subsequently failed to provide an adequate explanation for this downgrading (see **Appendix 1**). Furthermore, and despite requests, no appeal procedure has been put in place for a review of the scoring; in the circumstances, this seems like harsh justice. The apparent invitation from HfL for Ealing Hospital to submit a new proposal in collaboration with another provider is seen as a “sop” with which to fob off Ealing Hospital’s case for a proper re-assessment of the scores and the proposals. Overall, the downgrading of the scores, the inadequate explanations and the lack of any appeals procedure has led Scrutiny members to take very seriously the allegation that there are other agendas or forces at play.
- 4.1.3 Concern about the assessment made of Ealing Hospital’s services by Healthcare for London’s independent expert panel is heightened by the results of the National Sentinel Stroke Audit Phase II (clinical audit) 2008, as recently-published by the Royal College of Physicians. At the time of the Scrutiny Panel, the overall report had not been published but Ealing Hospital had obtained approval for the presentation of its own ‘Process domain and total score: site variation’ results (in section 15.4) to the Scrutiny Panel. This showed that Ealing Hospital had advanced in performance from the “Middle half” in 2006 to the “Upper Quartile” in 2008.
- 4.1.4 The full results of the Stroke Audit were published in w/b 20th April 2009. These show that the quality of the stroke unit at Ealing Hospital compares very favourably with other services in NW London:

Trust name (site name)	Overall position 2006	Overall position 2008
Ealing Hospital NHS Trust	Middle half	Upper quartile
Hillingdon Hospital NHS Trust	Middle half	Middle half
Imperial College Healthcare NHS Trust	n/a	Upper quartile
North West London Hospitals NHS Trust (Central Middlesex Hospital including Willesden Community Hospital (Brent PCT))	Middle half	Middle half
North West London Hospitals NHS Trust (Northwick Park Hospital)	Middle half	Upper quartile
West Middlesex University Hospital NHS Trust	Middle half	Middle half

4.1.5 The Scrutiny Panel does not see any logic in de-commissioning a service of such high standards. It is very concerned about the possible waste of resources, both of staff expertise and facilities that may result from a de-commissioning of existing services. The facilities include dedicated ceiling mounted hoists and a gymnasium for patient rehabilitation both of which were only recently installed.

4.2 “Extra capacity is not required”

4.2.1 The consultation document does not give any data on the number of beds proposed at each stroke unit. There is therefore no evidence to back up the statement made in the document, in respect of Ealing Hospital, that *“extra capacity is not required in this area”*. Similarly, the letter from the HfL Senior Responsible Officer for the Stroke Project to Ealing Hospital’s Chief Executive stated that the *“preferred option configuration will provide enough bed capacity to meet the needs of all Londoners, including those living in Ealing”* but provided no data.

4.2.2 The Scrutiny Panel was informed that actual bed numbers at each stroke unit would not be determined until after the locations have been finalized. So, again, it is unclear how an assurance of sufficient bed capacity can be given.

4.2.3 The same letter from the Senior Responsible Officer states that *“The Collaborative Commissioning Group (CCG) for North West London is supportive of the preferred option for the North West London sector and is confident that sufficient bed capacity will be available at stroke units in this area.”* However, Ealing Hospital consultants provided the Scrutiny Panel with data (see **Appendix 2**) that contradicted this view, predicting a serious shortfall.

4.2.4 Statements were also submitted to the Scrutiny Panel by consultants in nearby hospitals that expressed concerns about bed capacity:

" I would like to express strong concerns over the large number of patient movements anticipated and inadequate bed numbers under these plans. We bid for 28 beds just to get 90% coverage on the stroke unit for our current numbers. We have planned no extra beds for the capacity which will be lost as a result of Central Middlesex and Ealing hospitals losing their stroke units."
(West Middlesex Hospital Clinical Consultant Physician)

"The planned Stroke Unit bed numbers in the surrounding Trusts will not be sufficient to cope with Ealing Patients. This will result in backing up of patients in the HASU with real discharge difficulties. Ealing patients and their carers will also lose out on the benefits of having a local service with community links for their stroke rehabilitation."

(Clinical Consultant Stroke Physician working in local NW London Trust designated as preferred HASU)

4.2.5 The Scrutiny Panel was further informed by Ealing Hospital consultants that none of the other hospitals in NW London had bid to provide beds for Ealing residents. Commissioners present did not necessarily accept this view but no evidence was provided to contradict it.

4.2.6 The Scrutiny Panel therefore welcomed the view of the HfL Stroke Lead and the Chief Executive of NHS Ealing that there is a need to review the proposed bed numbers. The Panel believes that the apparent shortfall in capacity should be filled by retaining and developing the existing stroke unit at Ealing Hospital supplementing this with continuation of TIA services on this site.

There are three further reasons why the Scrutiny Panel believes it is right for Ealing Hospital to continue to provide a stroke unit and TIA services. These are related to the incidence of stroke, the longer-term impact on Ealing Hospital NHS Trust and its patients, and travel distances for visitors:

4.3 Incidence of stroke

4.3.1 The Panel was informed that the map contained in the consultation document (p26) on the 'Prevalence of stroke in London' is based upon a predictive model developed by the London School of Economics. This shows LB Ealing as having one of the most extensive, if not *the* most extensive, geographical areas of stroke in NW London.

4.3.2 Meanwhile a report produced by NHS Ealing ('Ealing Whole System Review of Stroke Services – Part 1: Stroke Needs Assessment'), which was also considered by the Scrutiny Panel, records that:

"In the first 6 months of 2008/09, 349 people in Ealing have had a stroke. Whilst there has been some degree of variation in the number of strokes over the last 2.5 years, this year represents a

40% rise in the number of strokes, compared to the same period in 2007/08. It is unclear what the cause of this variation is.” (p28)

Men and South Asian populations are the two groups most likely to require hospitalisation following a TIA compared to women either due to higher incidence of TIA or more severe symptoms.” (p27)

“Similarly to TIA, populations from an ethnic minority background, in particularly those from South Asian origin seem to be over-represented compared to the standard ethnic breakdown of the borough.(p29)

“An analysis of the correlation between age, ethnicity and the incidence of stroke highlights the disproportionately high proportion of South Asian and African, Caribbean and other non-white ethnic groups who have a stroke before the age of 60, compared to White ethnic groups (in particular White British), where nearly 40% of strokes have occurred after the age of 80.” (pp29/30)

“Over 40% of the population are from Black or minority ethnic communities, with 25% describing their ethnicity as Asian or Asian British.” (p7)

4.3.3 Furthermore, admissions from Southall electoral wards – the area in which Ealing Hospital is situated – were described by Ealing Hospital as running at twice national levels.

4.3.4 The size of the population of LB Ealing, local demographics and the high level of incidence of stroke within the borough all make it desirable for some stroke services to be based within the borough.

4.4 Impact on Ealing Hospital NHS Trust and its patients

4.4.1 The Scrutiny Panel is seriously concerned that de-commissioning the current stroke services at Ealing Hospital will have a significant long-term negative impact on the hospital and the patients that it serves.

4.4.2 Ealing Hospital estimates that direct income of c. £1.5m would be lost if stroke services are no longer provided at Ealing with a resultant net loss to the Trust of between £0.6m and £1.4m. The Scrutiny Panel is therefore concerned about the impact that this may have on future services to patients.

4.4.3 More specifically, the Scrutiny Panel shares Ealing Hospital’s deep concerns that specialist acute services and procedures available at EHT, including acute surgery (especially vascular) and coronary angiography, will be under threat if the stroke unit is removed.

4.4.4 Patients facing acute procedures are known to be at higher risk of stroke. Should the stroke unit at Ealing Hospital be de-commissioned, staff at Ealing Hospital would have to call an ambulance to take anybody suffering a stroke to another hospital. A further reason, why it does not make sense to remove current stroke services from Ealing Hospital.

4.5 Travel distances for visitors

4.5.1 Lastly, the Scrutiny Panel is concerned about the travel implications for families, carers and friends who will be forced to travel further afield to visit patients.

4.5.2 Under the current proposals, Ealing patients would be taken from the HASU at Charing Cross Hospital (or St Mary's Hospital) or Northwick Park Hospital to Hillingdon or West Middlesex Hospitals for stroke unit care. It is not clear whether patients will be given any choice in this matter but in both cases they may be taken yet further away from their home. In some cases the journey may even pass the front of Ealing Hospital.

6.5.09

JULIE LOWE, CHIEF EXECUTIVE
Direct Line: 020 8967 5492
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Ealing Hospital 
NHS Trust

Uxbridge Road
Southall
Middlesex
UB1 3HW

8th January 2009

Rachael Tyndall
Senior Responsible Officer
Stroke Team
Healthcare for London

Dear Rachael

Ealing Hospital Stroke Designation Process

I am writing in response to the feedback provided via email on 23rd December. I was very concerned by some of the comments made by the evaluators and would wish to make the following comments:

Overall assessment

The bid was completed by two Executive Directors, Lead Physician for Stroke and Lead Neurologist for TIA. I am therefore at a loss to understand how they were of insufficient experience or seniority and on what basis the evaluators reached this judgement. I am also unsure how they decided that the clinical and managerial oversight of the stroke service is weak.

The bid was discussed in detail at Board level on several occasions. We understood that the only evidence required was the Chief Executive's signature. I am concerned that a willingness to accept significant financial risk created concern about corporate impetus as this appears to be contradictory. In fact we believe that local people need and deserve a local service even if it is not financially beneficial to the Trust. This Trust's financial position is more stable and secure than a number of Trusts who have been designated.

The comments about the TIA service are strange. It is precisely because the area is so deprived that we wish to provide the service – the standards are challenging and it is inevitable therefore that our bid was aspirational.

Bid evaluation scores (Stroke Unit)

2) Our plan was to increase the number of stoke beds to 26 ie to designate a complete ward. It is unclear why the evaluators believed this would be done in April 2010 rather than October 2009. I believe there was no logical basis for downgrading this score.

3) Our most recent audit did support the fact that we are meeting the target. The statement that the criteria cannot be met at the moment is therefore incorrect.

4) Noted.

6) Evidence was provided by reference to the Sentinel audit

7) Noted.

14) Our response describes how this standard is met. Note the comment about a larger unit.

17) Noted.

19) A comprehensive response was provided detailing existing links.

20) Noted.

22) Unclear why the evaluators thought we could not make an appointment by October 2009.

25) Rotational arrangements are already in place therefore it is unclear why the evaluators thought they would take until 2010 to establish.

28) Noted.

29) Noted.

30) Noted.

32) Our response provided evidence that leadership training has been completed. I am therefore unclear how the comment that it takes 18/12 to train in leadership is relevant. I would also challenge whether the assertion that it takes 18/12 to train in leadership is in any way evidence based.

33) The self assessment of '5' was based on demonstrated participation in 2 existing projects. Evidence of plan to do even more appears to have reduced our score?

34) Paragraphs 1 and 3 of our answer to this point are stroke specific. Paragraph 2 was included for context.

35) Our self assessment provided evidence that this is in place. The comment would represent good practice but does not mean the standard will not be met until October 2009.

Bid evaluation scores (TIA)

2) Noted.

3) TIA and stroke bids were interdependent as required by the process. The Trust began the process of establishing a TIA service over a year ago and therefore the October 2009 target was seen as achievable.

9) Response provided a clear and honest plan for compliance by October 2009 and covered all eventualities.

12) All required modalities are available with a contingency plan. It is unclear what the evaluators believed this to be aspirational.

14) Given it was not possible to bid for TIA service without an SU, it is unclear why it matters that this criteria is dependent on SU.


20) Noted.

23) Noted, but unclear why self-assessment has been down graded. It would be helpful for future reference to be given sight of a "good"/"compliant" bid and associated scores (anonymised if necessary).

In summary, I am very disappointed that local people will be deprived of a much needed service on the basis of what appears to be a somewhat subjective assessment. I would very much welcome the opportunity to meet with the evaluators to understand further their reasoning and to help my team come to terms with the loss of a service they have worked hard to develop. I hope you will be able to arrange this for us.

Meanwhile, we are working with the local PCT and neighbouring providers to see what can be salvaged from this situation for the people of Ealing.

Yours sincerely,



Julie Lowe
Chief Executive

cc. David Sissling, Programme Director for Healthcare for London

Julie Lowe
Chief Executive
Ealing Hospital NHS Trust
Uxbridge Road
Southall
UB1 3HW

6 March, 2009

Dear Julie,

Following my meeting with your colleagues on 19th January, I have recently written to Bill Lynn to follow up on the outstanding issues which we were not able to answer on the day. In this letter, I hope to address the issues that you raised separately with Don Neame, Head of Communications at Healthcare for London.

At the meeting with Bill, and other colleagues (including a representative from Ealing PCT), we discussed in some detail the outcome of the assessment process and the comments that the evaluators had made on the bid submission from your Trust. This included discussion of the detailed response which you had written to the evaluator's report. I apologise if you were expecting a written response to your letter. Our understanding was that the discussions at the meeting had addressed these issues and the only outstanding correspondence related to those issues which we agreed to follow up afterwards. These have now been addressed in my letter to Bill.

I note your concerns re the potential use of 'Clayponds' as a stroke unit for Ealing patients. It is my understanding that this facility has never been discussed as a stroke unit in place of Ealing Hospital. Ealing PCT have been strongly supportive of continuing post-acute rehabilitation continuing locally. In the new model of stroke services in London, all patients transferred from HASUs will go to Stroke Units designated as part of the current consultation and evaluation process (i.e. those in acute Trusts). The proposed number of HASUs and SUs in the preferred option configuration will provide enough bed capacity to meet the needs of all Londoners, including those living in Ealing. The Collaborative Commissioning Group (CCG) for North West London is supportive of the preferred option for the North West London sector and is confident that sufficient bed capacity will be available at stroke units in this area.

We used a number of models to reconcile the required stroke bed numbers for London and have tested this against future population changes. The new model demands that no Londoner is more than 30 minutes from their nearest

HASU. Although we did not set a parameter for travel time to a stroke unit, we accepted the general principle that journey times should be no more than 60 minutes by public transport. With the preferred option, all Londoners are within 30 minutes of a HASU and the average public transport journey time to a stroke unit in the preferred option is 35 minutes. The model will require a smooth flow of patients between HASUs, stroke units and community services in order to deliver high quality care to all. The Stroke networks are looking at how to manage these pathways effectively.

Every NHS acute Trust in London was invited to bid for stroke services and it was made clear that some units currently providing services may not continue to do so in the new configuration for London. As stated above, we and the North West London CCG are confident that sufficient capacity of stroke units beds will be available to the local population in that area.

The designation process stipulated that TIA services could only be provided at sites that have a HASU and/or a stroke unit. As there is no proposed stroke unit at Ealing Hospital it would not be possible to designate a TIA service at this site. A stroke unit is proposed at the West Middlesex Hospital and after discussion with local commissioners, it was agreed that they would also wish to commission a TIA service and if designated, they will be supported to develop this to the new standards.

I trust that this letter, along with my letter to Bill (into which I have copied you) have addressed your outstanding concerns. However, as I stated in my letter to Bill I remain happy to meet with you if you have any further issues you wish to discuss. Finally of course, the consultation period provides an opportunity for Ealing Hospital, potentially in conjunction with local partners, to offer comment and make proposals for consideration by the JCPCT

Yours sincerely



Rachel Tyndall
Senior Responsible Officer, Stroke Project
Chief Executive Officer, Islington PCT

Data provided by Ealing Hospital consultants to Scrutiny Panel

**Comparison : HfL projection for 2008
versus actual numbers of stroke unit patients**

	Current # ¹	HfL projection ²	Shortfall ³
Ealing			
EHT	350	307	350
Harrow/Brent			
CMH	350	291	
NPH	400	240	510
Hillingdon			
THH	300	259	41
Hounslow			
WMH	350	207	143
	potential # of patients without beds		1044

Notes

- 1 Numbers supplied by consultant physicians in charge of the relevant Stroke Units
- 2 Source: HfL Preliminary Stroke Strategy, Appendix 11 – numbers above are total of projected SU deaths + SU providers
- 3 Assuming current designation plans are implemented

The Shape of things to come – developing new, high quality major trauma and stroke services for London.
The views of Enfield Council's Scrutiny members attending the JOSC London.

Major Trauma Units

We have considered the clinical arguments for the consolidation of the major trauma services into three or four major trauma units in London.

We note that major traumas which happen in this area already go to Royal London Hospital but we would like further evidence to compare current patient flows with anticipated flows to demonstrate the impact this will have on our local population under the proposed models of care.

We are pleased that NHS London have recognised the need to address the care for patients suffering from severe knife wounds that unfortunately occur in this and many outer London Boroughs.

We note that Chase Farm is included in the Trauma network and seek clarification on its future role.

We note that the preferred option, with 4 Trauma networks, is better for our residents as North Middlesex, Chase Farm and Barnet Hospitals will all be in the same network and therefore the patient pathways should be easier to co-ordinate.

Clear patient pathways are key to any successful implementation. We would want to see how this will be achieved. We seek clarification as to who will be responsible in the major trauma unit for ensuring that all services are in place before the patient is transferred on or discharged home.

We have real concerns that the necessary support services are just not there and no funds are available locally to develop this service.

We seek assurance that the lack of provision will be addressed and that the changes will develop across the whole network, both in terms of workforce planning, training and development in secondary care; GPs and primary and community care.

Patients relatives and carers need to be assured at all times that their care is properly managed and that local services have the ability and the capacity to continue the care that has been started at these major trauma units.

The Ambulance service, when they are involved, need to recognise the treatment required and transport the patient to the most appropriate setting.

Stroke Services

The proposed hyper-acute stroke units sit uneasily with our residents, particularly as the NHS states that more strokes occur in the outer London.

We note that for Enfield, UCH will be our hyperacute unit. Assurance is needed that there will be the capacity to cover North London as Northwick Park will not be acceptable to our residents due to accessibility constraints.

We understand that North Middlesex Hospital was not successful in applying for Hyper- acute stroke status. We would like this to be reviewed given the population it serves.

More work needs to be done on exactly who would benefit from going to a specialised unit and who would still be going to the local hospital for their initial care.

The Health Scrutiny reviewed Stroke services in Enfield in 2005. We were concerned at the lack of a clear pathway for strokes and recognise the urgent need to address this.

We are aware of the lack of investment over the years to provide good quality dedicated stroke services locally. Scrutiny's recommendation regarding the need to provide rehabilitation services was accepted as a priority by Enfield PCT but never acted upon. Enfield PCT are now forecasting a £16m deficit this year with an additional £9 million to be paid back in 2010/2011. We want assurances that funding will be available to develop and sustain services that must be in place before the proposed model of care comes into force.

The proposed model of care depends on good patient pathways. Expertise developed from these hyper-acute units must be used to develop and maintain service improvement back at the local stroke units.

We seek clarification as to who will be responsible in the hyper acute unit for ensuring that all services are in place before the patient is transferred on or discharged home.

Consultation Response – Healthcare for London Consultation Major Trauma and Stroke Services from Health in Hackney Scrutiny Commission

Context

This response comes from the Health in Hackney Scrutiny Commission which is the London Borough of Hackney's nominated health scrutiny committee. Please note this is an Overview and Scrutiny Response not an LBH corporate response.

Hackney Health Profile

Hackney is a highly complex borough comprising of a highly diverse ethnic / mobile population and a significant number of people living on the margins of society. Hackney has a population of 207,800 according to the ONS; 218,000 according to the GLA estimates but 256,000 people on its GP registers.

The health profile for 2008 showed the following to be significantly worse in Hackney than the England average:

- In general, the health of people in Hackney is worse than the England average
- There are health inequalities within Hackney for example, men and women from the most deprived areas have a three year shorter life expectancy than those in the least deprived areas
- The percentage of children eligible for free school meals is higher than the England average across all ethnic groups
- Premature death from heart disease and stroke in Hackney are higher
- Teenage pregnancy in Hackney are higher
- Childhood obesity rates in Hackney are higher
- Although the rate of adults who smoke in Hackney is similar to the England average, the death rate from smoking is higher.

Our Response: Major Trauma

The Commission recognises the proposals for Major Trauma services present little change to health service networks operated by local health service providers for London Borough of Hackney residents, as major trauma services will continue to be provided at the Royal London.

The Commission would propose support for option 1, but still would express concern about the concentration of centres in central London and would ask Healthcare for London (HfL) to note public concern about the ability of London Ambulance Service to meet the travel time stated to carry patients especially from outer London to the specialist centres in particular during peak travel times.

The Commission notes little detail has been provided about rehabilitation services in relation to major trauma patients, and would ask HfL to outline if patients would remain in the specialist centre until fully recovered or be transferred to their local district general hospital (DGH).

Our Response: Stroke

HiH acknowledge and agree improvements to the stroke services care pathway are required to allow patients across London access to the same quality of care. HiH consider these proposals will provide little change to the set up of local health service provision for Hackney residents; but would like to express to HfL concern that the consultation document appears once again to be very medically weighted and provides little detail about the impact of the proposals to community / social care services e.g. domiciliary care.

Agreement to the number of HASUs in London would be hard to determine for non clinical or academic professionals. Again HiH is not in the position to agree or disagree with the number of hyper acute stroke units (HASU) but would note health professionals consulted through the Joint Health Overview and Scrutiny Committee (JHOSC) have not expressed concern about the number of units across London being too small or too large.

The security of our local DGH (Homerton Hospital) as a stroke unit remains unconfirmed and is subject to the North East London Review of acute services. HiH would express opposition and deep concern if the outcome meant that stroke services were to be provided out of the borough for Hackney residents.

In principle and pending the outcome of the North East London Review HiH endorses the proposals for stroke services in London.

General Comments for consideration:

- Concern there is a concentration of investment at the implementation of care pathway and none at the end of care pathway i.e. rehabilitation.
- Need good education campaign to raise public awareness about the specialist centres
- Assurance the appropriate workforce will be in place by implementation for each of the designated specialist centres and stroke units
- Guarantee of beds availability for transfer of patients from specialist centre to local DGH
- Would ask HfL to consider the proposal for all DGH's to have access to CT Scans with a consultant between 9-5 Monday to Friday
- The risk to patients at transfer stage in the early stages of treatment should not be underestimated especially as the proposals are to transfer patients within the 72 hours of the incident.
- Although the aim is to have seamless services there is the issue that health service provision is free at the point of delivery and social care services are subject to assessment and classified as paid services. HiH would urge HfL to identify how patients will be made aware of what are free and what are paid service
- HiH would also like HFL to give assurance the designation of The Royal London Hospital as a major trauma centre, hyper acute stroke unit and stroke unit will not impact its ability to provide quality local DGH services to its local residents and the workforce will be spread adequately across all services in the hospital.

Conclusion

We welcome the Healthcare for London proposals for major trauma and stroke services in broad terms and would urge the HfL to undertake a major health education campaign to educate the population about the changes to services.

We have highlighted some concerns above and hope that you find our observations useful in your deliberations.

Cllr Jonathan McShane

Chair of the Health in Hackney Scrutiny Commission

London Borough of Hammersmith & Fulham response to “The shape of things to come: Developing new, high-quality major trauma and stroke services for London”

Key Messages

The Council has three concerns regarding the Healthcare for London proposals for trauma and stroke services:

- The proposals will lead to the downgrading of Charing Cross Hospital from a regional specialist hospital to a community hospital that provides only local services. This amounts to “closure by stealth”.
- The lack of commitment to Charing Cross Hospital by the Imperial College Healthcare NHS Trust managers is evident in the original Imperial submission for the Major Trauma Centre at the Charing Cross site.
- The case for setting up the Hyper Acute Stroke Unit (HASU) at Charing Cross and then moving it to St Mary’s has not been made.. Neurosciences and neurosurgery are already established at Charing Cross site. Charing Cross Hospital offers a much more cost effective site for development than St Mary’s.Hospital where another HASU would be located just two miles away at University College Hospital.

Downgrading Charing Cross Hospital

The Council is concerned that the Healthcare for London proposals on trauma and stroke represents another step in the downgrading of Charing Cross Hospital from a regional specialist hospital to a community hospital providing local services. This amounts to "closure by stealth".

The lack of institutional commitment by Imperial College Healthcare NHS Trust managers to developing Charing Cross as a world class hospital is evident in the major trauma centre submission and the Trust’s decision not to recommend that Charing Cross is given the opportunity to reach the required clinical standard by 2012 (as in the case of the Royal Free Hospital)..

The failure to select Charing Cross as an option for the Major Trauma Centre and the stated intention to move the Hyper-Acute Stroke Unit (HASU) from Charing Cross to St Mary’s also demonstrates how specialist services are being removed, and the continuation of a downgrading process which has been going on for many years.

There is no case for moving the HASU from Charing Cross

The Council welcomes the proposal for the establishment of the Hyper-Acute Stroke Unit (HASU) at Charing Cross. However, the case for moving it to St Mary’s (should it be awarded the Major Trauma Centre) has yet to be made for the following reasons:

- St Mary's has no track record in neurosurgery and Charing Cross already has an established regional neurosciences department that includes neurosurgery..
- Moving the HASU to St Mary's would require redevelopment of the site. Charing Cross represents a significantly more cost effective option for redevelopment than St Mary's at a challenging time for public finances.
- Imperial College Healthcare NHS Trust is proposing to move the HASU to St Mary's when it is only two miles from the proposed HASU at University College Hospital.
- Ambulance travel times to the HASU will be essential in delivering improved outcomes for stroke patients. However, London Ambulance Service have been unable to provide an assessment of ambulance travel times going to St Mary's in Paddington rather than Charing Cross Hospital for residents living in the London Boroughs of Hammersmith & Fulham, Ealing and Hounslow.

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Friday 8 May 2009

Harrow Overview and Scrutiny Committee's response to the Healthcare for London consultation 'The shape of things to come: Developing new, high-quality major trauma and stroke services for London'.

We write in response to the consultation conducted by NHS Harrow (on behalf of Healthcare for London) on '*The shape of things to come: Developing new high-quality major trauma and stroke services for London*'. We are sharing this response with the pan-London Joint Overview and Scrutiny Committee (JOSC) on Healthcare for London which may consider this evidence to inform deliberations at a wider pan-London level.

By way of background to our processes, to facilitate our contributions to the JOSC, in Harrow we established a cross-party working group of scrutiny councillors to lead on the *Healthcare for London* scrutiny work. This working group¹ has pulled together this response on behalf of scrutiny in Harrow. We are clear that this response represents a Harrow scrutiny perspective and as such does not preclude any other groups/organisations/individuals from our organisation or the wider health and health and social care economy from submitting their own views. We acknowledge that as a JOSC has been established to consider Healthcare for London, NHS bodies are not obliged to respond to our individual Overview and Scrutiny Committee's comments.

Our comments are based on evidence from previous scrutiny work in Harrow, as well as conversations we have had with key players in the local health and social care arena. This culminated in a scrutiny challenge session on 28 April 2009 to explore the local ramifications of the Healthcare for London proposals around major trauma and stroke services². This

¹ The working group consists of Councillors Vina Mithani, Margaret Davine, Rekha Shah, Stanley Sheinwald, Dinesh Solanki and Mark Versallion. The following declarations of interest are to be recorded: Councillor Vina Mithani is an employee of the Health Protection Agency and Councillor Mark Versallion is a Non-Executive Director of North West London Hospitals Trust.

² Scrutiny councillors in attendance: Councillors Mithani, Shah and Sheinwald.

meeting involved colleagues from North West London Hospitals Trust, NHS Harrow, Harrow Council Adults and Housing Directorate, Harrow Local Involvement Network, Harrow Association of Voluntary Services, as well as Harrow's Adults and Housing Portfolio Holder³. In addition we have considered written evidence from the Imperial College Healthcare Trust and verbal evidence from the London Ambulance Service⁴.

We welcome the opportunity to comment on proposals that will undoubtedly affect the healthcare for Harrow residents. This paper sets out Harrow Overview and Scrutiny's comments on both major trauma and stroke services. Should you need any elaboration on the evidence used in our comments, please do not hesitate to contact us through the Scrutiny Unit - details as given at the bottom of this page.

Major trauma

We are convinced by the argument for reconfiguring major trauma services in London to a model of major trauma networks with a number of major trauma centres (MTC). It is our belief that a four trauma network model better serves London as it offers resilience in a city with the size and complexities as London, as well as meeting the requirements of critical mass to achieve optimal clinical outcomes.

We support the consultation's preferred option of four network trauma networks with major trauma centres at:

- The Royal London Hospital
- King's College Hospital
- St George's Hospital
- St Mary's Hospital

We are of this view for a number of reasons which are detailed below.

³ Those who gave evidence at the scrutiny challenge session were: David Cheesman and Claire Walker (NW London Hospitals Trust), Anne Whitehead and Karen Butler (NHS Harrow), Julia Smith (Harrow Association of Voluntary Services), John Hunter (Harrow Local Involvement Network), Barbara Huggan (Harrow Council Adult Services), Councillor Barry Macleod-Cullinane (Harrow Council Executive Member).

⁴ Further evidence: 1) Letter from Rachel Barlow, Head of Operations, Surgery and Cancer Clinical Practice Group, Imperial College Healthcare Trust, dated 27 April 2009 and 2) Telephone conversation with Nick Lawrance, Head of Policy Evaluation and Development, London Ambulance Service on 27 April 2009.

Resilience

We are satisfied that a four-network model will provide enough patients to develop the expertise needed to improve outcomes for trauma patients, as well as provide London with a system with enough resilience to cope with major unforeseen incident(s).

History and experience

The Royal London Hospital has been an established major trauma centre for London for the past twenty years and therefore it would be best to make use of the history and the experience of dealing with major trauma that the institution has built up over the years. To site a fourth MTC at Royal Free Hospital would seem to impinge on this expertise and experience in that the Royal Free would then share some of the geographical area that the Royal London currently has and thus affect patient flow to reflect this. Given that the Royal Free would also be unable to implement a MTC with immediate effect, this would appear to be a counter-productive option to pursue. Furthermore the London Ambulance Service has established robust protocols and working relationships with a MTC at the Royal London and to disrupt this relationship in order to site a MTC at the Royal Free would seem unnecessary. The consultation document states that the bids for a fourth MTC from the Royal Free and St Mary's were of equal clinical standards and it seems to us therefore that considerations around history and experience hold even more weight if clinical standards are equal.

Accessibility to serve North West London

It is our belief that a three-network model does not serve North West London well. A four-network model with St Mary's Hospital as the fourth MTC option best fits the needs of our local residents and that of the rest of North West London. St Mary's scored higher than the Royal Free when compared on overall accessibility and has good accessibility to NW London along major roads, as well as good coverage of central London and Heathrow – a factor that must be taken into consideration when planning for major trauma incidents.

Strategic links

St Mary's has worked in established NW London networks for a number of years across a range of disciplines. Our local hospital trust (NW London Hospitals Trust) has established shared working practices and strategic links with St Mary's and we would like to see this developed under the major trauma network model. The Imperial College Healthcare Trust has a wealth of expertise in this area and first class training/research facilities. We would hope that local trauma centres could benefit from strategic links with and learn from such an institution. We are glad to learn that the Imperial College Healthcare Trust is committed to supporting improvements in trauma services in North West London.

Implementation

In addition to St Mary's strength in accessibility for the NW London sector which is otherwise poorly covered in the three-MTC model, we understand that a fourth MTC could be delivered before the date given in the consultation document. It is our understanding that a MTC at St Mary's could be delivered by October 2010.

The transition period whilst a fourth MTC positions itself well enough to implement the major trauma model will be critical and we support the view that the Royal London should extend its coverage to parts of north and NW London in the meantime.

Investment

We welcome the investment in implementing major trauma networks, given as £9-12million per year in the consultation document. Whilst appreciating that the focus may turn on the major trauma centres, we would urge that equal consideration is given to building up the local trauma centres which will continue to deal with the majority of trauma injuries in London, and that investment allocations reflect this. We would anticipate that investment flows equally to local trauma centres, for example Northwick Park Hospital in NW London, as to the major trauma centres. Investment should be seen not only in fiscal terms but also in workforce training and development, and improved performance management systems to facilitate continuous service improvement.

Stroke

We believe that it is unacceptable that currently whether a patient has access to 24 hour stroke treatment depends upon the hospital to which they are taken – all Londoners should have equitable access to high quality stroke care and treatment. Therefore having considered the clinical arguments relating to the reconfiguration of stroke services, we agree that stroke services would be more equitable and better provide care in a networked system of hyper-acute stroke units, supported by a larger number of stroke units and Transient Ischaemic Attack (TIA) services.

