Open Agenda

Pan-London Joint Health Overview and Scrutiny Committee: Trauma and Stroke Services

October 28 2009
10.00 am
Council Chamber, Kensington and Chelsea Town Hall, Hornton Street, London W8 7NX

Order of Business

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Agenda Item 1

Joint Health Overview & Scrutiny Committee to review "Shaping Health Services Together - Consultation on developing new, high-quality major trauma and stroke services in London"

10.00am Wednesday 28th October 2009

Venue: Council Chamber, Kensington and Chelsea Town Hall, Hornton Street, London W8 7NX

Contact officer: Julia Regan; julia.regan@merton.gov.uk, 020 8545 3864

Committee Membership: attached

Public Agenda

1. Welcome, Introductions and Apologies for Absence

2. Declarations of interest

Any Member of the Joint Committee, or any other Member present in the meeting room, having any personal or prejudicial interest in any item before the meeting is reminded to make the appropriate oral declaration at the start of proceedings. At meetings where the public are allowed to be in attendance and with permission to speak, any Member with a prejudicial interest may also make representations, answer questions or give evidence but must then withdraw from the meeting room before the matter is discussed and before any vote is taken.

3. Minutes - *to follow*

4. Discussion of the Joint Committee of PCTs' response to the JHOSC report plus presentations providing an update on subsequent progress with the development of major trauma and stroke services in London
(note – the JCPCT response was sent to JHOSC members by email on 4th August 2009)

Speakers:
Richard Sumray, Chair of the JCPCT and Chair of NHS Haringey
Christina Craig, Interim Director of London Programmes, Commissioning Support for London

Dr Fionna Moore (Trauma Director) will present on major trauma, accompanied by Shaun Danielli (Major Trauma Project Manager)

Dr Nick Losseff (current Interim Stroke Director) will present on stroke, accompanied by Dr Tony Rudd (Stroke Director Designate) and Michael Wilson (Stroke Project Manager)

5. Discussion on future of JHOSC arrangements

6. Any other business

[Each written report on the public part of the Agenda as detailed above:

(i) was made available for public inspection from the date of the Agenda;

(ii) incorporates a list of the background papers which (i) disclose any facts or matters on which that report, or any important part of it, is based; and (ii) have been relied upon to a material extent in preparing it. (Relevant documents which contain confidential or exempt information are not listed.); and

(iii) may, with the consent of the Chairman and subject to specified reasons, be supported at the meeting by way of oral statement or further written report in the event of special circumstances arising after the despatch of the Agenda.]

Exclusion of the Press and Public

There are no matters scheduled to be discussed at this meeting that would appear to disclose confidential or exempt information under the provisions Schedule 12A of the Local Government (Access to Information) Act 1985.

Should any such matters arise during the course of discussion of the above items or should the Chairman agree to discuss any other such matters on the grounds of urgency, the Committee will wish to resolve to exclude the press and public by virtue of the private nature of the business to be transacted.

Agenda Item 2

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 22 MAY 2009

Royal Borough of Kensington and Chelsea, Council Chamber, Hornton Street, London W8 7NX

PRESENT:

Cllr Marie West - London Borough of Barking and Dagenham
Cllr Maureen Braun - 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 Graham Bass - London Borough of Croydon
Cllr Greg Stafford - London Borough of Ealing
Cllr Mick Hayes - 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 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 Nicola Urquhart – London Borough of Richmond upon Thames
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
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
Anthony Clements – London Borough of Havering
Nikki Stubbs - London Borough of Hillingdon
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:

David Sissling - Programme Director, Healthcare for London

1. INTRODUCTORY REMARKS

Cllr Christopher Buckmaster welcomed everyone to the Royal Borough of Kensington and Chelsea and made some 'housekeeping' announcements.

Cllr Buckmaster referred to his letter of 29 April 2009 to Richard Sumray regarding three matters of concern, and to Mr Sumray's reply of 15 May 2009, copies of which had been circulated.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from:

Councillor Sachin Rajput (Barnet)
Councillor Ross Downing (Bexley)
Councillors Anne-Marie Pearce and Vivien Giladi (Enfield)
Councillor Janet Gillman (Greenwich)
Councillor Gideon Bull (Haringey)
Councillor Gilli Lewis-Lavender (Merton)
Councillor Ralph Scott (Redbridge)

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 May 2009 be approved as a correct record.

5. DISCUSSION OF DRAFT REPORT OF THE JHOSC

Cllr Buckmaster referred to the considerable number of responses which had been received from individual local authorities, but reminded members that it was appropriate only for points raised in the forum of the JHOSC to be reflected in its final report.

A detailed discussion ensued in which attention was given both to the general acceptability and comprehensiveness of the draft report (a copy of which had been circulated previously) and to its detail, on a section-by-section basis.

A number of suggestions were agreed which it was considered should improve the content and presentation of the final report. In particular, it was agreed that the recommendations for action should be generally strengthened.

Following the discussion, it was unanimously:

RESOLVED:

i) That any further suggested changes on the revised draft report (to be produced following the present meeting) should be circulated to all members of the JHOSC by email, but a further meeting (on 8 June 2009) would only be convened if there were substantial changes proposed - otherwise the final report, as amended in the light of comments made at the present meeting, and any subsequent minor amendments (to be approved by the Chairman and Vice-Chairman), be agreed;

ii) That the JHOSC reconvene in Autumn 2009 to consider the response of the JCPCT to the JHOSC's report, and to hear from the JCPCT on its plans for implementation.

6. CONCLUDING REMARKS

Cllr Buckmaster paid tribute to the commitment shown by all members of the JHOSC in working together over the previous several months, to produce a final report. He paid tribute, too, to the officers who had supported the work of the JHOSC. These sentiments were endorsed unanimously by the meeting.

Cllr Mary O'Connor proposed a vote of thanks to the Chairman Cllr Buckmaster, supported by the Vice-Chairman, Cllr Jonathan McShane, in steering the work of the JHOSC to a satisfactory conclusion. This was supported unanimously.

The meeting finished at 12.31 pm.

Agenda Item 3

Healthcare for London

NHS

Councillor Christopher Buckmaster
Royal Borough of Kensington and Chelsea
Campden Ward
23 Kensington Place
LONDON W8 7PT

Dear Councillor Buckmaster,

On behalf of the Joint Committee of Primary Care Trusts (JCPCT), I would like to thank you for the Joint Health Overview and Scrutiny Committee's (JHOSC) final report on *The shape of things to come* consultation.

I am pleased to enclose the JCPCT's response to the recommendations set out in your committee's final report.

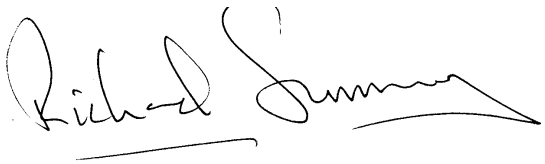
The JHOSC's report formed a vital part of the final decision-making and was considered by the JCPCT at a meeting in public on 20 July 2009.

At this meeting, the JCPCT approved the introduction of new stroke and major trauma services in London, with four major trauma centres and eight hyper-acute stroke units. The benefits of introducing these new services were determined to be in the best interests of all Londoners.

The JCPCT acknowledges the particular concerns expressed by individuals and organisations, including the JHOSC, and hopes that our enclosed response provides assurance and clarity on specific issues raised.

I trust that the JHOSC will accept our response in the positive and constructive manner it has shown throughout the consultation.

Once again, my thanks to you and your fellow committee members for the valuable contribution the JHOSC has made to this important consultation.



Richard Sumray
Chair of the Joint Committee of PCTs

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Healthcare for London

NHS

Healthcare for London
The shape of things to come

Response to the Joint Health Overview and Scrutiny Committee

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Foreword

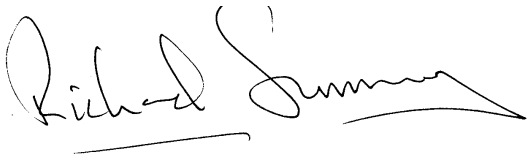
On behalf of the Joint Committee of Primary Care Trusts (JCPCT) may I thank you for your comprehensive and considered report on *Healthcare for London: The shape of things to come.*

The JCPCT found your comments to be insightful and challenging. The committee particularly appreciated the positive way that you had addressed the issues in hand and your diligence in considering such a wide cross-section of views and submissions.

The committee was pleased to accept your report at its meeting of 20 July 2009 and I hope we fairly reflected your views in our final documents and decisions. Certainly our discussions focused around how much we agreed with, and how we could best implement, your recommendations.

The JCPCT particularly recognised the concerns the JHOSC has regarding joint working and accepts entirely that in future, excellent engagement and partnership working with Councils and Overview and Scrutiny Committees will be essential if we are to truly transform health and social care services together.

I would be grateful if the JHOSC could consider our response in the positive manner it has shown throughout this consultation.



Richard Sumray
Chair of the Joint Committee of PCTs

Introduction

In July 2007 Lord Ara Darzi published his report *Healthcare for London: A Framework for Action*. The report set out a strong case for change, and issued an ambitious challenge to improve health and healthcare in London over the next 10 years. The primary care trusts (PCTs) in London took up the mantle and conducted an extensive consultation, *Consulting the Capital,* with the public and their elected representatives in every borough.

The consultation showed there was widespread support for the Healthcare for London vision:

- ill health is prevented as much as possible;
- primary care is comprehensive, accessible and of excellent quality;
- improvement in care is evidence-based, clinically-driven and patient-led and provided in the most appropriate settings;
- healthcare is focused on individual needs and choices – and is co-ordinated; and
- improvements are properly resourced, and carefully planned and implemented.

A joint committee of PCTs (JCPCT) was established to ensure *The shape of things to come* involved the public in the development of acute major trauma and stroke services across London, and met the legal requirements of a public consultation.

Following the consultation, PCTs now have a clear directive to commission services that meet the needs of patients. The JCPCT expects each PCT will want to utilise the wealth of information produced by the consultation to discuss the planned programme of implementation with their relevant Overview and Scrutiny Committee.

In the following pages the committee has set out:

- the decisions of the committee; and
- its responses to the JHOSC report and recommendations – using the same headings as the JHOSC report. Where appropriate the JCPCT has illustrated a point by quoting the relevant recommendation to commissioning PCTs. These can be cross-referenced to the JCPCT minutes using the figures in brackets after the recommendation. This response only includes the recommendations relevant to the issues raised by the JHOSC, but the full list of recommendations can be found in the minutes of the JCPCT meeting in public (20 July 2009) on www.healthcareforlondon.nhs.uk

Whilst the JHOSC made no specific recommendations regarding travel times, the JCPCT is acutely aware of the discussions that have occurred. Your report acknowledges the confidence that the London Ambulance Service has in the travel time modelling, and your support for the principle that the relatively few occasions when these travel times might be exceeded must not undermine the overall model of care and its resulting benefits. Nevertheless, the JCPCT recommended that commissioners: work with the London Ambulance Service to understand actual travel time performance and to promote awareness of actual blue light travel times in order to build public confidence (1); and monitor and evaluate the new arrangements to ensure the swift activation of contingency arrangements if necessary (26).

The JCPCT agree with the JHOSC on the importance of improving the whole pathway for stroke and major trauma care. The JCPCT made a number of recommendations regarding prevention and rehabilitation, including:

- For trauma; to support trauma networks in mapping and developing flexible rehabilitation services for patients with complex polytrauma (35) and seek to ensure consistency of access to rehabilitative care across London (36); and
- For stroke; to ensure consistency of access to rehabilitative care across London (45) and develop and implement plans (individually as PCTs and across sectors) to ensure patients receive a quality of rehabilitation which is of an equal standard to the initial high-quality acute care (46).

These cannot be delivered in isolation and must involve partners from across London.

Decisions of the Joint Committee of PCTs

On the 20 July 2009 the JCPCTs agreed that:

1. Major trauma centres should be commissioned at:
   - The Royal London Hospital, Whitechapel
   - King's College Hospital, Denmark Hill
   - St George's Hospital, Tooting
   - St Mary's Hospital, Paddington

2. Eight hyper-acute stroke units (HASUs) should be commissioned at:
   - Charing Cross Hospital, Hammersmith
   - King's College Hospital, Denmark Hill
   - Northwick Park Hospital, Harrow
   - Queen's Hospital, Romford
   - St George's Hospital, Tooting
   - The Princess Royal University Hospital, Orpington
   - The Royal London Hospital, Whitechapel
   - University College Hospital, Euston

In taking this decision the JCPCT recognised that commissioners will develop a plan to realise the benefits of future collocation on the St Mary's Hospital site. This would be the responsibility of the relevant commissioners and Imperial College Healthcare NHS Trust, which runs both St Mary's and Charing Cross hospitals. Clinical standards of these services would need to be at least the same, if not higher, than the current proposed configuration. All planning and associated decision-making processes would be informed by appropriate stakeholder engagement and public consultation.

3. Stroke units and transient ischaemic attack (TIA) services should be commissioned at:
   - Barnet Hospital, Barnet
   - Charing Cross Hospital, Hammersmith
   - Chelsea and Westminster Hospital, Fulham
   - Homerton University Hospital, Hackney
   - King's College Hospital, Denmark Hill
   - Kingston Hospital, Kingston upon Thames
   - Mayday University Hospital, Croydon
   - Newham General Hospital, Newham
   - National Hospital for Neurology & Neurosurgery (part of University College Hospital), Bloomsbury with TIA services at University College Hospital
   - North Middlesex Hospital, Edmonton
   - Northwick Park Hospital, Harrow
   - Queen Elizabeth Hospital, Woolwich
   - Queen's Hospital, Romford
   - St George's Hospital, Tooting
   - St Helier Hospital, Carshalton
   - St Mary's Hospital, Paddington

- St Thomas' Hospital, Waterloo
- The Hillingdon Hospital, Uxbridge
- The Princess Royal University Hospital, Orpington
- The Royal Free Hospital, Hampstead
- The Royal London Hospital, Whitechapel
- University Hospital Lewisham, Lewisham
- West Middlesex Hospital, Isleworth
- Whipps Cross University Hospital, Leytonstone

In taking this decision the JCPCT accepted the recommendation of the north east London commissioners regarding continuing providing stroke services in that sector.

1 General comments

Implementation timescale

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

1a) that a detailed action plan is drawn up which sets out effective measures for ensuring that mutually supportive arrangements will be achieved.

1b) that the action plan includes contingency provisions covering steps that would need to be taken if the envisaged collaborative arrangements fail.

2) that the action plan (referred to above) sets out clearly how the specialist centres will assist other centres during the transitional period, and identifies the resource implications involved.

3) that the JCPCT undertakes a risk analysis of the stroke services to be relied upon during the transitional period, in order to demonstrate clearly how services will be maintained.

Response

The JCPCT discussed the implementation proposals at some length. Mindful that any change in service carries an inherent risk, the JCPCT sought reassurance from the project teams and project boards that effective measures for transition were both in place, and robust.

The appendices to the main paper (for both stroke and trauma) regarding implementation and transition assurance, workforce, finance and commissioning assurance, information technology and whole pathway assurance (prevention and rehabilitation) summarise the plans that are either in place or being developed. These summaries satisfied the JCPCT that decisions could be taken with a good degree of confidence.

Responsibilities and governance

To address the issues of implementation and transition of services, and to minimise risks, the JCPCT recommended that commissioners (in this case PCTs), put in place appropriate pan-London oversight of the implementation of major trauma and stroke services (20).

In the case of stroke, the London stroke clinical director, working closely with the cardiac and stroke networks and providers, will ensure there is strong clinical leadership for the future development and implementation of the new stroke system across London. The clinical director will be supported by the London stroke programme manager, who will ensure London-wide co-ordination of implementation and transition. It is also proposed that five project managers work in the stroke networks to bring the disciplines of formal project management to implementation and transition, including governance, planning, reporting and risk management. This will ensure that implementation is driven in a controlled way and with an effective grip at both sector and pan-

London levels. Overall oversight of the implementation will rest with the London stroke project board, which includes the five stroke network chairs. The stroke networks will be held to account by the project board, which in turn reports to the London Commissioning Group. Once the project board judges that implementation is securely established, and that any major risks have been resolved, the project board will transfer accountability for pan-London oversight to the board of London stroke networks.

In the case of trauma, the London trauma director will ensure there is strong clinical leadership for the future development and implementation of the London trauma system. In order to support the London trauma system and director, a London trauma office will be established. This will be the co-ordination function of the London trauma system and will comprise managerial support and information analysis. The London trauma director will sit on a London trauma board that will act as the formal link between providers and commissioners. Oversight of the implementation of the new trauma model in London will be provided by the London trauma board. The London Specialised Commissioning Group (LSCG) – which acts as the lead commissioner – will be represented on the board, which will have the authority to review milestones and agree changes to implementation timeframes where necessary.

Stroke transition

The introduction of new stroke services has been planned using a phased approach, based on agreed transition principles. This is particularly important for HASUs in hospitals which have not provided HASU-type services previously, in order to support the step-change in provision of services and recruitment of adequate staffing.

In order to ensure a smooth transition the JCPCT agreed that full stroke unit capacity will be in place before expanding HASU bed numbers to ensure that patients can be transferred to an appropriate local stroke unit upon discharge. The committee also wished to make it clear that there should be no deterioration of services for patients during transition to the new model and configuration of care (24) – this will include ensuring that current services are not curtailed until high-quality alternatives are in place.

The JCPCT agreed that two of the HASUs that need significant development (Queen's Hospital and The Princess Royal University Hospital) require longer than the original April 2010 timeframe to achieve the high-quality service. Queen's Hospital will begin to provide thrombolysis from April 2010 but will not achieve full capacity until October 2010. The Princess Royal University Hospital should begin to provide thrombolysis from October 2010, with full capacity achieved by summer 2011. The project board recommended that services be provided at St Thomas' Hospital while these other units develop. The committee also accepted that St Thomas' Hospital would have a vital role in providing transitional support for south east London. Transitional capacity has been agreed with (and will be provided by) St Thomas' Hospital.

We believe that The Royal London Hospital (the only other hospital judged to need significant development needs) can provide hyper-acute stroke services from 1 February 2010, with full capacity reached by April 2010. Transitional capacity provided by another hospital is therefore not required.

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

4a) that the JCPCT ensures that Hospital Trusts and PCTs prioritise recruitment, with a timetable to ensure delivery of appropriate staff;

4b) that the JCPCT identifies what action it will take to address any shortfall in the numbers of specialist staff, including the reliance that will be placed on the use of agency staff in order to fill the number of places required;

4c) that the JCPCT reports back to this JHOSC by October 2009 on progress being made to recruit staff for the new stroke and major trauma networks.

Response

The JCPCT accepts that recruitment of staff (particularly for stroke) will be challenging but has received papers (workforce assurance papers – appendices 6b and 7c of the report to the JCPCT) that indicate that there is sufficient understanding of the issues involved and recognition of the scale of the task. Nevertheless, the committee appreciates the opportunity to report back to the JHOSC by October 2009 to discuss progress on implementation (12).

Stroke

Workforce was identified as a key challenge to implementation early in the assessment of provider bids. The JCPCT is satisfied that workforce issues are being appropriately addressed by:

- Assurance from the NHS London People and Organisational Development Directorate that sufficient workforce will be available from within the system.
- Detailed workforce plans developed by each provider and reviewed by networks.
- Assessment of the combined workforce needs of all providers which shows that while still significant, the numbers of nurses and therapists needed will be considerably smaller than early indications (based on original bid documentation). Medical workforce requirements have also been more accurately characterised.
- Work being carried out to address the skills gap, including work on competencies and development of education and training.

Estimating the current composition and size of the stroke medical workforce is difficult because significant numbers of stroke patients are cared for by medical staff outside of a stroke unit, and care is provided by a range of specialists. However, at all grades, the number of medical staff (doctors and consultants) estimated is 100 whole time equivalents (WTE). It is estimated that the number of additional consultants required will be approximately 20 WTE and for junior doctors will be around 60 WTE.

The consultant gap can be closed by opening additional stroke subspecialty training posts, developing accelerated courses for existing geriatricians and acute consultants, domestic recruitment and international recruitment. The junior doctor gap can be closed by transferring training posts from oversupplied specialties to stroke. Plans are being put in place to ensure that all medical staff including GPs are appropriately skilled.

Plans set out by providers for non-medical staff suggest that approximately 500 WTE nurses (qualified and unqualified); 30 WTE physiotherapists; 35 WTE occupational therapists; and 25 WTE speech and language therapists will be needed in addition to the existing stroke workforce in post.

The requirement for non-medical staff represents a small proportion of the labour market currently available to recruit from within London. A significant number of the non-medical workforce required is already working in stroke units. Based on these two assumptions, there is sufficient non-medical workforce supply in the system to meet the staffing requirements of the proposed stroke pathway. The potential sources of non-medical workforce supply other than from within the current NHS workforce in London are the NHS workforce outside London, education, the local labour market, and those who may be available due to the current economic climate, for example those working in the private sector.

Filling nursing posts is of particular concern because, although it is possible to provide supply from the London pool, for many providers, particularly those in outer London which are not teaching hospitals, this poses a significant challenge. The pan-London workforce group, chaired by the interim stroke clinical director is taking the lead on pan-London actions to ensure sufficient appropriately trained workforce will be in place to support the acute part of the proposed new stroke pathway. This includes making working in stroke care a more attractive career choice and marketing careers in acute stroke services.

Trauma

Whilst recruitment to deliver the new model of care for trauma will also be challenging, it is likely to be less so than for stroke. In particular, the major trauma centres will be considered an attractive setting to work within, as it will be a new and dynamic service, set in a teaching hospital environment, with the opportunity to learn new skills and competencies.

As the requirement for staff will be spread across a number of different service areas, such as A&E theatres and intensive care units, there is a very strong likelihood that full recruitment will be achieved.

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

5) We recommend that NHS London engages immediately with higher education bodies and the Royal College of Nursing and the Allied Health Professionals Federation, in order to agree the training necessary for specialist stroke staff, so that this training can be provided without delay.

Response

Engagement with higher education bodies and relevant professional bodies is part of the work being carried out to ensure that sufficient appropriately trained staff are in place in HASUs and stroke units.

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

6) We recommend that flexible working arrangements are explored, allowing opportunities for staff rotation within, and between, networks.

Response

The JCPCT recognises that specialist units have the potential to have a magnet effect, drawing the more experienced and better qualified staff away from other hospitals. The committee is clear that any recruitment campaign must bear this in mind so as not to destabilise services in stroke and trauma centres, or indeed any other services.

The committee recommended that the impact of the new arrangements on the movement of staff be monitored (26) and agreed with the JHOSC that commissioners should work with networks and hospital trusts to explore flexible working arrangements, allowing opportunities for staff rotation within, and between, networks and units (25).

Resourcing

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

7) We recommend that suitable investment is made in all aspects of care, including rehabilitation and prevention, in order that the benefits of improvements to acute-end care can be maximised.

Response

The JHOSC questioned whether the additional costs referred to in the consultation paper (£23 million per annum for stroke and £9-12 million for major trauma) covered non-specialist units. The JCPCT welcomes the opportunity to clarify that:

- For stroke, a tariff approach has been devised to reflect the new model of care. This involved splitting the existing tariff into two elements: a tariff for the HASU component based on bed-days and a tariff for the stroke unit element based on spells. The Department of Health is considering basing the national stroke tariffs on a 'best practice' approach. As such, the London tariff approach would become convergent with the national tariff. Therefore, of the £23 million identified to deliver the acute stroke care pathway, £20.4 million is for all acute hospitals (£10.4 million for HASUs and £10 million for stroke units). The additional £3.1 million is for other system costs including the London Ambulance Service. PCTs are committed to providing the additional funds. Provider implementation plans indicate that the phasing of the estimated cost to PCTs is (2009/10: £4 million; 2010/11 £19.5 million; 2011/12: £20.4 million). Reduced admissions

- For trauma, the estimated additional recurrent cost to the system of four networks is £13.9 million per annum. PCTs are committed to investing resources in major trauma services. This funding will support the extra costs associated with providing an enhanced level of care to major trauma patients. The distribution of these funds to the major trauma centres is part fixed and part variable.

Prevention and rehabilitation

Whilst the costs for improving the prevention of stroke and trauma, and improving community-based rehabilitation were outside the scope of this consultation, the JCPCT recognises that current services are of variable quality and entirely accepts that suitable investment is needed in these areas so the benefits of improvements in the acute-end care can be maximised.

The costs to support stroke units include an element of rehabilitation. This is the intensive rehabilitation that takes place whilst patients are in the stroke units and a significant component of the care received in an inpatient setting.

Overall, the JCPCT recommended that commissioners develop and implement plans (individually as PCTs and across sectors) to ensure patients receive a quality of rehabilitation which is of an equal standard to the initial high-quality acute care expected (46) and to ensure consistency of access to rehabilitation across London (36 and 45).

Specifically, the JCPCT recommended that commissioners support trauma networks in mapping and developing flexible rehabilitation services for patients with complex polytrauma.

Regarding prevention, all London PCTs have plans for supporting vascular prevention in this year's operating plans. Indeed London is well in advance of the rest of England in developing vascular health check programmes. All 31 PCTs in London will set up or enhance vascular health check programmes during 2009/10. These health checks will be an important mechanism for early identification of people at risk of a stroke; and for enabling preventive action.

The *Go London* campaign that is looking to increase physical activity at all ages in the London population will also contribute to reducing individuals' risk of a stroke.

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

8) We recommend that implementation of future plans flowing from "Healthcare for London: A Framework for Action" require that detailed financial appraisals from Trusts are included in their bids.

Response

The purpose of seeking bids from NHS trusts was to assess how organisations would set up and deliver a service that met the standards outlined in the service specification. For most acute services, the price paid by PCTs to NHS trusts is standardised in a system called Payment by

Results, whereby the price paid for a given course of treatment is the same throughout London (except for an adjustment to reflect the higher costs of inner London). The system is designed so that competition is based on quality of services not price.

The discussions that took place with NHS trusts was focused on how much the extra requirements – outlined in the service specification – would cost and this was used to calculate the investment required from PCTs.

Prevention

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

9) We recommend that NHS London develops a long-term strategy to promote healthy, sensible lifestyles, including an emphasis on stroke prevention, and factors related to the cause of major trauma injuries, particularly among the young.

Response
(Please also see response to Resourcing – above.)

The JCPCT agrees with the JHOSC regarding the importance of prevention.

NHS London has developed a health prevention strategy, *Improving public health prevention: a London prevention strategy*. This strategy has five key areas. Two of these priority areas are vascular prevention and smoking cessation. The work on vascular prevention includes the promotion of healthy lifestyles linked to reducing obesity and increasing physical activity. This prevention strategy is focused on reducing the risk of all vascular events including strokes.

NHS London is also working with the police, local government, hospitals and other key stakeholders on the issue of knife crime in London – a substantial cause of major trauma in the young in London. Many of the other causes of major trauma, such as the factors that lead to road traffic accidents, have strong environmental and social contributory factors and thus will require multi-agency approaches to reduce injuries. NHS London is supporting a local focus on these issues through the Joint Strategic Needs Assessment, and joint health and local government borough-level action to address the needs identified.

The JCPCT recommended that commissioners work with NHS London to:

- Promote the development of prevention campaigns in plain English, which focus on certain geographical areas or causes of major trauma (for example road safety and knife/gun crime) (33).
- Develop a long-term strategy and co-ordinate the development of effective relationships between agencies (especially with local authorities) to promote healthy, sensible lifestyles, including an emphasis on stroke prevention (40).
- Take action on prevention by promoting the development of prevention campaigns in plain English, which focus on certain geographical areas or causes of stroke (for example smoking and lack of exercise). Prevention strategies should include a strong emphasis on secondary prevention, with GPs taking responsibility for

Rehabilitation

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

10a) that future consultations by the JCPCT address the whole care pathway more thoroughly, rather than concentrating predominantly on a particular element, such as acute care;

10b) that local services to support the new high-quality stroke and major trauma services are in place and operating effectively before any changes or closures of existing units are made.

11) We recommend that the Association of Directors of Adult Social Services (ADASS) and London Councils - as well as London local authorities and social services authorities bordering London - need to be engaged more fully in developing plans for a seamless care pathway.

12) We recommend that the JCPCT undertakes an audit of rehabilitative stroke and trauma services across London, with a view to determining:
a) those PCTs which need to invest more in rehabilitation, and their capacity to fund this further investment;
b) the capacity of PCTs to put in place follow-up teams needed at Stroke Units and Trauma Centres to take responsibility for ensuring that once a patient is discharged, they do not 'fall through the care net';
c) how the JCPCT will ensure that all PCTs are in a position to ensure consistency of access to rehabilitative care across London.

13a) that there should be an early involvement of hospital social work teams in planning longer-term care pathways following front-end clinical treatment;

13b) that an assessment of joint financial incentives is undertaken, in order to allow more co-ordinated investment in enhanced community-based resources to be achieved.

Response

The whole pathway

The acute part of the pathway proposals represented a substantial service change. It was therefore necessary to consult on them. Proposals around rehabilitation should be developed at a local level to reflect local needs.

Nevertheless, the acute part of the care pathway consulted upon does include substantial elements of rehabilitation with stroke units providing an important component of inpatient rehabilitation. The JCPCT recognises that it would have been helpful to have explained this in

more detail, and further developed proposals for prevention and rehabilitation in order to inform members of the public.

The importance of rehabilitation (and prevention) were given prominence in the *Stroke strategy for London*, and was also part of the work of the trauma project.

During the course of the consultation, the JCPCT requested assurance that plans were being developed to improve the rehabilitative part of the care pathway across London. Given the interest of the JHOSC in this area, the three assurance papers are attached.

Any changes to local services will be subject to appropriate discussion, engagement and consultation with overview and scrutiny committees, patients, the public and key stakeholders (including councils). In particular the JCPCT recommended that PCTs should provide more support to enable carers play an active role in pathway planning and rehabilitation (11).

Local services

The proposals are, in almost all circumstances, to enhance existing acute services. As such there are very few instances, where there are likely to be significant services withdrawn. In these rare instances the JCPCT fully accepts the need to ensure that new services are operating effectively before existing services are withdrawn, and recommended that there should be no deterioration of services during transition to the new model and configuration of care (24).

As noted above, the JCPCT agrees that local services need to be in place and operating effectively before changes are made and in order to ensure a smooth transition, the JCPCT agreed that full stroke unit capacity will be in place before expanding HASU bed numbers to ensure that patients can be transferred to an appropriate local stroke unit. (See Implementation Timescale – page 8).

Whilst the JCPCT also accepts that rehabilitation services need to be significantly improved across London, it does not believe that this should delay the improvement of acute services. Although the benefits of improved acute care will not be best realised until better rehabilitation services are introduced, the JCPCT does not believe that the proposals will have a significant detrimental impact on rehabilitation services. On the one hand, more patients will survive a major trauma or stroke – potentially with disabilities; but on the other hand, many patients will have reduced disabilities from the better acute care.

The JCPCT agrees with the JHOSC that effective integration of health and social care services is essential in providing a world-class service and ensuring a well-managed transition from hospital to community care. The JCPCT welcomed the JHOSC's recommendation that commissioners should engage locally with London local authorities and social services authorities bordering London, and across London with the Association of Directors of Adult Social Services (ADASS) and London Councils – in order to develop plans for seamless care pathways and (to facilitate prevention) the promotion of healthy lifestyles (11).

Auditing current services

Whilst the JCPCT accepts the need to ensure consistency of access to high-quality rehabilitation services (36 and 45), specialists in trauma rehabilitation recommended that the most effective approaches to improving rehabilitation would include:

- enhancing existing service specifications;
- developing indicators of rehabilitation performance;
- developing a documentation structure to support consistency of approach and collection of data; and
- exploring novel approaches to delivering improved rehabilitation services.

Guidance on commissioning stroke rehabilitation is being developed, which will include recommendations for commissioning stroke rehabilitation services that meet the required performance standards set out in the *Stroke strategy for London*.

In addition, the JCPCT recommended that commissioners consider the development of rehabilitation caseworker (or navigator) roles, which would ensure that rehabilitation needs are identified and met, especially when responsibility for patient care is handed over at different parts of the pathway.

Joint working

The JCPCT accepted and agreed with the JHOSC that commissioners should explore opportunities to develop proposals for jointly planned and commissioned community-based services (9) and involve social services early in the planning of longer-term care pathways following acute treatment (10).

PCTs are expected to work closely with local partners to plan and deliver service change. The focus on borough-level commissioning supports this approach.

Hospital transfers

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

14a) that clear clinical and administrative protocols for the transfer of patients are agreed with all relevant service providers, and established before the new systems go 'live';

14b) that systems should be put in place for monitoring transfer arrangements, to allow early corrective action to be taken where necessary.

Response

The JCPCT agreed with the JHOSC that traditionally, transfers between hospitals and from hospital to community-based care have not been an area of strength, and that facilitation of

timely transfers back to local stroke or trauma units is essential (18). Therefore the JCPCT recommended that commissioners work with hospitals to:

- ensure transfer protocols are in place before 'go-live', enabling patients to be transferred safely to stroke units closer to their homes as soon as clinically appropriate, including an efficient bed management model and escalation policies should a stroke unit bed not be available after 72 hours (44);
- ensure transfer and discharge protocols are in place before 'go-live', to ensure patients are transferred to trauma centres closer to their homes as soon as clinically appropriate (34); and
- ensure protocols are developed and clearly communicated before 'go-live' for the management of stroke 'mimics' and patients attending at a hospital with no HASU who are discovered to have had a stroke.

Transfer arrangements would be monitored and evaluated to ensure the benefits of the system are being realised and enable the swift activation of contingency arrangements if necessary (26).

Travel arrangements

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

15) We recommend that every specialist centre draws up a hospital travel plan, in liaison with Transport for London and the relevant local authority(ies). This should include provision of clear travel information; car parking charging arrangements which do not disadvantage those arriving in haste; and identify a Board-level 'travel champion'.

Response

Whilst accepting that travel arrangements for friends and families could be improved across the capital, it should be recognised that work with patient and carer groups has shown this issue to be far less important than most other aspects of the care pathway. It should also be noted that for major trauma in particular, in many instances journeys for friends and families will be little different to current journeys (as up to two-thirds of patients are transferred to a different hospital). In fact, with the addition of three new major trauma centres, journeys may be considerably shortened.

The JCPCT accepts that a very small number of patients may arrive by public or private transport – this is most unlikely for major trauma, but potentially possible (although not to be encouraged) for stroke patients.

The JCPCT has recommended commissioners engage with acute hospital trusts and Transport for London to:

- ensure comprehensive travel information is provided on hospital websites and at the hospital itself. This should be accessible to disabled people and those who do not speak English (2);

- ensure hospital travel plans address any impacts of these proposals. Travel plans should address the needs of staff, visitors and patients, and encourage sustainable travel (3);
- ensure appropriate public signage to specialised centres at nearby bus stops, underground stations and railway stations, and within hospitals. This should be comprehensible for different equality groups (4);
- consider transport solutions for visitors, and enter into discussion with Transport for London, with a view to ensuring suitable bus routes to major trauma and stroke centres (5); and
- consider facilitating local accommodation for relatives to use at critical times (6).

The committee would expect these discussions to be held in conjunction with relevant local authorities.

Cross-border co-ordination

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

16a) that visitor journey times to the new specialist centres for areas up to ten miles outside the Greater London Authority border be modelled, so that the implications can be taken into account in planning visitor journey times;

16b) that the JCPCT ensures that PCTs and Ambulance Services serving areas adjacent to London's borders are fully involved in forward planning for the new arrangements;

16c) that joint working 'across the borders' is undertaken to produce transfer protocols which will provide clarity to Ambulance Services and hospitals.

Response

Visitors from outside London

Whilst cogniscent of the needs of communities outside of London, the JCPCT agreed that the responsibilities of NHS London and the acute and primary care trusts are predominantly to the residents of London and visitors to the capital. In this consultation the JCPCT also recognised that Essex County Council (and NHS South West Essex) decided that the proposed changes could materially affect residents, and therefore the committee was particularly mindful of any effect that decisions could have on those communities.

The consultation did not draw a large response from people living outside of London and no issues were raised that lead the committee to believe that potential visitors from outside of London are not (or would not be) satisfied with our proposals.

The recommendations to ensure the timely transfer of patients back to a local hospital, described above, will go some way in ameliorating any difficulties posed to visitors living outside of London.