We strongly support the preferred option as stated in the consultation document, which includes the creation of a new hyper-acute stroke unit (HASU) at Northwick Park Hospital, to sit alongside a stroke unit and TIA services. We are assured that Northwick Park Hospital is proactively preparing and forward planning to facilitate an efficient implementation should its

bid to become a HASU be successful. Northwick Park Hospital should be ready to implement the new services from November 2009 if its bid for all levels of stroke services is successful.

Prevalence and prevention - meeting the needs of our diverse communities

The consultation document uses the London School of Economics predictive model of stroke prevalence in London. This shows that there are vast areas of Harrow and Brent with a high prevalence of stroke.

Harrow has an ageing population. 13.6% of Harrow's population are 65+ and this is greater than the London average. The projections for older people estimate that by 2027, there will be an increase of 11% of older people aged 65+ and within this the 85+ population will increase by 24%. The number of strokes in older people (aged 65+) is expected to rise quite significantly. It is predicted that in 2015, 899 older people in Harrow will be admitted into hospital having suffered a stroke – an increase of 91 (11.3%) since 2008. This may actually be a conservative estimate and the actual figure may be higher than predicted for Harrow due to poorer health amongst older Asians⁵.

Harrow and Brent are both in the top ten most ethnically diverse boroughs in England and Wales. Having a large local BME population is particularly pertinent to discussions around stroke as people from BME communities are disproportionately affected by stroke⁶. Considering that Brent and Harrow have significant BME populations and Harrow has an above average number of older residents, this adds weight to the argument that Northwick Park Hospital is best placed to provide the range of stroke services (HASU, stroke unit and TIA services) so that large numbers of people who are statistically more likely to suffer from stroke are close to the facilities.

We believe that given the stroke profile and projections for North West London, a greater emphasis must be given to work around stroke prevention, and that the development of local TIA services will be pivotal to this. Enhanced TIA services must be aligned with work to raise local public awareness around stroke prevention and also build upon the national FAST campaign. In a Harrow context, NHS Harrow's commissioning strategy prioritises vascular and stroke care. We would encourage that this joins together stroke prevention, public health promotion and continues to work with primary health professionals, for example GPs, to consider the whole stroke care pathway. Harrow's multi-agency joint stroke strategy group should play a critical role in this development. Whilst much of the attention in the discussions

⁵ Harrow Joint Strategic Needs Assessment, November 2008.

⁶ Stroke Strategy for London, 2008.

around the stroke model has focussed on the HASUs, the importance of getting TIA services right must not be underestimated. Investment and efforts must reflect this.

Access to care

With regard to effective stroke care and rehabilitation, accessing the appropriate treatment in a timely fashion is critical. It is critical that people having suffered a stroke reach a hospital with the appropriate stroke services as quickly as possible.

Northwick Park Hospital is geographically excellently positioned to serve the people of North West London, as it is located on the borders of Brent and Harrow. We are concerned that if the other option of locating a HASU at Barnet Hospital was pursued, the proximity to the necessary stroke services would make it very difficult to access, not only for client groups in Harrow and Brent, but also other parts of the region such as Hillingdon and Ealing. Given the time critical nature of accessing effective stroke treatment this is most definitely a concern. Indeed this would reinforce the consultation document's analysis that Northwick Park Hospital has better travel times and location to reflect existing patient flows.

Northwick Park Hospital scores better on the Public Transport Accessibility Levels (PTALs) – which are used to measure the quality of access to the transport network - than Barnet Hospital⁷. Furthermore as we have heard from London Travel Watch through the JOSCS⁸, Northwick Park Hospital has a particularly active travel and transport plan that is commended by Travel Watch. This plan should form a good foundation upon which to further improve travel and accessibility to the hospital site.

Care package for stroke care pathway

We would strongly urge that the investment in acute stroke, which is highly welcomed, is matched by appropriate levels of investment in rehabilitation services, so as to ensure a more seamless care package for patients. The stroke care pathway must be seen holistically and from the eyes of patients – the importance to whom is the high quality of the care, not the health or social care organisation which provides it.

We are convinced that the new stroke model will deliver better clinical outcomes for patients and this will place additional emphasis on the need for equally improved rehabilitation services. This will impact upon social care budgets to provide ongoing care in home or

⁷ Evidence from Transport for London at the Joint Overview and Scrutiny Committee on 24 April 2009.

⁸ Evidence from London Travel Watch at the Joint Overview and Scrutiny Committee on 24 April 2009.

residential care settings. And therefore we must also see an investment in rehabilitation services matching that of acute care.

Workforce development

Part of the success in implementing the new stroke model will rest with a skilled workforce. Northwick Park Hospital is currently recruiting extra stroke nursing staff as well as investing in upskilling current nurses, so as to be in a better position to meet the needs of enhanced stroke care provision should its bid to host stroke services be successful.

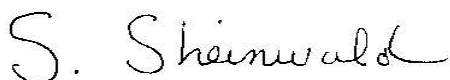
Ongoing support and partnership working

At a trust level, should the preferred proposals be accepted, Northwick Park Hospital would need to ensure that the decommissioning of services at Central Middlesex Hospital and more widely at regional level at Ealing Hospital for example, are fully supported and a seamless transition achieved. We understand that senior managers at North West London Hospitals Trust have already been discussing potential arrangements for repatriation with commissioners at Ealing Hospital. The repatriation of patients after the critical 72-hour period will be vital and we would encourage trusts to prepare for this at the earliest opportunity.

Northwick Park Hospital has an innovative early discharge scheme for cardiac patients which involves effective partnership working between the Trust and the voluntary sector. We support plans to further open this out to stroke rehabilitation. The development of community support packages is also encouraged.

The proposals for a new model of stroke care are ambitious and welcomed. The success of their implementation will heavily rest upon effective change management within the NHS and more broadly with partner organisations involved in health and social care – Healthcare for London will need to provide ongoing support to facilitate this. The best way forward will be to continue to build on the strong existing strategic links with partners and expanding existing shared working arrangements.

Yours faithfully



Councillor Stanley Sheinwald,
Chairman of Harrow Overview & Scrutiny Committee

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Scrutiny is an independent, councillor-led function working with local people to improve services

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Our ref:
Date: 8 May 2009

Dear Healthcare for London,

Healthcare for London Consultation on Stroke and Trauma: Response from the London Borough of Hounslow

The London Borough of Hounslow is pleased to provide its views on the proposals for major trauma and stroke services in London. **Please note this response is a joint response from the Council's Executive and the Adults Health and Social Care Scrutiny Panel.** In preparing our response we have drawn upon local knowledge and experience of stroke and trauma services in Hounslow and the evidence heard to date from the Pan London Joint Health Overview and Scrutiny Committee.

Major Trauma Services

We accept the need to consolidate major trauma services into three or four major trauma units in London as set out in the consultation document.

We are in favour of service reconfiguration and consider that in order to ensure that there is an effective trauma service for Hounslow residents we conclude that four major trauma units are required for the whole of London. In order to provide resilience at all times. We have noted that it is very likely that the Royal London, St George's and King's College Hospital will be the site of three of the trauma centres. *We strongly suggest that the fourth trauma unit should be located at St Mary's Hospital, Paddington rather than the Royal Free in Hampstead for the following reasons (option 1):*

- *A trauma centre at St Mary's will ensure accessibility for Hounslow residents.*
- *We support the proposal that the Royal London takes patients from a larger geographical area than the three other trauma centres. As it has hosted a major trauma centre for the past 20 years, it is essential that all Londoners benefit from their expertise in dealing with major trauma.*
- *It is important for everyone living, working in and visiting the North West area of London that a major trauma centre serves this region. With Heathrow Airport, the M4, M40, M25 and M1 in close proximity, St Mary's is the best option for North West London than the Royal Free because of its closeness to the airport and motorways and also to central London, where most major trauma currently occurs.*

- We are worried that if the Royal Free is commissioned to provide major trauma services, its location will affect patient flows to the Royal London where much expertise lies in respect of major trauma. Indeed, the Royal Free would manage the largest trauma network in London. This concerns us, as it will not meet its clinical standards until April 2012 compared to April 2010 for the others. This makes the case for St Mary's even stronger because of its location in relation to the Royal London. Furthermore St Mary's will be the lead centre in a smaller network, which will give it time to upgrade its facilities and focus on reaching the required clinical standards. During this period local hospitals in West London will need good network support from Imperial in order to provide a good service for local residents.
- Four trauma centres in London will *enable professional staff to develop the expertise* needed to improve outcomes for trauma patients as is the case in the USA – i.e. a higher survival rate of severely injured patients who are alive when they reach hospital. *Resilience to cope with a major incident (or series of major incidents) or any unforeseen circumstances is more likely to be met.*

We would wish to see an investment in major trauma centres mirrored by an investment in local trauma centres, as they will continue to deal with the majority of trauma injuries in London.

For Hounslow, this would mean investment in West Middlesex Hospital. One of the benefits of these proposals is that it will raise the standards and performance management of local trauma units. *This can only be sustained if additional investment supports local trauma units.*

We are aware that the *major trauma centres will create opportunities for nursing staff. We would not want this to have a detrimental impact on the number and quality of specialist nursing staff available at the West Middlesex Hospital.*

We believe that West Middlesex Hospital and other local hospitals should be given further support (both financial and workforce planning) over and above that which they currently receive to ensure that as the proposals take effect, local hospitals are able to recruit and retain adequate levels of high quality nursing staff. An increase in the use of agency nursing staff is neither in the interest of patients nor of financial benefit and we would seek assurance that workforce planning addresses such issues satisfactorily.

Stroke Services

We agree that stroke services would be better provided in a networked system with a small number of hyper acute stroke units and a series of local stroke units and Transient Ischaemic Attack (TIA) services. We also agree that a small number of eligible patients (less than 10%) currently being offered thrombolysis represents the current position and makes the case for change.

The London Borough of Hounslow (as well the rest of North West London) has a significant black and minority ethnic population. According to the GLA census estimates, BME groups as at 2008 account for 38% of Hounslow's population and this figure is expected to rise significantly at the next census in 2011.¹

As you know already the large, local BME population is relevant because people from BME communities are disproportionately affected by stroke.

13% of premature deaths in Hounslow are caused by stroke. This equates to almost 30,000 of our residents.

The common profile of those suffering from stroke in Hounslow is predominantly older people and those from deprived neighbourhoods. The number of older people in the borough based on the GLA figures is set to increase from 2008 onwards and it is therefore expected that there will be a parallel increase in the number of those needing to access stroke services.²

¹ In 2008, there were estimated to be almost 24,000 people in the Black Other/ Other Asian/ Other ethnic categories, more than one in ten of the local population. By 2011, the figure is expected to reach almost 27,000

² In Hounslow, the GLA figures tell us we should expect there to be 276 (2.1%) more people aged 65-74 living in the borough in 2011 than in 2008. The increase for 75-84 year-olds over the same period is 126 (1.5%). The increase over the same period for those 85+ is 241 (7%).

Most deaths of people aged 65+ in Hounslow are caused by stroke or respiratory disease. *Using this data and projections we believe it makes sense to locate a hyper acute stroke unit at Charing Cross Hospital and a stroke unit and TIA services in West Middlesex hospital.*

Charing Cross is well known to Hounslow residents and is clearly best placed to continue serving patients from Hounslow as well as those from Hammersmith and Fulham. For Hounslow residents it provides shorter travelling times and it has the advantage of having neurosciences on site.

However we note with some concern that the consultation documentation states that if Imperial is successfully designated as a trauma centre, then hyper acute stroke services will be relocated from Charing Cross to St Mary's.

This is unacceptable to us as this location would not be 'local' enough for Hounslow stroke patients or for their relatives. The next best location in relation to local access would be for the HASU to be at Chelsea and Westminster for Hounslow patients. However we wish to stress that our preferred option is for Charing Cross to be a designated HASU so that services are kept as local as possible.

We are pleased that the West Middlesex Hospital is cited as a designated stroke unit within the proposals. We support this. *As a newly remodelled up to date facility in outer west London, the West Middlesex is well placed to build upon its clinical excellence and provide for excellent future stroke services. As you are already aware they have designated a ward to stroke care and have good plans in place to receive patients from HASUs. These plans will ensure that the excellent services at the West Middlesex will continue to develop.*

We are aware that the final location of the HASUs will impact on the size of stroke unit required at the West Middlesex. We are concerned whether or not there will be sufficient bed capacity to manage demand both at West Middlesex and across the North West sector. *We suggest that detailed proposals for bed capacity across North West Sector should be separately consulted upon when they have been drawn up.*

Also, whilst we support the proposals for improving outcomes for stroke patients we are less sure about how exactly rehabilitation, which is key to achieving the outcomes, will be supported. At a time of increasing pressure on local council and health resources, we are concerned that *post discharge from hospital, additional stress will be placed on social care and voluntary sector services* to support these proposals so that patients can be provided care at home or through residential care supported by the community.

Although pleased about the plans and proposals to invest into acute stroke care *we are concerned that equal consideration and attention has not been given to rehabilitation services, the impact on social care and the community and voluntary sectors.*

We are further concerned on the *impact on carers.*

We would expect to see additional investment in rehabilitation services, which matches that put into acute care so patients and their carers receive a complete package of care and support.

Rehabilitation also requires dedicated staffing numbers of professionally qualified and skilled stroke nurses and consultants. *We are concerned that the staffing levels to support these proposals will not be achieved at the local district general hospitals.* For example, we are aware that there are not enough suitably qualified stroke nurses at present and where there are they may be drawn into working in the HASUs from local stroke units.

Evidence shows that more strokes occur in outer rather than inner London due to the number so older people living in outer London. *We believe that eight hyper acute units are not enough for the following reasons:*

- We have considered the evidence provided to the pan London joint health overview and scrutiny committee to date by Professor Hugh Markus and others as to what are 'safe' and appropriate numbers of patients to be treated through these specialist units. Professor Markus believes that *between 1200 and 1500 stroke patients is about right and safe for a specialist stroke unit.*

- On this calculation we suggest that *about four more specialist units* should be considered. Additional HASUs will also reduce journey times and improve recovery rates.³
- Mott MacDonald (who presented emerging findings of their integrated health impact assessment to the JHOSC) stated that *HfL has underplayed the numbers of older people in outer London. Also that HfL has not considered young adults with mental health problems or those with learning disabilities who are more likely to have a stroke at a younger age.*

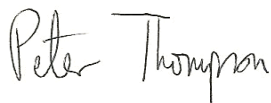
We have *further concerns as regards transfers from the HASUs to local hospitals.* The West Middlesex has and continues to have a higher bed occupancy rate than many hospitals in London and the success of local repatriation relies on enough beds in local units. There will be clear challenges in Hounslow around repatriating some residents back to their local hospital.

Outcomes for our residents will only improve if there is *investment in rehabilitation services* – intermediate/step-down care services in Hounslow remain stretched and we are worried that a focus solely on investment at the front end of the acute stroke and trauma pathway fails to recognise the importance of investment once patients are discharged into the community. *Without the necessary level of investment in rehabilitation, it will be difficult to improve the overall quality of life of patients.*

We would hope to see *close liaison between health and social care organisations, with clear leadership from Healthcare for London, so that there is better understanding of what the cost implications for community care are and how they will be met.*

Finally, we consider that for this configuration to work *centres should provide 24/7 thrombolysis and that Telemedicine should be thoroughly investigated* given its success at St Thomas in London and Surrey.

Yours sincerely



Councillor Peter Thompson
Leader of Hounslow Council



Councillor Pam Fisher
Executive Lead Member for Adult Social Services and Health



Councillor Jon Hardy
Chairman of Adults, Health and Social Care Scrutiny Panel

³ 1:2 chance of full recovery if thrombolysis given within one and half hours compared with 1:8 chance between one and half and three hours.

ROYAL BOROUGH OF KENSINGTON AND CHELSEA CONSULTATION ON THE PROPOSALS FOR MAJOR TRAUMA AND STROKE SERVICES IN LONDON

INTRODUCTION

The Royal Borough of Kensington and Chelsea's Overview and Scrutiny Committee (OSC) accept the rationale behind the case for specialist centres for strokes and major trauma.

MAJOR TRAUMA

On the figures given in the draft - a minimum of 400 patients a year and a current need for 1600 patients - there is clearly a case for four centres. This is underpinned by the fact that to deal with an extreme event would need additional higher capacity.

The OSC supports the Healthcare for London's preferred option for establishing trauma networks in London with four major trauma centres at: The Royal London Hospital; King's College Hospital; St George's Hospital; and St Mary's Hospital. There had been concern that with only 3 centres N W London could have been placed at a disadvantage.

Under the proposals, the fourth major trauma centre (St Mary's being the preferred site) would not be set up until April 2012 (ie the date by which it demonstrated it could meet the required clinical standards), and the consultation states that a transition plan for handling major trauma cases in NW London (for the period April 2010 - April 2012) would need to be developed. Further details of these transitional arrangements are awaited.

It is stated that "Under our proposals, all Londoners will be within 45 minutes 'blue light' ambulance journey of a major trauma centre" (page 1). This looks optimistic for the times of peak traffic, or in the case of a major incident (e.g an act of terrorism). The public will need to be assured that within 45 minutes they can get treatment.

STROKE

The 8 hyper acute stroke centres, and 23 other units, proposed should alleviate public concern over the changes as they adequately cover the whole of London.

The OSC supports the proposal for a hyper acute stroke centre to be based at St Mary's hospital alongside a major trauma centre. Healthcare for London should again clearly articulate the need and benefits of co-location on the St Mary's site to the relevant commissioners and Imperial Healthcare NHS Trust.

It is considered that the treatment of strokes should be seen not just as an acute hospital issue but also as one which will have implications for other bodies such as Social Services.

LONDON AMBULANCE SERVICE

Plans need to be developed for additional training for London Ambulance Service personnel - including extra training that will be required to ensure correct diagnosis, and travel plans for different eventualities and in the different parts of London.

The OSC would have liked more information on how transport times will be kept down to the stated levels (30 minutes – stroke, 45 minutes – trauma) for all the new centres.

FINANCE AND TIMETABLE

The plans state: "An extra £9 - £12 million per year will be needed to deliver the proposed improvements in major trauma care. PCTs will work with NHS hospitals during 2009/10 to agree contract arrangements." For stroke, an "extra £23 million investment per year (on top of the £65 million already spent)" will be needed . . . All PCTs in London will fund improvements in stroke services".

There needs to be clarity on where the money is coming from and the outlook for Primary Care Trusts over the next 5-10 years. An assurance that the additional funding required, both initial capital and ongoing current expenditure, will be found and has been authorised. And, clarity on the effects on PCT provision of other services from this money spent on trauma and stroke.

The paragraph on page 23 about "a 5-15 times return on the investment" for each trauma patient returned to work is a broad estimate, and it is unclear what this really means in practice. The article referred to in the consultation document is about improving outcomes rather than improved finance. Improved outcomes are not a return "in financial terms" on investment.

Further details are sought of the proposed London Trauma Office (which will oversee trauma care in London and provide guidance to the trauma networks in introducing the proposed changes from April

2010), since clearly it will have a pivotal role to play in implementation.

There is a need to give a clear timetable as to when these changes are likely to be implemented, particularly if all the changes proposed for St Mary's come together on one site.

CONCLUSION

The Royal Borough of Kensington and Chelsea's Overview and Scrutiny Committee on Health is in broad support of Healthcare for London's proposals for specialist centres for strokes and major trauma.

Cllr. Christopher Buckmaster

Chairman of the Overview and Scrutiny Committee on Health
The Royal Borough of Kensington and Chelsea

DEVELOPING NEW, HIGH-QUALITY MAJOR TRAUMA AND STROKE SERVICES IN LONDON – Consultation document

Comments for Joint Health Overview and Scrutiny Committee.

Evidence summary and a view from Health Overview Panel, LB Kingston upon Thames.

[Letters/words in square brackets refer to evidence sources.]

MAJOR TRAUMA. [MT]

All the evidence so far from our witnesses supports specialist services for major trauma being concentrated in a small number of centres.

..

There is a clear evidence base that the proposals achieve a critical mass of patients for maintaining clinical expertise, capable of guaranteeing effective clinical outcomes for this group of patients.

Simon Robborn, Royal London, suggested that one MT centre would be enough, but two would provide back-up if one was out of commission for whatever reason. – He suggested similar arguments could be put for a third centre, but that politics (both within and without the health service), rather than medical /economic arguments, are the main drivers for a larger number of MT centres.

Simon Robbins, Healthcare for London [HfL], said that there is no definitive evidence favouring a three centre network over four, hence the decision to consult on both.

The main concerns of witnesses centre around staff training for pre-hospital care services i.e. London Ambulance Service and the Helicopter Emergency Medical Service staff and Paramedics; the Trauma Centre Team; as well as around the financing of these proposed changes.

HYPER ACUTE STROKE UNITS [HASUs].

Reasons given for organising treatment of stroke patients into eight HASUs with transfer to designated stroke units at District General Hospitals [DGHs] after approximately three days are:-

1.If thrombolysis is to contribute to the treatment of some strokes, then it must be administered within a very short period of time [3/4.5 hours] from the onset of the stroke. – Therefore diagnosis must be swift and accurate, which requires the expertise of a consultant radiologist available ‘24/7’. - The general view of our witnesses appears to be that treatment is relatively simple, but diagnosis is critical.

2. Currently major gaps exist in the provision of a '24/7' service in NE and SE London.
3. Current death rates from strokes in London are high.

HOWEVER

What is the right number of HASUs?

The model proposed by Prof. Boyle involving 14 or more HASUs across London has not been adopted. Candace Imison, [CI] Kings Fund.

Where is the cost/benefit analysis?

There will be a lack of HASUs in outer London. [Age Concern, Miss Strothers].

8 HASUs might be sensible in short/medium term but many DGH s could provide specialist stroke care in the longer term. [Dr Ginsberg, Royal Free Hosp.].

8 HASUs is a minimum [Stroke Asscn.].

8 HASUs may be too low [Royal College of Nursing [RCN].

'HfL originally strongly in favour of 12-14 HASUs – no evidence of improved clinical outcome with 8 larger HASUs'. -Guys and Thomas's

There is a real danger of destroying existing high quality care without putting required capacity and quality into outer London. [GT]

What about the care pathway after the first three days?

Existing provision further along the stroke care pathway is patchy and can involve long waits for rehab, speech therapy etc; inadequate time given to each patient given their needs; insufficient cooperation between health and social services.- Dr. Glackin, Local Medical Committees.[LMC]

There are long waits for therapeutic treatments and speech therapy is not widely available [Age Concern].

General Practitioners said they were hugely supportive of the proposals – However they added that the primary/secondary interface is inadequately addressed and [e.g.] rehab. provision for patients who had been treated at the specialist heart centres is 'patchy'. [LMC]

The quality of rehab. is 'crucial' to recovery – Stroke Asscn. [SA]

Our HEADWAY witness argued that there are currently severe shortages in the provision of rehabilitative care.....Health Service and local authorities providing social care need to work more closely in funding and delivering joined-up services. – Simon Williams, Asscn.of Directors of Adult Services supported this view.

We need a care pathway which is strong throughout from specialist consultants to ancillary care. - Rachel Tyndall, HfL.

Rehab. in a community setting close to home is important - We need rapid intervention and good rehab.[CI]

What are the implications of the three day transfer to DGHs?

Since patients would normally have to transfer to their local DGH after three days, there is likely to be overload of bed provision, if the transfer system is not smooth. – It is not likely to be practical to ring-fence beds in DGHs for stroke patients.[CI]

If patients cannot be moved efficiently from HASUs, they may have to close for new admissions until beds are available. [various]

Co-location with MT Centres will exacerbate pressure on HASUs - Guys and St Thomas's [GT]

It is clearly preferable for stroke patient treatment to be in one hospital. 'The NHS is not good at managing patient transfers'. - Royal Free Hosp. [RFH] and Asscn. of Directors of Adult Social Services.[ADASS].

RCN commented on repatriation to DGHs and the need for beds to be available. - 'Patient transfer requires clear protocols both clinical and administrative – the size of this task should not be underestimated'

Do patients having strokes whilst in hospitals, transfer to a HASU?

Surrey PCT encourages all its hospitals to provide access to scans and thrombolysis. [CI]

What problems are associated with diagnosis?

Although thrombolysis is close to being a magic bullet according to some evidence [e.g. Glasgow experience], the treatment is nevertheless regarded as unproven by some others, who think money and resources would be much better used elsewhere in the care pathway.

Is the need for a 24/7 service from a Consultant Radiologist and immediate access to a scanner sufficient justification for the disruption to patients, who are involved in moves from HASUs to District General Hospitals with Stroke units?

A person may not realise s/he is having a stroke and, in consequence, breach the critical time factor.

Why is 24/7 diagnostic care not provided more widely by the NHS? [ADAS]

Is there a better, alternative model?

The samples of witnesses' comments below, as well as much of the evidence already quoted, strongly suggest that there is:-

We need 'a strong pathway of care throughout from specialist consultants to ancillary care' [RT HfL]

Need is for rapid intervention *and good rehab*. [CI-Kings Fund]

RFH one care pathway for heart attack and stroke works very effectively.

Improve discharge planning and provide better community based rehab. services - 'crucial' [Stroke Asscn.].

Need for carefully phased implementation not a 'big bang' approach. [GT]

COMMENT re Stroke Provision.

We first of all have to clear from our minds that provision for major trauma and stroke patients are somehow connected, since they are part of the same consultation. – For all practical purposes they are not connected and should not really have been part of the same consultation exercise.

The evidence tells us we must look at the *whole care pathway*, if we are to improve stroke treatment. – However, the potential benefits of thrombolysis have put all the emphasis in the consultation proposals on the first 3 hours of treatment. – Given this fundamental contradiction, we should at least advise that HfL pause and think again.

We know that there is more than one way to provide '24/7' expert diagnosis (e.g. remote reporting of CT scans).

We know that prompt access to a scanner is now relatively straightforward in DGHs.

We know that thrombolysis treatment for the minority of stroke patients, who will benefit from it, is relatively simple for suitably trained staff.

So.... maintain efficient stroke units in DGHs across London and expand the service in shortage areas (NE and SE London) - say 14/16 HASUs in all – then concentrate improvements along the whole stroke pathway to ensure that the rehabilitation is as good and comprehensive as possible – even 'world class'!

04.05.09

Don Jordan

Your Ref:

Our Ref:

Stroke and Trauma Consultation

**Freepost RSAE-RCET-ATJY
Healthcare for London
Harrow
London HA1 2QG**



11 May 2009

LAMBETH COUNCIL - SCRUTINY RESPONSE TO HEALTHCARE FOR LONDON CONSULTATION (STROKE/TRAUMA SERVICES)

Dear Healthcare for London

Lambeth Council's Health and Adult Services Scrutiny Sub Committee would wish to submit the following comments in response to the Healthcare for London consultation 'The shape of things to come – developing new, high quality major trauma and stroke services for London'.

TRAUMA (Q 1 & 2)

The committee is supportive of the proposals for specialised trauma centres as set out in the consultation document and considers that the four trauma centre network provides London with the best coverage in the event of major incident.

The committee strongly supports the recommendation of Kings College Hospital as the site of a major trauma centre and welcomes the trust's inclusion within all the three options proposed by Healthcare for London (HfL). Kings has a strong record of working in partnership with hospitals serving the south east sector and as a member of an Academic Health Science Centre (Kings Health Partners) already works collaboratively with Guys and St Thomas NHS Foundation Trust, itself a major acute hospital providing coverage for central London populations. Accordingly we believe that the strategic location of Kings, its existing excellent facilities and service specialisms, and the capital investment which has been made available to re-design the Emergency Department combine to provide the best locality option for an integrated trauma service serving London generally and the south east population specifically.

STROKE (Q3 – 7)

The committee has some key concerns about the proposals for stroke and in particular the recommendation that hyper-acute stroke care should be delivered at no more than eight sites across London.

The consultation document states that stroke is the second-highest cause of death in London and the most common cause of adult disability. The ward data on incidence of projected stroke sufferers records high incidence of stroke in some of the outer London boroughs and the consultation document cites the need for services at some of those associated hospital locations. However it also acknowledges that some of those hospitals will require significant development and intensive support over a number of years if they are to meet the new standards for stroke care. The committee's concerns are two fold – firstly the impact on stroke services during the transitional period with the potential

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INVESTOR IN PEOPLE

decline of some existing services which are acknowledged to currently provide first class stroke care whilst the new units are still developing, and secondly whether at a time of a financially constrained environment the funding arrangements for bringing the new developments into play (estimated at an extra £23m investment on top of £65m already spent) are robust within the timeline envisaged.

Our comments are specifically relevant to the circumstances of two of the hospitals which currently serve Lambeth residents and which are also accessible to/provide hyper acute stroke care for the wider London population. In the national stroke audit both Kings College Hospital and St Thomas' Hospital are two of the highest scoring units, each providing amongst the best services for stroke care in the country with consistent records of good outcomes. The trusts have recently been accredited as an AHSC and submitted a joint bid to provide a hyper acute stroke unit, sharing the number of beds, consultants, nurses etc. Our understanding is that there is not an excess of capacity at the centre yet the HfL proposed strategy will designate only Kings as a hyper-acute unit. We believe the rejection of the AHSC bid will potentially undermine the continuity of high quality stroke services that is currently in place before having anything complete to replace this with. Ensuring adequate capacity during the period when the proposed new units are being developed may be a significant risk – not just in relation to Bromley (which is the relevant location for the south east sector) but also at the other sites which require *'very strong and intensive support'*. Not only will there be little motivation for those units/hospitals not selected as HASUs to maintain/develop their services, but the de-commissioning of those existing hyper-acute units will no doubt impact on staff levels and reduce the opportunity for the support envisaged by HfL to be provided to the new developing units. Whilst the Princess Royal University Hospital is continuing to develop the HfL proposal would leave Kings as the only continuing acute stroke provider in south east London; the hospital will itself need to expand to provide the necessary capacity, and we believe this may leave the sector vulnerable particularly should there be times of unexpected crisis/peaks within A&E.

The committee therefore fully endorses the partnership approach promoted by Kings Health Partners (i.e. that the AHSC should be designated to provide a HASU) as providing the most advantageous and flexible coverage for future acute stroke care. The AHSC integrated and phased approach involving both Kings and St Thomas' would best provide continuity of access to excellent stroke services and mean that the AHSC would be in a better position to provide support for the development of a HASU in Bromley. Accordingly the response submitted by Kings Health Partners on 7/5/09 which sets out the detailed position of the four partners working together is noted and supported.

In this context the committee would also state its concerns about the funding available to make the new stroke/trauma strategies a reality (and particularly where these involve new developments) within the timeline envisaged. An extra £9 -12 million per year is needed to deliver the proposed improvements in major trauma care as well as the additional £23m for stroke mentioned above. The committee has heard that no extra money is being pumped into the new acute stroke/trauma centres by NHS London nor are we aware that there have been any estimates of affordability on the capital costs of relocation. It is further understood that on-going revenue for staffing at designated acute units will be met by the hospitals.

Healthcare for London will be aware that several hospitals in the outer south east sector have faced severe financial problems which are continuing to be resolved through contributions from pan-London PCT budgets (of which Lambeth PCT is the largest contributor) and through the reconfiguration proposals 'A Picture of Health'. If the service improvements described in 'A Shape of Things to Come' are truly to be delivered then clinical change must be supported by a compelling financial management

strategy to ensure that those trusts which have faced financial difficulties in the recent past and which now face major development do not again become financially challenged.

Additional Issues

The committee would also like to comment on the importance of the provision of rehabilitation services and record its regret that this matter has not been explicitly addressed as a key part of the patient pathway for stroke/trauma care. Although the consultation document states that there are economic and social benefits in reducing disabilities resulting from trauma and stroke, the prevention and rehabilitation aspects have not been considered in any meaningful way beyond the comment that some PCTs may need to invest more in rehabilitation. We believe that access to rehabilitation services – both during the period when patients are in hospital and following their discharge - are as fundamentally important to full recovery as the initial clinical response if clients are to re-gain their physical and emotional health. Yet the anecdotal evidence suggests that there is a great variation in patients' experiences, and great variation in access to services across trusts (both acute and PCT) particularly access to physiotherapy services following discharge.