The work undertaken on visitor journey times has, as recognised by the JHOSC, shown good accessibility for members of the London community. The work of the Integrated Impact Assessments also indicated that the preferred (and subsequently agreed) options are the most accessible for all visitors using public transport – the JCPCT believes this is satisfactory analysis for the purposes of developing (or updating) hospital travel plans.

Involving out of London PCTs and ambulance services

Whilst recognising that the proposed services are designed for the benefit of Londoners, the JCPCT entirely accepts that the services do not operate in geographical isolation and that the units will serve areas well beyond the Greater London Authority boundary. It is therefore imperative that protocols are developed that recognise (and take account of) different models of care in surrounding communities.

The stroke and major trauma project teams are in discussion with commissioners, Strategic Health Authorities (SHAs) and ambulance services from areas adjacent to London to agree the pathways, funding and boundaries for patients being transferred into London for stroke and major trauma care.

The JCPCT recommended that commissioners collaborate closely with bordering authorities to ensure transfer protocols are developed that address cross-border inflows, outflows and transfers for the acute and repatriation parts of the pathway; and enable extra trauma capacity in the event of a major incident (27).

North east London

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

17) We recommend that on future pan-London proposals, the JCPCT ensures that the intention to provide improved healthcare at the earliest opportunity is not compromised by public consultation which is partially limited by timescale considerations.

Response

The JCPCT accepts that the decision not to include stroke unit and TIA proposals for north east London has proved challenging, and agrees that every effort should be made to ensure any further pan-London consultations include discussion of a comprehensive set of proposals for the whole capital. It should be noted that the proposals for major trauma centres, trauma centres and HASUs are, of course, for the whole of London.

The JCPCT discussed at length the request by north east London PCTs not to include specific proposals for stroke unit and TIA services in that area. The decision was taken in view of the strategic review of acute and out-of-hospital services in north east London taking place concurrently with the London-wide stroke and trauma consultation. The committee discussed the

advantages and disadvantages of including north east London stroke services in the pan-London consultation or the more local service review and, on balance, decided that the best fit was with the local service review.

The options emerging from the sector review will inform the future organisation of hospital care, including stroke care. It would therefore have been premature to undertake formal consultation on the location of stroke units in north east London in advance of the findings of the local review.

The committee also discussed delaying the pan-London consultation but it was mindful that many Londoners (including the previous JHOSC) have encouraged us to get on with making the changes quickly so residents can benefit from better healthcare as quickly as possible. The committee had a difficult decision to make and appreciated that the situation was not perfect.

The JCPCT is keen to see quick progress on the north east London acute sector review and has been kept up to date with progress in this area. At its meeting on 20 July 2009, the JCPCT was informed about the progress of the review by commissioners in north east London:

"North East London NHS recommends that at this point in time there should be no change to the location of stroke units in the sector. Stroke units with TIA services will therefore continue to be provided at Whipps Cross, Homerton and Newham and these hospitals will be required to meet the standards set out by Healthcare for London. The bid from Newham Hospital did not meet the bid overview requirement, however the sector recommend continuing to commission stroke services from Newham Hospital to ensure that appropriate local access and sufficient capacity is available. This would not be possible without providing stroke care at Newham. The network has reviewed and assured plans for implementation at all of these hospitals. No further consultation needs to take place at this time because this does not represent a change from the current configuration of services.

King George's Hospital does not currently admit acute stroke patients and is not needed to provide access or capacity.

If, following the review of acute services, there is an emerging view that the role of certain hospitals should change, then this will be consulted on locally, and plans for stroke care would be part of that consultation.

North East London Cardiac and Stroke Network is able to provide assurance that the HASU providers in the preferred option and SUs and TIA services at Whipps Cross, Homerton and Newham have robust plans in place to provide services."

The JCPCT believes this to be a sensible way forward at this point in time and agreed to appropriate commissioning of stroke unit and TIA services at Whipps Cross, Homerton and Newham.

Communication with the public

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

18a) that, with future proposals, the JCPCT produces information for the general public which explains in more simple terms, from a patient perspective, the impact of the proposed changes in healthcare;

18b) that, at the earliest appropriate point after admission, patients should have explained to them, in simple terms, their care pathway: from specialist centre, to local unit for rehabilitation, and a return to community care. A leaflet containing basic information would be helpful.

Response

The JCPCT agrees that the public, as a whole, do not fully appreciate the rationale that specialisation of care at a few centres is better than providing (necessarily) poorer quality care at a local centre. However this erroneous belief is embedded in the psyche of much of the population – perhaps based on the trust in local clinicians and non-medical staff in all settings across the NHS. If this is the case, then this belief needs to be sensitively managed, without detriment to local, high-quality services and first-rate staff. This will not be overcome by a single consultation.

The JCPCT is pleased that around 11,000 people engaged with the consultation, the vast majority of whom, having read the literature, appeared to understand the implications of the proposals. However the JCPCT agrees that information for the general public could be improved and will take the opportunity in any further consultations to reiterate the key messages and provide consultation materials that better explain the expected patient experience.

The JCPCT agrees that, as a matter of principle, patients must be informed about their care pathway and the choices they have, and recommended that at the earliest appropriate point after admission, patients, families and carers have explained to them, in simple terms, their care pathway: from specialist centre, to local unit for rehabilitation, and a return to community care (16).

Health Impact Assessments (HIAs)

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

19a) that, given the higher incidence of stroke among some BME groups, there should be access to an interpreter at a HASU, to explain the next steps in a patient's pathway, and to answer questions or concerns;

19b) that the conclusions and recommendations from phase 2 of the Health Impact Assessment consultants' study (which will focus on BME groups) are provided to the JHOSC for comment as soon as they are available.

20) We recommend that future consultations by the JCPCT ensure that the full results of HIAs are made available to the public and a London-wide JHOSC before the end of the public consultation period, to allow consultation responses to be suitably informed.

Response

Whilst the JCPCT agrees it is important that there are effective systems in place in hospitals to address the needs of people whose first language is not English, like most councils, hospitals generally have established systems in place.

Nevertheless, the JCPCT has taken the opportunity to recommend that commissioners work with acute hospitals to ensure:

- translation/interpretation services are available for patients/families from ethnic minorities (13);
- appropriate access to advocacy is provided, particularly for people with language difficulties or a disability (14); and
- staff receive diversity and cultural awareness training in order to equip them better with the cultural needs of their patients and visitors and/or respond to the needs of people with particular disabilities (15).

The work undertaken by Health Link with traditionally under-represented groups highlighted that the needs, concerns and views of these populations are very similar to those of the broader community. Where particular issues have arisen (such as those for people with sickle cell disease) the JCPCT has made recommendations or forwarded the issues to the project teams.

The Integrated Impact Assessments (IIA) are now complete and have been considered by the JCPCT. Officers of the JHOSC were notified of the posting of the reports on the website at www.healthcareforlondon.nhs.uk/jcpct-meeting-in-public/ however if the JHOSC would like paper copies then this can be arranged. The JCPCT would welcome the comments of the JHOSC.

An important element of the IIAs was to consider the views of consultees on the proposals and their impact on health and healthcare, and to address these issues as part of the assessments. The JCPCT felt that the production of an initial report during the consultation enabled stakeholders to comment on the impact assessments and allowed the impact assessments to investigate and reflect some of the views emerging from the consultation – something that would

not be possible if the assessments were completed prior to consultation. The committee is also keen to highlight that the IIAs took over six months to complete.

Monitoring and evaluation

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

21a) that the JCPCT ensures that robust arrangements for data collection and analysis are in place by April 2010;

21b) that the proposed changes are monitored closely, in order to identify the impact on specialist service provision, patient experience, and to ensure that other services provided by the specialist centres have not experienced an adverse impact. We would expect a review report on the findings to be published 12 months after implementation in April 2010;

21c) that the JCPCT monitors the impact of the new arrangements on the movement of staff to the specialist units from other hospitals, to ensure that there is no negative impact upon the latter;

21d) that the JCPCT addresses a further meeting of the JHOSC in Autumn 2009, to share its plans for implementation, developed following the conclusion of the consultation phase.

Response

The JCPCT agreed with the JHOSC that the implementation of these new services need to be carefully scrutinised. To ensure a greater understanding of the issues and to support future developments, the JCPCT recommended that commissioners put in place effective monitoring and evaluation to ensure the benefits of the new system are realised. This should:

- ensure that the mutually supportive arrangements envisaged in the new networks are achieved;
- enable the swift activation of contingency arrangements if necessary;
- help administer culturally sensitive care;
- monitor trends in numbers and types of injuries being admitted to trauma and major trauma centres and who is most susceptible to them;
- ensure that other services and patient care do not experience an adverse impact.
- monitor the impact of the new arrangements on the movement of staff;
- allow commissioners to better understand and review the quality of, capacity, and demand for services in each HASU and stroke unit – in order to review the number and location of units required if demand is not as expected or changes; and
- enable a review to be published 12 months from implementation.

2 Stroke

General

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

22a) that the immediate eight HASUs should be seen as the minimum number, and the JCPCT should be prepared regularly to review this number and to increase the number if demand justifies it;

22b) that planning for patient numbers at HASUs takes account of the likely significant percentage of non-stroke admissions, and patients arriving by means other than blue-light ambulance;

22c) that no existing centres of stroke specialist care should cease functioning until the new model of provision is fully operational and adjudged to be delivering to the high standards anticipated under the consultation proposals. Where removal or reduction of services is proposed, the local PCT must liaise with the local health scrutiny committee, to ensure that the views of residents are taken into account.

23a) that the JCPCT explains how it will ensure that adequate clinical capacity will be achieved during the initial period of development;

23b) that the JCPCT ensures that effective monitoring arrangements are in place which will allow a re-assessment to be made, if necessary, of the optimum number of HASUs for London's population, and whether the designated HASUs are the best providers possible.

24) We recommend that the JCPCT investigates the potentially important role that telemedicine can play in helping to provide a cutting-edge 24/7 stroke service across the capital, and advises the JHOSC of the outcome of this work.

Response

The JCPCT agrees with the JHOSC that there is no definitive evidence to suggest that the proposal for eight HASUs is insufficient to address anticipated patient numbers. However the JCPCT accepts and recommends that there should be effective monitoring and evaluation to allow commissioners to better understand the quality of, capacity and demand for services in each HASU and stroke unit – in order to review the number and location of units required if demand is not as expected or changes (26).

Planning for patient numbers takes into account both non-stroke admissions to a HASU and patients arriving by means other than blue light ambulance. The JCPCT recommended that protocols are developed for the management of stroke 'mimics' and patients attending at a hospital with no HASU who are discovered to have had a stroke. These protocols should be in place and clearly communicated before 'go-live' (39).

The JCPCT agreed that there should be no deterioration of services during transition to the new model and configuration of care (24).

Transition arrangements described above (and in appendices 6a and 7b of the *Report of the outcomes of consultation and recommended decisions for the Joint Committee of PCTs*) will ensure adequate clinical capacity during the initial period of development.

The JCPCT agrees that there is good evidence that higher rates of thrombolysis are achieved when patients are taken to a 24/7 specialist centre rather than units providing only a partial service, or a service without 24/7 coverage by stroke experts.

The use of telemedicine in order to offer facilities at more hospitals, and therefore provide care for patients (either self-presenting or misdiagnosed) who have had a stroke and arrive at a hospital not designated as a HASU, was discussed by the JCPCT. However clinicians (both from the Clinical Advisory Group and independent experts – see below) have advised that face-to-face care from a clinical expert represents best practice. In London, the density of population and hospital facilities will allow all patients to receive prompt face-to-face care from stroke specialists in a dedicated HASU.

In addition, as with heart attacks, thrombolysis is likely to be the first step in the development of more effective, specialist treatment for stroke. In future, it is likely that care will be more interventional – such as the use of intra-arterial thrombolysis and stents. These, and other developments, will need to be supported by more sophisticated approaches. This may not be possible using telemedicine. Clinical advisors feel that in this regard the proposed model has some 'future-proofing'.

The board considered the response from an independent review, which was commissioned to look at the issues raised during consultation and the project board's draft commentary. The review team, made up of Professor Roger Boyle, National Director for Heart Disease and Stroke; Dr Damian Jenkinson, National Clinical Lead for Stroke Improvement; and Professor Gary Ford, Director of the UK Stroke Research Network concluded that:

"In general, we are happy that the case for change remains valid and that the proposed model is right both in terms of overall numbers of HASUs and acute stroke units for a city the size of London and the incidence of stroke currently."

The stroke clinical expert panel considered that telemedicine could have a role as an adjunct to the hyper-acute model, and Healthcare for London will look at ways of building on the expertise that providers, particularly St Thomas' Hospital, have built up in this area.

Increasing the public's awareness of stroke

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

25a) that the JCPCT calls on the Government to build upon the initial success of the 'FAST' campaign, in order that its key messages are reinforced and translated into better stroke outcomes;

25b) that the JCPCT undertakes a London-wide public awareness campaign to refresh the 'FAST' message after a suitable period. This should also address lifestyle factors which can lead to stroke, and what to do to lessen the chance of a stroke;

25c) that appropriate information about strokes be made widely available at health service centres throughout London, on health service websites, and at other locations (e.g. libraries, supermarkets). This literature must include a focus on TIAs;

25d) that the JCPCT takes steps to ensure that GPs receive good training in stroke recognition, including TIAs;

25e) that there should be a maximum referral time target of 24 hours from identifying a TIA to access to a specialist.

Response

The JCPCT supports the good work of the Government's *FAST* campaign and took every opportunity at roadshows, presentations and workshops to promote the FAST test. The JCPCT recommended that commissioners work with NHS London to develop a long-term strategy and co-ordinate the effective relationships between agencies to promote healthy, sensible lifestyles, including an emphasis on stroke prevention (40).

The JCPCT appreciates the JHOSC's highlighting the importance of good TIA services and the need for the public to be aware of TIAs. The maximum referral times incorporated into the new TIA service standards for referral to a specialist are 24 hours for high-risk patients. Low-risk patients will access TIA services within seven days. This is in line with the markers of a quality service set out in the *National Stroke Strategy* published by the Department of Health in 2007.

The JCPCT recommended that commissioners work with NHS London to:

- develop appropriate information about strokes and make it widely available at health service centres throughout London, on health service websites, and at other locations (e.g. libraries, supermarkets). This literature should include a focus on TIAs (42); and
- take steps to ensure that GPs receive good training in stroke recognition, including TIAs (43).

Prevention

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

26a) that there should be an increased provision of 'plain English' advice aimed at promoting a better understanding of the personal health factors (e.g. smoking, lack of exercise, eating too much of the 'wrong' sort of foods) which may contribute to a greater likelihood of a stroke;

26b) that greater joint working take place between PCTs and local authorities around the promotion of healthy lifestyles.

Response

The issue of prevention has been discussed earlier in this report, but the JCPCT is pleased to reiterate its commitment to encouraging commissioners to do more to prevent the occurrence of stroke, and recommended commissioners work with NHS London:

- to develop a long-term strategy and co-ordinate the development of effective relationships between agencies (especially with local authorities) to promote healthy, sensible lifestyles, including an emphasis on stroke prevention (40); and
- to take action on prevention by promoting the development of prevention campaigns in plain English, which focus on certain geographical areas or causes of stroke (e.g. smoking, lack of exercise) (41).

Developmental needs

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

27a) that the need for prompt action to improve services must not be at the cost of compromising the standard of services during the transitional period. There must be a suitable degree of flexibility in the introduction of HASUs, with a continuing role during the transitional period for other hospitals which have demonstrated a high standard of stroke care;

27b) that the JCPCT makes its development plans available, so that the details of the "very significant development needs" can be clarified. Clarification is also sought as to whether the necessary funding to address these needs forms part of the additional £23 million per year referred to in the consultation paper.

Response

The JCPCT agrees with the JHOSC that the need for prompt action to improve services must not be at the cost of compromising standards of service during the transitional phase. On developing the implementation and transition proposals for HASUs and stroke units, the project

board recognised that the proposed ‘go-live’ dates would be challenging – in particular for the three HASUs requiring significant development needs.

The role of other hospitals in facilitating this transition has been discussed earlier in this report.

The £23 million is to recompense trusts to deliver the new higher standards of services, as the current tariff does not reflect this. The costs of setup are not part of the £23 million and are borne by providers.

Transfers from HASU

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

28a) that provision in HASUs allows for the percentage of patients who need to remain longer than the 72-hour period referred to in the consultation paper, as well as those patients admitted as a result of incorrect diagnosis. Pressure on bed space must not lead to premature transfers, nor should beds dedicated for transferred stroke patients be allocated to general patients, thus making transfers to the most appropriate hospital more difficult;

28b) that protocols set out clearly the arrangements for patient transfer, and include adequate provision for dedicated beds and specialist stroke teams for patients in Stroke Units.

Response

The provision of HASUs takes into account a number of variables including patients who need to remain in a HASU longer than the 72-hour average, and those patients who have not suffered a stroke, but who are admitted whilst tests are carried out to confirm diagnosis.

Capacity planning has ensured that there will be sufficient stroke unit beds in the system to allow the timely transfer of HASU patients and this will also be encouraged by the new tariff structure. It is expected that the London cardiac and stroke networks will work together to support and facilitate the proper flow of patients through the system.

As previously described, to address issues of transfers and to minimise risks of negatively impacting on other services, the JCPCT recommended that commissioners work with acute hospitals to:

- facilitate timely transfers back to local stoke or trauma units (18); and
- agree and establish clear clinical and administrative protocols and monitoring arrangements for the transfer of patients with all relevant service providers before the new systems ‘go-live' (19).

Children and young people

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

29a) that Stroke Units address the particular rehabilitation needs of children and younger people, and ensure a continuity of care beyond discharge;

29b) that future consultations from Healthcare for London adequately address the proposals' implications for children and younger people.

Response

Children and young people under the age of 17 who suffer a stroke are best cared for by paediatric services. This includes rehabilitation services which must be age appropriate. Stroke in children and young people would need to be considered as part of any review of paediatric services.

The approach to providing stroke care for young people over the age of 17 is the same as for all adults.

The JCPCT agree with the JHOSC the importance of addressing the needs of young people over the age of 17 following discharge, and this will inform the ongoing work on the rehabilitation and long-term care of stroke patients in London.

3 Major trauma

General

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

30) We recommend that the capacity of the Royal London Hospital to build on its present role as London's primary MTC under the consultation proposals is monitored, particularly within the initial period before the fourth MTC becomes fully operational.

31) We recommend that the JCPCT advise the JHOSC as to how it will ensure that designated MTCs maintain a good level of care to all patients, and do not compromise patient care by the sudden demands of a major trauma incident. We expect the JCPCT to address this in its evaluation of the implementation phase.

32) We recommend that MTCs draw up plans in co-operation with Trauma Centres to establish agreed assessment criteria and protocols which will set standards of quality care throughout the patient pathway.

Response

The JCPCT has accepted the view of the JHOSC and agreed the development of four major trauma centres. In part this decision was taken in order to address the concerns raised by the JHOSC, namely that the new structure must be able to cope with occasional peaks of demand and because public perception is important.

The decision to commission St Mary's Hospital rather than The Royal Free Hospital was partly based on the geographical location of the two hospitals compared to The Royal London Hospital. The JCPCT felt it was sensible to utilise the experience of The Royal London Hospital to manage the biggest trauma network at the earliest date.

In line with the JHOSC view, the JCPCT recommended using The Royal London Hospital, which is close to operating as a major trauma centre, as a case study to help identify what is and is not working effectively (21). This role will be monitored, as described in recommendation 26 to the JCPCT, as will the effect of the major trauma centres on other aspects of hospital care (26).

All hospitals in the London trauma system will be required to submit data on their performance, including numbers of patients and outcomes and the committee recommended that appropriate pan-London oversight of the implementation of major trauma and stroke services be put in place (20).

Agreed assessment criteria and protocols which will set standards of quality care throughout the patient pathway have already been established. The London trauma director will undertake further assessment of trauma centres against these criteria to ensure consistency of care. This includes the triage protocol which will be used by London Ambulance Service crews to determine where patients will be taken.

Major trauma centres are working with trauma centres and networks to support them in delivering the quality of service required. In addition, networks are drawing up local protocols for specific pathways within their networks.

North west London

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

33a) that the JCPCT make immediate arrangements to place in the public domain details of the criteria, methodology and weighting used in the assessment process for the fourth MTC;

33b) that a public commitment for the fourth MTC is made by the JCPCT, so that in the event of any future reductions in funding to the NHS, the fourth centre is not 'sacrificed';

33c) that the fourth MTC becomes operational as soon after April 2010 as feasible.

34) We recommend that local authorities serving N.W. London are consulted at an early stage on the proposals for a transition plan.

Response

The JCPCT is surprised and disappointed regarding the JHOSC's belief that the criteria for assessing the bids for the fourth major trauma centre has never been published. The criteria used were the same as for the original bids. These can be found at: www.healthcareforlondon.nhs.uk/assets/Publications/Major-trauma/6-MT-Designation-Criteria-v1.1.pdf

Both bids were considered to be of equal clinical quality. In order to assess each bid against the other – to agree a preferred option, the bids were then assessed against nine criteria – these were described at the JCPCT meeting in public on 27 January 2009 and can be viewed at: www.healthcareforlondon.nhs.uk/assets/Stroke-and-major-trauma-consultation/JCPCT-papers/Major-trauma-Final-2-Presentation-on-Major-Trauma-Services.pdf

The JCPCT believes that the reasons behind the consultation paper's description of potential implementation dates are robust and fairly reflected the issues at that time. The three hospitals (King's College, St George's and The Royal London hospitals) were expected to be ready to provide new major trauma services by April 2010. Charing Cross and The Royal Free hospitals originally provided bids that did not meet the specified criteria (a new service by April 2010). Rather than invite new bids for a lower quality service (clearly unacceptable), bids were invited for north west London on the same quality criteria and benchmark, but that gave hospitals a longer time to introduce the service – by April 2012. Both St Mary's and The Royal Free hospitals provided bids that were judged to be of sufficient quality and could be delivered by that time.

During the consultation The Royal Free and St Mary's hospitals both indicated to the project team at Healthcare for London that they could establish the service earlier than April 2012. However doubts surrounded the actual date that the centres could become operational and the

independent evaluation team was not convinced on the robustness of plans to bring forward the implementation date.

Working with both hospitals over the past six months, the project team is now in a position to confirm that the current plans for St Mary's Hospital indicate a potential implementation date towards the end of 2010 – if this can be achieved then this will benefit residents in north west London. The London trauma director will be assessing these plans regularly to ensure the service can be provided by this stated timeframe. However, to allay any fears of the JHOSC, the JCPCT has publicly stated that commissioners should ensure that the development of any fourth major trauma centre is developed as quickly as possible (23).

The JCPCT recommended that robust transitional arrangements for north west London be developed, setting out clear protocols regarding which patients should be transferred to a major trauma centre elsewhere in London and which should continue to be taken to a more local hospital (22). The views of local authorities and other stakeholders will be considered in the development of the transitional plan, ensuring residents of north west London have an appropriate major trauma service during this period.

Skilled diagnostic care

Recommendations by the Joint Health Overview and Scrutiny Committee (JHOSC)

35) We recommend that adequate resources are available on a continuing basis to ensure that training in the best triage methods is offered by paramedics at scene.

36) We recommend that diagnostic expertise is retained at DGHs, to allow the rapid transfer of a patient to a MTC, should that be necessary. Clear systems covering cases for onward transfer will need to be put in place.

37) We recommend that, as part of achieving high-quality rehabilitation after the initial principal clinical intervention, staff on wards should possess relevant neuro-training.

38) We recommend that the London Trauma Office monitor the recruitment and training of staff across the networks, to ensure that adequate numbers of suitably trained staff are available by April 2010.

39) We recommend that specialised neuro-rehabilitation services are linked into the work of the Trauma networks. We would like to see all - and not just some - PCTs provide multi-specialist rehabilitation.

Response

The JCPCT agrees with the JHOSC that the role of London Ambulance Service paramedics will be critical in ensuring the service offered is truly world-class. The JCPCT has recommended that assessment and triage protocols that are already developed are supported by appropriate training and skills development before 'go-live' (31). The London Ambulance Service has

developed implementation plans, including appropriate recruitment and training. A clinical co-ordination desk will assist paramedics remotely with triage decisions at the scene.

In response to concerns from the Spinal Injuries Association regarding the triage and treatment of spinal cord injuries, the JCPCT recommended that commissioners assess the system once the initial triage protocol is successfully established, monitoring outcomes and taking responsive action as necessary – taking into account the recommendations in *Preserving and Developing the National Spinal Cord Injury Service* (May 2009) (28).

The JCPCT also agrees it is essential that diagnostic expertise is retained at trauma centres and that clear systems covering cases for onward transfer will need to be in place. The system will be made more robust as Healthcare for London and the London Programme for IT are currently working to improve the ability of trauma centres to transfer patient images electronically to the major trauma centre. The pre-hospital care sub-group of the expert panel is examining the options for transfer protocols and will be making recommendations shortly. These will be informed by the Royal College of Anaesthetists' *Guidelines for Interhospital Transfer 2009*.

The recommendation that networks and hospital trusts should explore the rotation of staff within and between networks and units (25) will help to ensure expertise is retained at trauma centres, as will the establishment of clear clinical and administrative protocols and monitoring arrangements for the transfer of patients with all relevant service providers before the new systems 'go-live' (19).

The JCPCT has agreed that commissioners, through the auspices of the London trauma office, need to ensure:

- specialised neuro and spinal rehabilitation services are linked into the work of the London trauma system (37); and
- staff on wards possess relevant training to support them in their role (for example neuro and musculo-skeletal) (38).

Further work is being undertaken to explore provision of trauma rehabilitation as part of the London trauma system, and at a local level. Trauma networks are mapping rehabilitation pathways within their networks and will be linking with PCTs to ensure adequacy of service provision.

A needs assessment will be undertaken to identify the training needs, skills and competencies required for staff caring for major trauma patients, including those with neurological problems following trauma.

The recruitment and training of staff will be monitored and assessed as part of the evaluation regime recommended (26) and described in the evaluation appendices to the report to the JCPCT. The number of staff required will vary per provider. Current recruitment plans and initiatives have indicated that full recruitment to all posts required will be achieved.

4 Appendices

The JCPCT received a number of papers providing evidence supporting the deliverability of the proposals. These include:

Appendix 1: Whole pathway – prevention (stroke)

Appendix 2: Whole pathway – rehabilitation (stroke)

Appendix 3: Whole pathway prevention and rehabilitation (trauma)

All other papers presented to the JCPCT can be found at www.healthcareforlondon.nhs.uk/jcpct-meeting-in-public/

Healthcare for London

NHS

The shape of things to come

Whole pathway assurance – rehabilitation
Major trauma

Appendix 6f

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1 Introduction

The aim of this paper is to provide the JCPCT with assurance that issues associated with rehabilitation are unlikely to cause any derailment to the plan to introduce a London trauma system; nor will the establishment of the system have a detrimental effect on current rehabilitation provision. It will also provide detail of other factors which should be considered in the decision making process and provide an overview of the current Healthcare for London rehabilitation workstream.

This will be presented in two parts:

- Part A provides assurance that there is nothing to indicate that the implementation of the major trauma system or any of the options set out in the consultation document would have a detrimental effect on rehabilitation.
- Part B provides an overview of the current work taking place in preparation for the establishment of the system with regard to the development of services associated with rehabilitation.

2 Executive summary

Part A – Assurance
Factors that determine whether a particular decision or option should be discounted

There is no indication that delivery of rehabilitation will be detrimentally affected by the establishment of a major trauma system for London, nor by the number of networks developed.

Other factors which may influence a decision

There will be potentially beneficial opportunities arising from systemisation and network development. The analysis of the consultation highlights the importance of addressing the rehabilitation issues associated with major trauma *(see Part B below).*

Part B – Supplementary information
This workstream will undertake 10 key pieces of work to underpin the development and improvement of rehabilitative aspects of the system. These have evolved from the work undertaken last year to identify the problems currently experienced with delivery of rehabilitation.

3 Scope and context

At the outset, the Healthcare for London major trauma project recognised that the organisation and delivery of rehabilitation for this patient group is complex. This is not least because, until recently, major trauma was not a formally recognised care pathway. In addition, although multiple problems require the involvement of multiple professions and organisations, there was little consistency of provision across the health economy. The first phase of this work was a review of the rehabilitation services for this patient group in the capital, commissioned in 2008.

In May 2009 a formal workstream for trauma rehabilitation was set up within the Healthcare for London project, tasked with taking the work forward to the next stage (including producing a set of recommendations). This paper provides information on the current understanding of the potential impact of establishing a major trauma system on the delivery of rehabilitation to this patient population. In addition, a summary of the previous work and overview of current deliverables of the Healthcare for London rehabilitation workstream are provided.

4 Part A – Assurance

Factors that determine whether a particular decision or option should be discounted

Rehabilitation is unlikely to be any worse as a result of implementing the London trauma system. The number of trauma networks (i.e. three or four) does not appear to have an impact on the proposals for rehabilitation.

Other factors which may influence a decision

No other factors associated with rehabilitation have been identified which may influence the configuration decision. However, the broader issues regarding rehabilitation which require attention are set out in the section below.

5 Part B – Supplementary information relating to implementation and workstream deliverables

5.1 Introduction to Part B

There are early indications that rehabilitation could be improved as a direct result of a London trauma system which concentrates resources in a defined number of networks, supported by some early 'quick win' recommendations from this workstream. These focus on the co-ordination of existing rehabilitation provision and communication between organisations and professionals. The network model is seen as an important vehicle for supporting this approach.

The London trauma system concentrates resources for major trauma in fewer centres which will require flow to be maintained in order to be successful. Rehabilitation and repatriation play a critical role in this, and therefore major trauma centres will be expected to demonstrate their ability to manage the early phase of rehabilitation and demonstrate a joined-up approach with the other providers in their networks.

The analysis of the public consultation on major trauma by Ipsos MORI highlights the importance to respondents of addressing rehabilitation aspects of the system. This is echoed by the recommendations put forward by the Joint Health Overview and Scrutiny Committee (JHOSC) and the findings of the Integrated Impact Assessment (IIA) which has been commissioned by Healthcare for London. These views can be summarised as follows:

- rehabilitation is crucial to the success of the system. In future phases of work it should be given the same priority as the early part of the pathway;

- future consultations by the JCPCT should address the whole care pathway, rather than concentrating predominantly on a particular element, such as acute care;

- the Association of Directors of Adult Social Services (ADASS) and London Councils (as well as London local authorities and social services authorities bordering London) need to be engaged more fully in developing plans for a seamless care pathway;

- the JCPCT should undertake an audit of rehabilitative trauma services across London, with a view to determining:
  - which PCTs need to invest more in rehabilitation; and their capacity to fund this further investment;
  - the capacity of PCTs to put in place follow-up teams at trauma centres to take responsibility for ensuring that once a patient is discharged, they do not 'fall through the care net';
  - a mechanism for JCPCT assurance that all PCTs are in a position to ensure consistency of access to rehabilitative care across London.

- there should be early involvement of hospital social work teams in planning longer-term care pathways following initial clinical treatment;

- assessment of joint financial incentives needs to be undertaken, in order to allow more co-ordinated investment in enhanced community-based resources to be achieved;

- staff on wards should possess relevant neuro-training as part of achieving high-quality rehabilitation;

- specialised neuro-rehabilitation services should be linked into the work of the trauma networks and that all PCTs provide multi-specialist rehabilitation.

5.1.1 Rehabilitation workstream report, September 2008[1]

This work focused on adults who have sustained major traumatic injuries, and aimed to cover the rehabilitation pathway in its entirety - from critical care through to the achievement of maximum functional potential and discharge from services; definitive care package; and/or ongoing case-management. The intention at this stage was not to be specific or prescriptive in how rehabilitation should be provided following major trauma, but rather to establish what the overarching problems are and how these impact upon rehabilitation provision. Information was gathered through focus groups and general discussion with clinicians involved in the delivery of rehabilitation and associated services, and from service users on the major trauma project's patient panel. Comment and general agreement was sought from these groups on the conclusions drawn and suggestions made within the report. In addition, providers of specialised regional services were consulted as part of the process, including the military rehabilitation facility at Headley Court. The key findings of the report are outlined below:

- the spectrum of rehabilitation needs within the major trauma population is broad. By addressing the problems with provision of rehabilitation for this group, the needs of other less-severely injured patients are also likely to be better met;

[1] Worrall B (2008), Rehabilitation Workstream Report, Healthcare for London

- the range of rehabilitation pathways followed by major trauma patients is necessarily diverse. It is important to have the range and flexibility of services in order to meet needs in a patient-centred way;

- in order to ensure that patients achieve their maximum functional potential, including return to paid employment wherever possible, services need to be developed which are comprehensive, consistent and collaborative in their approaches to rehabilitation and social care delivery;

- clear, consistent standards, governance structures and data management are needed to underpin effective and efficient functioning of the rehabilitation aspects of the system. This will enable the system to be able to accurately evaluate provision and develop services to improve outcomes.

The report identified problems with the existing system in the following areas:

- co-ordination of health and social care and navigation through the system;
- cross-boundary working, including policies, knowledge and access to equipment and adaptations;
- repatriation;
- access to rehabilitation services;
- service delivery and access;
- data management;
- housing and immigration issues.

Table 1 outlines the strategies to address the inequalities and inefficiencies in the current system. These are being addressed through the rehabilitation workstream deliverables set out in Table 2 on the following page.

Table 1: Developing a strategy for trauma rehabilitation

1. Service delivery models and structure	**2. Workforce**
• Development of acute rehabilitation facilities • Common standards and policies • Governance opportunities • Shared care models	• Development of a workforce model • Workforce development plan • Case management/co-ordination
3. Information	**4. Capacity**
• Development of common data standards across the system • Directory of services	• Detailed capacity analysis of services contributing to major trauma rehabilitation

5.2 Rehabilitation workstream – project plan

5.2.1 Preliminary work – rehabilitation service specification

The original designation criteria references rehabilitation. However at the time of the bidding process it was recognised that the focus needed to be on pre-hospital care and early management of patients since this follows the natural sequence of the pathways along which patients travel. It was always intended that further work would

be undertaken to enhance the rehabilitation aspects of the service specifications. The report produced in 2008 initiated the work now being progressed by this workstream[1]. It also takes into account the recommendations from the JHOSC.

The service specifications used for the designation of major trauma networks has been reviewed and updated to indicate requirements for rehabilitation. This updated version will be reviewed and agreed by an expert panel to be set up with the support of the London trauma director. A phased approach may be necessary to achieve the specifications.

At this stage, the service specifications for rehabilitation focus on the acute phase of care which takes place within the major trauma and trauma centres (in line with the original framework). However, it is recognised that rehabilitation stretches far beyond the acute phase and therefore further additions to reflect the requirements of the longer term community-based rehabilitation phase will need to be developed once the system is established (see JHOSC recommendations above).

5.2.2 High-level overview of the project deliverables

Table 2 outlines the intended deliverables of this workstream. These represent the practical ways in which the strategies outlined above in Table 1, and key recommendations from the JHOSC, can be implemented. The direct links between the strategy (Table 1) and the deliverables of the workstream are referenced in column three in the table below. For example, development of the navigation model (deliverable 5), which includes a defined role in co-ordinating the rehabilitation pathway, addresses elements of sections one, two and three of the strategy.

Table 2: Workstream deliverables

Deliverable	Description	Strategy link	Phase one	Phase two	Phase three
1	Service specification	1, 2, 3, 4	✓		✓
2	Acute rehabilitation service	1, 2, 4	✓	✓	✓
3	Trauma rehabilitation pathway	1, 2, 3	✓	✓	✓
4	Core rehabilitation data-set	3, 4	✓	✓	✓
5	Navigation model	1, 2, 3	✓	✓	
6	Directory of services	3		✓	✓
7	Documentation	1, 3	✓	✓	✓
8	Clinical governance	1, 2, 3, 4		✓	✓
9	Evaluation			✓	
10	Outline of future work			✓	

This project plan will be delivered in a series of phases:

- Phase 1 – May to June 2009
- Phase 2 – July to mid-August 2009
- Phase 3 – continues and extends the work of Phase 2 and also focuses on embedding outputs from Phases 1 and 2, which are deemed viable. The latter will be determined by commissioners of the networks and the London trauma office. Resourcing of Phase 3 is yet to be confirmed.