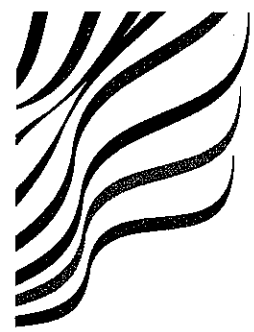
This also builds on one of the criticisms of Darzi/Consulting the Capital that in developing proposals there had been no work on the model of social care to mirror and integrate with HfL health care proposals. Again with the stroke and trauma proposals it would seem that there has been limited discussion or interaction with Directors of Adult/Social Services about potential impact on community/social care provision arising from discharge back into a community setting, the implication being that the pathway ends with the acute clinical intervention. We strongly feel there needs to be more discussion on discharge planning and the provision of community support services where the funding impact falls between NHS and social services.

Yours sincerely,

Cllr Helen O'Malley
Chair, Health and Adult Services Scrutiny Sub Committee
Lambeth Council

HOMalley@lambeth.gov.uk

cc **Kevin Barton, Chief Executive, Lambeth PCT**
Cllr Lorna Campbell, Cabinet Member Health and Social Care
Jo Cleary, Executive Director Adult Community Services



Your Ref:

Our Ref: May 1129

Freepost RSAE-RCET-ATJY
Healthcare for London
Harrow
HA1 2QG

Date: 8 May 2009

The shape of things to come: developing new, high quality major trauma and stroke services for London Borough of Newham

This response from the Mayor of Newham has been jointly agreed and is on behalf of the following agencies:

- London Borough of Newham Health Scrutiny Commission
- London Borough of Newham Cabinet
- London Borough of Newham Chief Officers
- NHS Newham (formerly Newham Primary Care Trust), including Newham Community Health Services
- Newham University Hospital Trust
- Newham Stroke Board

We welcome the opportunity to be consulted and share our views with NHS London, and we would expect you to take on board these views and note the degree of consensus achieved by the local authority, NHS organisations, and some voluntary sector partners through the Stroke Board in Newham.

Sir Robin Wales
Mayor of Newham

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The North East London Review of Acute Provision

Below we set out our response to the key consultation questions. However, we would like to express our concern over the lack of clarity for stroke and TIA services in North East London, and the initial assessment of current services which suggested that a number of services (such as those in Newham) were not up to the standard required for designation as a stroke unit or TIA clinic, within the framework of the new model.

While we appreciate the benefits of linking the consultation to the North East London review, the delay in making proposals for the North East London sector has caused uncertainty and created a negative impression of existing services. There is consensus amongst the signatories to this response that, whilst services can always be improved, the current integrated stroke services in Newham provide good quality for patients and their families. This is not simply our view but has been validated by the National Sentinel Stroke Audit - where Newham University Hospital Trust achieved a score in the top quartile nationally - and by Partnership UK who identified our integrated services as an excellent model of service. Already, in Newham, we have genuinely integrated services along the stroke pathway, within a single commissioning framework that includes acute, primary, community and social care services.

In Newham, there is evidence of stroke affecting people at an earlier age than average. Services need to be developed and resourced so that children and young people and people of working age can access suitable prevention, treatment and rehabilitation services in appropriate settings. Given the risk factors in the local population and the high stroke mortality rates, we consider it to be critical that stroke and TIA services are available within the borough. We hope that clarity can be provided as to the proposals for the configuration of stroke and TIA services in North East London as soon as possible.

Major Trauma

We support the proposed designation of the Royal London Hospital as a major trauma centre. This hospital already serves our population and we think that its designation as a major trauma centre can only enhance the services in this area. The proposals will concentrate resources into three or four specialist sites, which should lead to better specialist care and outcomes for all of London.

Therefore all of the three options for trauma networks proposed in the consultation document are acceptable to the agencies in Newham.

Stroke

We support the new pathway for stroke services in London, with the creation of a number of hyper-acute units, linked to more local stroke units and TIA clinics. We agree that the creation of hyper acute units will greatly improve the care of our residents who experience strokes in being better able to access the best possible care at an early stage, which is crucial to both the short and longer term outcomes and rehabilitation of stroke sufferers.

However, we are concerned that the review appears to have started with acute provision, along the pathway to stroke units and TIA clinics, rather than - in line with World Class Commissioning - starting with assessment of need and how health and wellbeing agencies can work together to prevent this condition. Whilst we recognise that getting urgent treatment at the right time is crucial, we also need to ensure the continuation of local acute and inpatient rehab provision and find the resources to invest far more in preventative activity.

From the evidence presented in the consultation document, as well as other sources of information we have seen, we support the proposed number of 8 hyper-acute stroke units as it would seem to provide for the right levels in terms of population numbers, concentration of clinical expertise and geographical coverage to benefit all of London. We recommend that Healthcare for London keep the evidence underpinning their proposals under close review, in light of population changes.

We welcome the preferred option of the designation of the Royal London Hospital (RLH) as a hyper-acute stroke unit, as this is in reasonable distance for most of our population. RLH has experience of serving diverse populations and currently has advocacy services that can provide language support and the required cultural sensitivity to serve most sections of our population, including those most at risk of stroke. We further support the proposed designation of Queen's Hospital, Romford as a hyper-acute stroke unit, as this will provide an alternative option, particularly for our communities in the north east of the borough.

We would also welcome an assurance that the necessary investment and support will be given to the Royal London and Queen's Hospitals for them to develop their capacity to provide hyper-acute services as soon as possible so that residents of North East London can benefit fully from hyper-acute stroke care.

Whilst supporting the designation of the Royal London Hospital and Queen's Hospital as hyper-acute centres for stroke care, we also want to raise the

importance of ensuring the best possible arrangements for transfer to local stroke units in North East London. We would expect that any transfer arrangements are timely, safe and appropriate and supported by robust protocols for transfer and receipt of vulnerable patients. It is important that any transfer services operate seven days a week, in order to avoid unnecessary stays in hyper-acute units. This is for clinical reasons and because it will be much easier for family and friends to provide support, once a patient is transferred to a more local stroke unit.

We strongly support that Newham University Hospital Trust is designated as the local acute stroke and TIA unit for Newham.

General comments

In order to make the proposals for major trauma and stroke care effective and to deliver the best outcomes for all Londoners, the issue of resourcing needs to be fully assessed and a focus on prevention to be strengthened and supported.

The London Ambulance Service will need ongoing support to ensure that there is sufficient ambulance capacity to deal with the longer road journeys envisaged in the new care pathways for stroke and trauma.

We recommend that work is undertaken immediately to ensure there is an appropriately-trained workforce of sufficient size and scope to deliver these new service models across the pathways. This includes clinical staff (e.g. consultants and nurses) and social care staff and community therapists to support rehabilitation. We would welcome a commitment to investment in nursing for all stroke care services as there is currently a national shortage. Getting these staff into post quickly will be crucial if the newly-designated units are to deliver the capacity required to serve the population of London.

The London Borough of Newham, NHS Newham, Newham University Hospital Trust and the Newham Stroke Board are committed to developing the highest standards of care for stroke and trauma. We look forward to working with the newly designated hyper-acute stroke units and major trauma centres to provide this high quality care for the residents of Newham and await the publication of the proposals for stroke and TIA services in North East London.

Yours sincerely

A handwritten signature in black ink, appearing to be 'RW', with a long horizontal line extending to the right.

Sir Robin Wales
Mayor of the London Borough of Newham

With agreement and on behalf of:

Councillor Winston Vaughan, Newham Health Scrutiny Commission

Melanie Walker, Chief Executive, NHS Newham

Andrew Woodhead, Newham University Hospital Trust

Rachel Flowers, Chair, Newham Stroke Board



Julia Regan
Scrutiny Manager
London Borough of Merton
C/o Pan London JOSC
Sent via email to : julia.regan@merton.gov.uk

Councillor Mahboob Chaudhary
Cranbrook Ward

3 Holcombe Road
Ilford
Essex, IG1 4XF

Mobile Tel: 07904 499203

Date: 8th May 2009

Dear Julia,

London Borough of Redbridge response to the Pan London JOSC regarding the Consultation on developing new Major Trauma and Stroke Services in London

In response to the above consultation, Redbridge Health Scrutiny Committee would like the JOSC to receive its views for inclusion in the final report, as follows:

“Redbridge Health Scrutiny Committee will fully support any views submitted by the Outer North East London JOSC. In addition, we would add that whilst supporting the proposed role of Queen’s and & The London Hospitals for major acute cases, we wish to preserve the existing locations for transitional treatment, and we insist on having a high quality standard of rehabilitation and after care for our residents.

We would like to see the continuance of the current facilities offered in King George for rehabilitation after the initial 72 hours period for stroke patients with better equipment and appropriately trained and skilled staff.”

Yours sincerely,

Cllr Mahboob Chaudhary

Vice-Chairman, Health Scrutiny Committee

Cc Health Scrutiny Committee; Outer North East London JOSC

Town Hall, Forest Road, London E17 4JF

Stroke and Trauma Consultation
Freepost RSAE-RCET-ATJY
Healthcare for London
HARROW
HA1 2QG

Date: 11th May 2009

Health, Adults and Older People's Overview and Scrutiny Sub-Committee response to Healthcare for London consultation: The shape of things to come: developing high quality major trauma and stroke services for the London Borough of Waltham Forest.

Dear Healthcare for London,

Waltham Forest's Health, Adults and Older People's Overview and Scrutiny sub-committee would like to submit the following comments in response to the Healthcare for London consultation.

TRAUMA (Q 1 & 2)

At its meeting of 22nd April, the sub-committee considered the proposal put forward by Healthcare for London and is of the view that a four trauma centre network will serve the needs of the London sufficiently, in the event of a major Trauma.

The proposed designation of the Royal London Hospital as a major trauma centre, re-affirms the current arrangement whereby this hospital already serves our local population. As such we support the proposals.

STROKE (Q3-7)

With respect to Stroke services, the sub-committee agreed with your proposals on the treatment of stroke patients, with hyper-acute stroke units (HASU's), stroke units and TIA centres but was dubious about your recommendations of no more than eight hyper-acute sites across London. With higher incidences of Stroke in outer London, the sub-committee is concerned that eight HASU's may not be enough.

The sub-committee has grave concerns that for North East London, whilst the designated HASU have been identified as the Royal London Hospital in Whitechapel, and the Queen's

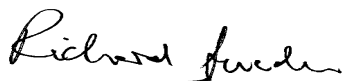
Hospital in Havering, no detail has been provided about proposals for local stroke units and TIA centres.

The sub-committee understands that Whipps Cross University Hospital Trust performed better in the quality ratings, in its treatment of stroke but Queen's and the Royal London have been identified as HASU's instead. Whilst the sub-committee appreciates the reasons for this choice, such as the obvious demographic imperatives in view of a 30 minute maximum journey time, the sub-committee is dissatisfied about the current lack of consultation on local stroke units. The sub-committee also noted a concentration on hospital reorganisation with respect to initial treatment and the little attention paid to adequate provision of post acute, including therapeutic, services together with their delivery and integration with other forms of treatment. Concerns were also expressed that support for carers of stroke victims was not addressed in the consultation document. The sub-committee also expressed concerns about workforce planning and investment, in particular the adequate recruitment and training of *additional* personnel in order for existing necessary expertise and other resources at local stroke units to be maintained and not absorbed by the HASU's.

The 'Case for Change' review further complicates where services will be allocated and as such the sub-committee recommends Healthcare for London to consider the need to instigate a contemporary and discreet consultation on local stroke services, in North East London.

The Health, Adults and Older People's Overview and Scrutiny Sub-Committee, will feed back its position to the Outer North East London Joint Health Overview and Scrutiny Committee (ONEL JHOSC) which is examining the 'Case for Change' proposal and the Pan London JHOSC.

Yours sincerely,



**Chair
Health, Adults and Older People's Overview & Scrutiny Sub-Committee**

Copy: Members of Health, Adults and Older People's Services Overview and Scrutiny Sub - Committee, Paul Rogers (Interim Head of Scrutiny), Daniel Fenwick (Director – Governance and Law), Cllr Liz Phillips (Cabinet Member - Health, Adults and Older People), Cllr Clyde Loakes (Leader) and Andrew Kilburn (Chief Executive).

Anthony Clements – Outer North East Joint Health Overview and Scrutiny Committee.



WANDSWORTH BOROUGH COUNCIL

HEALTH OVERVIEW AND SCRUTINY COMMITTEE – 21ST APRIL 2009

Report by the Chief Executive and Director of Administration on the consultation on major trauma and stroke services for London

SUMMARY

Background: A Joint Committee of PCTs for London and South West Essex has issued a consultation document on the future of trauma and stroke services in London. This proposes networks for trauma and stroke care, at the heart of which will be four major trauma centres and eight hyper-acute stroke units. St George’s Hospital is identified as a proposed site for both a major trauma centre and a hyper-acute stroke unit.

Policy: Although the formal scrutiny powers in relation to the substantial changes proposed in the document rest with the Joint Overview and Scrutiny Committee of the London Boroughs and Essex County Council, the Health Overview and Scrutiny Committee will be concerned to assess the impact of the proposals on Wandsworth residents. In general, these seem beneficial. The overall plans are clinically guided and have a clear focus on saving lives and improving treatment outcomes. The identification of St George’s as a major trauma centre and hyper-acute stroke unit will ensure that Wandsworth residents have good access to these specialist services and is positive development for the hospital. The one potential concern is that the development of these specialist services may limit the space available within the hospital site to offer more routine care for local residents.

Issues/proposals: It is recommended that the Overview and Scrutiny Committee respond to consultation as set out in paragraphs 14 and 23 below, strongly supporting the proposals in the consultation document. It is also recommended that the committee seek assurances from the St George’s Healthcare NHS Trust in relation to the space for routine local services.

Director of Finance and other services’ comments: n/a

Supporting information: The full consultation document has been circulated to Members and is available at www.healthcareforlondon.nhs.uk.

Conclusions: Overall, the proposals in the consultation are good news for St George’s Hospital and for Wandsworth residents. They demonstrate the potential strength of St George’s as a major teaching hospital some distance from the central London cluster of teaching hospitals, and provide a vindication for the emphasis that the hospital has placed on the specialisms central to emergency care.

GLOSSARY

Thrombolysis	Clot-busting drugs
Transient ischaemic attack	A ‘mini stroke’

1. **Recommendations.** The Health Overview and Scrutiny Committee are recommended to agree:
 - (a) to respond to the consultation document on stroke and trauma services as set out in paragraphs 14 and 23 below; and
 - (b) to seek assurances from the St George's Healthcare NHS Trust that its plans for redevelopment of the hospital will allow sufficient capacity to provide the full range of local care services outlined in *Healthcare for London* as appropriate for all acute hospitals, alongside the new specialist services proposed in the consultation document.
2. If the Overview and Scrutiny Committee approve any views, comments or additional recommendations on the report, these will be submitted to the Executive or to the relevant NHS body as appropriate for their consideration.
3. **Introduction.** At their meeting on 29th October 2008, the Health Overview and Scrutiny Committee were advised of a forthcoming consultation on the future of major trauma and stroke services for London. As the proposals would affect services across the whole of London, the consultation would be managed by a joint committee of primary care trusts and the formal scrutiny powers relating to significant service change would be assigned to a joint overview and scrutiny committee of the local authorities whose populations would be affected by the service change. The Committee supported a recommendation that the Council should be represented on the joint overview and scrutiny committee when it was formed.
4. In preparation for the consultation, a joint overview and scrutiny committee of all London Borough Councils and Essex County Council was established in December 2008. The Council appointed the Chairman of the Health Overview and Scrutiny Committee as its representative on this committee. A formal consultation document, setting out the proposed service changes, was issued by a joint committee of all the London Primary Care Trusts and South West Essex PCT at the end of January 2009. Consultation closes on 8th May 2008.
5. Although, for the purposes of this consultation, the Health Overview and Scrutiny Committee's formal scrutiny powers are ceded to the joint overview and scrutiny committee, it remains open to the Health Overview and Scrutiny Committee to submit comments on the proposals and to put its own views forward to inform the work of the Joint Overview and Scrutiny Committee. The present paper analyses the impact of the proposals on Wandsworth residents and suggests comments on them.
6. **The proposals for major trauma.** Major trauma accounts for around 0.1% of the accident and emergency caseload. Major trauma patients are those with the most complex, multiple and life-threatening injuries. In London, there are about 1,600 major trauma cases per year, or about one per accident and emergency department per week.
7. In general, treatment for major trauma patients in the United Kingdom is poor. The *National Confidential Enquiry into Patient Outcome and Death* found that over 50% of major trauma patients receive sub-standard care, and the death rate for major trauma is over 40% higher than in some parts of the United States where there are effective trauma systems. There is evidence that dedicated major trauma centres with specialist teams, who are able to improve their skills by treating a larger number of cases, will achieve better

outcomes. At present, the one trauma centre in London which achieves this standard is the Royal London Hospital in Whitechapel.

8. It is proposed to establish a small number of trauma networks in London, each of which will be centred on a major trauma centre. Other accident and emergency departments within the network will host trauma centres which will treat people with less serious injuries and to provide follow-up treatment and rehabilitation for all patients. Patients taken to a major trauma centre would be transferred to a more local hospital as soon as it was clinically safe to transfer them.
9. The clinical expert panel advising on the proposals was of the view that a major trauma centre should see at least 400 major trauma cases a year if the expertise of the team in the centre is to be fully developed. This meant that there could be no more than four trauma networks in London. Conversely, it was considered that just two major trauma centres would offer insufficient capacity in the event of a major incident. Thus, all of the consultation options involve three or four trauma networks, each based on a major trauma centre. It is claimed that all of the options considered would ensure that no-one was more than 45 minutes by blue light ambulance from a major trauma centre.
10. Submissions from hospitals wishing to provide major trauma care were assessed by an expert panel of clinicians and other health experts from within and outside London. Three hospitals (The Royal London, King's College Hospital, and St George's Hospital) were assessed as meeting the required standards by April 2010. A further two hospitals (St Mary's Hospital and the Royal Free Hospital) were assessed as capable of meeting the required standard, but not until April 2012. On this basis, three possible options are proposed:
 - (a) *Option 1.* Four major trauma centres at the Royal London Hospital, King's College Hospital, St George's Hospital and St Mary's Hospital.
 - (b) *Option 2.* Four major trauma centres at the Royal London Hospital, King's College Hospital, St George's Hospital and the Royal Free Hospital.
 - (c) *Option 3.* Three major trauma centres at the Royal London Hospital, King's College Hospital and St George's Hospital.
11. Within each of these options, each major trauma centre is linked to a network of trauma centres based in other accident and emergency departments. The consultation document argues that a system dependent on just three major trauma centres could become overstretched in the event of a major incident, and that each network would be so large that it may be difficult to lead improvements. Although the proposals from the Royal Free and St Mary's Hospital are assessed as of equal quality, Option 1 is preferred to Option 2 for the following reasons:
 - (a) the position of St Mary's is such that it would serve a smaller area than would be the case for the Royal Free. It is argued that this is desirable, because a larger part of London would be able to benefit from the immediate readiness of the Royal London Hospital to lead a trauma network; and
 - (b) St Mary's is better placed than the Royal Free to deal with potential major incidents, given its good access to both Heathrow and Central London.
12. From Wandsworth's perspective, the choice between these two options makes little difference, as in each case St George's Healthcare NHS Trust (St. George's) will be the

major trauma centre, with a network of seven other hospitals across South West London and Surrey: Kingston, St Helier, Mayday, St Peter's Hospital, East Surrey Hospital, Frimley Park Hospital, and the Royal Surrey County Hospital. If there were just three trauma networks, four other hospitals would come within St George's network: Charing Cross, West Middlesex, Ealing and Hillingdon.

13. Three other issues are identified in relation to the major trauma proposals:
 - (a) *Care for children.* There are around 300 major trauma cases per year involving children. Whilst these require many of the same facilities as adult major trauma cases, some additional services are needed. Proposals in relation to major trauma care for children are being developed;
 - (b) *Burn care.* It is anticipated that a specialist burns unit for London will be required. Proposals are being developed; and
 - (c) *Helicopter Landing Pads.* A shortage of landing sites and crowded air space in London mean that helicopter transport will be suitable for only a very small proportion of major trauma cases. As the Royal London already has a helipad, this would not be needed in any of the other major trauma centres.
14. **Consultation question.** The consultation document asks for views as to which of the three options is preferable, and why. It is proposed that the overview and scrutiny committee should indicate that it favours four over three trauma networks, but does not have a preference between Options 1 and 2. Having just three trauma networks would extend the network centred on St George's Hospital to include hospitals with which it has hitherto had few links, rendering the network less easy to manage. One of the reasons presented in the consultation document for selecting St. Mary's as the preferred location for the fourth major trauma centre – that it will serve a smaller segment of the London population than the Royal Free – appears counter-intuitive, and in the longer run there may be advantages in establishing trauma networks of a similar size. However, the proximity of St. Mary's to central London and Heathrow appears a stronger argument in favour of this option.
15. **Proposals in relation to stroke.** Around 11,000 patients per year are admitted to London hospitals following a stroke. The likelihood of suffering a stroke is closely associated with age, and consequently the incidence of strokes is higher in outer than inner London. The incidence of strokes is 60% higher in black African and Caribbean people than in the white population, and the risk of stroke is also higher in more deprived communities.
16. The death rate from stroke is higher in the United Kingdom than in other western European countries or the United States, and this appears to be associated with poor treatment. The use of thrombolysis (clot-busting drugs) within three hours of a stroke can reverse the damage caused. However, thrombolysis can be damaging in some types of stroke, and thus it can only be used by an expert team following a scan. Currently, only 10% of eligible patients are offered thrombolysis. Likewise, patients who suffer a transient ischaemic attack ('mini stroke') are 80% less likely to go on to have a full stroke if their symptoms are fully investigated within 24 hours, yet one third of acute hospitals in London are not meeting this target.
17. The proposed approach involves three types of stroke unit:
 - (a) *Hyper-acute stroke units.* These will provide the immediate response to a stroke, caring for patients for the first 72 hours or until their condition is stabilised. Anyone in London who suffers a stroke will be taken to one of these units, which will be

open 24 hours a day. There will be eight such units in London, and the distribution will be such that all Londoners will live within 30 minutes' ambulance drive of a unit. An initial proposal that there should be some additional centres available in daytimes only was abandoned because of concerns this form of operation would make it difficult to provide the highest standard of care, and concerns that it would complicate arrangements for ambulance transport.

- (b) *Local stroke units.* These units will provide ongoing care and rehabilitation once a patient is stabilised. Following their period in a hyper-acute stroke unit, patients will be transferred to a local stroke unit either in the same hospital or in a hospital nearer to their home.
- (c) *Transient ischaemic attack services.* These will provide for rapid assessment and access to a specialist.

18. The recommended sites for the eight hyper-acute stroke units are:

- (a) Charing Cross Hospital, Hammersmith;
- (b) King's College Hospital, Denmark Hill;
- (c) Northwick Park Hospital, Harrow;
- (d) Queen's Hospital, Romford;
- (e) St George's Hospital, Tooting;
- (f) The Princess Royal University Hospital, Orpington;
- (g) The Royal London Hospital, Whitechapel; and
- (h) University College Hospital, Euston.

19. Possible alternative sites for these centres are offered. For St George's, the alternative offered is the Mayday Hospital. Whilst there is no difference in overall travel times to these two hospitals, St George's Hospital is preferred because of its neurosciences facilities, which will be reinforced by its designation as a major trauma centre.

20. In all, over twenty sites were identified for local stroke units. These include all of the acute hospitals in or close to South West London, as follows:

- (a) St George's Hospital;
- (b) Kingston Hospital;
- (c) St Helier Hospital;
- (d) Mayday Hospital;
- (e) Chelsea and Westminster Hospital;
- (f) St Thomas' Hospital;
- (g) Charing Cross Hospital;
- (h) West Middlesex Hospital;
- (i) King's College Hospital; and
- (j) St Mary's Hospital.

21. It is noted that some of the sites identified, including St Helier Hospital, will require significant development support to reach the standards required of a local stroke unit. Five hospitals that currently provide stroke services have not been designated as local stroke units, but none of them are used by significant numbers of Wandsworth patients.

22. The proposed number and location of sites to provide services for transient ischaemic attack is identical to that proposed for local stroke services.

23. **Consultation questions.** The consultation document poses a number of questions on the proposals for stroke services. A recommended response from the Health Overview and Scrutiny Committee is set out below:

- (a) *Do you agree or disagree with our proposal of how we provide stroke care in future? If you disagree with our proposal on how we provide stroke care in the future, please tell us why?*

The proposals for stroke care appear to reflect a professional consensus and reflect the best evidence on treatment outcomes for stroke. They are therefore strongly supported.

- (b) *For good urgent care for stroke patients it is important to reach excellent-quality care, fast. Do you agree that eight hyper-acute stroke units would provide the best urgent care for stroke patients in London?*

Yes. There is an unavoidable trade-off between maintaining centres with a sufficient concentration of expertise and ensuring that services are sufficiently dispersed to minimise patient journey times. The proposal appears to represent a reasonable compromise.

- (c) *Do you agree with our preferred option for the location of hyper-acute stroke units?*

Yes. St George's Hospital is well-located to serve the population of South West London, and its existing expertise in neurosciences means that it is in a very good position to develop a hyper-acute stroke unit. Indeed, it has already provided hyper-acute stroke services across the South West London sector at night and weekends on a pilot basis, and this appears to have been successful.

- (d) *Do you agree or disagree that the proposed configuration of stroke units will provide the best possible care for Londoners.*

Agreed. In South West London the proposal confirms the provision of stroke services in all of the sites where they are currently offered, and establishes clearer standards in relation to the organisation of these services.

- (e) *Do you agree or disagree that the proposed configuration of transient ischaemic attack services provides the best possible care for Londoners?*

Agreed. The co-location of transient ischaemic attack services with local stroke units makes sense in terms of use of available expertise and in ensuring accessibility of services to users.

- (f) *In reaching a final decision, the Joint Committee of PCTs proposes to judge the options in terms of the clinical quality of services offered to Londoners; geographical coverage and especially ensuring that no-one is more than 30 minutes by ambulance from a hyper-acute stroke unit; and the potential fit with other services, in particular the possible benefits of co-locating hyper-acute stroke units with major trauma services. Do you agree or disagree with these criteria.*

All of these criteria seem sensible. The primary concern of people suffering a stroke is to receive the best possible treatment, and the speed with which they are able to access services is a crucial determinant of quality.

24. **Implementation.** If the proposed changes are agreed, it is intended that hospitals should begin offering the new models of both trauma and stroke provision from April 2010. The cost of implementing the new model of trauma services is estimated at £9-£12 million per year (or £5,625-£7,500 per major trauma case) and the cost of the new model of stroke

services will be £23 million a year (or £2,090 per stroke). Although these costs will fall on PCTs at a time when they are experiencing very limited growth in funding, the real improvement in outcomes offered suggest that they represent good value for money.

25. **Impact on St George's.** The proposals in the consultation document are very positive for St George's Hospital. They are indicative of St George's potential strength as a major teaching hospital located at some distance from the cluster of teaching hospitals in and around central London, and also provide a vindication for St George's focus on the clinical specialisms most associated with emergency care. It will be a real benefit for Wandsworth residents to have both a major trauma service and a hyper-acute stroke unit located within the Borough.
26. Providing both of these services on the St George's site will require space and equipment for two teams, each operating for twenty-four hours a day. A rough estimate is that each service will require approximately fifteen intensive care beds. In addition, although many patients will be discharged to local hospitals following their period in the most specialist units, it can be expected that the development will increase demand for the local trauma and acute services provided within the hospital. Given the general constraints on space within the site, there is a risk that this could have an impact on the availability of space within the hospital for the full range of local care services identified as desirable in *Healthcare for London*. Members may wish to emphasise to the St George's Healthcare NHS Trust the importance that they attach to these services, and ask the Trust to review its redevelopment plans to ensure that they offer sufficient scope for both the new centres of expertise and for enhanced local care provision.
27. **Conclusion.** The proposals in relation to both major trauma and stroke are clinically guided and represent a real opportunity to secure improved treatment outcomes. The identification of St George's as both a major trauma centre and a hyper-acute stroke unit is good news for the hospital and for Wandsworth residents. It is therefore recommended that the Overview and Scrutiny Committee should submit a response to consultation strongly supporting the proposals. The one possible area of concern, to be addressed with the St George's Healthcare NHS Trust, is to ensure that the development of these new centres of expertise is not at the expense of the provision of the routine local care services which residents are entitled to expect on the site of their local acute hospital.

Town Hall
Wandsworth SW18 2PU

03th June 2009

G.K. JONES

Chief Executive and Director of
Administration

Background papers

The following background papers were considered in the preparation of this report:

The shape of things to come: Developing new, high quality major trauma and stroke services for London. Healthcare for London consultation document, issued January 2009

Available from Dr. Richard Wiles (020 8871 6020) (rwiles@wandsworth.gov.uk)

All reports to the Overview and Scrutiny Committees, regulatory or other committees, the Executive and the full Council can be viewed on the Council's website

(<http://www.wandsworth.gov.uk/moderngov/uuCoverPage.asp?bcr=1>) unless the report was published before May 2001, in which case the committee secretary jrichardson@wandsworth.gov.uk (020-8871-6022) can supply it, if required.

Westminster City Council's response to the proposals on the consultation for major trauma and stroke services in London

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Introduction

Whilst intentions are to make a real genuine improvement to the healthcare for all Londoners, the process to do this has we believe not been patient based but administration based i.e. which hospital is best placed to deliver these services, rather than where the need is greatest. We are happy to join in with the pan London consultation on the basis that we are responding to the vision of the document 'The shape of things to come' and not necessarily to our vision in delivering the best solution for our residents or all Londoners.

In the context of this reservation we are happy that improved services are being given attention and it is essential that we urgently deliver a higher quality service, as all Londoners are not presently receiving the best care available.

Key Messages

These services must be seen as an addition to what is presently delivered. We must ensure we keep our local hospitals delivering what they presently deliver good local services.

There is a great possibility that present excellent services such as those specialist cancer units may suffer unless there is a willingness not to cut their budgets, beds or poach their staff to train for these services. There has been talk by some clinicians that to avoid this happening, they will consider relocating specialist cancer care.

We and some of the witnesses are not convinced that the allocation of £23M is sufficient to deliver the services planned and that the brunt may well rest on the already overstretched commissioning budget of NHS Westminster. This deserves further consultation.

Co-ordinated travel and access still remain uncertain as to the total journey times 30/ 45 minutes and to see the communications system improved to enable the ambulance drivers to deliver the patient to the appropriate hospital first time. We do still have to bear in mind not all travel is by ambulance but some still by private means and public transport.

The ambulance teams are presently delivering a quality service, however, they are key to ensuring that cases are accurately diagnosed and transferred with speed to the appropriate hospital.

Major Trauma

Clearly the NHS has demonstrated the need to improve this service. The current demand is around 1600 patients and we only have one specialised Trauma Unit. It would seem to make sense to agree a minimum of 4 locations although some have argued that 5 should be in the forward plan. Certainly not the three centre option. If a trauma centre requires a minimum level of 400 patients to achieve the quality of care required, then 5 centres does not seem unreasonable to have in the forward plan.

The four major Trauma hospitals most appropriate and best located are: Option 1 : The Royal London, King's College, St George's and St Mary's.

In selecting the option for four centres it still leaves a gap in the northeast of the City where need is greatest and this is where London should consider its fifth centre when the number of patients increase, as this area needs to be represented. However, four major trauma centres would be a real step forward. The reasoning behind our decision, are the main concerns of accessibility in meeting need and location.

Stroke

The 8 HASU's (hyper acute stroke unit) and TIA (transient ischaemic attack) centres suggested are again the minimum and we may be short sighted in not considering more. The backup of 23 local stroke units sounds adequate, although, again we are concerned that vital services now presently delivered at some hospitals maybe lost.

Presently St Mary's is not included and we recommend that St Mary's Hospital, especially due to location, should be included in delivering a HASU. We note that if they are selected to deliver a Major Trauma Unit (option 1 above) the stroke service will be automatically included. However if St Mary's do not get the trauma unit, we strongly recommend a HASU on this site. However, if this is not to be the case, we must at all costs be included and continue delivering a service for a local stroke unit.

The argument for more concentrated expertise is well put, however, we must consider that there is evidence that a smaller number of HASU's with large patient numbers over medium sized HASU's may not be so compelling. Physical location, clinical expertise is paramount and immediate access to scanning is vital in delivering this service.

The development of this service needs to be a partnership with Social Services and Healthcare Trusts and Local Authorities. Further investigations into the delivery of joint commissioning and the highest standards ensuring all Londoners receive the same high quality care, is urged.

The challenge still to be debated is rehabilitation and the transfer of patients and bed supply. This is an important part of the planning process and requires multi agency discipline, enough resources and skilled co-ordinators.

It was noted that the clot-busting drug, Thrombolysis is licensed for 18-80 years but question what will happen to our other patients outside this group. This does need clarification if we are to address the service fully to all our patients. It is not satisfactory in this day and age that research in this field does not include all ages and this is something we need to address as our residents are living longer.

Conclusion

We are pleased to note the desire to improve the quality and level of Stroke and Trauma services for all Londoners and this is welcome.

Together with the recommendations above we accept these proposals.

Yours Cllr Susie Burbridge,
Appointed Representative for the City of Westminster.
18th May 2009.



DEVELOPING NEW, HIGH-QUALITY MAJOR TRAUMA AND STROKE SERVICES IN LONDON

Summary

This paper sets out London Councils' response to the Healthcare for London consultation on the provision of major trauma and stroke services in London. The key points are:

General

- London Councils has made a deliberate decision not to take part in debates about specific hospitals that have or have not been designated. London Councils' concern is to make sure that the strategy provides good coverage across all parts of the Capital and achieves better health outcomes Londoners.
- London Councils would be looking for a full review (with member involvement) of any stroke and major trauma models taken forward within 12 months of their start up.
- **Travel times:** The travel times stated in the consultation are highly ambitious. London Councils has a real concern as to whether these travelling times are achievable and realistic, particularly with respect to patients travelling from some outer London boroughs. Travel times should be rigorously monitored to ensure that expectations are achieved.
- **Funding:** London Councils would like to see a clear breakdown of how the additional funding for stroke and trauma services will be invested, specifically in respect of funding for the community led services, voluntary and third sector organisations.
- **Workforce and training:** The proposals will require the appointment of a substantial number of staff. London Councils is concerned that these numbers are appropriate but ambitious and that immediate measures should be implemented to recruit and train new staff needed.
- **Rehabilitation and community led services:** London Councils would like to see more detail on how community services will be supported to ensure consistent high standards across the Capital.
- **Transfer arrangements:** London Councils would like to see effective protocols and adequate discharge arrangements in place for transfer patients. The same applies when patients leave hospital and return home. Reliable community led services will play a pivotal role if a person is to gain a full recovery; these services should be available and in place as soon as the patient leaves hospital.
- **Caring for children:** A coordinated London approach to caring for young children should be adopted to ensure that the specific needs of children do not get lost in a large specialist hospital unit focused more on the needs of adults.

Stroke proposals

- London Councils is concerned that the eight proposed Hyper Acute Stroke Units (HASUs) may not be in the most appropriate locations given that the highest incidences of stroke are in the outer London boroughs. Close attention should be paid to the responses of individual boroughs and local groups regarding the location of HASUs and stroke units.

Major Trauma Proposals

- London Councils remains concerned over the concentration of specialist units in central London. Four major trauma centres (MTCs) are preferred to three as this would ensure better coverage of North West London. However, the four MTCs should provide a geographic spread to ensure coverage and should not be clustered together.

1 INTRODUCTION

- 1.1 London Councils is committed to fighting for more resources for the capital and getting the best possible deal for London's 33 local authorities. We lobby key stakeholders, develop policy and do all we can to help our boroughs improve the services they deliver. We also run a range of services ourselves, all designed to make life better for Londoners.
- 1.2 London Councils' response to the Healthcare for London consultation on the provision of major trauma stroke services is set out below. The response makes some general points followed by points on the major trauma proposals and the stroke proposals. The final section of this response answers some of the specific questions posed in the consultation paper.
- 1.3 London Councils has made a deliberate decision not to take part in debates about specific hospitals that have or have not been designated. London Councils' concern is to make sure that the strategy provides good coverage across all parts of the Capital and achieves better health outcomes Londoners.

2 GENERAL COMMENTS

- 2.1 Since summer 2008 the pace of change in NHS London commissioning and delivery has accelerated. London Councils has responded to developments as they arise highlighting its belief that stronger commissioning should be borough led. While London Councils welcomes moves to reform the provision of services for major trauma and strokes in London, it is concerned that these moves could have the effect of emphasising centralisation of healthcare and reducing the scope for joint work between PCTs and London boroughs.
- 2.2 Reassurance would be welcome that acceptance of healthcare centralisation, where it can benefit Londoners, will not reinforce centralisation where it may reduce the quality of care received by Londoners and go back on recommendations in the Darzi review of healthcare in London to devolve most care to more local levels.
- 2.3 **Travel times**
 - 2.3.1 The travel times stated in the consultation are highly ambitious. The consultation envisages that the trauma patients will be transported to a Major Trauma centre (MTC) within 45 minutes by 'blue light 'service. In respect of stroke care, there is an aspiration that patients would be no more than 30 minutes away from a Hyper Acute Stroke Unit (HASU).
 - 2.3.2 **London Councils has a real concern as to whether these travelling times are achievable and realistic, particularly with respect to patients travelling from some outer London boroughs.**
 - 2.3.3 Whilst accepting the clinical arguments for the new stroke and trauma architecture in London, London Councils remains concerned over the undue concentration of specialist units in central London. With regards to the major trauma proposals, four MTCs are preferred to three as this would ensure better coverage of North West London. However, the four MTCs should provide a geographic spread to ensure coverage and should not be clustered together.
 - 2.3.4 London Councils is particularly concerned that five of the proposed Hyper Acute Stroke Units (HASUs) are in inner/central London in a context of a disproportionately ageing

population in (some parts of) outer London and the significantly longer travelling times communities in these areas will experience travelling to HASUs.

2.3.5 It is vital that HASUs are located in the most appropriate areas from the outset, if this is not the case the proposed system will not work in practice. Decisions on the location of HASUs appear to be based on ability to meet future standards of care in preference to travel times, geographical coverage and current and predicted incidences of stroke.

2.3.6 While London Councils is aware that additional investment may be needed if hospitals in need of substantial support to meet future standards are selected as HASUs, there is concern that the eight proposed HASUs may not be in the most appropriate locations given that the highest incidences of stroke are in the outer London boroughs of Barnet, Bromley, Enfield and Havering. London Councils suggests that close attention is paid to the responses of individual boroughs and local groups regarding the location of HASUs and stroke units.

2.3.7 In addition, London Councils believes that travel times should be rigorously monitored to ensure that expectations are achieved. London Councils would be looking for a full review (with London Councils member involvement) of any stroke and major trauma models taken forward within 12 months of their start up, particularly focussing on:

- **Planned and actual patient travel times;**
- **Identification of significant travel time disparities and recommended remedial action;**
- **The clinical impact of travel times (where out of the target time) on patients by age, condition and area of London;**
- **A firm commitment (and resourcing) that the target maximum travelling times should not increase, and after a first year review a more ambitious suite of travelling time targets be set for upper end journey times from outer London; and**
- **An analysis of the effect of HASUs and MTCs on travelling times and accessibility for relatives and carers.**

2.3.8 It is also suggested that a public awareness campaign is undertaken in London to provide assurances to the public that travelling to a hospital further away from their local hospital is essential if patients are to receive the best specialist care possible.

2.4 Funding Issues

2.4.1 The estimated current cost of providing major trauma services is £34 million p.a. Healthcare for London estimates that it will cost an additional £9–12 million p.a. to improve services for people suffering trauma injuries. The direct cost of stroke care in London is estimated at £139 million p.a. (i.e. just over 1% of London PCT 2009/10 recurrent allocations). The consultation paper estimates that £23 million additional investment is needed every year to deliver improvements in acute stroke care.

2.4.2 The consultation document does not provide a clear breakdown of how the additional funding for stroke and trauma services will be invested and whether any of this funding will be allocated to community led services and voluntary and third sector organisations. Clarity on current and future thinking on these issues would be very welcome.

2.5 Rehabilitation and community-led services

- 2.5.1 The proposals for both trauma and stroke services rely heavily on the provision of hospitals providing specialist treatment with on-going support being delivered through linked networks. Integral to the success of the trauma and stroke proposals is the depth, effectiveness and design of 'follow-on' schemes. The consultation focuses on the high end services and lacks detail about how community services can be provided in such a way as to ensure good availability, consistency and access to treatment. The lack of detail about how community services are to support the proposals is of concern, particularly as London has existing, widespread and high levels of health inequality linked both to poor access and poverty.
- 2.5.2 London Councils believes that good quality rehabilitation services delivered by the voluntary and third sector agencies, for both stroke and trauma patients, are critical if these proposals are to succeed. Patients need to be confident that local services will be available and will support them. Often stroke and trauma can cause dramatic, life changing developments and other less obvious factors such as depression and emotional and behavioural personality changes. Consistent, available and high quality support delivered at a local level is key to addressing these issues.
- 2.5.3 There must be clear assurances that access and the provision of services to support patients remain of high importance and match the standards of care available in the hospital setting. Often levels of care following release from hospital fail to meet the expectations of care provided locally.**
- 2.5.4 Better and more consistent linkages between health and social services in providing comprehensive rehabilitation services should be in place to prevent patients falling through the net and resulting in inconsistent levels of service and health outcomes. London Councils would like to see more detail on how community services will be supported to ensure consistent high standards across the Capital.**

2.6 Workforce and training issues

- 2.6.1 The proposals regarding both stroke and trauma incidents across London need the effective support of specialist staff to deliver the first class service required. It is clear from the consultation paper that new staff will need to be recruited, for example the stroke proposals refer to the need to invest in nearly 600 more nurses, 200 more therapists, more stroke consultants and more junior doctors.
- 2.6.2 London Councils is concerned that these numbers are appropriate but ambitious and that immediate measures should be implemented to recruit and train new staff needed. Student numbers need to increase significantly if the numbers are to meet the required amount. The timescale pressure is of concern and action needs to be taken quickly if the majority of staff are to be in place by April 2010.**
- 2.6.3 Creative measures should be adopted to attract students into all aspects of stroke and trauma. In addition, a publicity campaign to support the benefits of nursing as a profession should be implemented.**

2.7 Transfer arrangements

- 2.7.1 The models of care as set out by Healthcare for London (i.e. specialist services supported by a network) will rely heavily on good transfer arrangements being in place. London

Councils believes it is essential to ensure that patients move smoothly between hospitals and that patients are not delayed due to administrative or organisational errors.

- 2.7.2 The consultation sets out that a 72 hour stay in a HASU is required before patients are moved on to their local stroke unit. Flexible arrangements should be in place to ensure that this requirement is adaptable for patients wishing to stay for longer periods and is based on clinical need and not bed availability. Stroke units should also be aware that bed occupancy rates may be affected in these circumstances.
- 2.7.3 Effective protocols and adequate discharge arrangements need to be established to guarantee that when a transferring patient leaves hospital the correct paperwork follows the patient and the bed is available when they arrive at the hospital to which they are being transferred.**
- 2.7.4 The same applies when patients leave hospital and return home. Reliable community led services will play a pivotal role if a person is to gain a full recovery. These services should be available and in place as soon as the patient leaves hospital as currently levels of care received after a person leaves hospital can be patchy and hinder a person's ability to make a full recovery.**

2.8 Caring for children

- 2.8.1 It is estimated that 300 children per year will be affected by the proposals, resulting in approximately one case per week.
- 2.8.2 London Councils suggests that a coordinated London approach to caring for young children is adopted to ensure that the specific needs of children are addressed sympathetically and do not get lost in the clinical surroundings of a large specialist hospital unit focused more on the needs of adults.**
- 2.8.3 Whenever possible, discharge arrangements should place an emphasis on ensuring that children are transferred to hospitals near their home so that family and friends can visit and any disruption to other family members and siblings is minimised. Specialist staff such as paediatricians should be available to offer support and care for younger patients and their families.**

3 MAJOR TRAUMA PROPOSALS

- 3.1 London Councils supports the focus on improving trauma services in London. As the consultation paper states: hospitals in London are currently unable to provide the specialist services needed quickly enough and with the expert care needed. There is also a lack of co-ordination between services which are essential if patients are to receive rapid treatment. Currently, two thirds of patients taken to a local hospital are then transferred to a hospital that has the facilities to treat them adequately.
- 3.2 The consultation document estimates that the number of people likely to be affected by a major trauma incident is around 1,600 a year (about one patient per hospital per week). Although the numbers affected are small in comparison to stroke incidents, it is clear that the severity of the injuries dictate that specialist treatment needs to be delivered quickly if the patients are to receive better health outcomes.

3.3 London Councils supports the suggested approach of developing a trauma system of trauma networks being established to support specialist major trauma centres. Specialist major trauma centres that offer professional diagnostic services available on a 24/7 basis will make a real impact on the current service. Trauma centres based within A&E departments will provide treatment for the less serious cases and rehabilitation arrangements for people being transferred.

3.4 Impact on services

3.4.1 When looking at the proposals for provision of major trauma services in London, consideration should be given to the impact on the other services provided by hospitals with both trauma centres and MTCs. There must be an assurance that specialist centres are not developed at the disadvantage of the local patients.

3.4.2 Any review of the revised service in London should include an analysis of the impact on other services provided by hospitals designated as trauma centres or MTCs.

3.5 A factor of the specialist services will be to attract the correct amount of specialist staff needed to deliver a first class service to patients. Given that the available pool of specialist staff needed is small, there is potentially a risk that specialist staff will be attracted to work within the MTCs, thus creating an exodus of staff leaving district hospitals and resulting in skill set shortage within the trauma centres. There should be a clear strategy in place to manage staff 'leakage' and local backfilling of posts as well as to ensure that both MTCs and trauma centres have sufficient specialist staff.

3.6 Trauma centres outside London

3.6.1 London Councils is concerned that the current proposals are being considered in isolation. London Councils believes it is counter intuitive not to consider and assess the effectiveness of the provision of services outside London. Readiness of trauma services around the periphery of London and how they will impact on the London network as a whole is still unclear.

4 STROKE PROPOSALS

4.1 London Councils supports the focus on improving stroke services in London. As the consultation paper states: in London, stroke is the second highest cause of death and the most common cause of adult disability. Currently around only 53% of strokes are treated in dedicated stroke units.

4.2 Age is a significant factor in stroke (over 75% of strokes occur in people over 65 years old). The highest incidence of strokes is in outer London boroughs with higher levels of older people; currently these boroughs have the most limited access to high-quality stroke services.

4.3 The two next most important factors in stroke are ethnicity and social deprivation. As stroke disproportionately impacts on black and ethnic minority groups it is essential that HASUs and stroke units give full recognition to their religious and cultural needs when developing services.

4.4 While London Councils welcomes the acknowledgement in the consultation document that the most important factors in stroke are age, ethnicity and social deprivation, it would

welcome specific analysis of the impact of the new proposals, once implemented, on these particular groups.

- 4.5 Local authorities would also want assurances that funding provided at a local level adequately reflects the diversity of their communities. As stated above (section 2.5) rehabilitation and community led services are vital to ensure continuing recovery and improvement once a stroke patient leaves hospital. It is important that these services are focused on areas with high levels of: older residents; ethnicity; and social deprivation. It is essential that these services are of a consistent high quality across London and are equally accessible to all communities.
- 4.6 **As stated earlier (paras 2.3.4 – 2.3.7), there is concern that the eight proposed HASUs may not be in the most appropriate locations given that the highest incidences of stroke are in the outer London boroughs of Barnet, Bromley, Enfield and Havering. In light of this, it is important that travel times and the impact on families and relatives are monitored and reviewed within one year of the establishment of the new system.**

5 CONSULTATION QUESTIONS

5.1 Question 1: (Which option do you think would provide the best trauma care for Londoners?)

- 5.1.1 London Councils believes that to provide an effective service for Londoners there should be at least four major trauma centres (MTCs) across London.
- 5.1.2 With regards to which hospitals should be designated as MTCs and trauma centres, London Councils has made a deliberate decision not to take part in debates about specific hospitals that have or have not been designated. London Councils' concern is to make sure that the strategy provides good coverage across all parts of London. London Councils is confident that individual local authorities and their stakeholders will make their own case for a preferred option that best meets the needs of the local community in question.

5.2 Question 2: (Why do you think this is the best option?)

- 5.2.1 London Councils believes that four MTCs and networks would treat an estimated 400 patients a year each in order to gain the expertise needed to make a real difference. London Councils' support for four MTCs is based on the assumption that four MTCs will ensure that maximum journey times of 45 minutes are more achievable. Four MTCs will help to ensure better geographical coverage of the Capital, particularly the North West sub region.
- 5.2.2 London Councils is concerned that three MTCs and networks would threaten the viability and effectiveness of the proposals as a whole. There is concern that three MTCs would be too stretched and would not be able to cope with the number of patients estimated and potential increases in patient numbers in the future, thus impacting adversely on clinical outcomes.

5.3 Question 3: (Do you agree or disagree with our proposal on how [not where] we provide stroke care in the future?)

- 5.3.1 London Councils supports Healthcare for London's proposal about how stroke care is structured and provided in the future. It is clear that there is a need for improving health outcomes for people suffering from a stroke condition. Providing specialist services in the

form of hyper acute provision, along with stroke units and transient ischaemic attack (TIA) services in London is the correct approach.

5.4 Question 5: (For good urgent care for stroke patients it is important to reach excellent-quality care, fast. Do you agree that eight hyper-acute stroke units would provide the best urgent care for stroke patients in London?)

5.4.1 London Councils believes that the provision of eight hyper-acute units is the correct number. However, there should be an awareness that the number of HASUs and stroke units may need to change in the future in order to respond to an increased number of people needing stroke care in future.

5.5 Question 6: (Do you agree or disagree that our preferred option of hyper-acute stroke units at the following hospitals will provide high-quality specialist care for residents in London?)

5.5.1 London Councils has made a deliberate decision not to take part in debates about specific hospitals that have or have not been designated. London Councils is confident that individual local authorities and their stakeholders will make their own case for a preferred option that best meets the needs of the local community in question.

5.5.2 London Councils' concern is to make sure that the strategy provides good coverage across all parts of London. In respect of HASUs, London Councils believes the real concern is their location and the fact that five of the hospitals chosen to deliver the services are located in inner or central London. See section 2.5 and paras 4.5 – 4.6 above.

5.6 Question 8: (Do you agree or disagree that the proposed configuration of stroke units (below) will provide the best care possible for Londoners?)

5.6.1 London Councils believes that the provision of stroke units across London needs to reflect the risk factors attributed to people most likely to have stroke. Old age, ethnicity and social deprivation are the three highest risk factors; however this is not reflected in the proposed locations of the HASUs. As stated in para 4.4 above, London Councils would welcome specific analysis of the impact of the new proposals, once implemented, on these particular groups.

BASP

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30 April 2009

Findings from British Association of Stroke Physicians (BASP) member consultation on the Healthcare for London changes in Acute Stroke Care

Following a circulation to the BASP membership, 8 responses were received, 6 of which were from clinicians working in centres directly affected by the proposed changes. The findings from the consultation were considered by the BASP National Executive.

In principle, the proposals to centralise expertise were accepted and the potential benefits to patients were recognised. Several recurrent themes appeared through the majority of the small number of responses, numbered below:

1. Transition Period.

There were significant concerns regarding the transition period, during which services will be decommissioned from centres currently providing hyperacute care while those in the designated centres are built up or, in some cases, started almost from scratch in centres without properly developed basic stroke services. The Healthcare for London (HfL) Stroke Strategy document envisages this transition process taking place over a six month period after 'go-live' in Autumn 2009. Several members, all of whom have themselves been involved with the process of developing expert stroke services over a number of years and are aware of how long it takes to develop such services, observed that the time and effort necessary to develop large functioning expert centres has been substantially underestimated in the proposals. This creates the very real risk of a traumatic transition from the current dispersed model to the new model of 8 hyperacute stroke units (HASUs). New services will struggle to develop rapidly enough to meet the deadlines in the proposals while current services will suffer planning blight and the loss of skilled and experienced staff. Some of the new centres will be required to recruit very large numbers of skilled and experienced staff and there are significant concerns as to whether these staff are available (even when taking into account movements of existing staff in response to the changes), and a failure to recruit will critically affect the ability of the new units to be functioning in time.

A longer and more carefully planned transition period is likely to be necessary – indeed even if this is not explicitly recognised, it is likely this will be forced through circumstance. It will be necessary to allow existing services to continue to be provided and for these to mentor and support the development of the newly designated centres. This arrangement would be particularly important in the South

East sector, where the lag time for the development of new services is likely to be the greatest.

2. Patient Flow and Repatriation.

Concerns were raised regarding patient flows through the proposed large hyperacute units. Maintaining bed availability in such large units will depend critically on arrangements for repatriation. Previous experience with repatriation arrangements in London and elsewhere is not encouraging, and problems will undoubtedly occur which may critically affect HASU services expecting 4 admissions per day. Repatriation difficulties over a long Bank Holiday weekend, for instance, could result in substantial overflows of patients with acute stroke in the HASUs, with corresponding impact on patient safety and the ability to continue to deliver hyperacute treatments.

The model is based on the assumption that the average length of stay in the hyperacute units will be 72 hours. However there are many reasons why a patient's stay in a hyperacute unit may appropriately need to be longer than 72 hours – patients with recurrent TIAs, or patients with neurological instability or progressive presentations of stroke may need close observation in a hyperacute centre for prolonged periods and would be too unstable to be transferred. Yet the assumption of a 72 hours average length of stay in the HASUs is crucial to the functioning of the whole model, and any even minor drift beyond that figure will have serious consequences for patient flow through the system and the availability of beds in the hyperacute centres. It is vitally important that the movement of patients from HASUs to local stroke units is clinically safe, and determined solely by clinical need, rather than being dictated by the need to achieve a particular average length of stay.

3. Patient Selection.

One way to address the issue raised in paragraph 2 would be to control the flow of patients to the HASUs by employing some form of selection for HASU admission – redirecting patients, for example, with symptom onset more than a certain time ago e.g. 12 or 24 hours. Observational data indicates that up to 20% of patients have symptom onset greater than 24 hours previously and these could be redirected to their local stroke unit instead of being taken to the HASU. The application of other criteria (e.g. some of the criteria determining eligibility for thrombolysis) would have to be applied by the London Ambulance Service (LAS) and would inevitably involve a proportion of false positives (patients taken to a HASU who have not had a stroke but who will still require treatment and repatriation) and false negatives (patients taken to their local emergency department in whom it emerges that they have suffered a stroke, but only when it is too late to intervene with an acute treatment). Use of the FAST test by the LAS to triage patients to a HASU will still result in significant numbers of both of these types of patients, particularly those with posterior circulation strokes, for whom the FAST test performs poorly as a predictive tool. The arrangements appear to take insufficient heed of the inevitability that the HASUs will be receiving a variety of 'stroke mimics' (approximately a quarter of all referrals based on the FAST test) who will require specific management.

4. Effect of the changes on training.

There is a significant danger that during the transition period there will be a lack of proper training opportunities for developing stroke physicians. Existing units that are decommissioned will no longer be able to offer the exposure to hyperacute care that is an essential part of training, at a time when the developing units will be too inexperienced and/or preoccupied to be able to offer appropriately supported training. This imbalance may last for several years (see comments under 1. above) and will occur just at a time when the expansion of the specialty of Stroke Medicine is reaching a critical stage. Although it does not relate directly to our membership, it is likely that there will be similar effects on the training of nurses and allied health professionals.

BASP wholeheartedly supports the improvement of services for people with stroke, a need repeatedly highlighted by the findings from the National Sentinel Audit of Stroke over the last ten years. There are areas of London where this need is particularly acute, and where there is considerable demographic pressure on stroke incidence. The strategy initiative taken by Healthcare for London to introduce a substantial 'step-change' in provision of stroke services is therefore to be welcomed, but great care is required with these changes as they risk prolonged disruption. Expert stroke services cannot be built from scratch or substantially enlarged in a short timescale. There remains a significant risk that changes introduced too quickly will result in a difficult and disruptive transition period, which is likely to be much longer than currently projected.

Thank you for inviting our response.

Yours sincerely

*Dr Martin James, Consultant Stroke Physician, Royal Devon & Exeter Hospital and
President-Elect, BASP on behalf of the BASP National Executive*

Research - Clinical Services



Cllr C. Buckmaster
Chairman
Joint Health Overview and
Scrutiny Committee
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6th May 2009

Cllr Buckmaster,

Re: Trauma and Stroke Consultation – Royal Free Hospital

As Chair of the Camden LINK, and as someone who has been involved in the proposals from the outset I would like to voice my concern as to the way the decision making is being undertaken.

In the first instance the public doesn't really understand that they have a choice. Secondly the decision as to between St. Mary's and the Royal Free for both these services would seem to be flawed.

The criteria seems to have taken 2012 as to a possible start date for the Royal Free, when in fact they have stated all along that they could be ready by 2010, some two years earlier.

St Mary's seem to have been the preferred option because of its nearness to certain motorways. However more to the point is the fact that too much weight is being given to assurances by the London Ambulance Service to be able to reach the major trauma and stroke centres within 30 minutes under a blue light. This still has to be proved.

Bearing in mind that the majority of stroke occurrences are around the periphery of the London conurbation, this seems to leave the North / North West of London disadvantaged.

When considering costs, it seems laughable that a major acute hospital currently supplying both a trauma and a hyper-acute stroke centre is to be downgraded. It would take only a marginal expenditure to upgrade these service to a 24/7 operation.

Finally has sufficient notice been taken of the load that might need to be carried by the major centres in the event of a critical need created by a major incident?

The only other comment is that for the last 20 years, London has been totally neglected and NHS London needs to be congratulated to at last waking up to this bad situation.

Yours Sincerely

Arthur Brill

Chair
CamdenLINK

22nd April 2009

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Chairman
The Royal Borough of Kensington and Chelsea
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Dear Councillor Christopher Buckmaster,

Re: 'The Shape of Things to Come – Developing new, high-quality major trauma and stroke services for London' consultation

Thank you for your letter of the 11th of April 2009 inviting us to give you a written submission of our views on the current consultation for major trauma and stroke services for London.

We are firmly of the view that centralisation of services should be pursued where this will be of benefit to patients, and as such Chelsea and Westminster is supportive of these services being provided from organisations that have the specialist skills and infrastructure to deliver the highest quality of care for London's population.

However, we are opposed to the plans for North West London to locate hyper-acute stroke services at Charing Cross Hospital and major trauma services at St. Mary's Hospital, with an assumption that hyper-acute stroke services would move from Charing Cross to St. Mary's should St. Mary's be designated a major trauma centre.

Our own organisation Chelsea and Westminster Hospital NHS Foundation Trust submitted proposals to provide hyper-acute stroke services from our hospital site and the consultation sets out that although both Charing Cross Hospital and our Trust had bids that were both able to meet future standards, Charing Cross was preferred on the basis of slightly shorter travelling times and because of the co-location of neurosciences on that site.

Our concerns in relation to the plans for our sector of London are set out below:

- Whilst we were supportive of the hyper-acute stroke services being sited at Charing Cross, we are not supportive of the same services being moved to St. Mary's Hospital. The quality of our bid to provide hyper-acute stroke services was compared with that of Charing Cross, not against the quality of services that could be provided at St. Mary's Hospital. This seems a clear flaw in the designation process, and is not offset by the statement within the consultation that before services were moved to St. Mary's Hospital a plan would need to show that "clinical standards of these services would need to be at least the same, if not higher, than the current proposed configuration".
This is not an equitable basis upon which to compare the relative strengths of service provision from our site against those of an alternative in north west London.
- There is no evidence that travel times are better for St. Mary's Hospital than for our site and St. Mary's Hospital does not have on-site neurosciences – the only two factors on which Charing Cross was chosen ahead of our hospital as the site for hyper-acute stroke services.
- Suggestions have been made that neurosciences could be provided at both Charing Cross Hospital and St. Mary's Hospital in future should St. Mary's be designated as a major trauma centre. I do not believe that the financial implications of running services at both hospitals have been factored into commissioners'

- assessments, which is of particular relevance given the current economic environment.
- Of similar concern, it is not clear to me that the capital investment in making St. Mary's Hospital fit to accommodate both hyper-acute stroke services and major trauma services has been taken into account. In a more financially constrained NHS, a value-for-money assessment is crucial to decision-making. Our Trust submitted plans to site hyper-acute services on our site which would not require major capital spending; furthermore, as a Foundation Trust we would finance this development ourselves from surpluses we generate rather than asking the NHS for additional funding.

We are confident that Chelsea and Westminster could provide an extremely high quality hyper-acute stroke service, as acknowledged in the own consultation paper. As you are no doubt already aware, we currently provide such a service, with the 2008 national Sentinel Audit report showing us as having the 3rd strongest stroke service in the country. On this basis, we would ask the commissioners to reconsider their decision to site hyper-acute stroke services at Charing Cross Hospital in the short term with a likely move to St. Mary's Hospital in future. Your support in encouraging this re-assessment would be most appreciated.

With regards to the plans for four major trauma centres including one at St. Mary's Hospital, we would work in a networked manner with any major trauma centre that fully meets the criteria of such a centre. We do not necessarily believe that this major trauma centre needs to be located within north west London and would be comfortable working with St. George's Hospital which is one of the options outlined in your consultation document. Again, I feel that if three major trauma centres could cover all of London in networks by April 2010 – as is set out in one of the options in the consultation - then the value-for-money of having a fourth major trauma centre needs serious consideration.

Kind regards,



Heather Lawrence
Chief Executive



Developing High Quality Trauma and Stroke Services for London

Response from the College of Occupational Therapists

Introduction

The College of Occupational Therapists is pleased to provide a response to the consultation Developing High Quality Trauma and Stroke Services for London, which has been assisted by COT's Stroke Forum, part of COT's Specialist Section – Neurological Practice.

The College of Occupational Therapists is the professional body for occupational therapists and represents over 28,000 occupational therapists, support workers and students from across the United Kingdom. Occupational therapists work in the NHS, Local Authority social care services, housing, schools, prisons, voluntary and independent sectors, and vocational and employment rehabilitation services.

Occupational therapists are regulated by the Health Professions Council, and work with people of all ages with a wide range of occupational problems resulting from physical, mental, social or developmental difficulties.

The philosophy of occupational therapy is founded on the concept that occupation is essential to human existence and good health and wellbeing. Occupation includes all the things that people do or participate in. For example, caring for themselves and others, working, learning, playing and interacting with others. Being deprived of or having limited access to occupation, for example as a result of stroke, can affect physical and psychological health.

General

The College of Occupational Therapists (COT) welcomes Healthcare for London's plans to develop new high quality major trauma and stroke services for London. The COT views the efforts which are being made to reduce risk of mortality and impairment for patients through rapid response times and provision of specialised care immediately following major trauma or stroke as very positive. The COT also appreciates the attempt to tackle variations in service, and to ensure that people living in London will be within 45 minutes ambulance journey of a major trauma centre and within 30 minutes journey of specialised treatment for stroke. Although it is appreciated that the strategy is for both major trauma and stroke, most of this response is concerned with the impact the strategy will have on occupational therapy for clients with stroke.



In order to ensure that the new strategy brings about a comprehensive improvement in outcomes, it is important that all parts of the care pathway, from the acute phase to long term rehabilitation, are considered. In terms of service provision for stroke, occupational therapy has an important role to play in the acute phase within the first 48 hours, through intensive rehabilitation including early supported discharge, to long term rehabilitation and social care (Logan 2007). In the light of this, the COT would like to draw attention to a number of concerns.

1. Ensuring an adequate number of occupational therapy posts

The report mentions that '200 additional therapists will be needed in order to deliver the new stroke services' (p44), and it is appreciated that a detailed review of the stroke workforce is underway. It is unclear however, how this figure, for all therapists, has been derived, given that the results of the workforce review are not yet known. Additionally, it would be helpful if the figure of '200 additional therapists' to be broken down by profession.

The COT is concerned that whilst the options for the geographical location of stroke services (including hyper-acute units, stroke units and transient ischaemic attack services) appears to have undergone considerable testing prior to this consultation (including scrutiny by an expert panel plus engagement with clinicians, charities and members of the public), the workforce implications of the proposed changes have received less attention. This comes at a time when the problem of inadequate staff numbers for stroke services in England is being highlighted. A survey of 140 stroke units in England, conducted for the Health Workforce Bulletin (March 2009) has shown that:

- Patients are receiving low levels of nursing and therapy time, with wide variation in provision.
- 75% of patients receive less than one hour of therapy per day and 25% receiving less than half an hour in every 24 hours.
- The survey estimates that to provide an optimal service, 435 additional occupational therapists would be needed in England.

If the new strategy is to be successful in reducing the impact of stroke, then commissioning for adequate and appropriate staffing levels would appear to be a basic requirement. This needs to be given full and serious consideration. For information, minimum staffing levels per stroke patient are given in the 2007 document 'Occupational Therapy Following Stroke'. The recommendations state, for example, that in the intensive rehabilitation phase of the pathway, at least one Band7 occupational therapist is needed for every five patients (Logan 2007). Currently, members from COT's Stroke Forum are reporting that the staff patient ratio is 1:10 on some units.