5.2.3 Description of deliverables

Deliverable 1 – Development and agreement of major trauma centre and trauma centre rehabilitation service specifications
The original designation criteria contained 'greyed out' areas in the rehabilitation section, indicating that further service specifications were to be developed. These had been drafted as part of the preliminary work of the rehabilitation workstream and now need to be scrutinised and reviewed by a panel of rehabilitation experts. This will ensure they reasonably reflect the minimum requirements to deliver rehabilitation services in both major trauma centres and trauma centres, whilst acknowledging the need for further enhancements of these specifications in the future. Once agreed by the panel, Healthcare for London and/or the London trauma office, these specifications will be rolled out to the networks to guide service delivery.

Proposed timescale: agreement by mid August 2009.

Deliverable 2 – Service model for an acute rehabilitation service for major trauma patients
A paper will be provided detailing the rationale, estimated volume requirements and potential delivery models for acute rehabilitation for complex and polytrauma. This is based on a service model developed for neuro-rehabilitation designed to improve patient outcomes and efficiency. This is a service which is more intensive and therefore distinct from, and in addition to, the rehabilitation delivered during the acute phase of recovery. This phase will largely take place in the major trauma centres and trauma centres. At present no such service exists for polytrauma within the UK as far as can be determined (other than Headley Court) and the absence of this was highlighted by the 2008 report. The model will be tailored to the major trauma population and emergent system for London.

Proposed timescale: mid July 2009.

Deliverable 3 – Pathway for major trauma rehabilitation
An overview pathway will be produced outlining key milestones, critical decision points, interventions, competencies, resources and facilities required to deliver effective and efficient rehabilitation to major trauma patients. This will encompass existing guidance; for example the NICE critical illness rehabilitation guidelines[2], and will provide a framework for assimilation of relevant information, such as guidelines, policies and protocols, developed through the London trauma office and the networks. The intention is to develop this in conjunction with experts from the field of rehabilitation. A forum for engagement of appropriate experienced healthcare professionals will be developed once the London trauma director is in post.

Proposed timescale: overview of entire pathway by mid August 2009; further development of detailed proposals will be ongoing.

Deliverable 4 – Core rehabilitation dataset
Performance metrics for rehabilitation aspects of the major trauma system will be identified and contributions will be made to the development of a performance management framework in partnership with the Trauma Audit & Research Network (TARN). This dataset intends to enable accurate and effective review and evaluation

[2] NICE (2009), Critical Illness Rehabilitation Guidance, http://guidance.nice.org.uk/CG83 (accessed 12.06.09)

of rehabilitation aspects of the trauma system. This work will include consideration of the practicalities of collection within, and across, different organisations.

Proposed timescale: mid August 2009.

Deliverable 5 – Rehabilitation navigation

An understanding of the skills required to facilitate the patient pathway through the process of rehabilitation will be developed using models from other countries and other care pathways where these roles have already proved successful. An example job description for a complex-case manager, or navigator, for the major trauma centres will be developed and banded. In addition, suggestions will be made for the establishment of key workers in community settings. This will facilitate the transition of patients between organisations and provide ongoing support after discharge from inpatient settings. This work can be distributed to networks to give an overview of potential benefits and associated finances. This paper will also include references to other elements of the workstream that are designed to facilitate patients' progression along their rehabilitation pathway, such as the prescription for rehabilitation, shared documentation and governance arrangements.

Proposed timescales: for distribution to networks end July 2009.

Deliverable 6 – Directory of services

A scoping document will inform the development of a directory of health and social care services that relate to the rehabilitation pathways for the London trauma networks.

This resource is essential to improve the efficiency of planning and executing patient transitions between organisations. This resource will allow clinicians to have easy access to up-to-date and local information about services that their patients may require, thus enabling timely and appropriate referrals. It is proposed that a resource specification will also be developed as part of this phase, with the development of the directory outsourced to a specialist provider.

Proposed timescale: resource specification mid August 2009 for tendering. Resource goes live April 2010.

Deliverable 7 – Documentation for rehabilitation

It has been recognised that a common approach to trauma documentation supported through the London trauma office would be beneficial in facilitating pathways and data collection in a more consistent manner. A draft framework for documentation of the rehabilitation aspects will be developed. This will provide a centralised record of rehabilitation assessments, goals and interventions during the patient's acute phase of care. In addition, the scope and purpose of a prescription for rehabilitation will be considered. The documentation structures outlined will facilitate the achievement and monitoring of performance measures and indicators which links to deliverable four.

Proposed timescale: draft documentation and briefing paper by mid August 2009.

Deliverable 8 – Outline potential clinical governance structures for major trauma rehabilitation

This will support the ongoing delivery and development of the rehabilitation aspects of the major trauma system. An overarching governance framework will be developed that will reflect and complement the governance structures used by other

parts of the system in particular those used by the medical profession such as case reviews. This framework will have key links to other elements of the workstream such as the development of the pathway, documentation and data management. It is proposed that this work will also outline other initiatives such as multi-professional, cross-network case reviews and suggestions for future developments.

Proposed timescale: paper outlining clinical governance framework and structures mid August 2009.

Deliverable 9 – Evaluation

A summary paper will indicate how the deliverables of this workstream will address the identified problems in the current system evaluating their potential impact, to enable the London trauma office and commissioners to prioritise and implement the products of this workstream.

Proposed timescale: evaluation paper completed mid August 2009.

Deliverable 10 – Development of future work plan

This rehabilitation workstream will culminate in the development of a paper outlining suggestions for the future development of trauma rehabilitation. This plan is likely to include the following:

- audit, evaluation and analysis of rehabilitation services to establish an accurate demand:capacity ratio – as recommended by the JHOSC and the IIA;
- establishment of initiatives to support the ongoing development of the pathway, and associated system and workforce requirements;
- exploring the use of patient goal setting as an outcome measure;
- development of the potential commissioning model based on outcomes – linked to opportunities arising from Commissioning for Quality and Innovation (CQUIN);
- an intensive rehabilitation model for polytrauma potentially developed in partnership with the existing specialised neuro-rehabilitation and spinal services and with the military (i.e. Headley Court);
- consideration of the role of shared care models within networks to better enable delivery of care in local services, facilitate patients' progression along the rehabilitation pathway and develop skills across the workforce.

The future work plan will include any other opportunities or initiatives identified through the current phase of the workstream.

Proposed timescale: mid August 2009.

Whilst it is proposed that a full cost-benefit evaluation of the above solutions is undertaken, it is also acknowledged that in the current economic climate solutions which aim to make the most efficient use of existing resources should be prioritised (for example, the navigator roles, prescription for rehabilitation, data collection, documentation and network governance). This aligns with the discussions held with Keith Willett, National Clinical Director for Trauma Care, and gives consideration to the importance of maximising efficiency of existing provision in the first instance.

5.3 Links to other work

A number of the strategies (Table 1) and the workstream deliverables outlined above cross-reference to other Commissioning Support for London (CSL) and NHS London initiatives:

5.3.1 Links to continuing professional development (CPD) framework for major trauma

The continuing professional development (CPD) Project is being set up to establish a framework for professional development of allied health professionals working with major trauma patients throughout recovery and rehabilitation. The intention is to identify the skills required and map these to *Skills for Health* and the *Knowledge and Skills Framework*, and design a specification for an associated education programme and network supervision function. This addresses key aspects of section two of the strategy (Table 1). There are important links between this CPD project, the rehabilitation workstream and the NHS London workforce initiative (see below). These links will be established and maintained through regular contact across all project teams.

5.3.2 Development of expert panel for rehabilitation

It may be appropriate to create an expert panel (similar to that established for the designation phase of the trauma project) to scrutinise and inform suggestions made by the products of this workstream.

5.3.3 NHS London workforce initiative

The People and Organisational Development Directorate (POD) within NHS London is responsible for considering London's future healthcare workforce needs. Close links will be developed to ensure that the workforce implications associated with the recommendations and suggestions made as part of the rehabilitation workstream are incorporated into the work being undertaken by POD.

5.3.4 Stroke project

There is some congruence between the rehabilitation services required for stroke patients and those who have sustained traumatic injuries. The synergies will be explored and links will be forged as appropriate. The CPD framework development is being run as a project in conjunction with the stroke project which will therefore facilitate this process.

6 Conclusion

This paper provides assurance to the JCPCT that whilst rehabilitation for major trauma is a deeply complex area with recognised gaps in service provision and co-ordination, it is unlikely that these will decline further as a result of implementing the London trauma system. On the contrary, early indications contribute to the view that the London model, which concentrates co-ordination of clinical expertise into defined number of networks, will create a helpful framework for the ongoing development of rehabilitation systems.

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Whole pathway – prevention
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Appendix 6e

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1 Introduction

This paper outlines the options and requirements for an effective prevention strategy which will form part of the London trauma system. It will include evidence-based criteria for an effective strategy and recommendations as to the best approach for implementation within the system. Finalising this strategy will be the responsibility of the London trauma director, and will be included within the performance management framework.

This paper will be presented in two parts; Part A, which will provide an outline of the description of any assurance affecting the JCPCT decision and Part B, which outlines additional information about the prevention strategy proposal which relates directly to implementation.

2 Executive summary

Part A – Assurance

Factors that determine whether a particular decision or option should be discounted

No factors have been identified within the proposal for a major trauma prevention strategy which would impact on any decision made by the JCPCT in such a way as to discount a particular decision or option of networks.

Other factors which may influence a decision

No factors have been identified relating to the proposal for a major trauma prevention strategy that would influence any decision reached by the JCPCT.

Part B – Supplementary information

- an effective prevention strategy is an approach designed to limit the risk or impact of a particular problem and enhance protective factors, in this case major trauma injuries;
- no new initiatives are proposed within the implementation of a strategy, rather the co-ordination of existing agencies/programmes within the system;
- prevention strategy principles: evidence suggests that an effective prevention strategy should be based on a three-tier model - primary, secondary and tertiary
- key stakeholders of a potential strategy have been identified, including prevention campaigns/programmes and relating injury causes;
- the strategy should be targeted to the local population of specific trauma networks;
- proposed implementation of a prevention strategy will operate at different system levels - network, system and major trauma and trauma centres.

3 Scope and context

As one of the only causes of death that is truly preventable, it is important to note that the major trauma pathway extends far beyond the clinical care received post-injury. An important aspect of the implementation of an effective trauma system is the inclusion of a prevention strategy. A trauma prevention strategy will describe the

position of the trauma system in assisting to prevent future injuries. An effective strategy could potentially reduce the costs of trauma care by decreasing both the number of injuries sustained and admission rates. It is essential for the strategy to encompass current prevention initiatives and agencies and to identify opportunities for collaboration. Injury prevention, in addition to pre-hospital care and triage to a specialist centre, should be delivered at local level. The co-ordination of existing local services and engagement with external agencies within networks is key to the delivery of an effective prevention programme.

4 Part A – JCPCT Assurance

This section outlines the description of assurance affecting the decision to be taken by the JCPCT:

Factors that determine whether a particular decision/option should be discounted:

Within the remit of the proposal for a prevention strategy for major trauma, no factors have been identified which would contribute to a discounting of a particular decision or option of networks. The purpose of a prevention strategy for the trauma system is to examine the entire pathway, pre and post injury and to assess the opportunities available for the prevention and impact limitation, of traumatic injuries in partnership with existing agencies and providers. It is proposed that this is delivered by all tiers of the trauma system regardless of the final system configuration and therefore does not impact on any potential options evaluation made by the JCPCT.

Factors that influence a decision and should be considered:

There are no factors that have been identified relating to the proposal for a prevention strategy for major trauma that would influence any decision reached by the JCPCT. The purpose of this paper is to contribute to the 'whole pathway' assurance sought by the JCPCT.

5 Part B – Supplementary information relating to workstream implementation

This section provides a description of the proposal which relates directly to the implementation of the strategy within the system and the proposed structure of the strategy.

5.1 Principles

Evidence from the implementation of other trauma systems and existing effective prevention programmes advocate the use of a three-tier strategy. This three-tier system is also endorsed by the World Health Organisation in their *World Report on Violence and Health*[1].

[1] Krug EG et al., eds. *World report on violence and health*. Geneva, World Health Organization, 2002; p.10

Primary
Strategies or campaigns which are used to *prevent* the occurrence of the injury in the first instance or prevent it from leading to injury.

Examples of primary prevention strategies include legislation over the sale of alcohol/knives to teenagers, anti gun or knife campaigns by the Metropolitan Police and crime prevention initiatives by government offices, such as the Youth Justice Board.

Secondary
Limiting the impact of injury on the patient.

There are two types of examples of secondary prevention principles:

1. Precautions such as seatbelts/bicycle helmets.

2. Early diagnosis and appropriate management of an injury (for example, applying basic first aid at the scene of an incident to stop an injury from having more serious consequences).

The prevention strategy within the trauma system will be more concerned with the injury prevention precautions as opposed to the diagnosis and effective management of the injury. The latter will be addressed through the implementation of relevant triage protocols and training for ambulance paramedic staff as well as treatment at an appropriate centre with the appropriate skills.

Tertiary
Improving final patient outcomes following major trauma, (for example, acute rehabilitation), involves preventing further complications in the form of more severe injury which could lead to disability or death.

The provision of an organised trauma system which delivers improved care at all stages of the pathway will also incorporate linkages. It is likely that these will occur between the tertiary level of the prevention strategy and the rehabilitation pathway.

5.2 Key stakeholders

The dataset for trauma injuries provided by the London Ambulance Service for January 2005 - March 2008 identifies the most common causes of injury:

- road traffic accidents (RTA)
- assault
- falls
- accidental injury
- other – including train/tube incidents, fire - burns, self harm, aeroplane incidents

The key stakeholder groups for these types of injury have been identified as:

- Transport for London
- government organisations
- public – children, road users, elderly, teenagers
- Department for Transport
- Metropolitan Police
- Health and Safety Executive

- trade unions
- social services/community based services
- voluntary sector

It is logical that the strategy will focus on the groups listed above, due to the high prevalence of trauma injuries resulting from them. Many existing prevention campaigns and programmes target a wide audience including children, young adults (particularly those identified as vulnerable and in lower social classes), the elderly and users of public service such as trains.

It should be noted that mortality rates are falling more slowly in the young adult population – particularly amongst young men[2]. In deprived sections of the community, mortality rates vary considerably with some relationship to the level of deprivation in each borough[3]. These are issues to consider when examining existing services and audiences or users within a specific network or borough to ensure that local need is met.

5.3 Implementation

Issues to consider include:

- the best way in which injury prevention initiatives can be implemented within the system and networks;
- how work carried out by existing strategies and agencies could further improve current practices;
- ongoing engagement with current prevention programme providers and specific interventions where the networks can support other agencies;
- establishing links with existing programmes already undertaking this work.

In line with the three-tier prevention strategy principles outlined above, there are three different levels at which these can be delivered - system, network, major trauma centres and trauma centres.

System-level:

Prevention measures, which could be delivered, include primary prevention - such as injury specific campaigns (for example knife crime or road traffic accidents). There is an opportunity for the system to function as the mediator between current providers of prevention initiatives and the trauma networks. This could be through information-sharing, targeted initiatives and the establishment of nominated contacts for networks. Within this function, the system could also facilitate the implementation of prevention measures. This could include implementing the falls prevention measures set out in the National Service Framework for Older People. These include environmental checks and modifications in home, work and care settings which would be delivered at a local level through the major trauma or trauma centre.

Network level:

It is likely that the network level delivery of prevention will incorporate both the secondary and tertiary principles, and will be tailored to local need. It could include initiatives such as a trauma case manager on trauma wards. The function of this role is to coordinate the multidisciplinary approach to patient care, and act as a liaison

[2] *Injury Prevention* 1998; (Supplement 1):S42-S45; doi:10.1136/ip.4.2008.S42 Copyright © 1998 by the BMJ Publishing Group Ltd

[3] Lowdell et al., eds. *Too High a Price. Injuries and accidents in London,* 2002, Health of Londoners Programme

between the various healthcare professionals. Alcohol intervention practices (for example, those currently being piloted at the Royal Free Hospital), are good working examples of secondary prevention measures.

Major trauma centre/trauma centre level:

'In-house' local delivery of prevention measures at major trauma and trauma centres is key to the effectiveness of a comprehensive prevention strategy. These could include risk assessment and follow-up for vulnerable groups (for example those who have experienced a fall) and hip protectors for the very frail. These measures work on both secondary and tertiary levels, ensuring that recovery is supported adequately but also ensuring the risk/impact of future injury is mitigated appropriately. Another option for local prevention delivery is the situating of acute-ward social workers and/or charity representatives. These groups would work at a tertiary level to limit the effect of the injury on the patient and to co-ordinate services for the patient following discharge/repatriation.

6 Conclusion

An effective prevention strategy consists of prevention measures which should be delivered on each tier: primary, secondary and tertiary. Within the trauma system, implementation will occur at all levels – system, network and centres. The suggested function of the London trauma office will be to co-ordinate the creation of effective relationships between agencies and networks. It will also facilitate the implementation of additional network and system-specific prevention initiatives. The trauma office should ensure that prevention measures are delivered and implemented at all principle levels, and targeted to local need across the system.

Healthcare for London

NHS

The shape of things to come

Whole pathway assurance paper
Stroke

Appendix 7f

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1 Introduction

The first phase of the Healthcare for London stroke project outlined the strategy for implementing new stroke services for London. While emergency and acute care have been the initial focus, the scope of the project covers the whole pathway from prevention to rehabilitation and life after stroke. The ongoing Healthcare for London work on the non-acute stages of the stroke pathway is the subject of this paper.

This paper is presented in two parts.

1) Part A outlines the description of any assurance affecting the Joint Committee of Primary Care Trusts' (JCPCT) decision.
2) Part B outlines the additional information relating to the proposed further development of work on the whole stroke pathway.

2 Executive summary

Part A

No factors have been identified within the proposed plans to further develop work on the whole stroke pathway that would impact on any decision made by the JCPCT so as to discount a particular decision or option.

No factors have been identified in relation to the plans for further whole pathway work that would influence any decision reached by the JCPCT.

Part B

2.1 Prevention

A significant amount of work has already been carried out on stroke prevention as part of the *National Stroke Strategy* and the *NHS Health Check*.

This preliminary work has identified that London is performing poorly against stroke prevention indictors.

Commissioner guidance on stroke prevention is planned for publishing in autumn 2009. Recommendations will be developed with clinical colleagues and will fall broadly into three categories: primary prevention, secondary prevention and public awareness.