Whilst the strategy appears to acknowledge to a certain extent that more rehabilitation staff will be needed for successful implementation, it also needs to be appreciated that the starting point is currently one of under provision of those staff. This problem will need to be addressed, as well as the additional staffing which the strategy will require.



COT's Stroke Forum has pointed out that there is frequently an assumption that the need for occupational therapy will predominantly occur during the rehabilitation stage of the pathway. Whilst there is certainly a need for occupational therapists at this stage, the occupational therapy requirements at the hyper-acute and acute stages should not be under-estimated. Occupational therapists need to be available at the hyper-acute stage, for example for cognitive and perceptual screening, positioning and to check for deficits which may have an impact on discharge.

The acute phase is the starting point for rehabilitation. Clients should have access to daily rehabilitation. Arrangements for early supported discharge should be being made with appropriate clients and there is usually a high demand for occupational therapy home assessments at this stage. Home visits are essential for many clients with stroke, because the stroke usually represents a sudden and major decline in functioning. However, they take a significant amount of occupational therapy time and also mean that occupational therapists are not available on site to be working with other clients whilst carrying out those visits. These factors need to be taken into consideration when determining staffing levels, to ensure that there is adequate occupational therapy cover.

2. Recruitment and Training

In addition to planning for adequate numbers of occupational therapy and rehabilitation posts, Healthcare for London needs to be aware that COT members are reporting severe difficulties recruiting to Band 7 posts in the London area. In one area of London, a vacancy rate of 25-50% has been reported by members of COT's Stroke Forum. Further reports suggest that in North East London, for example, there are Band 7 vacancies in five out of 12 inpatient and community units (North East London Cardiac and Stroke Network 2009). The situation becomes more complex when it is realised that some previously advertised positions have been filled by downgrading them to Band 6 positions, and that some vacancies are not being advertised. This has implications for quality of care, since clients with stroke require specialised and intensive rehabilitation, particularly at the early stages of recovery

The reasons for the difficulty in recruiting to higher grades are not clear but may be related to occupational therapists being unable to attend post qualification training and/or being unable to gain the supervision and experience necessary to progress to the higher grades. Whilst occupational therapists have basic skills in rehabilitation, building up expertise in stroke rehabilitation takes time and supervision from suitably experienced senior staff. The strategy appears to represent a good opportunity to address the need for on-going training and experiential learning, but it must be appreciated that this can only happen over time.

COT's Stroke Forum has been working to improve training opportunities through running the 'Starting Out in Stroke' road show. To date, 220 therapists have attended this training, and there have been numerous requests for further courses to take place. However, there is also a need for experience to be gained through 'on



the job' training, and this can only be provided if there are adequate posts and adequate staff in those posts to provide supervision, training and mentoring.

The COT welcomes fact that there will be 'an approved training and development programme for stroke professionals' (p44), but points out that there needs to be more information about what this training will entail. What aspects of occupational therapy will be included, and what provision will be made to ensure that staff are able to take time out from their clinical caseloads to pursue this training? If the training provided is not appropriate for occupational therapy, there must be provision to allow occupational therapists to pursue their own continuing professional development.

3. Attention to long term stroke rehabilitation and care

This aspect has been partly covered in point one, above, in that adequate attention needs to be given to the whole of the patient pathway rather than focusing mainly on the acute stage. Two related concerns are:

- a. The report mentions that, 'Improved acute care will mean that more people survive from stroke and require rehabilitation. However, the severity of disability and dependency is actually likely to reduce'(p44). This will have implications for occupational therapy, in that the focus of intervention is likely to change, but is not likely to be reduced. For example, rehabilitation for a client who has a high level of impairment following stroke is likely to focus on optimising independence in activities of daily living and possibly communication, social and leisure activities. For a client with a lower level of impairment, training for independence in activities of daily living may need to be addressed but other issues such as vocational rehabilitation, re-training for social roles and outdoor mobility/transport may also be a priority. Thus the role for occupational therapy may change, but is unlikely to be reduced.
- b. The proposed new strategy will have an impact on social services based occupational therapy provision. Workforce planning was highlighted in the COT's response to the Stroke Strategy (2007). To quote from this consultation: 'Occupational therapists work across sectors. For many years, the numbers of local authority social serviced employed occupational therapists has been excluded from health services workforce planning. Commissioning of undergraduate training places has been underestimated and as a result there has been an ongoing shortage of occupational therapists in the NHS. Workforce planning must take into account employment opportunities outside the NHS if it is to maintain staff numbers. This will be of increasing importance as more services are commissioned to non-NHS providers' (COT 2007). The College recommends consultation with the local authority departments in order to ensure that the new proposals are fully integrated.



4. Training in emergency care

Although occupational therapists receive basic life support training, this does not currently include specific training on what to do in the event of a suspected TIA or stroke. Given that the strategy aims to reduce response times for these events, it would seem prudent to provide this training for all occupational therapy staff, regardless of whether they work in a specialised stroke service or not.

Summary

Whilst the COT welcomes the efforts being made to reduce risk of mortality and impairment for patients suffering major trauma or stroke, it recommends that further attention be given to:

- The importance of **considering the occupational therapy role along the whole pathway for stroke care**. This includes the role in the hyper-acute units and the importance of occupational home assessments during the acute stage.
- **Staffing levels:**
 - Current inability to recruit to higher grades, such as Band 7, in some areas.
 - The starting point is one of under-staffing for some units, which has implications for quality of care and the ability of occupational therapists to improve their skills.
 - In long term rehabilitation, although overall severity of disability for patients may be reduced, the need for occupational therapy will still be present.

It would be helpful if explanation of how an additional workforce requirement of 200 therapists has been derived, as well as a breakdown of that figure, so that the numbers of therapists from each profession are known.

- **The role of occupational therapists in local authority social services departments** and the impact the strategy will have on those departments.
- **Training:**
 - Need for occupational therapists working with stroke patients to have access specialist training and other learning opportunities to ensure quality of care.
 - Need for all occupational therapists to have training on how to respond to suspected TIA or stroke.

For further information, please contact Amy Edwards, Professional Affairs Officer - Long Term Conditions, College of Occupational Therapists, e-mail amy.Edwards@cot.co.uk



References

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Many thanks to the COT's Specialist Section - Neurological Practice Stroke Forum for their assistance in producing this consultation response.



Appendix 1

The role of the occupational therapist in the treatment of people who have had a stroke

The main occupational therapy interventions with people who have had a stroke are described as:

1. Assessment, to determine the degree of limitation in activities of daily living.
2. Goal setting, with patient and carer to develop a patient specific treatment programme.
3. Treatment, to help the patient achieve maximum functional ability:
 - a. - functional activities of daily living, e.g. washing, dressing, bathing, toilet,
 - b. - kitchen skills, eating and drinking
 - c. - sexual intercourse
 - d. - physical ability e.g. upper limb movement and function
 - e. - management of spasticity through splinting
 - f. - posture and positioning
 - g. - cognitive and perceptual ability
 - h. - wheelchair requirements
 - i. - vocational rehabilitation, work roles, voluntary jobs
 - j. - driving and outdoor mobility, walking and using electric scooters
 - k. - leisure activities, hobbies
 - l. - community reintegration.
4. Getting out of hospital:
 - a. Pre-discharge home visits
 - b. Early supported discharge/intermediate care
 - c. Provision of assistive devices, home adaptations
 - d. Liaison with community services e.g. home care, social services, meals at home, benefit advice, mobility centres, equipment centres.
5. Psychological support and counselling for the patient, family, carers and professionals.
6. Education for the patient, family, carers and professionals.
7. Long-term support, falls prevention advice, stroke clubs, day centres, and night-sitters.
8. Return to work.

Evidence for occupational therapy specific treatments listed above can be found in the document *Occupational Therapy Concise Guide for Stroke* (Logan 2007).

Text of email from Dr David Goldhill, 27.04.09

Dear Deepa

If appropriate could you please pass the following comments on to the committee? I am a member of the Council of the Intensive Care Society and was Chair of the working party that produced the recent Association of Anaesthetists' guidelines on interhospital transport. The opinions and comments below are my own views and should not be taken to represent the views of any organisation.

At present there are far too many inter hospital transfers for non-clinical reasons. Many of these are because of the unavailability of critical care beds. Other transfers, for specialist care such as head injury, acute myocardial revascularisation or stroke management, may be avoidable if patients are taken by the ambulance service directly to hospitals with the appropriate clinical services. The provision of acute services within London is far from optimum with few hospitals able to offer all necessary specialties on one site.

Although progress is being made transfers are all too often undertaken in vehicles that are unsuitable being looked after by junior, untrained and inexperienced staff.

The transfer is only in the best interests of the patient if they are to receive care that is not available in the hospital to which they are first taken. There is a good argument for centralisation of some services. However experience suggests that time critical transfers, for example for patients with head injuries, very often do not take place quickly enough to ensure best possible outcomes.

The competencies for caring for sick patients during transfers are predominantly with anaesthetists and intensivists. Before transfer a patient needs to be stabilised and essential treatment should continue. A transfer may take hours to complete and often removes a valuable member of the on-call or theatre team from the hospital. There is rarely any provision for this and it can jeopardise other important clinical work in the transferring hospital. There are courses available for those undertaking transfers but there is no system to ensure that those undertaking the transfers have completed such training and are competent. There is no universal or satisfactory system for ensuring that staff undertaking the transfers are properly insured.

The transfer places the patient in an isolated, hostile environment. Although evidence shows that transfers can be undertaken very safely we know that critical incidents are not uncommon. There is some merit in a transfer service. This would need to be properly funded, equipped and staffed. However there would still need to be provision for those circumstances where the transfer is time critical and the transfer service is not available.

It might be worth soliciting the official views of the Intensive Care Society as many patients transferred are critically ill and are being transferred to an intensive care unit, often because of lack of beds in the referring hospital.

I hope this helps

thanks

David

Trust Board Paper No:

09/03/01

TITLE OF REPORT: Response to the Healthcare for London consultation on developing new, high-quality major trauma and stroke services in London "The shape of things to come"

FOR APPROVAL

DATE: March 2009

DIRECTOR RESPONSIBLE:

AUTHOR: Dr Jenny Vaughan, Consultant Neurologist and Lead Clinician for Neurology and Julie Lowe, Chief Executive

SUMMARY:

This paper provides background information on the consultation on changes to stroke services across London. It recommends that the Board does not support the recommended options within the consultation.

The proposed changes to major trauma services are covered in a separate paper.

RELATIONSHIP WITH THE BOARD ASSURANCE FRAMEWORK:

A1 – Provide accessible high quality and responsive services to meet the needs and expectations of our diverse population.

SPECIFY ANY ADDITIONAL COSTS OR LOSS OF INCOME AND HOW THIS WILL BE RESOURCED:

Whilst the prime reason for the stroke bid was not financial there are, nevertheless, costs associated with losing stroke services, as there would also be with a successful bid.

It is estimated that direct income of c. £1.5m would be lost if stroke is no longer provided at Ealing, losing a £600k contribution to fixed costs and overheads. Variable costs associated with this income are only £100k, whilst the remaining

£800k is in semi-fixed ward costs. Therefore the net loss to the Trust will be between £0.6m and £1.4m.

A successful stroke unit bid has an increased cost of between £1.2m and £1.7m attached to it (associated with additional staff and therapy costs), although this is based on provisional changes to stroke income tariffs which Healthcare for London have said may be subject to further review.

HOW THIS POLICY/PROPOSAL RECOGNISES EQUALITY LEGISLATION:

N/A

LEGAL IMPLICATIONS:

N/A

COMMUNICATION/CONSULTATION AND PATIENT & PUBLIC INVOLVEMENT:

Public consultation is currently taking place.

RECOMMENDATION(S):

The Board is asked to:

1. Support the attached response to the consultation document which recommends locating a SU and TIA service on the Ealing site.
2. Mandate the Executive team to continue to work towards a stroke unit and TIA service at Ealing.
3. Highlight concerns to a range of local partners via the Executive team and senior clinicians.
4. Consider potential partners who might be willing to provide and manage an SU on the Ealing site.

EALING HOSPITAL NHS TRUST

REPORT TO TRUST BOARD – 26 March 2009

Response to the Healthcare for London consultation on developing new, high-quality major trauma and stroke services in London “The shape of things to come”

1. Summary

- 1.1. This paper provides background information on the consultation on changes to stroke services across London. It recommends that the Board does not support the recommended options within the consultation.
- 1.2. The proposed changes to major trauma services are covered in a separate paper.

2. Introduction

- 2.1. Healthcare for London (HfL) published a public consultation document outlining its plans for the future of stroke and trauma care in London. This is attached at appendix 1. If the preferred options described in the document are implemented, the existing Stroke Unit at Ealing Hospital will be closed.

3. Background

- 3.1. Stroke is a major public health challenge across the world. It is the second most common cause of death in the United Kingdom, and one of the leading causes of disability. There have been significant advances in stroke care over the last two decades, driven by the Royal College of Physicians’ clinical guidelines on stroke, and by the biannual National Sentinel Stroke Audit. This has led to the establishment of Stroke Units (SUs) in virtually every major hospital in the United Kingdom, and thereby to significant decreases in mortality and morbidity attributable to stroke. In the last five years several centres have introduced thrombolytic (‘clot-busting’) treatment for acute stroke. The decision whether to give this treatment is complex, and the infrastructure required to deliver treatment within the required 3 hour time-window is extensive; a consensus view has emerged therefore – both within London and more generally across the UK – that this treatment is best centralised in a small number of Hyperacute Stroke Units (HASUs).

- 3.2. These plans were first outlined by Lord Darzi in his review of health services in London, published in 2007. Lord Darzi's guiding principle in this review was 'centralise where necessary, localise where possible'. This principle applies to stroke services. Patients will be taken to HASUs for initial assessment and treatment, before being returned to their local hospital for ongoing medical treatment and rehabilitation in the local Stroke Unit (SU). This ties in well with Department of Health policy, outlined in the Green Paper *Our Health, Our Care, Our Say*, which emphasises the importance of delivering care locally.
- 3.3. The current HfL proposals envisage 7 or 8 such centres in London. Within North West London HASUs are proposed at North West London Trust (Northwick Park site) and Imperial College Trust (Charing Cross site). Stroke units and TIA services are proposed at Hillingdon, Chelsea and Westminster and West Middlesex as well as co-located with the HASUs.

4. Stroke is a major problem for Ealing residents

- 4.1. Figures produced for NHS Ealing indicate that 170 people died from stroke in Ealing in 2006/7; that year there were also approximately 1600 admissions for stroke-related conditions, with admissions from Southall wards running at twice the national levels. Approximately 4000 people in Ealing have had a stroke at some time, so there is an existing population who experience problems with speech, mobility and daily life activities as a result of stroke.

5. The current Ealing Hospital stroke unit

- 5.1. The hospital currently has a 12 bedded stroke unit (which at times increases to as many as 18 beds). The community arm of the service is based at Clayponds Hospital (and managed by the provider arm of NHS Ealing), where there are 18 beds for continued rehabilitation of which approximately 12 are occupied by stroke patients. The multidisciplinary team consists of a consultant stroke physician, five junior doctors, a stroke specialist nurse, nurses, physiotherapists, occupational therapists, speech and language therapists, dieticians, psychologists, and rehabilitation assistants. The stroke service receives significant support from three consultant neurologists, radiologists (one of whom has a particular interest in neuro-imaging), and a vascular surgeon. The SU has recently been refurbished to a high standard, with dedicated ceiling mounted hoists, and a gymnasium for patient rehabilitation.

6. Stroke services at Ealing have improved significantly year-on-year

6.1. The results of the National Sentinel Stroke Audit show that the performance of the Ealing Hospital SU has improved steadily over recent years. The most recent report, based on our performance in 2008, puts Ealing in the top 25% of SUs in the country for the total process score. We perform in the top 25% in four of the nine key performance indicators. We also demonstrate excellence in previously unaudited areas such as secondary prevention of stroke and discussion of risk factors with patients. There remain areas in which further work is necessary (early assessment by occupational therapists), but overall the Audit demonstrates a SU that is providing excellent care to its patients. These results reflect the efforts of clinical staff on the SU, and also the success of recent new initiatives to improve the organization of stroke and TIA care at Ealing Hospital. For example, a neurovascular clinic was established in April 2008, providing a consultant-delivered Transient Ischaemic Attack (TIA) (sometimes referred to as a "mini stroke") service for low-risk patients, to complement the in-patient investigation and management of high-risk patients. This has led to an increase in the referrals to our vascular surgeon, who now performs approximately 20 carotid endarterectomies at Ealing Hospital each year, with excellent results and very low levels of morbidity or mortality. Comparative data with other units is due to be published in April 2009.

7. Further developments are planned to achieve future high standards that will be required of SUs

7.1. The National Stroke Strategy, published by the Department of Health in 2008, sets high standards for the future management of stroke services in the UK. This has been taken on board by HfL, who have required every SU to demonstrate how it will achieve the necessary standards by April 2011 at the latest. Considerable support will be required throughout London to meet these standards, but this is a challenge for which Ealing Hospital is prepared. As a concrete example, the radiology department has recently purchased a new MDCT scanner, which will provide ever more rapid access to state-of-the-art brain imaging for stroke and TIA patients.

8. The Trust's response to the designation process

8.1. HfL asked Trusts to express an interest in becoming a HASU, Stroke Unit (SU) and/or TIA service in September 2008. Ealing expressed an interest in a Stroke Unit and a TIA service. Interest was not expressed in a HASU

on the basis that the Trust could not realistically provide a 24/7 thrombolysis service given the level of investment this would require for a small number of patients and the fact that HASUs are probably best sited within tertiary centres. A copy of the Trust's bid is attached at appendix 2. These bids were then evaluated and a copy of the evaluation report is attached as appendix 3. On 8th January 2009 the Chief Executive wrote to express concern about the process and a copy of this letter is attached as appendix 4. A meeting was held with the Medical Director, Director of Operations, Consultant-Neurologist and Consultant-Elderly Caree on 19th January 2009 with Rachel Tyndall, Chief Executive of NHS Islington and Senior Responsible Officer (SRO) for stroke. At the meeting Rachel agreed to review the process and evaluation. A copy of her response was received on 6th March 2009 and is attached as appendix 5.

9. What would happen if the Ealing stroke unit were closed?

- 9.1. 350 patients each year are managed in the Ealing SU. Of these approximately 250 are found to have had a stroke or TIA. Current plans envisage that these patients will have their initial assessment carried out at a HASU (either Charing Cross or Northwick Park) but then they will returned to their local Stroke Unit within 72 hours. It is not clear who will look after the patients currently managed at Ealing Hospital. The HfL consultation document states that the patient capacity currently supplied by Ealing Hospital is 'not required'. HfL have indicated at recent meetings that final decisions on capacity have not in fact yet been made, and that designated SUs will be asked to provide information on how many beds they will provide. In reality if there is no Stroke Unit at Ealing, Ealing residents will be sent from the HASU to Hillingdon or West Middlesex for SU care, even when they have had no previous contact with these hospitals. The proposed HASUs at Charing Cross and Northwick Park have already expressed concerns about their ability to repatriate Ealing residents in a timely fashion if there is no SU at Ealing Hospital. If patients cannot be moved away from the HASUs efficiently, then they may have to close to new admissions, and the London Ambulance Service would then have to take patients to HASUs in other parts of London.
- 9.2. If there is no SU at Ealing, then this will have serious implications for the running of other local services, both in the hospital and in the community. There are specialist acute services and procedures available at EHT which will be under threat if the SU is removed. These include acute surgery (especially vascular) and coronary angiography. Patients undergoing these procedures are at an increased risk of stroke and the removal of an on-site SU means that if they suffer stroke as a complication their treatment

then optimal subsequent management may be compromised. If a patient does have a stroke whilst in the hospital, they will be unable to access immediate stroke care, which significantly worsens outcome, and they will then have to be transferred away from Ealing for further management. Access to key therapists (speech and language therapists, physiotherapists and occupational therapists) will also be impaired, as they will not be available on site.

10. Alternative options

- 10.1. The bid was based on a SU and TIA service located at Ealing Hospital and managed by the Trust. This remains the preferred option. However, rather than provide no service on the Ealing site, it might be possible to consider providing space on the Ealing site that is managed by one of the sites that is accredited.

11. The Financial Impact of removing stroke services from Ealing Hospital

- 11.1. Whilst the prime reason for the stroke bid was not financial there are, nevertheless, costs associated with losing stroke services, as there would also be with a successful bid.
- 11.2. It is estimated that direct income of c. £1.5m would be lost if stroke is no longer provided at Ealing, losing a £600k contribution to fixed costs and overheads. Variable costs associated with this income are only £100k, whilst the remaining £800k is in semi-fixed ward costs. Therefore the net loss to the Trust will be between £0.6m and £1.4m.
- 11.3. A successful stroke unit bid has an increased cost of between £1.2m and £1.7m attached to it (associated with additional staff and therapy costs), although this is based on provisional changes to stroke income tariffs which Healthcare for London have said may be subject to further review.

12. Conclusion

- 12.1. No clear evidence has been produced by HfL to justify their proposals to i) decommission the current successful SU at EHT or ii) non-designate our current TIA service. Stroke care at Ealing is currently of a standard which meets the needs of the population it serves. The self-assessment suggested that the Trust could meet the standards required of a modern stroke unit and TIA service. The evaluation downgraded the self-assessment scores but the reasons for this remain unclear. The most recent National Sentinel Stroke audit shows Ealing Hospital is delivering

care that places it in the top 25% of all Trusts nationwide, and has made major improvements since the last audit. It is expected that when the full results of this independent national audit are made public in the near future, Ealing Hospital's position will be very favourable when compared with other Trust's in the NW London area. NHS Ealing's own study looking at stroke needs of their population (drafted before the recent audit results became available), attached as appendix 6, showed that in many areas Ealing Hospital's performance was equivalent to neighbouring North West London hospitals over a range of different indices.

- 12.2. There is real concern that the capacity issues caused by the removal of the SU at Ealing Hospital cannot be managed by other local providers. There is also a significant potential adverse impact on other services provided by the Trust.

13. Recommendation

- 13.1. The Board is asked to:

- Support the attached response to the consultation document which recommends locating a SU and TIA service on the Ealing site.
- Mandate the Executive team to continue to work towards a stroke unit and TIA service at Ealing.
- Highlight concerns to a range of local partners via the Executive team and senior clinicians.
- Consider potential partners who might be willing to provide and manage an SU on the Ealing site.

**Dr Jenny Vaughan, Consultant Neurologist and
Lead Clinician for Neurology**

Julie Lowe, Chief Executive

March 2009

CHAIRMAN AND CHIEF EXECUTIVE'S
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Ealing Hospital 

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8th May 2009

David Sissling
Programme Director
Healthcare for London
NHS London
Southside
105 Victoria Street
London
SW1E 6QT

Dear David

Healthcare for London Stroke Consultation

Ealing Hospital NHS Trust has already made a formal response to the above consultation. As you know we support the establishment of Hyper Acute Stroke Units (HASUs), but oppose the proposal that Ealing Hospital will have neither a stroke unit nor a Transient Ischaemic Attack (TIA) service. We have also been in continuous dialogue with Healthcare for London colleagues throughout the process.

The purpose of this letter is to state formally that we believe that the consultation process around stroke is inadequate and, as such, that due process for a public consultation has not been followed. This step is not being taken lightly, but is the result of a repeated failure on behalf of Healthcare for London to respond to questions and requests for further information. These concerns are well summarised in Robert Creighton's note of 17 April.

The grounds on which we believe the consultation to be inadequate are:

1. There has been a failure to undertake an impact assessment on Ealing (or any other Borough) detailing what will happen if the local SU closes. Specifically there has been no **detailed clinical risk assessment for patients with suspected stroke from the Ealing area in the event that there is insufficient capacity and patient flow through the system**
2. There has been a failure to undertake an equality impact assessment on the proposals within The Shape of Things to Come
3. There has been a failure to provide details of the bed modelling analysis despite repeated requests
4. There has been a failure to provide any detailed explanation about why Ealing Hospital's self-assessment scores were marked down by the assessors

We are aware that in the last few days considerable effort has been made to try to find a solution for Ealing and we are keen to cooperate with further work. However, we are aware that today is the final day for making comment before public consultation closes.

Cont/d.....

Specifically we welcome Chris Streater's discussion yesterday with our Medical Director, Dr Bill Lynn, and his agreement to compare our bid with a couple of other bids that were 'borderline' in meeting the accreditation standard.

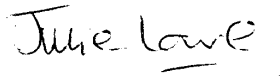
We also welcome the emerging views that implementation will take place on a sector wide, phased basis avoiding any precipitate action that might prevent a good flow of patients from the HASUs. We understand that this will make it possible for Ealing to retain its stroke unit in the short term, whilst our strategic direction is clarified and the number of stroke beds in the sector is further refined by more bed modelling work. We understand that Ealing PCT would be prepared to continue to commission from us on this interim basis. We understand that this will need to be taken forward through a strong link to a HASU and, depending on the best strategic fit, this could be with either Imperial or with the Northwick Park HASU. There are already close clinical and managerial links with both organisations so we do not anticipate any problem with this approach.

We are copying this letter to the Joint Health Overview and Scrutiny Committee for their further consideration.

Yours sincerely,



Ian Green
Chairman



Julie Lowe
Chief Executive

cc. Rachel Tyndall, Senior Responsible Officer, Stroke Team - Healthcare for London
Julia Regan, Scrutiny Manager, Joint Health Overview and Scrutiny Committee

22nd April 2009

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Chairman
Joint Health Overview & Scrutiny Committee
Royal Borough of Kensington & Chelsea
The Town Hall
Kensington
London W8 7NX

Dear Cllr Buckmaster

Re: The shape of things to come – developing new, high quality major trauma and stroke services for London

I refer to your letter of 20th March and thank you for inviting our views on the Healthcare for London (HfL) proposed configurations for stroke and trauma services, which are currently out to public consultation.

This consultation relates to the number and locations of new major trauma centres, Hyper-Acute Stroke Units (HASUs), Stroke Units (SUs) and Transient Ischaemic Attack (TIA) services. It does not specifically deal with the proposed new models of care – these having been consulted upon previously in 2007/08.

As with many health (and non-health) related services, there is a need to balance the benefits of local access – ease and short-travel times – with those of centralisation – to achieve a critical mass of activity that supports maintenance of specialist skills, will assure improved outcomes and allow management of scarce resources.

Our comments below consider the trauma and stroke-related issues separately.

Trauma

a) The overall vision set out in the consultation paper

The Trust is supportive of the proposed model for trauma services.

This Trust operates two acute hospitals (St Helier Hospital, Carshalton – in the London Borough of Sutton – and Epsom Hospital in Epsom, Surrey) each of which provides A&E services to their local populations and fall within the proposed St George's trauma network.

In recent years, there has been a progressive shift of care for the most seriously injured patients away from local hospitals to centres where patients have round-the-clock access to trauma, vascular and neurosurgery services, as they may require. At the same time, we have continued to provide trauma services to the majority of patients attending our A&Es, who have suffered uncomplicated trauma.

The proposed changes, to some degree, formalise existing roles and allow the opportunity for appropriate investment and strengthening of networks where it is required.

b) The proposed configurations, in terms of number of major trauma centres

The Trust is only able to comment in relation to the geographical area it serves. However, for this area, we believe a single major trauma centre, based at St George's Hospital, as a hub for a network of hospitals covering south-west London and Surrey, is appropriate. It must be borne in mind that major trauma cases represent only a very small proportion of overall A&E activity and the vast majority of trauma patients will continue to be treated locally.

c) The assumptions made regarding ambulance travel times

Our knowledge and ability to appraise travel times from areas outside our catchment is limited but the assumptions made in relation to patients accessing our hospitals appear to be reasonable. London Ambulance Service and South East Coast Ambulance Service will be better placed to comment on the reasonableness of these assumptions.

Stroke

a) The overall vision set out in the consultation paper

Our hospital in Epsom, and the population it serves, is outside the geographical boundaries of London and consequently is not covered by the HfL consultation. The following comments, therefore, relate only to services provided from St Helier Hospital, principally for residents of the London boroughs of Merton and Sutton.

HfL's proposed model is designed to ensure that all London residents have round-the-clock access to highly specialist assessment and treatment for stroke within a reasonable travel time (no resident being more than 30 minutes blue-light travel time from a HASU).

This model will allow a critical mass of specialist health professionals in the HASUs to provide 24/7 diagnostic and interventional stroke services including access to CT scans and thrombolysis within 30 minutes of arrival at A&E and within 3 hours of stroke onset, where appropriate. They will also have access to MRI imaging and swallowing assessments within 24 hours and rapid access to physiotherapy assessments and to neurosurgery, if required. It would not be reasonably practicable to provide the desired timely access to this breadth of specialist services at every proposed location for a Stroke Unit and, currently, this level of service is not available at the majority of hospitals receiving acute strokes through their A&Es.

b) The proposed configurations, in terms of number of hyperacute stroke units

Again, we can only really comment in relation to our catchment area. For this area, we believe a HASU service provided at St George's, with sufficient capacity to service demand and

supported by SU and TIA services at St Helier and other south west London hospitals, is an acceptable configuration.

However, we are concerned with regard to the overall HASU capacity required at St George's – and that a single HASU serving the whole of south west London will be too large (c.30 beds compared with between 14 and 19 beds at the other London HASUs). We believe that the option to have two HASUs serving south west London – one at St George's and one at Mayday, each with c.15 beds – should be explored further. Unfortunately, this option is not proposed for consideration within the current consultation.

This 2-site option would obtain sufficient critical mass to ensure achievement and maintenance of specialist skills whilst offering better geographical access and providing a "safety net", if a unit was forced to close to admissions due to unforeseen difficulties – e.g. *C. difficile* outbreak, major incident etc.

c) The assumptions made regarding ambulance travel times

Please see our comments under Trauma above.

d) How the proposed transfer of patients between the HASUs and the SUs will work in practice – will there be sufficient beds at the SUs? How will the transfers impact on the workload of the London Ambulance Service?

The transfer of patients between HASU and SU needs to be considered in the context of the whole stroke care pathway.

The timing of the onset of an acute stroke is unpredictable and patients entering the pathway at the A&E of the HASU site will be unplanned. Therefore, HASU services will need the capacity to be able to cope with variable levels of demand.

HASUs will be dependent on timely repatriation of patients to SUs to free up capacity. Similarly, further downstream, the SUs will be dependent on supported discharge schemes to provide community-based rehabilitation.

Repatriation of patients from St George's to St Helier already takes place, albeit on a smaller scale than will be required in the future. However, it should be noted that all repatriations will take place as "planned" activity and, as such, should be more manageable than dealing with the uncertainties of unplanned activities.

HfL has reviewed demand at all levels of service and is seeking, through the implementation of the new configurations, to increase capacity at each level. For our part, St Helier Hospital plans to increase the capacity of its Stroke Unit from 18 beds to 24 – based on the modelled demand arising from our catchment area. This should be adequate to ensure that >95% of stroke patients are admitted directly to the Stroke Unit and that >95% remain within the Stroke Unit for their full hospital stay.

A key factor in ensuring the model is successful is the provision of timely and comprehensive community stroke services to allow suitable patients to leave the SUs and thereby free up capacity. Currently, St Helier stroke patients stay in hospital for a median of 14 days but with an average stay of 24 days and, at any one time, approximately 40% of stroke unit beds are occupied by patients who have stayed beyond the average. Early facilitated discharge is needed to ensure patients can be supported at home or in community settings as soon as

possible to avoid lengthy hospital stays. Further discussions with Sutton and Merton PCT are necessary to expand and strengthen community services for stroke patients in our area.

Co-ordinated management of care throughout the pathway will be necessary to prevent disruptions and delays of transfers.

We are not in a position to speculate about the implications of increased inter-hospital transfers for the ambulance service but understand that additional monies are available to them to increase their capacity to do this work.

We trust the above comments will be helpful.

Yours sincerely,



Peter Coles
Chief Executive (Interim)

Slide 1

NHS in collaboration with **Greater Manchester & Cheshire Cardiac and Stroke Network**

The Association of Greater Manchester Primary Care Trusts

Redesigning Acute Stroke Care The Greater Manchester Experience

27th January 2009

Janet Ratcliffe - Director, GM&C Cardiac and Stroke Network
Warren Heppollette - Associate Director, Association of Greater Manchester PCTs

Slide 2

We are presenting on behalf of the Greater Manchester and Cheshire Cardiac and Stroke Network & The Greater Manchester PCTs

- This presentation covers our recent work on putting in place an Acute Stroke Service for Greater Manchester – which is only a part of the Network's scope of responsibility
- The Network is carrying out this work on behalf of the Association of Greater Manchester PCTs

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Slide 3


The scope of the National Stroke Strategy covers a number of areas, the Acute Stroke Service sits significantly in Urgent Response

- Public awareness
- TIA and minor stroke services
- Urgent response**
 - Hospital stroke care
 - Post hospital stroke care
 - Early supported discharge
 - Workforce

... *though our work does impact within other areas*

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Slide 4

Objectives for this session

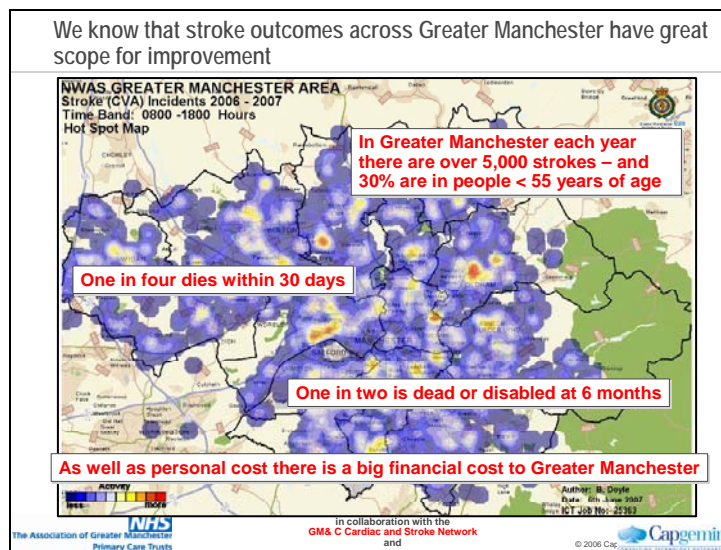
- Demonstrate the managerial, commissioning and clinical aspects of this work and how the Association & the Network have brought these together
- Link our work to the Stroke Strategy
- Tell the story of our journey
- Update you on where we are up to and what we will be doing next
- Share key lessons learned
- Answer your questions (hopefully!)
 - What are your expectations?

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Slide 5




Slide 6

- The National Stroke Strategy demands that we work collaboratively to deliver its desired clinical outcomes and quality markers
- To have structures in place which ensure a focus on quality of services and continuous service improvement, across all the organisations in the pathway
 - To grow a workforce that enables all people with stroke, and at risk of stroke, to receive care from staff with appropriate level of knowledge, skills and experience
 - Quality Marker 17
 - Networks are established covering populations of 0.5 to 2 million to review and organise delivery of stroke services across the care pathway
 - Quality Marker 4
 - People who have had a stroke and their carers are meaningfully involved in the planning, development, delivery and monitoring of services. People are regularly informed about how their views have influenced services
- The GM Cardiac Network formally took over Stroke from the Older People's Network during 2007*
- NHS**
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Slide 7

... and NICE Guidelines give us the clinical standards we must meet (locally interpreted)

- 'Immediate' (how defined?) admission to an ASU
- Seen by stroke physician within 24 hours
- Swallow assessment within 12 hours
- Administer aspirin to eligible patients as soon as possible but with 24 hours maximum
- CT scan preferably immediately but within 24 hours maximum
- Malnutrition universal screening tool (MUST) within 24 hours
- Carotid Doppler for all appropriate TIA patient within 24 hours
- Call to Needle time...
- All eligible thrombolysis patients achieve call to door time 60 minutes (unless legitimate reason for delay? – what would these be??)

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Slide 8

What does this mean for Greater Manchester?

The Vision for this Project is that every citizen in Greater Manchester presenting with stroke/TIA symptoms shall have equal access to a fully integrated, evidence-based hyper-acute and acute specialist stroke care pathway.

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Our challenge is to improve equality and quality of acute care for all citizens of Greater Manchester who suffer stroke symptoms

- Currently care varies across the conurbation
- In future instead of being taken to a local A&E those with suspected stroke those who present within 24 hours of onset of symptoms will be taken to one of 3 specialist centres which will between them give 24/7 cover
 - Ambulance staff will make preliminary diagnosis using "FAST"
 - "Call to door" target will be no more than 70 minutes max
- In specialist centres patients will be properly assessed (Swallow/Scan etc.) and if suitable will be thrombolysed
 - "Door to needle" target will be 30 minutes with a maximum of 60 minutes
- After acute care has been provided patients will be repatriated to their local Acute Stroke Unit (or discharged)
- There are SIGNIFICANT implications for all PCTS, Acute Trusts, Ambulance Trust as well as GPs, other Healthcare Professionals and the Public


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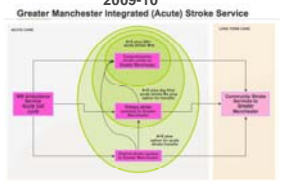
The need for an integrated approach for this time-critical hyper acute stroke care changes the way the service is delivered

2008





- Local commissioning of stroke services - 10 PCTs commission services on behalf of their populations
- 9 NHS and Foundation Trusts provide acute services from 13 hospital sites
- North West Ambulance Service cover whole population of Greater Manchester
- Patients and treated in local Acute Trusts.

2009-10
Greater Manchester Integrated (Acute) Stroke Service



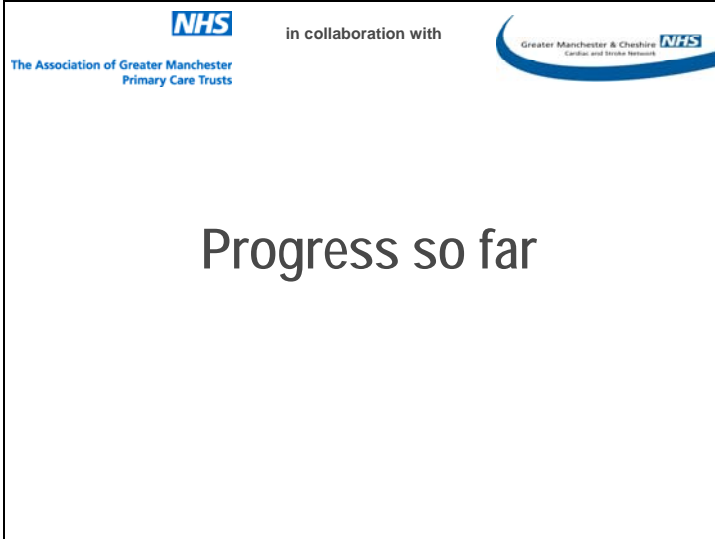
- Collaborative commissioning of parts of the service
- Centralised specialist hyper acute stroke care - hub and spoke / treat and return approach for better stroke services
- Patients taken initially to CSC / PSCs and then repatriated to ASU in DSCs
- Seamless flow of activities and information to enhance patient journey and outcomes.

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Slide 11



Slide 11 features a white background with a black border. At the top left is the NHS logo and the text 'The Association of Greater Manchester Primary Care Trusts'. At the top center is the text 'in collaboration with'. At the top right is the logo for 'Greater Manchester & Cheshire Cardiac and Stroke Network' with the NHS logo. The main text 'Progress so far' is centered in a large, black, sans-serif font.

Slide 12

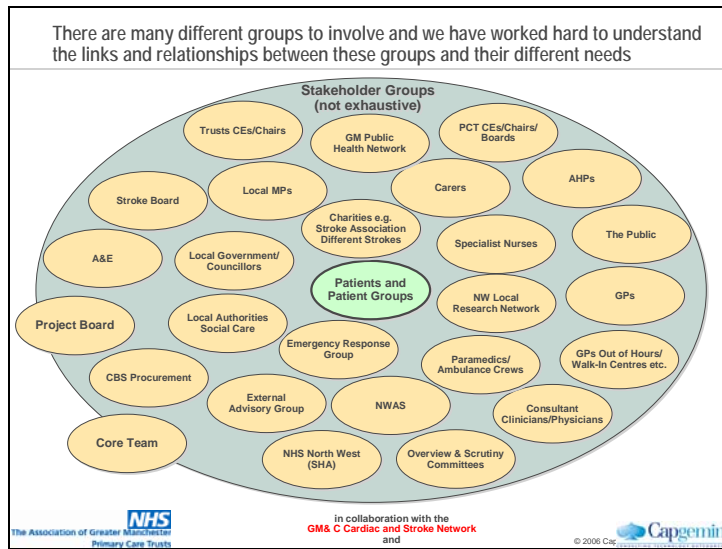


Slide 12 features a white background with a black border. At the top left is the NHS logo and the text 'The Association of Greater Manchester Primary Care Trusts'. At the top center is the text 'in collaboration with'. At the top right is the logo for 'Capgemini'. The main text 'Through collaborative efforts we have over the last year ...' is centered in a black, sans-serif font. Below this is a list of nine bullet points, each starting with a yellow square. The bottom of the slide contains the NHS logo and text 'The Association of Greater Manchester Primary Care Trusts', the text 'in collaboration with the GM& C Cardiac and Stroke Network and', and the Capgemini logo and text '© 2008 Capgemini'.

Through collaborative efforts we have over the last year ...

- Gathered the local Stroke Community behind this initiative and gained everyone's support to proceed and agreement on key principles;
- Built the Strategic Outline Case for transforming the services;
- Launched our Emergency Response Group which has developed the Stroke and TIA Clinical Pathway to a high level of detail;
- Designed specifications for the service and selected specialist centres;
- Designed and built a data model that represents the patient and financial flows;
- Designed and developed high level detail of the future Operating Model and high level organisation design to deliver the new service;
- Started to work out how much it will all cost the system as a whole and what benefits will be accrued and where;
- Begun the negotiations for the procurement and commissioning of the new service;
- Developed the long, mid and short term plans for implementation.

Slide 13



Slide 14

A set of overarching principles was established at our Autumn 07 consensus event

Overarching principles	
	<ul style="list-style-type: none"> Improve patient outcomes Provide equitable access to the services Ensure the integrated approach to stroke services demonstrates Value for Money Demonstrate openness and probity in the orchestration of services <ul style="list-style-type: none"> Provide a level playing field for competition amongst providers in GM Provide effective integration of service activity of providers in GM Patient services remain stable and safe during transition
Governance	<ul style="list-style-type: none"> Clear accountability and responsibility in governing both individual trusts and the overall network Open and transparent processes for governing the GM integrated acute Stroke service, supported by both evidence and negotiation to inform effective decision making
Finance	<ul style="list-style-type: none"> Openness and fairness of the payment for acute provider services <ul style="list-style-type: none"> Clarity is given to decisions making about the fixed and variable elements of acute provider payments Distribution of payment rewards both excellence and activity (volume and capacity) across the system Demonstrate-able value for money for the integrated acute stroke services at system and individual trust level Financial viability (tariffs able to cover the costs) at CSC, PSCs and DSCs Transparency of the budgetary process and resources allocation
Organisational /IT	<ul style="list-style-type: none"> Effective coordination of activities across parties involved to plan and deliver the services Seamless transfer of care
Clinical	<ul style="list-style-type: none"> Demonstration of safe delivery of clinical services Ability to meet the national and local clinical standards and guidelines


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Slide 16


The Strategic Outline Case is the first step in "Office of Government Commerce" guidelines for business case preparation

- **Purpose:**
 - Initiate and scope the process of effective decision making to achieve the strategic objectives of the Primary Care Trusts, NHS Trusts and Foundation Trusts
 - Provides foundation document upon which the health care system can determine the steps of how best to progress
- **Approach:**
 - Comes from the treasury Green Book (OGC)
 - Highlights primary issues; patient need, strategic case, economic case, financial case and project management case, which will deliver the ongoing decision making process.
- **Supports:**
 - alignment between the clinical corporate and financial functions across purchasers and providers in pursuit of improved acute stroke services;
 - approach to an options appraisal for deciding site(s) of Acute Stroke Services;
 - outline of benefits and costs related to the options appraisal;
 - framework that will support legitimate and functional decision making processes
 - preparation for the process of effective consensus building with Stakeholders

The Financial Case and Economic Case have just been completed

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Our Emergency Response Group provides independent input to the Stroke Board on clinical matters

- Lead Clinicians
- Network staff
- Stroke Physicians
- Public Health clinicians
- Neurologist
- A+E Consultants
- Patient and carer representative
- Vascular surgeons
- Physiotherapists
- Stroke Nurse
- Ambulance operational managers
- PCT and Acute Trust managers

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Slide 19

First of all we agreed principles informing stroke/ TIA pathway...

- Equal access to hyperacute and acute treatment
- Every eligible patient gets CT within 24 hours of onset of symptoms
- All acute stroke patients should receive 24 hour specialist care
- “High risk” TIAs should be formally assessed within 24 hours

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... and our own objectives as the ERG:

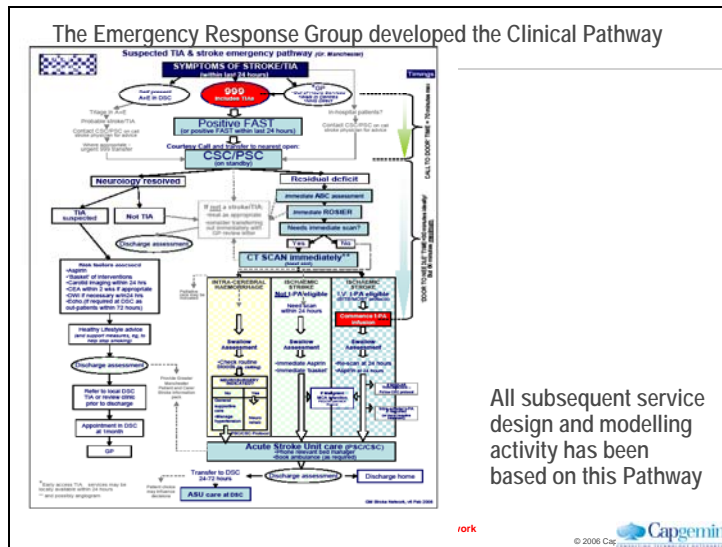
- To define the optimum clinical pathway for early care of acute stroke
- To facilitate the establishment of primary and comprehensive centres to allow early access to CT scan and consideration for ‘clot-busting’ thrombolysis therapy.
- To ensure that all patients with stroke (irrespective of thrombolysis eligibility) or TIA will receive early, evidence-based interventions aimed at reducing mortality and disability.
- To ensure that district centres will be a fully integral component of this “Early Hours” model.

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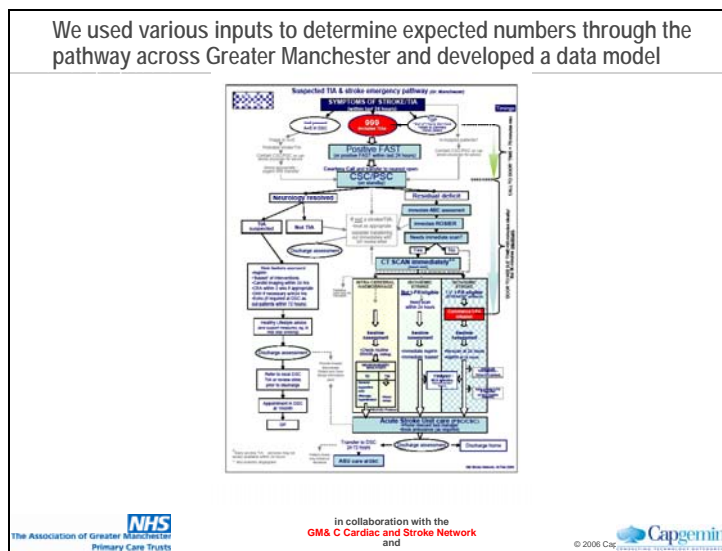
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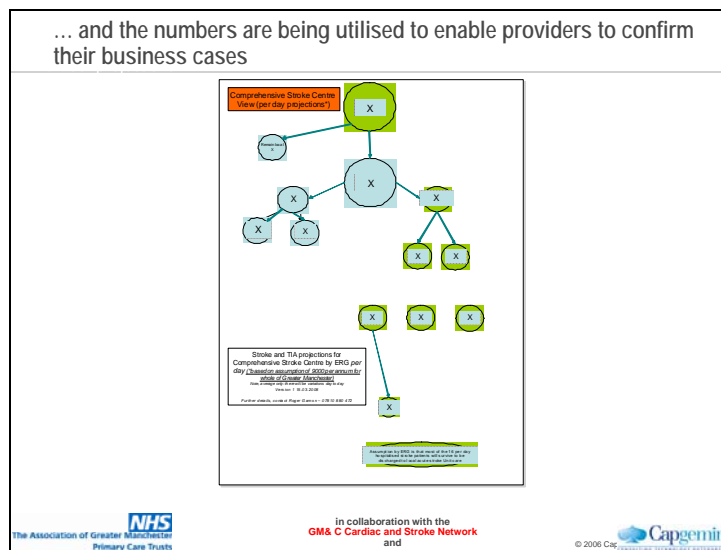
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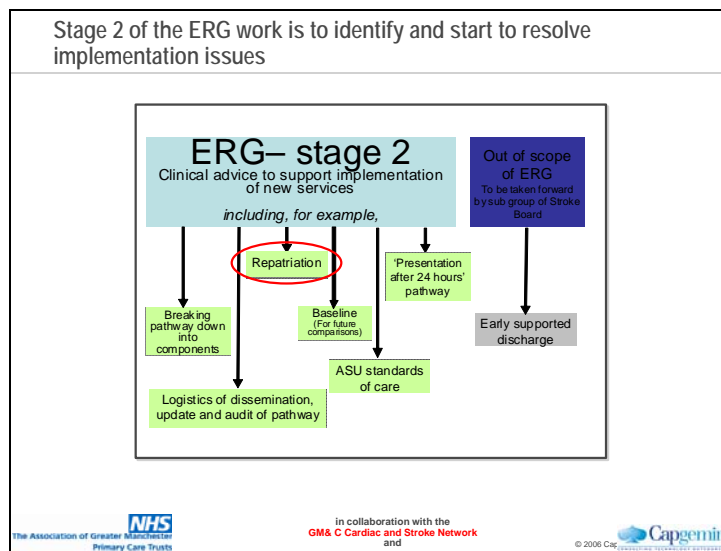
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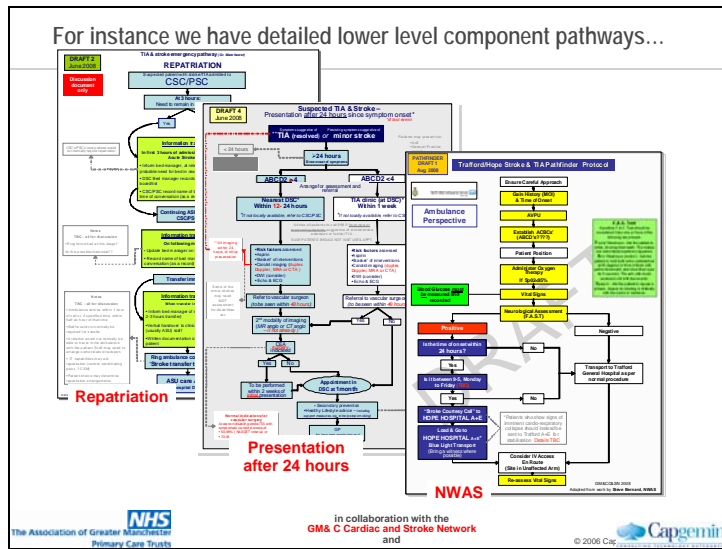
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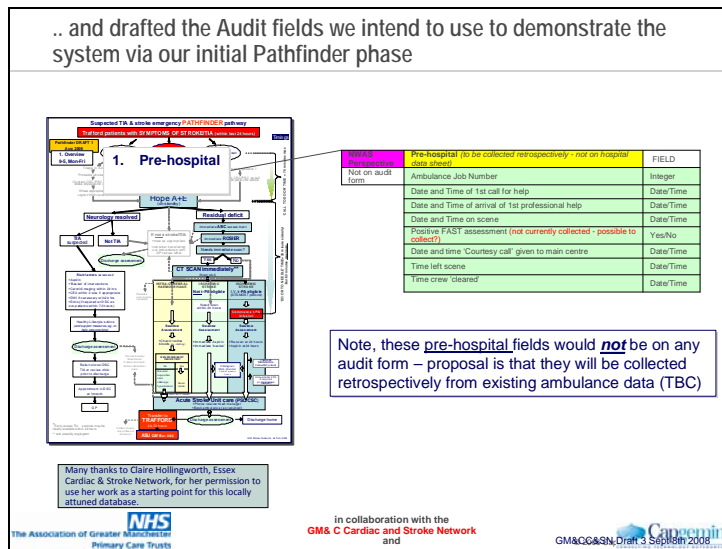
Slide 24



Slide 25




Slide 26



Slide 27

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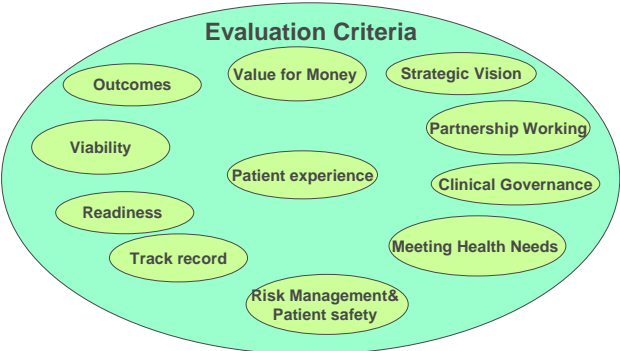
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We determined the criteria to be used to inform our decision making in selecting Specialist Acute Stroke Providers (CSC and PSCs)



The diagram shows a large light green oval containing ten smaller light green ovals, each representing an evaluation criterion. The criteria are arranged in a roughly circular pattern around a central point. The criteria are: Outcomes, Value for Money, Strategic Vision, Viability, Patient experience, Partnership Working, Readiness, Clinical Governance, Track record, Meeting Health Needs, and Risk Management & Patient safety.

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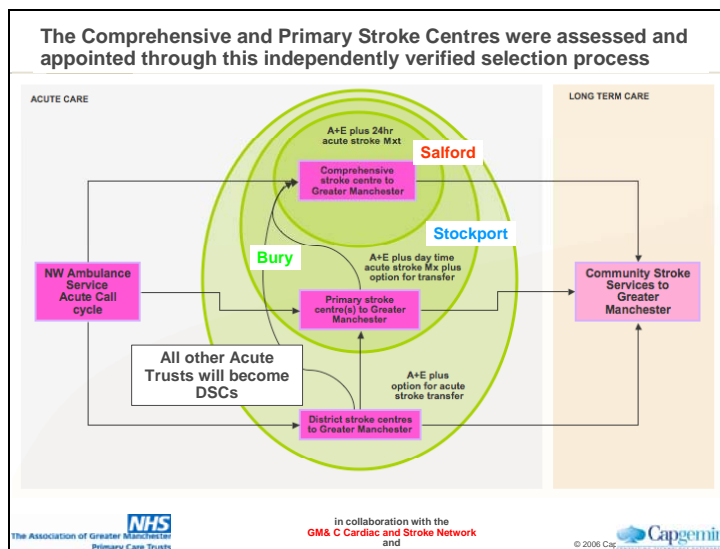
Our External Advisory Group weighted the criteria and then participated in the business case review and selection process itself

The EAG was an independent body of experts drawn from all areas within GM and including External Advisors Anthony Rudd and Damian Jenkinson

Order of Importance	Initial Score	Relative Weighting	Expressed as %
Track Record	12	19.92	15%
Outcomes and process indicators	14	17.07	15%
Readiness	15	15.93	15%
Viability	17	14.06	15%
Clinical Governance and quality Improvement	25	9.56	7.5%
Value for Money	26	9.19	7.5%
Strategic Vision included in Charter	31	7.71	6.25%
Partnership Working	32	7.47	6.25%
Patient Experience	33	7.24	6.25%
Risk Management and Patient Safety	34	7.03	6.25%
total	239	115.18	100.0%

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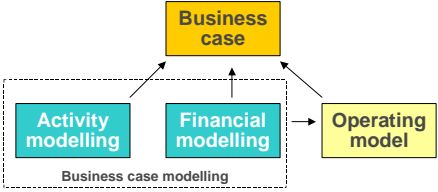
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The aim of the data model is to provide the evidence base for reorganisation of the GM Acute Stroke services

- **Data model is a dynamic platform**
 - informs business case options
 - provides evidence base for the re-commissioning of acute stroke services
- The model also demonstrates how different stakeholders will be impacted by the new stroke network and has helped obtain their buy-in




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graph TD; subgraph "Business case modelling"; direction LR; AM[Activity modelling]; FM[Financial modelling]; end; AM --> BC[Business case]; FM --> BC; OM[Operating model] --> BC;
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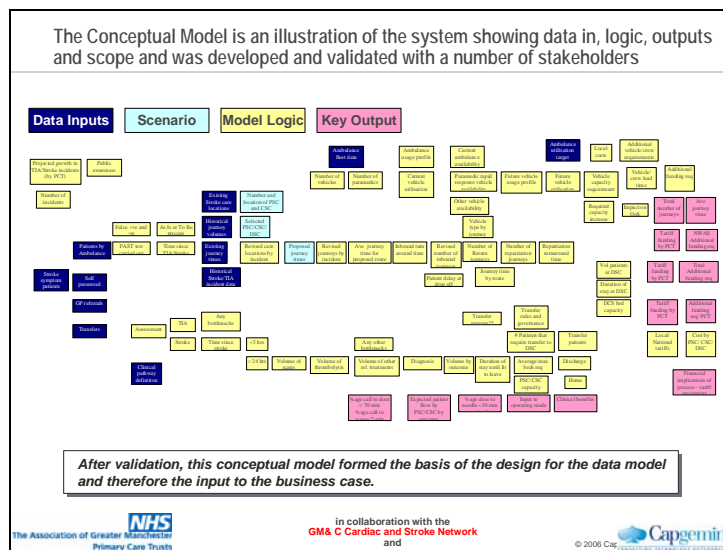
This modelling together with the Operating Model will inform the Full Business Case

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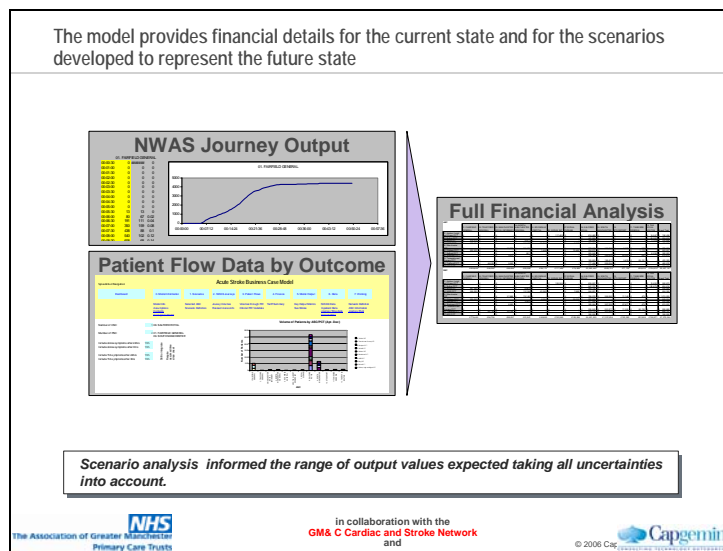
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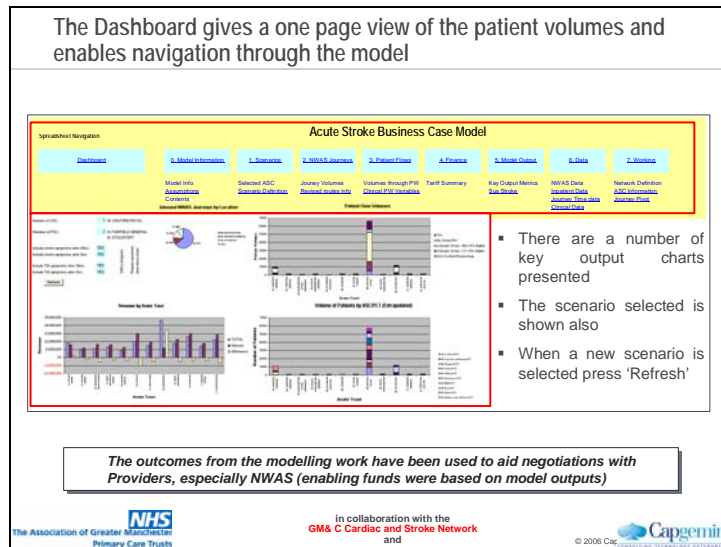


Slide 34



Slide 35

The Dashboard gives a one page view of the patient volumes and enables navigation through the model

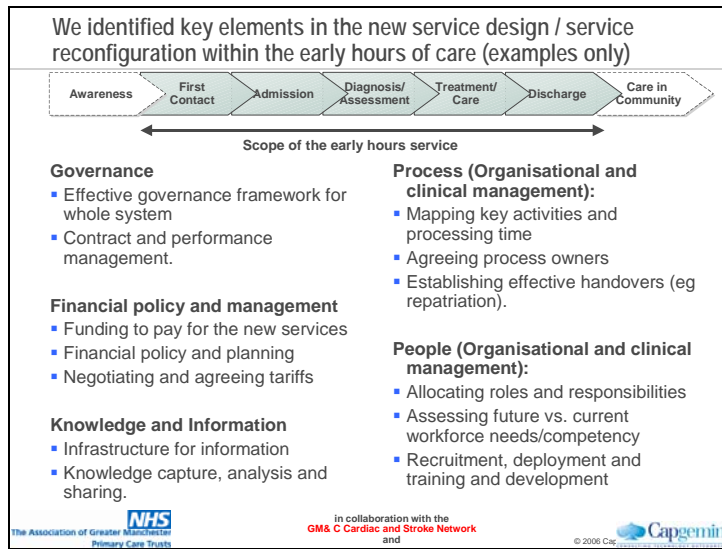


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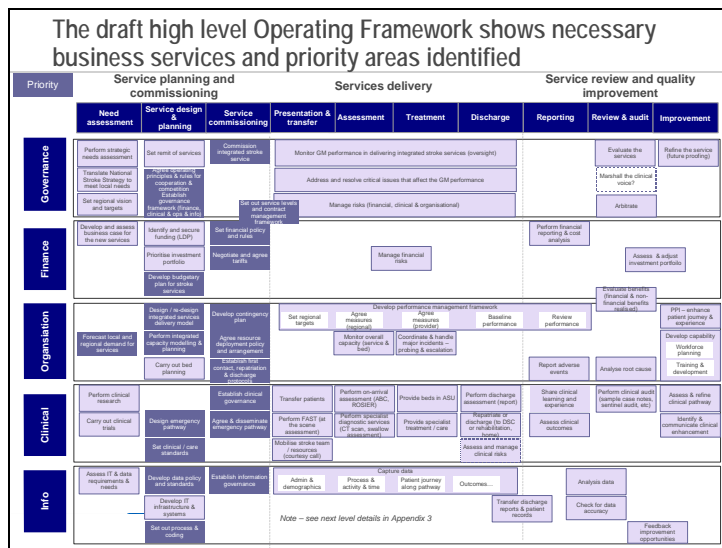
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- Launched our Emergency Response Group which has developed the Stroke and TIA Clinical Pathway to a high level of detail;
- Designed specifications for the service and selected specialist centres;
- Designed and built a data model that represents the patient and financial flows;
- Designed and developed high level detail of the future Operating Model and high level organisation design to deliver the new service;
- Started to work out how much it will all cost the system as a whole and what benefits will be accrued and where;
- Begun the negotiations for the procurement and commissioning of the new service;
- Developed the long, mid and short term plans for implementation.