2.2 Rehabilitation and life after stroke

Since the publication of the *Stroke strategy for London* in November 2008, further work on developing more comprehensive rehabilitation and community recommendations has taken place.

A directory of third sector services for stroke patients and carers will be available by 2 November 2009.

Further work on rehabilitation and life after stroke is planned for commissioning from specialists during the summer of 2009.

Commissioner guidance on rehabilitation and community stroke services is planned for publishing in autumn 2009.

2.3 Conclusion

The plans in place to continue work on the non-acute aspects of the stroke pathway allow assurance to be offered that a decision on the future of acute stroke services can be taken.

3 Scope

The purpose of this paper is to outline the planned outputs from the whole stroke pathway workstream and offer assurance that the work on the non-acute stages of the stroke pathway will not cause any disruption to the introduction of the proposed London-wide acute stroke services.

The paper provides assurance to the JCPCT in Part A before providing supplementary information in Part B. Part B outlines the work that has been carried out by Healthcare for London to date before setting out the further phase of work for both prevention, rehabilitation and life after stroke.

4 Context

4.1 Prevention

Prevention is the only part of the stroke pathway where it is possible to bring about a reduction in the overall number of strokes. In 2007, stroke accounted for well over 4,400 deaths in the capital; it is estimated that nearly 25% of these may have been prevented[1]. This amounts to around 1,100 lives a year that could be positively affected through primary prevention, in the general public, and secondary prevention, in those who have suffered from a previous stroke or transient ischaemic attack (TIA).

London is underperforming against the national average, as measured by a variety of stroke prevention indicators. While London's diverse population creates particular challenges such as the presence of language and social barriers, there is great potential to improve stroke prevention.

4.2 Rehabilitation and life after stroke

Currently there are over 6,000 people left with an impairment following a stroke in London[2]. Effective rehabilitation, initiated at the beginning of their treatment, can improve their opportunities to reengage with their lifestyle, family and friends.

[1] Healthcare for London, *Preliminary acute stroke strategy for London*, July 2008
[2] Healthcare for London, *Stroke Strategy for London*, November 2008

Across London, there is wide variation in the availability of rehabilitation and community stroke services between boroughs, with some areas having no dedicated community stroke service. In addition, there is wide variation in approaches to service provision. Because of this, it was judged inappropriate to identify a single central model of rehabilitation. Each Primary Care Trust (PCT) must commission locally appropriate services to meet best practice standards. The level of investment required will vary widely between PCTs so cannot be a shared investment decision: each PCT must determine its own investment locally (and work closely with borough social care). This investment is not included in the £23m already agreed for acute stroke care.

The introduction of hyper-acute stroke units (HASUs) and stroke units (SUs) as laid out in the consultation is expected to positively change the outcome of people who have had a stroke. It is expected that there will be an increased number of people who have had a stroke having mild disability or limited therapy needs and that there will be fewer people who die following a stroke. The impact of this decrease in mortality will mean that the number and profile of patients requiring rehabilitation and community stroke services may be expected to stay broadly similar. No study has prospectively looked at the issue of how hyper-acute care modifies therapy input; however, it is clear that thrombolysis increases the number of patients with a good outcome and very likely that hyper-acute care *per se* has a similar effect.

5 Part A – Assurance

This section will outline the description of assurance affecting the decision to be taken by the JCPCT:

1) Any factors that determine whether a particular decision or option should be discounted

   There have been no factors identified to suggest that the plans to further develop work on the whole stroke pathway would impact on any decision made by the JCPCT so as to discount a particular decision or option.

2) Any factors that influence a decision and should be considered 'in the round'

   No factors have been identified in relation to the plans for further whole pathway work that would influence any decision reached by the JCPCT.

6 Part B – Supplementary information relating to workstream implementation

6.1 Work to date

6.1.1 Prevention

National context
The early prevention work by the Healthcare for London stroke project recognises that a significant amount of work has already been carried out as part of the *National Stroke Strategy* and the *NHS Health Check*. This preliminary work has identified that London is performing poorly against stroke prevention indicators.

The Stroke strategy for London
The London strategy outlines a number of patient expectations from prevention services that were developed and tested with a range of patient representatives and patient organisations:

a) Public understanding what risk factors make a stroke more likely;
b) Increasing awareness amongst the public and healthcare professionals of the signs and symptoms of stroke;
c) Reacting quickly to reduce the chance of lasting impact on the lives of stroke survivors and their families.

The strategy outlines the biggest prevention concerns highlighted by stakeholders; these were a lack of:

a) Campaigns tailored for hard-to-reach and at-risk groups;
b) Education amongst healthcare professionals in recognising risk factors and symptoms;
c) Knowledge sharing and co-ordinated stroke prevention across London.

TIA services
The proposals for the reconfiguration of acute stroke services in London contain plans for transient ischaemic attack (TIA) services that will provide rapid assessment and access to a specialist within 24 hours (for high-risk patients) or within seven days (for low risk patients). These TIA services will form part of London's secondary prevention landscape as the access to expertise and further investigation provided in these units will reduce the likelihood that patients will go on to have a full stroke.

Draft prevention guidance for commissioners
Work has begun to develop draft guidance for commissioners to address these expectations and concerns. In developing the guidance, current performance and best practice examples have been considered alongside input from experts in the field. Following consultation with directors of public health, commissioners, general practitioners and acute experts, Healthcare for London has:

a) Identified key challenges to implementing the prevention agenda;
b) Developed high level solutions to address these;
c) Developed prevention standards for stroke to give assurance that the stroke prevention agenda is being delivered.

The Qualities and Outcomes Framework
The need to measure success of stroke prevention services in the capital was highlighted during this early work; standards for prevention were therefore developed from existing QOF (Quality and Outcomes Framework) data. QOF is a payment schedule for primary care based on targets for patient activity. QOF was chosen because it is currently the best and most comprehensive data source of preventative interventions. The indicators that were selected give assurance that both primary and secondary prevention interventions are in place.

The high level of exception reporting in QOF gives it limitations as a health indicator. GPs can choose to report patients as exceptions and these patients will not appear in QOF data and little may be known as to why patients are reported as exceptions. Looking at QOF data in isolation does not therefore provide an accurate view of the health of the population. Healthcare for London therefore also looked at the data that were excluded from QOF. Metrics were then developed from both of these approaches. Stroke awareness is not covered in QOF so non-QOF based standards were also created to ensure that stroke awareness is delivered in London.

Gaps in services
Areas have been identified where there are gaps in prevention services. These include a lack of emphasis on the maintenance of the stroke registers that allow the follow-up of stroke patients to be co-ordinated and assured.

In addition, some groups may be excluded from prevention services. For example, the exclusion from the *NHS Health Check* screening programme of those over 74 years of age means that individuals with stroke risk factors may fall through the prevention net. In addition, QOF measures the process of prevention rather than the outcomes. As such, patients may be on treatment to control their blood pressure but this may not necessarily mean that their blood pressure is under control. The stroke prevention guidance for London commissioners will address such gaps in services.

6.1.2 Rehabilitation and life after stroke services

The *Stroke strategy for London*
Support for the development of non-acute services for stroke survivors has been identified as a priority by the JCPCT. Early work by the Healthcare for London stroke project on rehabilitation and life after stroke developed recommendations and performance standards for inpatient rehabilitation, initial access to community rehabilitation, and the review of patients in the first year following a stroke.

These recommendations and performance standards, published in the *Stroke strategy for London*, were developed through a process of clinical and patient engagement at large workshops, working groups and through the Healthcare for London stroke project governance panels. The stroke project team also engaged with stroke survivors, carers and their representatives. Six stroke engagement events were held, including one focussed specifically on rehabilitation and community care. Each event was attended by up to 200 people including staff from inpatient and community stroke services, social care and the voluntary sector and a number of patients and carers. In addition, presentations were made to specific groups including directors of social services and intermediate care managers.

The *Stroke strategy for London* states that:

> 'Rehabilitation and care services should be delivered around the needs of the individual and their family. These include aspects of care related to clinical issues and residual impairments (including communication problems), but also to the person's functional and activity-based goals and ongoing social participation. The psychosocial needs of the individual and their family, and their re-engagement back into society, also need to be addressed.' (p32)

The strategy outlines recommendations based on feedback from service users, London commissioners and providers, examples of good practice and the *National Stroke Strategy*. The *Stroke strategy for London* continues: (p32-33)

> 'The recommendations aim to help PCT commissioners develop user-friendly rehabilitation services which respond to the needs of stroke patients and their carers. The stroke project will complete further work on long-term care and the links with primary and social care.
>
> 'The following are overarching recommendations that all London PCTs should adopt in commissioning stroke rehabilitation services. Specific performance standards for these services are set out for inpatient and community rehabilitation, GPs and the voluntary sector.
>
> 1. Inpatient rehabilitation should be available for all stroke patients. Rehabilitation starts as soon as possible and continues for as long as required. This must meet all of the performance standards.
> 2. Every PCT should commission a community rehabilitation service for stroke patients that includes staff with specialist stroke skills. The configuration of this service is for local determination but it must meet all of the performance standards.
> 3. Every PCT should commission an early supported discharge service that includes staff with specialist stroke skills. This service must meet all of the performance standards.
> 4. Everyone who has had a stroke, and their carers, should have:
>   i) A key support worker such as a family support worker or community matron to provide:
>   - longer-tern support;
>   - navigation and advocacy; and
>   - a link with the inpatient and community rehabilitation teams and other care providers.
>   ii) A designated person from health or social care who is the key contact for the patient and carer whilst in each setting, such as a therapist, social worker, or healthcare assistant.
> 5. For the first 12 months following a stroke, all individuals and carers will have a regular review and assessment of ongoing medical, social and emotional needs as both an inpatient and in the community.
>
> 'The recommendations aim to greatly improve current rehabilitation services in London, reducing inequalities in provision that exist between different localities. The recommendations also aim to improve communication between different care settings and with the patient.'

Post *Stroke strategy for London*

Since the publication of the *Stroke strategy for London* in November 2008, follow up work has been completed with a working party consisting of representatives from health, social care and the voluntary sector. Other interested individuals and groups such as GPs and community rehabilitation teams were also engaged. This work

clarified some of the services currently available across London. A number of service gaps and examples of good practice were identified that informed the further development of Healthcare for London's recommendations. Evidence from a range of national strategies and guidelines was also drawn upon.

This work has developed more comprehensive rehabilitation and community recommendations, including commissioning guidance and recommendations for the longer-term provision of services in the community setting (life after stroke). A third sector working group and a grassroots user group have been established to support the workstream in the development of life after stroke recommendations. The work of these groups has focused around the care model described in the *National Stroke Strategy* and any areas that were identified as not being represented within this care model.

Network level
In addition, work has been carried out at the local level with London cardiac and stroke networks comparing the services being provided for stroke patients with the quality markers defined in the *National Stroke Strategy*. This process identified where services meet the quality markers, such as the established early supported discharge teams in some boroughs and vocational rehabilitation services in others. The process also identified where there are gaps, outlined some recommendations for meeting the quality markers and provided a high-level project plan for the implementation of those recommendations for the networks.

Third sector
In addition, the Stroke Association has been commissioned to map third sector services across London and produce an accessible directory of services for use by health and social care professionals, service users, third sector organisations, PCTs and the general public.

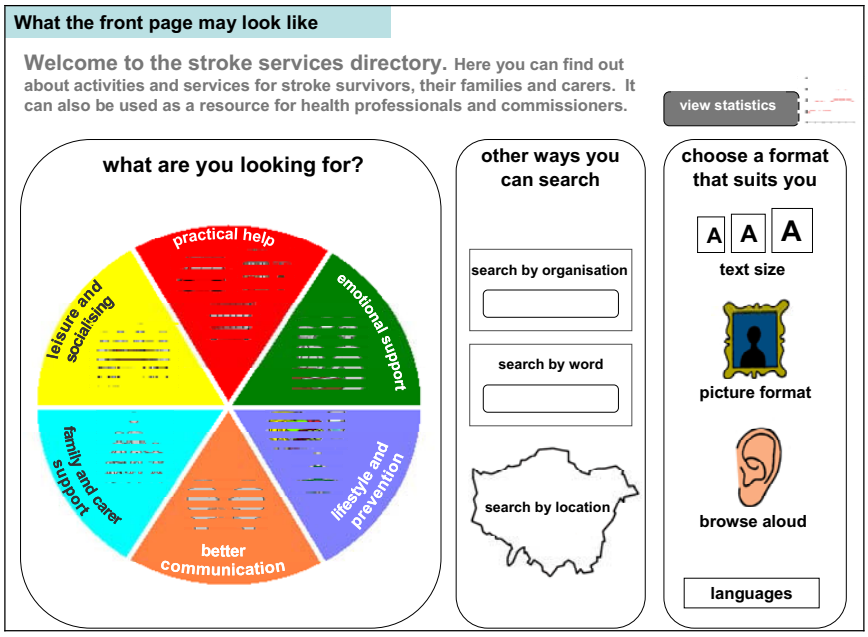
This resource will assist stroke survivors and carers in continuing to access services in the months and years following their stroke. Some services are provided across London and others at a very local level and it is difficult for patients to know exactly what services are available, how they are accessed and how they are funded. Moreover, many statutory organisations providing services to stroke patients may benefit from a repository of the details of all of the third sector services available.

The first stage of the project involved the mapping of the voluntary sector organisations providing services to stroke survivors across London. Information was collected through a variety of means including a postal survey, work with localised mapping co-ordinators (for example, at Hillingdon and Kingston PCTs), and by meeting with members of other voluntary sector organisations already known to Healthcare for London and the Stroke Association.

Research was conducted across all 31 London PCTs and organisational data was collected from 728 voluntary sector organisations. It is anticipated, however, that data gathering will continue into the second stage as new organisations emerge and information changes.

As well as the mapping exercise, the preliminary work for stage two has been completed. This stage will produce a directory of mapped services in an accessible format and a proposal for the maintenance of this directory. This has involved developing a structure on which to base the navigation of the online directory so that it is accessible for all of those within the stroke pathway.

The following visualisation gives an indication as to what the final directory could look like.



6.2 Further development phase

The further phase of whole pathway development is led by the conclusions of the work completed to this point. The current schedule runs until end of December 2009 and will encompass the development of:

1. Commissioner guidance on stroke prevention
2. Commissioner guidance on rehabilitation and community stroke services
3. A directory of third sector stroke services

6.2.1 Commissioner guidance on stroke prevention

Guidance for PCTs in the commissioning of prevention services will be further developed. Recommendations will be developed with clinical colleagues and will fall broadly into three categories: primary prevention, secondary prevention (including the development of the TIA pathway) and public awareness.

This commissioner guidance will provide direction on stroke prevention to PCTs in order that:

a) They can understand the prevention needs in their area;
b) They can assess the suitability of forming partnerships with other organisations to improve stroke prevention;
c) The London population and the wider stroke community have confidence that stroke prevention is being delivered throughout London.

Drawing upon the material already collated by the Healthcare for London stroke project, coupled with emerging work from across London, the following elements will form part of the prevention guidance:

a) Existing prevention initiatives and guidance on the methods that PCTs can use to support the wider prevention and healthy lifestyles agenda;

b) The identification of service gaps within the current prevention services as derived from the *National Stroke Strategy* and the *NHS Health Checks* programme;
c) The description and analysis of current prevention performance indicators (QOF);
d) Links between prevention services and community based urgent care providers;
e) The development of the TIA pathway and secondary prevention services.

Proposed timescale
Publication of commissioner guidance on stroke prevention is planned for autumn 2009 following development with clinical stakeholders.

6.2.2 Commissioner guidance on rehabilitation and community stroke services

The aim of this guidance is to assist PCTs in commissioning services that:

a) Are easy to navigate and that respond to patient and carer needs;
b) Improve the quality and effectiveness of the rehabilitation and community stroke care that is delivered across London;
c) Improve support for people who have had a stroke and carers to access the right services in a timely manner;
d) Reduce the inequity of access to rehabilitation and community stroke services across London;
e) Improve links between acute, community stroke services and social services.
f) Make best use of investment in post-acute care.

Two high level components of this deliverable have been identified for further investigation: a life after stroke model and investment priorities.

Development of life after stroke care model as identified in the *National Stroke Strategy*
Working with the Healthcare for London stroke project's expert panels and other members (professional and non-professional) of the London stroke community, the following additional priorities have been identified to ensure that the Healthcare for London commissioning guidance is comprehensive and is appropriately focussed:

a) Carers and family
b) Re-enablement
c) Communication
d) Practical help
e) Care and support
f) Adult protection
g) Local engagement

Investment priorities
An analysis of south London services providing stroke rehabilitation in the community with the *Stroke Strategy for London* suggested a very considerable gap between current and proposed standards in some PCTs. Financial analysis indicates that the scale of this gap is such that achieving the standards would be unaffordable for some PCTs under present NHS funding assumptions.

Further work is therefore needed to:

a) Seek more efficient approaches to provision of care, where necessary reviewing the performance standards;
b) Identify the potential for funding investment in community rehabilitation from disinvestment elsewhere in the pathway (e.g. split tariff arrangements for early supported discharge, reduced reliance on medium and long-term bed based care);
c) Identify which investments give the greatest return in terms of patient benefit and in terms of savings elsewhere in the pathway.

Proposed timescale
Further work on rehabilitation and life after stroke, commissioned from specialists, is planned for the summer of 2009. The full guidance for commissioning rehabilitation and community stroke services is planned for publishing in autumn 2009.

6.2.3 Directory of third sector services

The stroke project team has commissioned the Stroke Association to develop a directory of third sector services. The project team will continue to manage the development of this work. This resource is essential to assist stroke survivors and carers in continuing to access services in the months and years following their stroke. Many of these services are provided by voluntary sector organisations – some through statutory funding and others on a charitable basis.

Some services are provided across London and others at a very local level. It is difficult to obtain a clear map of what these services provide, how they are accessed and how they are funded. Moreover, many statutory organisations providing services to stroke patients may not know that some third sector services exist and therefore stroke survivors may miss out on services from which they may benefit.

Proposed timescale
Stage one was completed on 12 June 2009. This stage comprised of the mapping and documenting of all of the third sector organisations providing services to stroke survivors and carers across all 31 London PCTs and the provision of a stage one report.

Stage two is expected for completion by 2 November 2009. This stage will produce a directory of mapped services in an accessible format and a proposal for the maintenance of this directory.