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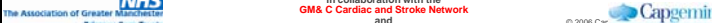


Slide 39

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Commissioning & Financial Framework

- A prerequisite for a robust commissioning strategy to facilitate the movement from historic to a new model of care is an agreed evidence based clinical pathway
- Full stakeholder involvement including public health, clinical and public and patient consensus
- From this a new financial mechanism can be developed based on relevant HRGs
- Early monitoring is crucial to ensure implementation of the pathway and appropriate financial reimbursement

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Indicative Tariffs for Redesign of Stroke Services - GM

Principles Adopted

- To take forward the funding of the Integrated Service will require a different approach on utilising the tariff. To take this forward the DH produced a fact sheet in July 2007 which can be found on the following web site <http://www.dh.gov.uk/publications>.
- This document and the guidelines have been used to calculate the indicative tariffs for funding the redesign of the patient pathway
- A key factor that will need consideration is the materiality of the potential loss of income to Providers due to the redesign of the pathway which will become known when the model has been verified.
- The GM PCTs developed a Financial Policy to cover the change and address non-recurring cost issues & funding proposals (including services transferring to another provide, services due to expand/open anew

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Slide 43

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We have developed a long term milestone plan as well as short term Provider plans for early stages of implementation

Overall Milestones 2008 - 2011

Phase 1 (Pathfinder) plan


Provider aspirations for service commencement

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Last but by no means least:


- We have developed a communications plan
- Using communications expertise from across Greater Manchester
- Commissioned a PR agency to support this work
- Linked closely with Stroke Association and DH plans
- Using various types of media
- Expected launch date for professional and patient awareness in early March

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Lessons Learned

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We have learned some lessons along the way

1. The Commissioning Proposition
 - Evidence based
 - Clinically led
 - Population focussed
2. Clarity of Intent
 - Clear Chief Executive commitment
 - Focussed, dedicated leadership
 - Tested
3. Engagement
 - Acute Support
 - Tested and confirmed clinical consensus


The case for change was clear, compelling and evidence based. It has maintained solid support from commissioners across the 10 PCTs

Progress has relied on consistent Chief Executive leadership, and dedicated support within and beyond the network team. It has maintained momentum and withstood challenge.

1st stage work to establish broad clinical and organisational consensus has provided the most important element of the change process



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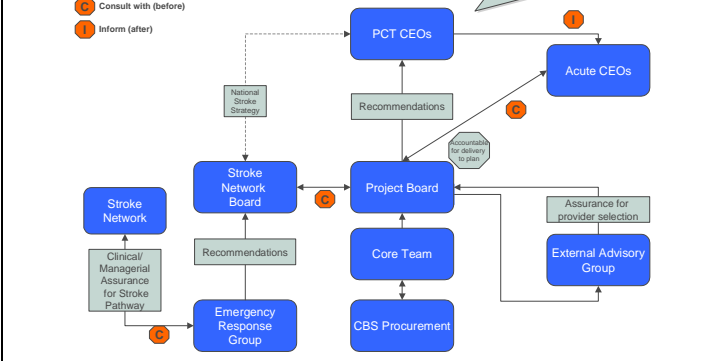


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We have learned some lessons along the way

4. Project Governance
 - Consult with (before)
 - Inform (after)


Clarity of decision rights and processes and a clear analysis of accountability and responsibility is key to commissioning across boundaries



The flowchart illustrates the governance structure. At the top are PCT CEOs and Acute CEOs. Below them is the Project Board, which receives 'Recommendations' from the Stroke Network Board and the Core Team. The Stroke Network Board is supported by the Stroke Network and Emergency Response Group. The Core Team is supported by CBS Procurement. An External Advisory Group provides 'Assurance for provider selection' to the Project Board. A 'National Stroke Strategy' box is at the top left. A legend indicates 'C' for 'Consult with (before)' and 'I' for 'Inform (after)'. Arrows show the flow of information and recommendations between these entities.



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We have learned some lessons along the way

5. Procurement


- Principles and decision criteria
- External Advisory Group
- Open Competition
- Making the decision


The open application of clear principles. Let everyone know when and how sites were selected


6. Network Role

- Network Team and Project Support
- Network structures & role

Occupying the space between commissioner and provider – and the importance this has for the Governance of the overall model

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And some tough lessons...

- The time from intent to implementation
- Maintaining engagement and active involvement across key stakeholders
- Little capacity for project support
- The effort of communications (Internal and External)
- The final steps to implementation are the hardest – resources required to implement
- The importance of advertising potential loss in the context of major reform projects

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Thank you for listening

Any questions?

Email:

Janet.ratcliffe@gmccardiacnetwork.nhs.uk

Warren.heppollette@salford.nhs.uk



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and



Board of Directors Meeting

Wednesday 8th April 2009

(BDA/07/xxx)

**King's Health Partners response to Healthcare for
London Consultation
'The shape of things to come - developing new, high
quality major trauma and stroke services for
London'**

Status: A Paper for *Decision*

History: *No previous history*

Martin Shaw
Director of Finance

Board of Directors Meeting

8th April 2009

A paper prepared by Jackie Parrott / Marian Ridley,
Joint Directors of Partnership & Planning
and presented by Martin Shaw, Director of Finance

King's Health Partners response to Healthcare for London Consultation 'The shape of things to come - developing new, high quality major trauma and stroke services for London'

1.0 Introduction

- 1.1 Members of the Board will be aware that NHS London's *Framework for Action*, published in 2007 and consulted upon in 2008, signalled an intention to improve the quality of trauma and stroke services for the London population by rationalising these specialist services into fewer centres.
- 1.2 Following a process in the latter half of 2008 when Trusts were invited to bid to provide trauma and stroke services, the attached consultation document was published at the end of January 2009, setting out Healthcare for London's proposed future configuration of trauma and stroke services, and some alternative options. The consultation is being led by a Joint Committee of the 31 primary care trusts in London and NHS South West Essex (the JCPCT).
- 1.3 It is proposed that the Trust should respond jointly with King's College Hospital NHS Trust, under the auspices of King's Health Partners. The closing date for responses to the consultation is the 8th May, however since the proposals in the consultation document have important implications for the Trust and for King's Health Partners, we wish to submit our joint response before the closing date so that we ensure appropriate profile for the issues of concern to us.
- 1.4 The Council of Governors will be briefed on the issue and have an opportunity to discuss it at the Service Strategy Working Group on the 16th April, and their views will inform the final draft.

2.0 Draft response

- 2.1 Attached is the draft response, which has been developed by Maggie Hicklin, Divisional Director and other Trust colleagues, together with colleagues at King's College Hospital. Both trusts are supportive of the underlying aims and objectives of Healthcare for London's proposals for delivering high quality stroke and trauma in London, but have concerns about some of the proposed changes, particularly in relation to stroke services. These concerns are set out in the attached draft.
- 2.2 The Board will also be mindful of recent discussions on the future role of the St. Thomas's site and its importance as a Major Acute Hospital serving central London. In that context our Corporate Development team have been commissioned to do some modelling of the locations of major trauma centres. We believe that this will, in addition to supporting the designation of King's College Hospital as a Major Trauma Hospital serving south east London, support the case for recognition of the importance of the St Thomas' site as a

Major Acute Hospital, as the site providing the most comprehensive coverage of central London populations and strategically important locations. St Thomas' would be the ideal site to be brought into play for purposes of overall London-wide resilience, linked with King's College Hospital.

2.3 This work is not yet completed, but we hope to update the Board at its meeting. Subject to the outcome of this analysis, the views of the Board and of King's Health Partners colleagues, our conclusions from this work may be used to supplement the final version of our joint response to this consultation.

3.0 Recommendation

The Board of Directors is asked to:

- **Support the line taken in the attached joint draft response to the consultation**
- **Note that further changes to the draft will be agreed with King's College Hospital NHS Foundation Trust before submission to the JCPCT.**

Martin Shaw
Director of Finance

1st April 2009

Annex

King's Health Partners' Response to Healthcare for London Consultation

Current Position

We are strongly supportive of the underlying aims and objectives of HfL's proposals for delivering high quality stroke and trauma care in London, the overall model in principle and its feasibility.

Currently the organisation of stroke and trauma services in London fails to provide high quality of care for the majority of the population and it is evident that most of the current good services are located around the centre of the city leaving much of suburban London with poor quality provision.

Within Trauma we support the adoption of the 3 Major Trauma Centres and the subsequent networks of trauma centres (with the possibility of a fourth centre in April 2012). We will continue to develop King's Health Partners trauma service with the designation of King's as the MTC whilst providing clinical and managerial support to all our network partners.

Within Stroke we support the principle that the HASU designation process should take both journey time and quality of service into account, however, the plan as currently proposed raises significant uncertainties about the feasibility of implementing it without causing a significant deterioration of clinical services in the short to medium term.

The professional consultation exercise undertaken by HfL during the development of their stroke plans came out strongly in favour of a larger number of smaller HASUs (around 12-14 HASUs each with 10-15 beds) as opposed to a smaller number of larger units.

King's and St Thomas' have a long history of collaboration on Stroke services and this will inevitably increase as a result of the successful accreditation of King's Health Partners as an Academic Health Sciences Centre. Currently King's and St Thomas' hospitals are consistently two of the highest scoring units in the National Sentinel Stroke Audit.

Our Response to the Consultation

The case for a small number of large trauma units is accepted and the location of King's supports the 45 minute journey time target. The same case for very large HASUs is less compelling. There is no evidence that eight large HASUs with twenty beds each will provide better clinical outcomes than a larger number of medium sized units.

Designation of a small number of HASUs raises concerns about resilience, both in terms of the stroke service and in terms of A&E capacity and capability. To achieve the sort of door to needle times and thrombolysis rates that the best units are currently achieving requires a seamless pathway from A&E to HASU with rapid access to scanning in A&E. London has experienced major problems this winter with A&E departments struggling to manage peak capacity resulting in failure to meet performance targets, delays in unloading ambulances and requests for divers. There have also been significant bed problems, which have had a knock on effect on elective activity and on the ability of community services to cope with supported discharges.

There is real concern that with only eight hyper acute stroke units there may be insufficient reserve to cope with peaks of A&E demand or an unexpected drop in HASU capacity if one unit had to reduce activity, say to manage an outbreak of infection or a staffing crisis.

The co-location of HASUs with trauma units will exacerbate the pressure on those hospitals and is likely to cause capacity issues at each stage of the pathway, A&E, imaging and beds. East London will be particularly vulnerable and, under HfL's preferred model, will be reliant on

DRAFT

King's College Hospital to provide high quality HASU services. It is likely to take some years for Bromley, the Royal London and Queen's Hospitals to be brought up to speed.

In the medium term until those units are well established, a very short door to needle time in central London will mitigate against a slightly longer journey time from areas with no provision. St. Thomas' already has the expertise to support the overall objectives of the consultation. St Thomas' Hospital is currently achieving door to needle times of as low as 12 – 17 minutes. Given the shortage of high quality HASU provision, and the fact that many Londoners do not currently have timely access to thrombolysis treatment, we challenge the proposal to reduce high quality provision in central London with the closure of the St Thomas' Unit, which is regarded as a centre of national and international excellence.

We have major concerns about the use of a rigid sector model to plan the provision of clinical services in London. Central London poses a particular health challenge, with the population requiring urgent and emergency care changing rapidly as people move in and out of London for work, travel and social events. Any resultant service should take account for the visiting as well as the resident population.

Ensuring adequate clinical capacity during the three to five year period when the proposed units are being developed will be difficult:

- There will be no incentive for existing units to increase capacity during this time if they are not designated as long term providers.
- The designated units are unlikely to be able to meet demand in the required time frame.
- King's College Hospital would be the only existing provider in South East London and would need a 30 bed HASU to provide the necessary capacity. This would require an additional 80 nursing staff and with about 3,000 acute admissions per year would require a significant increase in the medical establishment and substantial capital investment.
- The same problem is likely to arise in other sectors. Being able to manage a HASU of 30 beds will be heavily dependent on there being effective stroke units with sufficient capacity to receive local patients within 72 hours of admission. Many of the stroke units are not yet at a stage where this level of service is likely to be deliverable and there will need to be a considerable investment both financially and in terms of education and training support to help these units reach a level where they sustain a comprehensive stroke service.
- Of the eight HASUs being proposed for designation by HfL, four were regarded as currently providing high quality HASU care, the remaining four require varying levels of support and development to achieve the standards set out in the designation process.
- In addition, the designation of only King's as a provider of HASU care is detrimental to maximising the benefits of the Academic Health Sciences Centre.

Identified Risks

There are a number of significant risks we have identified with the current proposal for the distribution of stroke services:

- There is a national shortage of trained specialists (nurses, physicians and therapists). Thus the feasibility of a rapid and radical development of specialist stroke care with a

large increase in capacity for hyper acute care in centres that are currently vestigial is unlikely to be delivered without significant investment and without strong support from the existing high quality stroke units, of which King's and St Thomas' are leaders in the field.

- There is a real danger of destroying existing high quality care without putting in the required capacity and quality into outer London. The flow of patients from Kent into South East London has not been adequately factored into planning. There is no experience in the UK of such large units, their cost effectiveness and the pressures they may put on diagnostic and therapeutic processes in hospitals.
- The result may be gaps in service provision and a lack of cohesive pan-London coverage for Londoners and visitors to London.
- It is short-sighted to be taking clinical capacity together with capacity for development, education and training out of the system at this early stage and we believe that adequate consideration has not been given to these issues.
- The four units that are already providing high quality care will themselves have major training requirements for their large increase in staffing and will be challenged to achieve the necessary internal change. Providing support to other developing units at a time of substantial increase in the workforce and the consequent teaching and training required will further hamper the development of the proposed units.
- The proposal to de-commission the existing hyperacute units will have an impact on the quality of care for other patient groups at St Thomas' Hospital. A significant number of patients have a stroke whilst in hospital undergoing treatment for other conditions, most notably heart disease. These are usually patients who have a stroke in the post operative period and are often complex cases requiring critical care facilities. Under the proposed HfL model, these patients would no longer be treated for their stroke at St Thomas but would have to be transferred to King's College Hospital, which will add unnecessary delay and a complicated transfer to the patient pathway. The same will be true of other centres.
- Stroke research is a major Department of Health priority as evidenced by the development of the Stroke Research Network. The proposed model may hamper the recruitment of patients into clinical trials as major research active centres will be excluded from hyperacute research. Follow up of patients, after moving patients back to their base hospital, will be more complex.

King's Health Partners Recommendation

The consultation aims to improve the quality of care for acutely ill patients in London. King's Health Partners supports the proposals for the development of major trauma centres. We believe that the ambition for high quality services for stroke is more likely to be achieved if there is a more careful phased implementation rather than the proposed big bang approach. The bids submitted by King's Health Partners proposed the running of a joint AHSC service with the sharing of medical staff between King's and St Thomas' hospitals. Our recommendations are:

1. The AHSC, rather than King's College Hospital alone should be designated to provide HASU, SU and TIA services, ensuring that south east London has the flexibility, capacity and resilience required to meet the demand.
2. South East London requires 30 HASU beds and we would initially envisage providing them at King's and at St Thomas' Hospitals. We believe that this is achievable within the timescale required and plans are in place to recruit and train staff to deliver this. We would work to one set of clinical protocols and implement a single patient pathway, a joint consultant rota with the advantage that implementation, whilst challenging, would be achievable and would provide resilience.
3. We have successfully installed telemedicine at St Thomas' Hospital and this has been an important factor in achieving door to needle times of less than 20 minutes (most recently 12 – 17 minutes). We are currently installing the same service into King's College A&E and believe that telemedicine could be used as a valuable asset to support Bromley in eventually delivering the required performance.
4. King's Health Partners is committed to supporting the development of a HASU for the population of Bromley (and part of Kent) and we are in discussion with Bromley about what that support might look like. We would expect to review the number and organisation of beds provided by the AHSC in 3-5 years time or when the Bromley HASU unit is delivering the required capacity and quality.

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15th April 2009

Dear Julia,

Re: The shape of things to come – developing new, high quality major trauma and stroke services for London.

Thank you for the invitation to outline our views in regards to the above. I will take each area in turn:

Major Trauma

The Hillingdon Hospital NHS Trust (THH) agrees with the vision for major trauma services as laid out in the consultation paper. This will only affect at most one patient a week in the Hillingdon area, and the hospital has always been clear it will not be able to treat patients with neurosurgical or cardiothoracic injuries.

Stroke Services

The Hillingdon Hospital has concerns about the vision for stroke services in London and these are:

- Many patients from the Hillingdon Borough will be inappropriately transferred to other hospitals. That is, we understand that only a small proportion of patients will meet the criteria for thrombolysis, although most patients with symptoms will be transferred to a HASU. They will then require being transferred back to their local hospital without receiving any treatment.
- The need for centralised HASU services is not clear. Most other SHA's are delivering thrombolysis services for stroke patients in many, if not all acute trusts. It is difficult to know why London is different.
- The reasons for us not achieving HASU status were difficult for us to comprehend. Even after trying to clarify the reasons with the SHA, we are unclear as to why our bid failed.
- The current proposal does not seem to be cost effective.

In terms of the Hillingdon position, we will have sufficient stroke beds for our patients. However, if Ealing Hospital doesn't have a stroke unit, we will need to understand the proportion of patients we will be expected to treat. In terms of the London Ambulance Service, I am sure they will be able to clarify what this means for them, but from our point of view and as already stated, it will double the amount of patient journeys.

Please do not hesitate to contact me further if you require any clarification on the above points.

Yours sincerely

A handwritten signature in black ink, appearing to read "David McVittie". The signature is fluid and cursive, with a large initial 'D' and a stylized 'M'.

David McVittie
Chief Executive

Copy to:
Abbas Khakoo
Anthea Parry
Jacqueline Totterdell

Response to “The shape of things to come” consultation Developing new, high quality major trauma and stroke services for London

1. Introduction

King’s Health Partners, comprising King’s College London and Guy’s and St Thomas’, King’s College Hospital and South London and Maudsley NHS Foundation Trusts, strongly supports the underlying aims and objectives of Healthcare for London’s proposals for delivering high quality trauma and stroke care in London. Many of the principles and service models set out in the document have already been implemented by King’s Health Partners, particularly in the field of stroke services, where both St Thomas’ and Kings College Hospitals have invested significantly in recent years and are leading centres of national excellence.

We think that the recognition of King’s College Hospital as a proposed major trauma centre and as a hyper-acute stroke unit is not only a fair recognition of the capabilities and capacity at Denmark Hill, but is also a platform for development of services in outer south east London. We have applied some of the applied research capabilities sitting within the AHSC to look at the proposals contained in ‘The shape of things to come’ consultation document, and in this response we have outlined what we hope will be considered as helpful suggestions that will contribute to the underlying aims and objectives of Healthcare for London’s proposals.

In developing this consultation response, we have drawn extensively upon the views of expert clinicians within our respective organisations who have been active contributors to the Healthcare for London work, and upon the views of our Governors, representing the patient, public and staff membership of our Foundation Trusts.

2. Summary of response

As stated earlier King’s Health Partners strongly support the underlying aims and objectives of Healthcare for London’s proposals for delivering high quality trauma and stroke care in London.

The key elements of our response are as follows-

Trauma

- We support the development of a limited number of Major Trauma Centres (MTC), including King’s College Hospital, and of the associated networks of trauma centres.

- We concur with NHS London's assessment that three major trauma centres would be sufficient to meet the estimated levels of need across London. We believe that a fourth trauma centre would add considerable costs with little or no clinical benefit.
- Our assessment is that there would be a more optimal three centre option, which was not included in the consultation document, and that is the designation of the Royal London, King's College Hospital and Imperial Healthcare. These centres would all meet the quality criteria by 2012, give comprehensive coverage across London and be more affordable.
- We believe that this three centre option would be complemented by the high quality trauma centres at St Thomas' and St George's, with the former in particular providing resilience across the central London area.
- King's Health Partners' trauma service will continue to develop and provide clinical and managerial support to all our network partners.

Stroke

- We support the proposal to designate networks of hyper-acute stroke units (HASUs), stroke units and transient ischaemic attack (TIA) centres.
- We believe however that greater patient benefit and a more rapid and secure transition to the achievement of excellence across London could be achieved through a more flexible approach to the designation and development of hyper-acute stroke units.
- Whilst we recognise the case for greater concentration of expertise, we believe that the evidence for improved outcomes arising from a small number of very large HASUs rather than a slightly greater number of medium-sized HASUs is less compelling than the evidence in relation to trauma centres, and we are unclear on the underpinning evidence for "about 7" HASUs across London.
- Our view is that a small number of HASUs raises concerns about resilience in terms of stroke services and also in terms of A&E capacity and capability.
- We consider that King's Health Partners should be designated as a hyper-acute stroke unit providing support to develop a south London network, with the eventual configuration of HASU beds to be determined on quality, outcome and access grounds rather than being predetermined now. Analysis of differential financial impact should also be available when a final decision about configuration is made.
- We are working with colleagues in outer south east London to support the development of services in Bromley.

General comments

- Viewing London as a whole as well as on a sector basis will encourage and facilitate more efficient networks, and we believe brings forward the opportunity to implement a slightly different set of recommendations which would improve access, reduce cost, improve quality, and improve resilience.
- The accreditation of three AHSCs within London presents an opportunity for these organisations to take the lead in implementing changes within their networks, held to account by Healthcare for London for delivering within agreed timescales. This is a different approach to that currently pursued of designating individual acute hospitals, and would build off existing excellence.

- As clinical services are to be increasingly effectively tendered across London through a series of bidding processes, it is critical that the evaluation criteria are transparently articulated and consistently applied.

3. Trauma proposals

3.1 *Current King's Health Partners trauma services*

King's and St Thomas' currently receive more LAS 'Blue Light Trauma' and HEMs patients than any other London hospital except for the Royal London, and have an established track record for the care of traumatically injured patients.

3.2 *Appraisal of Major Trauma Centre configuration*

We have undertaken a desktop exercise which sought to replicate the analysis of the populations to be covered within given travel times by the different possible configurations of major trauma centres across London. We believe that London could be covered by a three major trauma / network solution, but that there is a more optimal solution than the three centre option put forward. This option does not appear in the consultation document because of the precedence given to whether or not bidding centres meet the quality criteria by April 2010, over and above whether the resulting configuration gives comprehensive coverage of London. Because the criteria were applied in sequence, rather than modelling a wider range of possible configurations, we believe that the consultation has not considered an option which would give comprehensive coverage of London from 3 centres / networks, would meet quality criteria for 2 out of 3 centres by 2010, and for the third by 2012, and would be likely to be more affordable, given that it would reduce the scale of recurrent investment via the "supplement" proposed for each major trauma centre.

Using 30 minute isochrones we modelled the coverage of London's population that would be secured through designation of the Royal London, King's College Hospital and Imperial Healthcare. Our analysis suggests that this could cover a London population of 6.23m, plus a non London population of 1.27m (total 7.5m), compared to the three site option presented in the consultation document (London, King's & St George's) which covers a London population of 5.36m and a non-London population of 1.08m (total 6.44m). Population coverage compared to the 4 centre option is about 1.0m less, but the volumes required to ensure good outcomes point to a three site solution for major trauma being preferable.

The consultation makes the argument for preferring a four centre configuration over three centres based partly upon the need for "resilience" in case of major incidents, and highlights the advantages of Imperial in terms of accessibility for any Heathrow based incident. Heathrow would be covered through designation of Imperial as one of the three centres in our proposed alternative configuration. With the exception of Heathrow, the likelihood is that any future major incident will be targeted upon central London with its high profile sites and large daytime population. Isochrone analysis suggests that a high quality trauma centre at St Thomas' Hospital is potentially best placed to add capacity and resilience to a London-wide 3 centre trauma system for these very specific incidences, since Westminster, the City and all but three of the main train termini are within a 15 minute isochrone. London will also need this resilience in 2012 during the Olympics.

We recognise that this option would significantly expand the trauma network linked to the major trauma centre at King's College Hospital, effectively creating a single network for South London. We believe that St George's would play a significant role in this network, like St Thomas', as a large trauma centre with excellent multi-specialty and multi-disciplinary expertise and infrastructure. Depending on the final configuration of major trauma centres, King's Health

Partners, along with the other designated centres, will need to assess the likely flows of activity and ensure that capacity is in place to meet the expected demand.

3.3 *Development of London's trauma system: planning for implementation*

In addition to the questions about the configuration of major trauma centres and their associated networks, there are a number of challenges and risks to be considered in the process of developing a trauma system for London:

- **Definition of major trauma and uncertainty regarding the number of major trauma patients:** Definition of “major trauma” is not straightforward. Patients with an injury severity score (ISS) of 16 or greater has been used in Healthcare for London’s work, although many clinicians believe that this under represents patients with major trauma as it measures the number of organ systems affected and not the acuity of the injuries. Projecting the number of major trauma patients likely to be managed within trauma networks has therefore been problematic. In addition, few hospitals in London have consistently submitted data to the Trauma Audit Research Network (TARN) and as a consequence there is no aggregated information on the number of trauma patients, and particularly major trauma patients, that a trauma system for London will need to plan for. There is therefore more work for us to do collectively across London to develop appropriately robust projections.
- **The geographical scope of a trauma system for London:** Whilst Healthcare for London has focused on developing a trauma system to manage the flow of trauma patients within London, it is well understood that for many hospitals there are ‘cross border’ patient flows between London and the home counties. In addition, most of the proposed major trauma centres with existing tertiary specialties already receive (many by HEMs) trauma patients from outside of London.
- **Pre-hospital triage:** The development of a trauma system for London has been underpinned by a principle that major trauma patients will be conveyed by the LAS to ‘level 1 - major trauma centres’ and less severely injured trauma patients will be taken to ‘level 2 trauma centres’ within each network. Work will be required to monitor for “over-triage” resulting from uncertainty about the severity of a patient’s injuries when LAS assess the patient.
- **Reimbursement to cover costs of major trauma:** A set of clinical criteria was set by Healthcare for London and bidders were judged by external experts on their ability to deliver these. Economic or affordability criteria did not form part of the evaluation process and bidders were not asked to submit costs. The Healthcare for London Stroke and Trauma Pre-consultation Business Case produced in January 2009 estimated additional total recurrent costs for trauma of £11.4 million and £13.9 million for 3 and 4 major trauma centres respectively, which we understand equates to £2.6 million annual supplement per major trauma centre and £2,000 ‘top-up to tariff’ payable for “additional” patients (ie above existing activity levels) with an ISS score of 16 or more.

Our estimates suggest that this is unlikely to be sufficient to meet the additional costs, for example we estimate that the annual supplement for King’s College Hospital needs to be a minimum of £3.6 million per annum, and that the top-up tariff will be insufficient to cover costs.

- **Rehabilitation:** The care of patients with injuries resulting from major trauma includes access to appropriate rehabilitation following their acute care at the major trauma centre. This can be provided either at their local hospital or in a specialist rehabilitation facility. Currently there is a significant shortage of specialist rehabilitation facilities within London.

No tariff or reimbursement for rehabilitation of trauma patients has been agreed and there is therefore no incentive for local hospitals or rehabilitation facilities to take patients from the major trauma centres for their rehabilitation. Ensuring the seamless and timely transfer of patients out of major trauma centres will be essential if we are to ensure the necessary continuous availability of capacity for new admissions.

4. Stroke Service proposals

4.1 Current King's Health Partners stroke services

King's College and St Thomas' Hospitals, together with academic partners in King's College London, have a long history of collaboration on stroke services and this will inevitably increase as a result of the successful accreditation of King's Health Partners as an Academic Health Sciences Centre. Our collaboration has included Lambeth and Southwark PCTs, encompassing the full pathway of stroke care, including out of hospital care. The two hospitals have consistently been two of the highest scoring units in the Royal College of Physicians' National Sentinel Stroke Audit, including the most recent report published in April 2009. Healthcare for London's own assessment process in relation to hyper-acute stroke units concluded that our two hospitals are, together with St George's and University College Hospital, two of the best four units in London.

4.2 The evidence for a few very large HASUs

As highlighted above, it is in relation to the proposals for designation of hyper-acute stroke units HASUs, that King's Health Partners would like Healthcare for London to revise its recommendations.

Whilst we accept the case for a small number of large major trauma centres, based upon evidence from the Royal London and internationally about the impact upon clinical outcomes, we believe that the case for a small number of very large HASUs is less compelling. As far as we are aware, there is no direct evidence to support a conclusion that eight large HASUs with around twenty beds each will provide better clinical outcomes than a larger number of medium sized units. A paper from the German national stroke audit in 2004 (Heuschmann P et al) showed that the risk of in-patient death was highest in the hospitals treating few patients compared to those treating more patients. However the low activity hospitals were those classified as thrombolysing less than 6 patients a year and high activity hospitals those thrombolysing more than 15 patients a year. St Thomas' Hospital thrombolysed over 50 patients last year using 4 acute beds and KCH thrombolysed 97 patients using up to 8 beds.

The assumption that "about 7" HASUs would be required in London was first stated in A Framework for Action and repeated in Consulting the Capital. It is not clear whether there is robust scientific evidence underpinning this assumption or whether this simply draws upon the conclusions of the source cited based upon a Canadian model from a geographical area sharing few characteristics with London.

The consultation exercise involving stroke professionals undertaken by Healthcare for London during the development of their stroke plans during the summer of 2008 came out strongly in favour of a larger number of medium sized HASUs (around 12-14 HASUs each with 10-15 beds) as opposed to a smaller number of larger units. Whilst this is not reflected in the final published version of the London Stroke Strategy, earlier drafts clearly advocated "option 2", which was the option for 12-14 units with a minimum of 10 beds each, and initial expressions of interest from providers reflected this. Similarly, a Consultation Update briefing from December 2008 refers to the Project Board setting a minimum HASU size of 10 beds. The pre-consultation business case acknowledges in a footnote that the projects' clinical experts

recommended that the minimum size for a HASU would be 10 beds, but states that “larger units were considered better”, although no basis is given. While we accept that there is an important element of institutional learning, we would suggest that the link between the number of admissions and

staff experience is not a straight line, as staff numbers will necessarily rise with the number of admissions, and the staff to admissions ratio remain broadly constant.

There is no experience in the UK of the larger size of units proposed by the consultation, their cost effectiveness or the pressures they may put on diagnostic and therapeutic processes in hospitals. To achieve the sort of door to needle times and thrombolysis rates that the best units, such as St Thomas’ and King’s College Hospitals, are currently achieving requires a seamless pathway from A&E to HASU with rapid access to scanning in A&E.

Designation of a small number of HASUs raises concerns about resilience, both in terms of the stroke service and in terms of A&E capacity and capability. London has experienced major problems this winter with A&E departments struggling to manage peak capacity resulting in failure to meet performance targets, delays in unloading ambulances and requests for divers. There have also been significant bed problems, which have had a knock on effect on elective activity and on the ability of community services to cope with supported discharges. With only eight hyper-acute stroke units there may be insufficient reserve to cope with peaks of A&E demand or an unexpected drop in HASU capacity if one unit had to reduce activity, for example to manage an outbreak of infection.

The co-location of some HASUs with major trauma centres will exacerbate the pressure on those hospitals and is likely to cause capacity issues at each stage of the pathway - A&E, imaging and beds. East London will be particularly vulnerable and, under Healthcare for London’s preferred model, will potentially be reliant on King’s College Hospital to provide high quality HASU services for some years whilst Bromley, the Royal London and Queen’s Hospitals’ services are brought up to the new standards.

4.3 The central London daytime population

Central London poses a particular health challenge, with the population requiring urgent and emergency care changing rapidly as people move in and out of London for work, travel and social events. Whilst making the case for areas with relatively high levels of elderly residents such as Bromley needing improved access to stroke services on the grounds of the prevalence of stroke within the population, which we support, the consultation document does not include, and nor do the supporting papers available in the public domain, analysis of LAS data indicating where people are in London when they have a stroke. We believe that this would show a slightly different geographical distribution of need as the basis for population coverage analysis, given the c.1 million people who travel daily into central London for work and the 60+ million annual day visitors to central London boroughs.

4.4 Development of stroke services: planning for implementation

The consultation document does not cover how the transitional period between current and proposed future service configurations will be managed to ensure that the stated deadlines for development of new services are met and that there is no deterioration of existing clinical services in the short to medium term. It is essential to ensure that existing excellence is not allowed to wither away before capacity and quality have been put in place elsewhere, but with the proposals as currently framed, we believe that this is a significant risk.

It will be a considerable challenge for the designated hyper-acute units which do not currently meet the required standards to meet the quality standards and associated criteria in the

required time frame. Services at St Thomas' and Kings College Hospitals have taken many years of intensive effort to reach their current standards, and considerable investment, not least from Guy's and St Thomas' Charity.

There is a national shortage of trained specialists (nurses, physicians and therapists). Thus the feasibility of a rapid and radical development of specialist stroke care with a large increase in capacity for hyper-acute care in centres that are currently vestigial is unlikely to be delivered without significant investment and without strong support from the existing high quality stroke units, such as those within King's Health Partners.