6.2.4 Links to other work

A number of the aspects outlined link to other Commissioning Support for London (CSL) or NHS London initiatives.

1. The continuing professional development (CPD) framework for stroke. This project is being developed to establish a CPD framework for professionals working with stroke patients throughout recovery and rehabilitation. The intention is to identify the skills required and map these to Skills for Health and the *Knowledge and Skills Framework* to assist with workforce establishment and development.

2. The Healthcare for London major trauma project. There is some congruence between the rehabilitation services required for stroke patients and those who have sustained traumatic injuries. The parallels will be explored and links will be forged as appropriate. The CPD framework development is being run as a project in conjunction with the major trauma project and this will therefore contribute to this process.

3. The Healthcare for London long-term conditions project (Diabetes). Many of the prevention messages being developed by Healthcare for London are generic and will be strengthened if worked on collaboratively, rather than on a disease specific basis.

4. The long term conditions community – London region. This is a Department of Health (DH) initiative to help anyone with an interest in improving delivery of services for long-term conditions. Stroke is considered to be a long-term condition when services are delivered within the community setting and a member of the regional team is part of the life after stroke working group.

5. London local authorities – implementation of the *National Stroke Strategy* (Service Improvement Funding). The DH has provided financial support to deliver stroke care for adults in the community for each local authority with adult social services responsibilities.

6. The DH/Stroke Association FAST campaign. This is a three-year national campaign, launched on 9 February 2009, which aims to increase public awareness of stroke. Any pan-London awareness initiatives should be consistent with the national campaign.

7 Conclusion

Both prevention and post-acute stroke services in London can be improved. Healthcare for London will build on the work to date to produce a framework to enable this to happen. Commissioner guidance on stroke prevention is planned for publishing in autumn 2009. Commissioner guidance on rehabilitation and community stroke services is planned for publishing in autumn 2009. A directory of third sector services to assist stroke survivors and carers will be available from November 2009.

The plans in place to continue work on the non-acute aspects of the stroke pathway support the commissioning of the whole stroke pathway of care and provide assurance to the JCPCT that all elements of prevention and care are being considered.

Healthcare for London

NHS
Commissioning Support for London

Healthcare for London
The shape of things to come

Progress report to the
Joint Health Overview and Scrutiny Committee

28 October 2009

Introduction

1. The purpose of this document is to update the Joint Health Overview and Scrutiny Committee (JHOSC) on Healthcare for London's progress in implementing the Joint Committee of PCTs (JCPCT) recommendations.

2. The JHOSC recommendations were key to the development of the JCPCT recommendations. Other reports that informed the JCPCT recommendations, were;

    - Health Link report on the views of traditionally under-represented groups
    - Ipsos MORI report on consultation responses
    - Integrated Impact Assessment
    - Patient and Public Advisory Group response to consultation

3. For ease of reference;

    - this document lists every JCPCT recommendation, **and where they correlate to a JHOSC recommendation.**
    - the progress column sometimes contains a subheading to show where it refers to stroke, trauma or a specific JCPCT recommendation. Otherwise, the content is displayed as a general narrative.

4. JHOSC recommendations which were addressed in the report *Healthcare for London: Response to the Joint Health Overview and Scrutiny Committee* or did not have a corresponding JCPCT recommendation are not repeated here.

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
Travel The JCPCT recommends commissioners: 1. Work with the London Ambulance Service to understand actual travel times' performance and to promote awareness of actual blue light travel times in order to build public confidence.	No specific recommendation regarding travel times. However, in light of the fact the committee discussed travel times at length, we have provided a detailed response (see right-hand column) on our work with London Ambulance Service (LAS) on recording and monitoring travel times.	**Stroke:** The travel time from scene to HASU/MTC is only one part of this pathway which runs from call to HASU/MTC. To ensure that patients receive timely care we need to focus on all steps in the pathway. For stroke that means encouraging a rapid 999 call (which the FAST campaign supports), getting the ambulance to the scene quickly (which will be helped both by the reclassification of stroke as a category A emergency and by significant PCT investment to support the provision of additional ambulances and crews) time on the scene (which will be the focus of LAS training) and finally journey times from scene to HASU (influenced by choice of route which will be the subject of LAS guidance to crews, modified in the light of real world experience). Healthcare for London is working with the LAS to introduce monitoring that will capture all these elements. We do not expect that the 30-minute target will be achieved immediately: there will be a period of learning when the new system is launched. To support that learning approach, the LAS will not simply be capturing times, but rather will be following up all journeys that exceed 30 minutes to understand the reasons and putting in place improvement plans to address issues that arise. Through the use of PDSA cycles in this way, an improvement trajectory will be set. Under certain circumstances it will not be possible or sometimes even appropriate to achieve the target (for example if a crew needs to stop the ambulance in order to resuscitate a patient en route or when there has been exceptional traffic disruption) - it will never be possible to ensure that every single journey happens within the target time. Minor delays are unlikely to be of clinical significance. In order to provide reassurance of this, the Clinical Director will be leading the development of an audit approach to relate outcomes to travel times.

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
		The full HASU system will not be operational until Princess Royal University Hospital (PRUH) comes on stream: during that period journey times in the south east will be longer, but patients who are within the three-hour window for thrombolysis will be prioritised. **Trauma:** The LAS have recruited staff to monitor data to ensure that the travel times target can be managed appropriately. The LAS audit department will be undertaking a continual audit of travel times to major trauma centres. In addition, the clinical co-ordination desk will be able to provide real time data on the transfer of patients from incident to major trauma centre. The monitoring of travel times is included within the performance management framework. The London Trauma Office will work in partnership with the LAS to and will report audit findings to the London Trauma Board.
Access for relatives and carers The JCPCT recommends commissioners engage with acute hospital trusts and Transport for London to: 2. ensure comprehensive travel information is provided on their websites and at the hospital itself. This should be accessible to disabled people and those who do not speak English. 3. ensure hospital travel plans address any impacts of these proposals. Travel plans should address the needs of staff, visitors and patients and encourage sustainable travel. 4. ensure appropriate public signage to specialised centres at nearby bus stops, underground stations and railway stations and within hospitals. This should be comprehensible for different equality groups.	15) We recommend that every specialist centre draws up a hospital travel plan, in liaison with Transport for London and the relevant local authority(ies). This should include provision of clear travel information; car parking charging arrangements which do not disadvantage those arriving in haste; and identify a Board-level 'travel champion'.	**JCPCT recommendations 2 – 6** are being taken forward by PCTs working with acute providers.

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
5. consider transport solutions for visitors and enter into discussion with Transport for London, with a view to ensuring suitable bus routes to major trauma and stroke centres. 6. consider facilitating local accommodation for relatives to use at critical times.		
Joint working and investment The JCPCT recommends commissioners: 7. engage locally with London local authorities and social services authorities bordering London; and across London with the Association of Directors of Adult Social Services (ADASS) and London Councils – in order to develop plans for seamless care pathways and the promotion of healthy lifestyles. 8. consider the development of rehabilitation caseworker (or navigator) roles which will ensure that rehabilitation needs are identified and met especially when responsibility for patient care is handed over at different parts of the pathway. 9. should explore the opportunities to develop proposals for jointly planned and commissioned community-based services. 10. involve social services early in the planning of longer-term care pathways following acute treatment. 11. provide more support to enable carers play an active role in pathway planning and rehabilitation. 12. provide a progress report to the JHOSC, on the implementation of stroke and trauma services – by October 2009.	11) We recommend that the Association of Directors of Adult Social Services (ADASS) and London Councils - as well as London local authorities and social services authorities bordering London - need to be engaged more fully in developing plans for a seamless care pathway. 13a) that there should be an early involvement of hospital social work teams in planning longer-term care pathways following front-end clinical treatment; 13b) that an assessment of joint financial incentives is undertaken, in order to allow more co-ordinated investment in enhanced community-based resources to be achieved.	Links are established with ADASS and London Councils, and monthly meetings will take place with the Chair of the Joint Improvement Partnership (JIP) and the Regional Director for Social Care to enable joint commissioning and ensure we take forward the JCPCT recommendations. **Stroke**: Rehabilitation commissioning guidance which will be published shortly aims to achieve consistent access to high quality rehabilitation services. The document provides guidance on rehabilitation caseworker roles. Guidance for 'life after stroke' will be published in 2010 and will be a responsibility of the London Stroke Office. The rehabilitation guidance states that units delivering inpatient rehabilitation (including the designated stroke units) will have strong links with local social services, encourage early involvement of social services in a patient's care plan and seamless development of care pathways and transfer of care from each care setting. The guidance also recommends a joint approach (between PCTs, local authorities and other agencies) to vocational rehabilitation – where rehabilitation focuses on getting a person back to work. This is relevant for the quarter of stroke patients who are under 65. In addition, an event is due to take place for stroke rehabilitation commissioners to enable them to share experiences, identify strong rehabilitation services and learn from others.

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
		Trauma: A rehabilitation workstream is taking forward the work on rehabilitation including piloting a rehabilitation model and developing rehabilitation navigator roles. A team is currently being recruited to examine the skills and competencies required for navigator roles. Early involvement of social services will be considered as part of the rehabilitation model and we welcome input from social services on this aspect of the project.
Equality, diversity and information The JCPCT recommends that commissioners work with acute hospitals to ensure: 13. translation/interpretation services are available for patients/families from ethnic minorities. 14. appropriate access to advocacy is provided, particularly for people with language difficulties or a disability. 15. staff receive diversity and cultural awareness training in order to equip them better with the cultural needs of their patients and visitors and/or respond to the needs of people with particular disabilities. 16. at the earliest appropriate point after admission, patients, families and carers have explained to them, in simple terms, their care pathway: from specialist centre, to local unit for rehabilitation, and a return to community care. 17. specific protocols are in place to deal with issues relating to the ongoing care of those not entitled to receive free NHS care.	18b) that, at the earliest appropriate point after admission, patients should have explained to them, in simple terms, their care pathway: from specialist centre, to local unit for rehabilitation, and a return to community care. A leaflet containing basic information would be helpful. 19a) that, given the higher incidence of stroke among some BME groups, there should be access to an interpreter at a HASU, to explain the next steps in a patient's pathway, and to answer questions or concerns; 20) We recommend that future consultations by the JCPCT ensure that the full results of HIA are made available to the public and a London-wide JHOSC before the end of the public consultation period, to allow consultation responses to be suitably informed.	**JCPCT recommendations 13 – 17** are being taken forward by PCTs working with acute providers. High-level explanation of the expected care pathway to patients and families/carers will be a requirement post admission. Performance standards developed for HASUs require that patients are given information in a variety of formats. Adherence to this standard will be assessed and monitored by networks and commissioners. A learning exercise was undertaken by the health impact assessment team. A key point of learning was that 'the draft IA should be scheduled to be completed before the final response from the JHOSC, rather than around the same time. This would enable the JHOSC to consider the emerging findings and draft IA.' This, and other learning from the HIA, will be shared to inform future consultations.
Patient transfer The JCPCT recommends that commissioners work with acute hospitals to ensure:	28a) that provision in HASUs allows for the percentage of patients who need to remain longer than the 72-hour period referred to in the consultation paper,	**Stroke:** Protocols have been developed to ensure timely transfer to local stroke units, supported by clear rules in the new contract with penalties for local units that do not accept patients in a timely way.

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
18. facilitation of timely transfers back to local stroke or trauma units.	as well as those patients admitted as a result of incorrect diagnosis. Pressure on bed space must not lead to premature transfers, nor should beds dedicated for transferred stroke patients be allocated to general patients, thus making transfers to the most appropriate hospital more difficult; 28b) that protocols set out clearly the arrangements for patient transfer, and include adequate provision for dedicated beds and specialist stroke teams for patients in Stroke Units.	**Trauma:** Guidance on essential elements of repatriation is being developed and will form part of the performance framework. This will ensure consistency of approach across London. To inform the local protocols for repatriation to local hospitals and trauma centres within networks. Commissioners are considering potential penalties for refusal/delay in acceptance of patients from MTCs.
Implementation and transition The JCPCT recommends that commissioners: 19. agree and establish clear clinical and administrative protocols and monitoring arrangements for the transfer of patients with all relevant service providers before the new systems go 'live'. 20. put in place appropriate pan-London oversight of the implementation of major trauma and stroke services. For trauma, the JCPCT recommends commissioners: 21. use the Royal London, which is close to operating as a major trauma centre, as a case study to help identify what is and is not working effectively. 22. develop robust transitional arrangements for north west London (in the event of a fourth major trauma centre being agreed by the committee), which set out clear protocols regarding which patients should be transferred to a major trauma centre elsewhere in London and which should continue to be taken to a more local hospital.	1a) that a detailed action plan is drawn up which sets out effective measures for ensuring that mutually supportive arrangements will be achieved. 1b) that the action plan includes contingency provisions covering steps that would need to be taken if the envisaged collaborative arrangements fail. 2) that the action plan (referred to above) sets out clearly how the specialist centres will assist other centres during the transitional period, and identifies the resource implications involved. 3) that the JCPCT undertakes a risk analysis of the stroke services to be relied upon during the transitional period, in order to demonstrate clearly how services will be maintained. 10b) that local services to support the new high-quality stroke and major trauma services are in place and operating effectively before any changes or closures of existing units are made. 22c) that no existing centres of stroke specialist care should cease functioning until the new model of	**JCPCT recommendations 19 & 20** **Stroke:** Transition to the new service models has been carefully planned and is being formally project managed. Risks are assessed at both pan-London and network levels and reviewed by network boards and project boards. Healthcare for London continues to work with networks, providers and workforce specialists to ensure that units are appropriately staffed. Pan-London high level protocols have been developed and distributed appropriately. Networks are leading the localisation of these for each hospital. Protocols have also been developed to ensure patients are accepted into stroke units in a timely way. Pan-London oversight will be achieved through the London Stroke Board and the London Stroke Clinical Director. **Trauma:** A pan-London triage protocol has been developed and training for LAS staff is underway. Protocols are being developed within networks for patients who are under triaged. Work is also being

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
23. ensure that the development of any fourth major trauma centre is developed as quickly as possible. For stroke, the JCPCT recommends commissioners: 24. ensure that there is no deterioration of services during transition to the new model and configuration of care.	provision is fully operational and adjudged to be delivering to the high standards anticipated under the consultation proposals. Where removal or reduction of services is proposed, the local PCT must liaise with the local health scrutiny committee, to ensure that the views of residents are taken into account. 23a) that the JCPCT explains how it will ensure that adequate clinical capacity will be achieved during the initial period of development; 30) We recommend that the capacity of the Royal London Hospital to build on its present role as London's primary MTC under the consultation proposals is monitored, particularly within the initial period before the fourth MTC becomes fully operational. 31) We recommend that the JCPCT advise the JHOSC as to how it will ensure that designated MTCs maintain a good level of care to all patients, and do not compromise patient care by the sudden demands of a major trauma incident. We expect the JCPCT to address this in its evaluation of the implementation phase. 32) We recommend that MTCs draw up plans in co-operation with Trauma Centres to establish agreed assessment criteria and protocols which will set standards of quality care throughout the patient pathway. 33b) that a public commitment for the fourth MTC is made by the JCPCT, so that in the event of any future reductions in funding to the NHS, the fourth centre is not 'sacrificed'; 33c) that the fourth MTC becomes operational as soon after April 2010 as feasible.	undertaken to ensure the skills and competencies required by staff in trauma units are identified and appropriate training provided. The number of urgent secondary transfers (where a patient needs to be transferred from a trauma unit to a major trauma centre) is likely to be very small. However, plans to enable rapid transfer are in development. This will ensure that resources are not depleted from networks when transferring patients. Capacity of all major trauma centres will be monitored. A robust performance monitoring framework has been drafted to ensure data is collected at all points of the patient pathway. Data will be collated by the London Trauma Office and will help demonstrate the benefits of the system, ultimately through examining patient outcomes. The London Trauma Board will publish annual reports which will describe the impact and benefits of the system. The project has close links with the Department of Emergency Preparedness. Each Trauma network has been asked to submit plans for major incident planning. These will be collated to develop an overall plan utilising all four networks. The clinical co-ordination desk will have a real time overview of major trauma patients being transport Pan-London oversight will be achieved through the London Trauma Board and the London Trauma Clinical Director. **JCPCT recommendation 21** The Royal London Hospital has been, and continues to be, intrinsically linked with the trauma project and continues to provide expertise to the ongoing development of the London Trauma System. **JCPCT recommendations JCPCT 22 & 23** The JCPCT made a public commitment to a fourth major

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
	34) We recommend that local authorities serving N.W. London are consulted at an early stage on the proposals for a transition plan.	trauma centre on 20 July. The anticipated date for the fourth MTC becoming operational is October 2010. A transition group has been established, with membership from each network, to develop the transitional arrangements for trauma patients in NW London including any protocols or agreements between networks. The first meeting will be held in November. As soon as a draft plan is available, we will liaise with local authorities in the NW sector to take the plan forward. Implementation of the fourth network will continue to be supported by the London Trauma Office until the agreed 'go live date', with implementation plans submitted on a regular basis. **JCPCT recommendation 24:** Capacity for HASUs and SUs has been determined by the Healthcare for London team and new SUs are opening prior to any decommissioning of non-designated units and prior to HASU launch. This, together with the measures outlined above (**JCPCT recommendations 19 and 20 - stroke**) will ensure that services will improve and not deteriorate during transition. In general, PCTs have well-established lines of communication with local OSCs and regularly update them on Healthcare for London implementation
Workforce To address workforce issues, the JCPCT recommends that commissioners: 25. work with networks and hospital trusts to explore flexible working arrangements, allowing opportunities for staff rotation within, and between, networks and units.	4a) that the JCPCT ensures that Hospital Trusts and PCTs prioritise recruitment, with a timetable to ensure delivery of appropriate staff; 4b) that the JCPCT identifies what action it will take to address any shortfall in the numbers of specialist staff, including the reliance that will be placed on the use of agency staff in order to fill the number of	Healthcare for London continues to work with networks, providers and workforce specialists to ensure that units are appropriately staffed. **Stroke:** Networks are working with providers to encourage flexible working arrangements. Joint appointments and joint rotas (for example on-call) are