In the medium term until all the proposed HASUs are established and meeting the required standards, a very short door to needle time in central London will mitigate against a slightly longer journey time from areas with no provision. For example, St Thomas' Hospital is currently achieving door to needle times of as little as 12 – 17 minutes. However there will be no incentive for existing hyper-acute units to maintain or increase capacity during this transitional period if they are not designated as long term providers. It is probable that existing high quality units which are not designated will lose expert staff, not necessarily to other London stroke units.

During the transitional period should this happen at St Thomas', King's College Hospital will potentially become the only existing hyper-acute provider in South East London, theoretically needing a 30 bed HASU to provide the necessary capacity, pending the development of services at Bromley & the Royal London. This would require an additional 80 nursing staff and with about 3,000 acute admissions per year would require a significant increase in the medical establishment and substantial capital investment. We are not confident that this is feasible or affordable. King's College Hospital will also be dependent upon the development of effective stroke units with sufficient capacity to receive local patients within 72 hours of admission and to sustain a comprehensive stroke network.

Clinical capacity and the capacity for education and training are of course integrally linked, and it is not clear to what extent this has been modelled. The decommissioning of St Thomas' hyper-acute unit will remove capacity for education and training, at a time when units such as King's College Hospital will themselves have major training requirements for their large increase in staffing and will be challenged to achieve the necessary internal change. Providing support to other developing units at a time of substantial increase in the workforce and the consequent teaching and training required will further hamper the development of the proposed units.

We believe that the best possible future model would see the designation of King's Health Partners as a single hyper-acute unit, established in the first instance across the two sites of King's College and St Thomas' Hospitals. This will maximise accessibility for patients with a condition where, to quote the National Stroke Strategy, "time is brain", and will minimise the many potential risks and costs of transition, enabling King's Health Partners to turn its focus externally to support the development of equivalently excellent services elsewhere in the network, in particular at Princess Royal Hospital in Bromley. We recognise the importance of rapidly developing high quality stroke services accessible to all of London's population, particularly in those outer London areas which have not historically benefited from high quality stroke provision. We would welcome the opportunity for King's Health Partners to work with colleagues in Bromley to develop a plan for the rapid development of stroke services there, including a hyper-acute stroke unit, drawing upon the clinical and academic resources of the AHSC. These developments will be grounded in developing networks of clinical teams, with staff potentially rotating through locations.

Once services have been developed at Bromley and the Royal London which meet the necessary quality criteria, King's Health Partners undertakes then to review in partnership with

local commissioners the balance of hyper-acute stroke services across our sites, taking into consideration access, quality and cost criteria in the context of London-wide needs.

5. Methodological approach

5.1 Clinical leadership

The involvement of expert clinicians has been a central feature of Healthcare for London's approach, and this is to be welcomed. We believe, however, that further efforts need to be made to ensure transparency about the appointments process for clinicians involved in the development of future Healthcare for London proposals, to minimise the risk of any perceived conflicts of interest arising.

5.3 Choice and application of decision-making criteria

Trauma and stroke were initially undertaken as separate projects under the Healthcare for London programme. Whilst a single set of criteria for decision making is set out, these criteria have effectively been applied differently to the two service areas. In trauma, as highlighted above, a sequential approach has been taken, with quality forming a first "bar" to be crossed before population coverage is considered, whereas in stroke, population coverage and "strategic coherence" are the determining criteria. This has ruled out some options which we believe should have been included for consultation.

The lack of any assessment of differential economic impact or feasibility in distinguishing between options for consultation is something which we believe future consultations should reconsider, particularly in the anticipated economic circumstances facing us.

We also believe that the approach undertaken could lead to sub-optimal overall solutions emerging, as a result of an approach that is based upon an aggregation of separate project proposals.

5.4 "Strategic coherence" criterion

We fully agree that the HASU designation process must take both quality of service and comprehensive coverage of London into account. We are less convinced by the "strategic coherence" argument which has been applied after submission of bids by providers, in particular the co-location of major trauma centres and HASUs and the link being implied on page 8 of the consultation document between this and "likely" major acute hospitals, based effectively on the presence of neurosurgery services. As far as we are aware, previous Healthcare for London consultations have not explicitly made this link between the future designation of major acute hospitals and the presence of neurosurgical services. Access to, not co-location with, neurosurgery was a designation criterion for HASUs, and co-location of major trauma centres and HASUs did not appear in any of the designation criteria documentation supplied to trusts at the time of bidding.

We do however think that as commissioners progress Healthcare for London's programme of work, it will be important to ensure that the interconnectedness of clinical services is recognised, but not over-simplified or over-stated as there is a danger of destabilisation of organisations leading to potentially unaffordable major service reconfiguration programmes and loss of public confidence in London's health services.

6. King's Health Partners' Proposals

This consultation aims to improve the quality of care for acutely ill patients in London, and King's Health Partners is committed to playing an active and collaborative part in ensuring the successful implementation of resulting changes.

King's Health Partners believes that the development of three major trauma centres instead of four should meet the needs of Londoners and potentially at less cost than four centres, but this is predicated upon our proposed configuration of the three centres which is not the same as that contained within the consultation document. Of the options presented in the consultation document, we recognise the superiority in terms of population coverage of the four centre options. We will continue to work with other major trauma centres and with commissioners to develop implementation plans once the decision is made, including a robust and viable approach to reimbursement.

We believe that the ambition for high quality services for stroke is more likely to be achieved if there is a more flexible approach to designation and development of HASUs across stroke networks. The original bids submitted to Healthcare for London by King's Health Partners proposed the running of a joint AHSC service with the sharing of medical staff between King's and St Thomas' hospitals. We still think that this would be a better option than any of those proposed in the "either / or" approach set out in the consultation document. We believe that this option fully meets the available evidence in relation to the critical mass required to achieve the best outcomes. We would propose that:

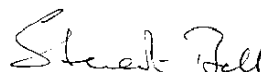
- a. The AHSC, rather than its individual constituent NHS Foundation Trusts, should be designated to provide HASU, SU and TIA services, ensuring that south east London has the flexibility, capacity and resilience required to meet the population's needs.
- b. South east London requires 30 HASU beds and we would envisage providing them between King's and at St Thomas' Hospitals, at least for the next few years, with the greater number at King's College Hospital. We believe that this is achievable within the timescale required and plans are in place to recruit and train staff to deliver this. We would work to one set of clinical protocols and implement a single patient pathway, a joint consultant rota with the advantage that implementation, whilst challenging, would be achievable and would provide resilience.
- c. King's Health Partners is committed to the rapid development of a HASU for the population of Bromley (and neighbouring parts of Kent) and we are in discussion with South London Healthcare NHS Trust about what support and leadership we can offer to achieve this. For example, we have successfully installed telemedicine at St Thomas' Hospital and this has been an important factor in achieving door to needle times of less than 20 minutes. We are currently installing the same service into King's College A&E and believe that telemedicine could be used as a valuable asset to support Bromley in eventually delivering the required performance.
- d. We would expect to review, in consultation with local commissioners and taking a view of the wider London context, the number and organisation of HASU beds provided by the AHSC in 3-5 years time or when the Bromley HASU unit is delivering the required capacity and quality.

On behalf of King's Health Partners



Tim Smart
CEO
King's College Hospital NHS Foundation Trust

Ron Kerr
CEO
Guy's & St Thomas NHS Foundation Trust



Robert Lechler
Interim Director
King's Health Partners
Academic Health Science Centre

Stuart Bell
CEO
South London & Maudsley
NHS Foundation Trust

7th May 2009

get electronic MS can.

9th April 2009

Kingston Hospital
Galsworthy Road
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Councillor Christopher Buckmaster
Chairman
Joint Health Overview & Scrutiny Committee
The Royal Borough of Kensington and Chelsea
The Town Hall
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Our ref:
Your ref
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Dear Councillor Buckmaster,

Thank you got your letter of 20th March 2009 re high-quality major trauma and stroke services.

I attach a letter from our Lead Stroke Clinician which is self explanatory. In summary, we fully support the proposed changes for major trauma services. While we fully support the objectives of the proposed changes to stroke services, we do feel that there are other models for delivering the outcomes that should be explored. In particular, we would like the opportunity to explore the pros and cons of the existing model in South West London and the opportunities for telemedicine alongside the proposed centralisation model.

If you would like further information or discussion please do not hesitate to contact me.

Yours sincerely



Kate Grimes
Chief Executive

WRM/hlt

3rd April, 2009

Councillor Christopher Buckmaster
Chairman

Joint Health Overview and Scrutiny Committee
The Royal Borough of Kensington & Chelsea
The Town Hall
Kensington
London W8 7NX

Direct Line: 0208 934 2276

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Dear Mr. Buckmaster,

Thank you for your letter of 20th March inviting comments about the proposal for the development of major trauma and stroke services for London. Stroke clinicians in South West London (St. George's, Kingston, Mayday and St. Helier's) met in June 2007 at the time of the approval of the licence for Alteplase, which is the thrombolytic agent used in acute ischaemic stroke. Following a series of meetings between commissioners, PCTs, LAS, Public Health and Acute Trusts, the South West London hub and spoke model pilot study began in February 2008. This provided thrombolysis under locally agreed protocols/care pathways at the district general hospitals during Monday to Friday daytime working hours with evening/night and weekend (24/7) service for the network at St. George's. Following acute assessment +/- thrombolysis, patients are admitted to acute stroke units. Repatriation to local stroke units from St. George's was agreed and has been operationally successful. Quality control for the pilot has been local with weekly neuro-imaging and clinical meetings and regional (network clinical meetings) with audit information provided to Public Health at Wandsworth PCT. The one year report and the pilot hub and spoke model for acute ischaemic stroke in South West London has recently been completed and is being submitted to Health Care for London.

In the first year a total of 78 patients have been thrombolysed. During the working day, St. George's thrombolysed 8, Kingston 14, Mayday 11, St. Helier's 7 and outside normal working hours St. George's thrombolysed 38 patients from this sector. Since the pilot was completed a further six patients have been thrombolysed at Kingston over the last four weeks.

It is the shared view of the network that the service has been operationally effective and more importantly has provided a rapid safe consultant-delivered service for acutely ill stroke victims. The outcomes have been good at both the peripheral and central sites.

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In the preliminary Acute Stroke Strategy for London document on page 6 it says that the "limited hours" service was "considered and excluded". No details of the reasoning were provided other than a brief list namely capacity, critical mass workforce (rotas and shift patterns), LAS knowing where and when and cost efficiency. I would like to comment further on these:

1. **Capacity:** This is potentially a bigger problem at the tertiary centres. Spreading the case load allows patients to be admitted to their local acute stroke units, avoiding the need for transfer and providing continuity.

2. **Critical mass:** The last fourteen months have been a learning experience for stroke physicians, both in central and peripheral sites. Patients have benefited from high quality care according to agreed protocols/pathways. "Critical mass" is mentioned without provision of detailed evidence that high volume necessarily leads to better outcome. If such evidence exists, the South West London stroke network and Healthcare for London should evaluate this. At present there is evidence that multidisciplinary acute stroke care rather than thrombolysis is the key to better outcomes though we have seen clear benefits from thrombolysis in individual cases.

3. **Workforce (rotas and shift patterns):** Within the normal working week (0830 – 1700 Monday to Friday) access to consultant/specialist advice is readily available at the different sites. Provision of out of hours senior opinion and help is more complex and probably less cost-effective in small units. This is the rationale for a limited hours hub and spoke model.

4. **LAS knowing where and when:** Outcomes from thrombolysis are critically dependent on the time from stroke onset to treatment. This logically favours rapid transfer to the nearest site where specialist treatment is available. Anecdotally there have been delays in transfer to the hub out of hours. Details and analysis of these delays are required. We have not heard of any confusion/indecision within LAS resulting from clearly defined time frame.

5. **Cost Efficiency:** Local acute stroke units are operational and additional extra costs for thrombolysis would be more than offset by improved outcome. This needs to be demonstrated. Cost analysis relating to size of units has not yet been provided.

Specialist assessment is the key. Treatment is simple and does not require a specialist centre but requires a consultant specialist decision. Local delivery close to home with reduced travel time (time is ? brain saved), avoidance of transfer during acute illness and continuity of care are important. Taking away the acute side from local stroke units will have an effect on the recruitment and morale of staff within stroke units.

Cont'd....

During the last year we feel we have provided efficient repatriation within our network. In South West London we have a very advanced network and we feel there is no logic to pan-London uniformity. There is considerable concern about the capacity of the hub.

We believe we have been working well as a network in South West London. We will need to continue to evaluate and evolve to improve the care of all stroke patients in a cost effective way that builds on the expertise gained at all centres since the pilot started. At Kingston we had a very poor performance in the 2004 National Sentinel Stroke Audit. We reached the median in 2006 after opening our acute stroke unit. I am delighted that Kingston are now in the top quartile for the 9 key process indicators for stroke care in the 2008 National Sentinel Stroke Audit.

We would like also to evaluate the role of telemedicine for out of hours management keeping stroke patients local while not compromising on the quality of care.

Yours sincerely,

Dr. W. R. McNabb MA MD FRCP
Consultant Physician

**Richmond upon Thames LINK response to:
Healthcare for London: The shape of things to come – major trauma and
stroke services for London**

General comments

Richmond upon Thames LINK welcomes the general proposition to develop new major trauma and stroke services in London through the establishment of new trauma networks and a three tier level of care for stroke services – as outlined in the consultation document.

Our specific comments below refer specifically to how these new services would affect the people of SW London and the population covered by our LINK.

Major trauma

Q1: We agree with the preferred option of four trauma networks.

Q2: St. George's Hospital is included in all three options and we consider that St George's Hospital provides the best option for a major trauma centre for the people of SW London and the borough of Richmond upon Thames. We agree that option one, which includes St Mary's Hospital provides the best coverage across London.

General comment regarding major trauma centres: there will be long and difficult journeys faced by those families who rely on public transport when visiting their relatives admitted for major trauma. We would urge consideration be given to providing/identifying temporary short stay accommodation for close relatives of major trauma patients, at all major trauma centres.

Stroke services

Q3: we agree.

Q5: we agree but as long as the provider hospital has robust funding for the provision of all associated services.

Q6: we agree with the preferred option for the siting of the eight hyper-acute stroke units and recognise the advantage of having on-site neuroscience facilities. Charing Cross and St George's Hospitals are appropriate choices for the people of SW London and the residents of the borough of Richmond upon Thames.

Q7: we support the 'preferred option' list of hospitals, particularly where the reasoning includes: shared location with a proposed major trauma centre; on site neurosurgery or neuroscience facilities; better access and journey times.

Q8: we agree with the proposed configuration of stroke units. However, for the residents of Richmond upon Thames who are likely to be admitted to West Middlesex Hospital or Kingston Hospital, it is essential that these providers receive adequate funding, resources and support to bring their level of care up to the standard required and anticipated in this reorganisation of stroke services and thus ensure the best outcome for patients.

Q10: we agree with the proposed configuration of TIA services but with same proviso as outlined in our answer to Q8 above.

Q12: we agree but with the following proviso: that robust plans are put in place to manage the transition of these services so that patients are not put at risk when care is being reconfigured and all the anticipated new provision arrangements are not fully in place.

In conclusion, overall we strongly support the development of new, high-quality major trauma and stroke services for London, leading to a reduction in mortality and levels of permanent disablement or morbidity. However, to ensure that optimum benefit is gained from providing these intensive services there will need to be a review of the availability and the quality of rehabilitation services and community support providing post-trauma/stroke care within both the statutory and voluntary sectors to ensure continuity of care/provision; the care pathway must be clearly defined and supported. Where services are commissioned from the voluntary sector, particular consideration should be given to the agreement of long term contracts/funding rather than short term to ensure stability.

We would also recommend that there should be a review of public transport access to St George's Hospital and measures taken to improve access for people across SW London.

Richmond upon Thames LINK
May 2009



Your ref:
Our ref:

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15 May 2009

Dear Healthcare for London

Re: Transport for London's response to the Stroke and Major Trauma consultation

Thank you for your letter of 2 March 2009 inviting Transport for London (TfL) to comment on your proposals to improve develop new, high quality major trauma and stroke services in London. TfL supports the development of consistently high standards of care for all Londoners and measures to improve the access of all Londoners to world class health care are welcomed. The period up to 2026 is likely to see an increase in congestion in central London (see illustrations in attachment) and the Mayor is developing policies and proposals in a new Transport Strategy to address this issue which will be subject to public and stakeholder consultation later this year. We have reviewed your consultation document 'The shape of things to come' and welcome the opportunity to comment on the proposed changes.

Major Trauma Centres

As far the proposals for all Londoners to be within 45 minutes of a major trauma centre is concerned, TfL sees no reason for not proceeding with the preferred option of providing four centres. The preferred option gives a better network of Major Trauma and Trauma centres, including proximity to Central and west London. There are likely to be worsening traffic conditions over the next twenty years. However, TfL anticipates that the preferred configuration can meet the 45 minute target for Blue Light vehicles.

Hyper Acute Stroke Units

TfL supports measures to improve the standard of care for stroke patients and appreciates the necessity for patients to reach excellent quality care in a timely manner. Furthermore, TfL support the proposals to improve access to high quality stroke services particularly for people in outer London. As far as the preferred configuration is concerned, TfL consider that the proposals for all Londoners to live within 30 minutes ambulance drive of work class specialist stroke services is achievable.

Public Transport Accessibility Levels (PTALs)

From the perspective of access to the public transport network, patients will only remain in the centres whilst they require specialist emergency care, and so there will be little travel to and from the centre by patients or visitors.

However as far as TfL's methodology of determining public transport accessibility (PTAL's) are concerned, three of the four major trauma centres have a rating of 6a or 6b (very good) and one has a rating of 4 (fairly good). For Stroke most of the centres have a good PTAL rating of 6a or 6b, two have ratings of 3 and 4, The Princess Royal University Hospital has a lower rating (2) and the new Queen's Hospital has a PTAL score of 4.

It is assumed that patients would only be expected to remain in the centre for a relatively short period of time, before transferring to their local hospital as their condition stabilised. This means that the PTAL ratings are less relevant than they might be for other services. On balance slightly increased visitor journey times could be outweighed by the benefits of ensuring better equality of care for all Londoners.

We also look forward to continuing to work closely with Healthcare for London in the future planning of services. We will of course continue to provide advice and support to better understand traffic issues and manage congestion impacts, which will result in better health outcomes for Londoners.

I have enclosed some illustrative maps which were requested by the Joint Health Overview and Scrutiny Committee to demonstrate the issues of congestion and public transport accessibility levels (PTAL's) for visitors.

Yours sincerely

pp 

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3 June, 2009

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Dear Julia

Re: The shape of things to come – developing new, high quality major trauma and stroke services for London

Thank you for your letter dated 20th March 2009, in which you requested a view from the West Middlesex University Hospital NHS Trust on the proposals for the development of major trauma and stroke services in London.

In relation to trauma, we fully support the development of major Trauma Centres in London in order to ensure that this relatively small patient group is provided with the most effective, high quality care. As a local provider of services, already working with our more specialist neighbouring hospitals, we do not envisage the designation of trauma services to have a significant impact either on the Trust or on the travelling times of our patients.

In relation to stroke services, we welcome the proposal to further develop our stroke unit and TIA services to meet the full requirements of the Healthcare for London specification for a Stroke Unit. Indeed, we have already designated a ward to stroke care to ensure all patients are provided with optimal treatment and have in place detailed plans to enable our services to continue to develop. We did not select to bid to be a Hyper Acute Stroke Unit as we believe that this specialist service is best provided in an environment where it can be supported by the full range of services provided within a large teaching hospital environment with specialist and tertiary services

In relation to the provision of Hyper Acute stroke care, our bid was submitted in partnership with Imperial who planned to provide this service from their Charing Cross site. This represented the closest unit for our local population to access. However, we are concerned that within the consultation documentation it is noted that if Imperial are successfully designated as a trauma centre, then Hyper Acute Stroke services will be relocated from Charing Cross to be adjacent to the Trauma Centre on the St Mary's site. This would not be an optimal location for our patients and under this scenario we would wish to support Chelsea and Westminster's designation in order to maintain services as locally as possible for our patients.

Clearly, the selected configuration for the Hyper Acute Stroke Units will impact on the size of Stroke Unit required at the West Middlesex. We will continue to work closely with our health care partners including acute providers and the London Ambulance Service to ensure that we have sufficient bed capacity to manage demand.

We will be responding to the Healthcare for London consultation with these views.

I hope that this response is helpful to your discussion. If you require any further information, please do not hesitate to contact me.

Kind regards

Jacqueline Docherty
Chief Executive

Councillor Christopher Buckmaster
Chairman
Pan London Joint Health Overview and Scrutiny Committee.

17/04/2009

Dear Councillor Buckmaster

Re: The Shape of things to come – developing new, high –quality major acute trauma and stroke services for London.

Thank you for inviting us to comment on the consultation document for Trauma and Stroke in particular around the proposed configuration and the arrangements for response from the London Ambulance Service.

Please find our response for the Pan London Joint Health Overview and Scrutiny Committee. Our response is focussed on the proposed configuration and impact on patients within North East London.

Having submitted a bid for the Stroke services including Hyperacute, Stroke and TIA the Trust would like to express its disappointment that, as well as meeting the Stroke and TIA designation criteria, we were not successful in being identified as one of the centres for delivery of a comprehensive Stroke service. This is also in spite of having one of the best clinical outcomes in terms of;

- a significantly lower than national average mortality rates of 22.7%
- a national expected average of 28.4%
- better than the majority of North East London Hospitals¹ (as demonstrated in appendix 1).

We would also like to draw your attention to the letter previously sent in response to the feedback from Healthcare for London (appendix 2).

In particular, the Trust needs to be reassured that the needs of our population are being taken into account in terms of the significantly higher incidence of stroke cases admitted to Whipps Cross, which shows that the Trust treated, between April 07 and January 09,

- in excess of 770 cases (17.5%) of all North East London patients
- against 530 cases at Barts and the London
- with the second highest activity as demonstrated in appendix 3².

The Trust is concerned that only sites that have a proven track record of high quality care to a critical mass of stroke patients should be selected.

¹ SOURCE: Dr Fosters Intelligence tools

² SOURCE: Dr Fosters Intelligence tools

1. Trauma:

The Trust is supportive of the proposals made regarding the location of the Trauma centre at The London Hospital for North East London. The Trust would like assurance that Trauma centres and HFL work with local sites to establish agreed assessment criteria and protocols to determine and deliver quality of care to high level trauma patients. This is to ensure that the local needs of the patients, once treated at the Trauma centre, are being met and there is support for the spoke centres to provide the right level of specialist and rehabilitation care.

Whilst we understand the interface between neurosurgery and trauma the Trust would like to see more evidence to demonstrate that the model of co locating hyperacute and trauma services is a robust clinical model, which will be cost effective and not destabilise other emergency services.

2. Stroke:

- **Configuration;** The Trust has significant concerns regarding the suggested Stroke configuration and the proposed clinical model, especially as the Whipps Cross catchment population has a high incidence of stroke cases and extremely poor transport conduits, especially for family support post Stroke hospitalisation.

The guiding principles are correct in having the best care in the best place. However, the final model of selection through geographical positioning, in some cases being the only selection criteria, does not provide evidence of best clinical outcomes being delivered for patients. The Trust would like to work further with you in addressing concerns regarding the Stroke configurations and the proposed clinical model and realistic expectations of the execution of service provision.

- **Timeliness and use of technology;** As outlined in the stroke strategy, clinical evidence suggests that best outcomes from thrombolysis are time critical. The Trust would like to see the advances of technology such as video telemetry units being used more prominently which would be a more innovative model of providing a networked approach to accessing remote on call expertise and review remotely with the provision of thrombolysis on local sites.
- **Pathway Development;** Similarly, the proposed model focuses on stroke as a stand alone disease without taking into consideration the treatment of multi-pathological patients and the care and continuity of care which they would receive from their nearest hospital. The Trust would encourage joint working with partner organisations in ensuring robust clinical pathways and communication networks are established.

Non HASU sites which are designated Stroke Units would need to have robustly agreed protocols in place with the Hyperacute sites and we would like to see evidence of a joint partnership approach to clinical modelling across the whole patient journey.

- **Bed Availability;** We envisage, as a provider of Stroke and TIA services, that an increase in appropriate Stroke patients would not occur and meeting the demand under the available bed numbers would be feasible if a robust and mutually agreed pathway model is in place between the Hyperacute, LAS and Stroke Units.

3. Impact on the London Ambulance service:

- **Travel times;** The location of Hyperacutes in terms of the distance, coverage and proven expertise across London is an area that needs to be reconsidered in particular in North East London. As evident in the consultation document, there is a wide distance in North East of London between the proposed hyper-acute whose successful clinical model depends on the ability of patients to be thrombolysed within three hours from the onset of stroke. This puts the onus on the LAS to transport our local patients to a hospital outside the catchment area within a short space of time. At the moment, the Trust does not have the confidence that this is, with the other pressures on emergency services, achievable.
- **Non Stroke patients;** There will also be a group of non-stroke patients being assessed by the FAST method by LAS as suspected strokes being transported to Hyperacute centres but with other complex needs and the Trust would like to see the clinical pathway being proposed to treat these patients and effectively ensure they are transferred to their local hospital.
- **Treat and Transfer;** The Trust would also like to highlight the potential in stretching the LAS service to the limit with journeys that need to be made in short timeframes to HASU's and then transfers for both the Stroke and non-Stroke patients to their local Stroke Unit. This needs to be balanced with the other pressures on the service including trauma patients, cardiac as well as increased pressure during the winter as demonstrated for the winter of 08/09 where the LAS were stretched to the limit to meet demand. Again, ensuring the LAS works closely with both Hyperacute and non-hyperacute providers to establish and monitor patient flows and manage trends throughout the year is critical to ensuring safe patient care.

4. Travel times for relatives and carers:

Travelling and convenience for patient's relatives and carers must be taken into consideration. Especially those who are older and those with small children using primarily public transport. The new model would mean that they would have to travel first to the Hyperacute and then subsequently to the local stroke unit, which may not be inconvenient.

We are committed to the provision of best stroke care for our patients and feel strongly that, given the opportunity, we can work with you and in partnership with the network to provide the right service that meets the local needs of our local population.

Yours Sincerely



Dr Lucy Moore
Chief Executive

Appendix1 - During April 07–Jan 09 period Whipps Cross had significantly less deaths than the national average for Mortality³

Provider	Spells	Superspells	% of all	Deaths	%	Expected	%	RR ⁴	Low	High
All	4383	4255	100.0 %	1015	23.9 %	1042.2	24.5 %	97.4	91.5	103.6
Barking, Havering and Redbridge University Hospitals NHS Trust	1869	1840	43.2 %	465	25.3 %	456.1	24.8 %	102.0	92.9	111.7
Whipps Cross University Hospital NHS Trust	768	753	17.7 %	171	22.7 %	213.7	28.4 %	80.0	68.5	93.0
North Middlesex University Hospital NHS Trust	539	534	12.5 %	137	25.7 %	130.7	24.5 %	104.9	88.0	124.0
Barts and the London NHS Trust	503	472	11.1 %	107	22.7 %	95.7	20.3 %	111.9	91.7	135.2
Newham University Hospital NHS Trust	363	338	7.9 %	78	23.1 %	78.0	23.1 %	100.0	79.0	124.8
Homerton University Hospital NHS Foundation Trust	341	318	7.5 %	57	17.9 %	68.2	21.4 %	83.6	63.3	108

³ Dr Fosters Intelligence Tools

⁴ Relative risk

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By email

Wednesday 14th January 2009

Our ref: LM/ah/140109

Rachel Tyndall
Stroke Designation Team
C/o Healthcare for London
NHS London
Southside
105 Victoria Street
London
SW1E 6QT

Dear Rachel

Thank you for the letter and feedback regarding our submission for Stroke.

We have already indicated that we wish to meet with the stroke project team and I believe this is being arranged. As part of the process the Trust would like to understand/seek clarification on the following in respect of our bid to provide hyper-acute services:

First, we are concerned that in the overall bid assessment the evaluators highlighted the fact that Whipps Cross does not have any existing hyper-acute experience – we assume this relates to the delivery of thrombolysis as we already provide good quality acute stroke care. We were aware of the position in respect of thrombolysis and would like to understand why this is relevant - Queens Hospital have been designated for hyper-acute services – yet we do not believe currently provide this service. Indeed Whipps cross has a significant advantage. The consultant stroke lead at Whipps Cross provides hyper-acute leadership to the UCHL service – a service which has been designated and does have current experience. We also have a medical model agreed with emergency physicians to deliver this.

Second we note that in the evaluators general comments on bids they state that if a provider is able to deliver a reasonable stroke unit service, they were more likely to be able to provide a reasonable HASU. As above Queens hospital did not satisfy the criterion for a stroke unit. We would be grateful if you could explain the logic behind the different outcome for Whipps cross as compared with Queens Hospital.

Third we are concerned that the evaluators do not believe we understand the level of change required to deliver the new models of care and would like to discuss further where our proposal is lacking. The Trust is under no illusion of the significant change agenda both to improve quality and to implement strategic change.

Fourth we are concerned to see that the assessment had been made on the perception that we have made 'very little improvement' in quality of services. The 2004 to 2006 data demonstrate a step change improvement with further change in 2008.

The specific improvements we have made from previous years include;

Organisational Change- New services for TIA and community rehabilitation commenced in August and the Audit was submitted in May, but we would hope that the HFL submission would have reflected this.

CT Imaging This has improved from 2006, from a 5-24 hour turnaround to 0-4 hours turnaround in hours in 2008. In addition, Carotid Dopplers have improved from 2006 greater than 48hours to 25-48 hours. We did not have access to scanning with in 3 hours of admission in 2006 which we have now at the time the audit was completed.

Patient communication- This has been a focus and this has improved with provision of patients information on the ward. Further work is in hand.

Staffing – The staffing ratios have improved from 0.76 in 2006 to 1.07 in 2008. There has also been significant improvement across MDT including Junior Dr cover from 4.69 to 7.8. We made the appointment of a of stroke co-ordinator which was an improvement on 2006.

Clinical Research- Improvement made from 2006 in that clinical research has now been included in the job plan for Stroke Consultant. We are also intending to fund a stroke research nurse post and this will be closely linked with the newly establishes clinical research unit.

Leadership Training- The Trust has in place a Clinical Leadership Programme which key senior stroke team members have access to and will be asked to attend. In addition the joint UCLH/WX stroke consultant will be initiating further specific training programmes internally and identifying external programmes that staff will be attending.

Recruitment of Staff- it is recognised widely that recruitment to various nursing and therapist posts will be challenging across London for all trusts. However, in addition to our recruitment strategies we would also be seeking to work with other providers for the pooling of staff to work across sites in the hub and spoke model of stroke provision. We feel that these strategies will mitigate the risk of under recruitment to key posts.

Finally, we are very proud of the improvement we have seen in reducing mortality following stroke at Whipps Cross. We are also aware through our work with the network in North east London that this is not the case in all providers and in particular the mortality at Queens Hospital remains significantly higher than that at Whipps Cross Hospital. We would be grateful for an explanation as to why this is not a significant influence on the outcome of designation especially for hyper-cute stroke services. The overall aim of the Healthcare for London proposals are aimed at improving outcomes for patients. I am sure you will appreciate that we to be able to explain to our staff and stake-holders alike especially in the context of a process to formally consult on the Healthcare for London proposals.

We have already indicated via a previous email that we would welcome a meeting with you to progress this further as we feel that we have a strong case for achieving designation for all three services. We feel strongly that, given the opportunity we can work with you and in partnership with the network and other established hyperacute units to gain from shared experience to overcome any areas that require focus.

We look forward to hearing from you.

Yours sincerely

A handwritten signature in black ink, appearing to read 'Lucy Moore', written in a cursive style.

Lucy Moore
Chief Executive

CC: Heather O'Meara, Chief Executive, Redbridge PCT
Alwen Williams, Chief Executive, Tower Hamlets PCT

Appendix 3- Patient activity for Stroke between April 07–Jan 09 Whipps Cross compared to North East London Hospitals⁵

Provider	<u>Inpatients</u>	<u>% of all</u>	<u>Episodes</u>
ALL	4439	100%	8606
Barking, Havering and Redbridge University Hospitals NHS Trust	1870	42.1%	3526
Whipps Cross University Hospital NHS Trust	778	17.5%	1525
North Middlesex University Hospital NHS Trust	540	12.2%	1314
Barts and the London NHS Trust	503	11.3%	800
Newham University Hospital NHS Trust	390	8.8%	817
Homerton University Hospital NHS Foundation Trust	358	8.1%	624

⁵ Dr Fosters Intelligence Tools