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
	places required; 4c) that the JCPCT reports back to this JHOSC by October 2009 on progress being made to recruit staff for the new stroke and major trauma networks. 6) We recommend that flexible working arrangements are explored, allowing opportunities for staff rotation within, and between, networks. 38) We recommend that the London Trauma Office monitor the recruitment and training of staff across the networks, to ensure that adequate numbers of suitably trained staff are available by April 2010.	already established in several locations. **Trauma:** Networks are exploring potential for staff rotation and training within and across networks. An education and training group established will provide a forum to develop these opportunities, and funding is available to support these initiatives.
Evaluation 26. To ensure a greater understanding of the issues and to support future developments, the JCPCT recommends that commissioners put in place effective monitoring and evaluation to ensure that the benefits of the new system are being realised. This should: • ensure that the mutually supportive arrangements envisaged in the new networks are achieved. • enable the swift activation of contingency arrangements if necessary. • help administer culturally sensitive care. • monitor trends in numbers and types of injuries being admitted to trauma and major trauma centres and who is most susceptible to them. • ensure that other services and patient care do not experience an adverse impact. • monitor the impact of the new arrangements on the movement of staff. • allow commissioners to better understand and review the quality of, capacity, and demand for services in each HASU and stroke unit – in order to review the number and location of units required if demand is not as expected or changes.	21a) that the JCPCT ensures that robust arrangements for data collection and analysis are in place by April 2010. 21b) that the proposed changes are monitored closely, in order to identify the impact on specialist service provision, patient experience, and to ensure that other services provided by the specialist centres have not experienced an adverse impact. We would expect a review report on the findings to be published 12 months after implementation in April 2010. 21c) that the JCPCT monitors the impact of the new arrangements on the movement of staff to the specialist units from other hospitals, to ensure that there is no negative impact upon the latter. 22a) that the immediate eight HASUs should be seen as the minimum number, and the JCPCT should be prepared regularly to review this number and to increase the number if demand justifies it. 23b) that the JCPCT ensures that effective monitoring arrangements are in place which will allow a re-	Clear commissioning and performance management arrangements are in place. Providers will be commissioned to provide an appropriate level of activity rather than a set number of beds. Regular contract monitoring will take place. A full benefits realisation plan is being developed. **Stroke:** we will closely monitor implementation to ensure it is successful; the networks will take a lead role in this work. In addition, the new stroke tariff will be linked to quality targets, giving hospital trusts further incentive to meet high standards. The establishment of universal hyper-acute care in London provides an ideal opportunity to undertake formal, scientific research to evaluate the impact of the new model of care. The stroke clinical director will work with the two stroke research networks for London to take this forward. The stroke clinical director will work with the stroke networks to develop a system, based on key measures, to assess the impact of the new model of care in

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
• enable a review to be published 12 months from implementation.	assessment to be made, if necessary, of the optimum number of HASUs for London's population, and whether the designated HASUs are the best providers possible. 38) We recommend that the London Trauma Office monitor the recruitment and training of staff across the networks, to ensure that adequate numbers of suitably trained staff are available by April 2010.	reducing disability. **Trauma:** The London Trauma Director and London Specialised Commissioning Group (LSCG – which has responsibility for commissioning major trauma services) are scrutinising plans for trauma networks on a monthly basis. This includes the provision of workforce and recruitment plans. In addition the National Clinical Director for Trauma will undertake an external assessment of these plans in January 2010.
Areas bordering London The JCPCT recommends that commissioners: 27. collaborate closely with bordering authorities to ensure transfer protocols are developed that address cross-border inflows, outflows and transfers for the acute and repatriation parts of the pathway; and enable extra trauma capacity in the event of a major incident.	16a) that visitor journey times to the new specialist centres for areas up to ten miles outside the Greater London Authority border be modelled, so that the implications can be taken into account in planning visitor journey times; 16b) that the JCPCT ensures that PCTs and Ambulance Services serving areas adjacent to London's borders are fully involved in forward planning for the new arrangements; 16c) that joint working 'across the borders' is undertaken to produce transfer protocols which will provide clarity to Ambulance Services and hospitals.	**Stroke:** Meetings have taken place with each neighbouring SHA. Letters have been sent to all SHAs outside of London, as well as the stroke networks and PCTs that border London. Once commissioning intentions are established, we will liaise with ambulance services outside London. **Trauma:** Meetings are taking place with each neighbouring SHA and ambulance service to agree patient flows to London major trauma centres and repatriation agreements following discharge. The LSCG has written to all neighbouring PCTs and SHAs to outline the plans for trauma and the corresponding tariff. Networks which extend beyond London will be working with the trauma units in those areas to ensure that patients are repatriated in a timely fashion.
Issues specific to major trauma		
Model of care The JCPCT recommends commissioners: 28. assess the treatment of spinal cord injuries once the initial triage protocol is successfully established, monitoring outcomes and taking responsive action	No specific recommendation	The project is working with the South East Spinal Cord Commissioning Group to develop specific pathways for spinal patients. The development of network staff capability will be considered by the education and training group linked to the London Trauma Office.

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
as necessary – taking into account the recommendations in *Preserving and Developing the National Spinal Cord Injury Service* (May 2009). 29. consider the further development of network staff capability once the London trauma system is operational.		
Use of helicopters The JCPCT recommends commissioners: 30. carry out further work to assess the need for (and location of) increased helicopter access in London once the London trauma system is in place.	No specific recommendation	The London Trauma System will undertake a needs analysis with the aim of improving helicopter access across London. Ongoing work reviewing journey times of ambulance and helicopter journeys will be taken forward.
Triage and inaccurate assessment The JCPCT recommends that commissioners: 31. ensure assessment and triage protocols that are already developed are supported by appropriate training and skills development before 'go-live'.	35) We recommend that adequate resources are available on a continuing basis to ensure that training in the best triage methods is offered by paramedics at scene. 36) We recommend that diagnostic expertise is retained at DGHs, to allow the rapid transfer of a patient to a MTC, should that be necessary. Clear systems covering cases for onward transfer will need to be put in place.	Implementation of a triage protocol within the LAS will be supported by a robust training timetable for all staff. Involvement in a trauma network where protocols exist for the diagnosis and transfer of patients to the MTC will facilitate the speedy assessment and rapid transfer of patients to MTCs from trauma units.
Prevention The JCPCT recommends that commissioners work with NHS London: 32. to develop a long-term strategy and co-ordinate the effective relationships between agencies to promote healthy, sensible lifestyles, including an emphasis on factors related to the cause of major trauma injuries, particularly among the young. 33. takes action on prevention by promoting the development of prevention campaigns in plain	9) We recommend that NHS London develops a long-term strategy to promote healthy, sensible lifestyles, including an emphasis on stroke prevention, and factors related to the cause of major trauma injuries, particularly among the young.	The development of prevention initiatives and co-ordination of effective relationships will be included in the scope of the major trauma prevention strategy due to be published in April 2010. Prevention will be taken forward by the London Trauma Office through implementation of the prevention strategy at network level and co-ordination of existing campaigns/agencies at a system level.

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
English, which focus on certain geographical areas or causes of major trauma (for example, road safety; knife/gun crime).		
Patient transfers and discharge The JCPCT recommends that commissioners: 34. ensure transfer and discharge protocols are in place to ensure patients are transferred to trauma centres closer to their homes as soon as clinically appropriate before 'go-live'.	14a) that clear clinical and administrative protocols for the transfer of patients are agreed with all relevant service providers, and established before the new systems go 'live'; 14b) that systems should be put in place for monitoring transfer arrangements, to allow early corrective action to be taken where necessary.	Transfer protocols are being developed within each network and will be evaluated as part of an external assessment in January. Local protocols for repatriation to local hospitals and trauma centres within networks are currently being developed by each network. Commissioners are considering potential penalties for refusal/delay in acceptance of patients from MTCs.
Rehabilitation The JCPCT recommends that commissioners: 35. support trauma networks in mapping and developing flexible rehabilitation services for patients with complex polytrauma. 36. seek to ensure consistency of access to rehabilitative care across London. 37. ensure specialised neuro and spinal rehabilitation services are linked into the work of the London trauma system. 38. ensure staff on wards possess relevant training to support them in their role (for example, neuro and musculo-skeletal).	12) We recommend that the JCPCT undertakes an audit of rehabilitative stroke and trauma services across London, with a view to determining: a) those PCTs which need to invest more in rehabilitation, and their capacity to fund this further investment; b) the capacity of PCTs to put in place follow-up teams needed at Stroke Units and Trauma Centres to take responsibility for ensuring that once a patient is discharged, they do not 'fall through the care net'; c) how the JCPCT will ensure that all PCTs are in a position to ensure consistency of access to rehabilitative care across London. 37) We recommend that, as part of achieving high-quality rehabilitation after the initial principal clinical intervention, staff on wards should possess relevant neuro-training. 38) We recommend that the London Trauma Office monitor the recruitment and training of staff across the networks, to ensure that adequate numbers of suitably trained staff are available by April 2010.	A pilot of a rehabilitation model will be developed; part of this pilot will look at how the rehabilitation needs of patients with complex polytrauma will be assessed. Links have been established with the South of England Spinal Injuries Board. Work is moving forward in identifying specific pathways for patients with spinal injury and spinal cord injury across the London trauma networks. Work is also being undertaken to ensure strong links exist between the neuro-rehabilitation centres and the London Trauma system. Workforce training is included within implementation planning for each MTC and network. Work is ongoing to support education and training for this group. Adherence to a set of core standards will underpin the rehabilitation guidance and so help to ensure consistency of access. In addition, we will work with SACUs to ensure they address rehabilitation in a consistent manner. A SACU is a Sector Acute Commissioning Unit; there are six in London. They bring together PCTs into sectors to facilitate more effective

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
	39) We recommend that specialised neuro-rehabilitation services are linked into the work of the Trauma networks. We would like to see all - and not just some - PCTs provide multi-specialist rehabilitation.	commissioning through a smaller number of units.
Issues specific to stroke		
Triage, incorrect assessment of patients and self-presentations The JCPCT recommends that commissioners: 39. ensure protocols are developed for the management of stroke 'mimics' and patients attending at a hospital with no HASU who are discovered to have had a stroke. These protocols should be in place and clearly communicated before 'go-live'.	22b) that planning for patient numbers at HASUs takes account of the likely significant percentage of non-stroke admissions, and patients arriving by means other than blue-light ambulance	Pan-London high level protocols have been developed and distributed appropriately. Networks are leading the localisation of these for each hospital.
Prevention The JCPCT recommends that commissioners work with NHS London: 40. to develop a long-term strategy and co-ordinate the development of effective relationships between agencies (especially with local authorities) to promote healthy, sensible lifestyles, including an emphasis on stroke prevention. 41. to take action on prevention by promoting the development of prevention campaigns in plain English, which focus on certain geographical areas or causes of stroke (for example, smoking and lack of exercise). Prevention strategies should include a strong emphasis on secondary prevention, with GPs taking responsibility for identifying patients with risk factors and treating them actively to reduce the risk	9) We recommend that NHS London develops a long-term strategy to promote healthy, sensible lifestyles, including an emphasis on stroke prevention, and factors related to the cause of major trauma injuries, particularly among the young. 25a) that the JCPCT calls on the Government to build upon the initial success of the 'FAST' campaign, in order that its key messages are reinforced and translated into better stroke outcomes; 25b) that the JCPCT undertakes a London-wide public awareness campaign to refresh the 'FAST' message after a suitable period. This should also address lifestyle factors which can lead to stroke, and what to do to lessen the chance of a stroke; 25c) that appropriate information about strokes be	**JCPCT recommendation 40** London boroughs and PCTs have a range of joint appointments, pooled budgets and local partnerships. There are strong local public health programmes including, for example, tackling child obesity, bullying and domestic violence. **JCPCT recommendation 41** Stroke is a vascular disease. Therefore the preventative measures for stroke are the same as for vascular disease, and they align with general measures for healthy lifestyles. Local and national healthy living programmes are in place. Guidance has been given to PCTs for completion of commissioning intentions for 2010/11. The London Social Marketing Unit (LSMU) has

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
of stroke and where appropriate linking in with the vascular screening programme. 42. to develop appropriate information about strokes and make it widely available at health service centres throughout London, on health service websites, and at other locations (for example, libraries and supermarkets). This literature should include a focus on TIAs. 43. to take steps to ensure that GPs receive good training in stroke recognition, including TIAs.	made widely available at health service centres throughout London, on health service websites, and at other locations (e.g. libraries, supermarkets). This literature must include a focus on TIAs; 25d) that the JCPCT takes steps to ensure that GPs receive good training in stroke recognition, including TIAs; 25e) that there should be a maximum referral time target of 24 hours from identifying a TIA to access to a specialist. 26a) that there should be an increased provision of 'plain English' advice aimed at promoting a better understanding of the personal health factors (e.g. smoking, lack of exercise, eating too much of the 'wrong' sort of foods) which may contribute to a greater likelihood of a stroke; 26b) that greater joint working take place between PCTs and local authorities around the promotion of healthy lifestyles.	supported the introduction of NHS Healthchecks in London, a national programme to prevent cardio-vascular disease and targeting 40-74 year olds. As many stroke events and stroke deaths occur in people over 75 years, additional local prevention initiatives targeting older people have been recommended, and should include active case finding for atrial fibrillation. Prevention is commissioned on a local level by each PCT. Networks provide support to this process. LSMU delivered a pan-London stop smoking programme in 2008/09 which resulting in a notable level of behaviour change amongst smokers with 6,276 people directly responding to the campaign. Learnings have been shared with London PCTs and will inform the design and delivery of future activity in London. **JCPCT recommendation 42** Publicly accessible information is available in a variety of locations and media including the Department of Health's FAST campaign and Stroke Association literature. **JCPCT recommendation 43** NHS London together with the Clinical Director for Stroke is working with Dr Ian Hastie who has recently been nominated as the stroke lead for the London Deanery to develop approaches to support the medical workforce in the areas set out below: 1. Developing a fast track stroke training for post-CCT (Certificate of Completion of Training) doctors in parent specialties. 2. Splitting the RCP stroke medicine curriculum into sections relating to different parts of the pathway for specific training e.g. A&E consultants. 3. Targeting doctors in the medicine parent specialties who could readily become stroke consultants 9, 6 and 3 months before CCT to influence career choice. 4. Utilising the revalidation initiative to make mandatory the enhancement of stroke competencies in existing

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		consultants dealing with stroke patients. This will include definition of the skill set and standards for medical workforce in stroke so they may be assessed against this as part of the competency / revalidation agenda. It is likely that this could then provide the benchmarks against which nurse consultants could be developed. 5. Developing longer term stroke rotations for junior doctors. 6. Alignment of the GP training/curriculum for undergraduate and post graduate to the 1st, 2nd and 4th stage of the stroke strategy care pathway. 7. Examining the role that physicians assistants could play in community based screening of stroke/vascular disease.
Patient transfers and discharge The JCPCT recommends that commissioners: 44. ensure transfer protocols are in place before 'go-live' to ensure patients are transferred safely to stroke centres closer to their homes as soon as clinically appropriate including an efficient bed management model and escalation policies should a stroke unit bed not be available after 72 hours.	14a) that clear clinical and administrative protocols for the transfer of patients are agreed with all relevant service providers, and established before the new systems go 'live'; 14b) that systems should be put in place for monitoring transfer arrangements, to allow early corrective action to be taken where necessary.	Protocols have been developed and supported by clear rules in the new contract with penalties for local units that do not accept patients in a timely way. Please see also response to **JCPCT recommendation 19.**
Rehabilitation The JCPCT recommends that commissioners: 45. ensure consistency of access to rehabilitative care across London. 46. develop and implement plans (individually as PCTs and across sectors) to ensure patients receive a quality of rehabilitation which is of an equal standard to the initial high-quality acute care.	7) We recommend that suitable investment is made in all aspects of care, including rehabilitation and prevention, in order that the benefits of improvements to acute-end care can be maximised. 12) We recommend that the JCPCT undertakes an audit of rehabilitative stroke and trauma services across London, with a view to determining: a) those PCTs which need to invest more in rehabilitation, and their capacity to fund this further investment; b) the capacity of PCTs to put in place follow-up teams needed at Stroke Units and Trauma	Rehabilitation commissioning guidance is being finalised with the aim of achieving consistent access to high quality services. In addition, networks have benchmarked services and developed local plans. Training for PCT commissioners and the development of detailed financial modelling will support widespread implementation of high-quality post-acute rehabilitation services. Please also see p5 for our response to JCPCT recommendations concerning **Joint working and**

JCPCT recommendations	Corresponding JHOSC recommendation(s)	Progress
	Centres to take responsibility for ensuring that once a patient is discharged, they do not 'fall through the care net'; c) how the JCPCT will ensure that all PCTs are in a position to ensure consistency of access to rehabilitative care across London.	**investment**
Stroke and sickle cell disease The JCPCT recommends that commissioners work with hospital trusts to ensure: 47. haemoglobinopathy centres agree care pathways with stroke providers based on clinical needs.	No specific recommendation	Each HASU is formalising its relationship with the appropriate haemoglobinopathy service, co-ordinated by the Stroke Clinical Director.

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Update on stroke implementation

1. Introduction

The purpose of this briefing is to provide a summary of the current project progress and describe a high level implementation timetable.

2. JCPCT decision

The Joint Committee of PCTs (JCPCT) agreed to commission eight hyper-acute stroke units at Northwick Park Hospital (Harrow), Charing Cross Hospital (Hammersmith), University College Hospital (Euston), St George's Hospital (Tooting), King's College Hospital (Denmark Hill), The Royal London Hospital (Whitechapel), The Princess Royal University Hospital (Orpington) and Queen's Hospital (Romford).

The JCPCT agreed to commission stroke units and TIA services at 24 local hospitals across London.

3. Implementation (general)

Together with support from networks, units across London are progressing well with implementation, some stroke units having gone live at the beginning of this month.

North West

Providers in North West London (Northwick Park, St Mary's, Charing Cross, Chelsea and Westminster, West Middlesex and Hillingdon) will be opening their stroke unit capacity between November 2009 and January 2010.

The hyper-acute stroke units at Northwick Park and Charing Cross are due to go live starting in February 2010 and with full capacity in April 2010.

North Central

Providers in North Central London (Barnet, North Middlesex, Royal Free and UCLH). will be opening their stroke unit capacity between November and January. They are all on track and are in the process of recruiting additional staff.

The hyper-acute stroke unit at University College Hospital is due to go live starting in February 2010 and with full capacity in April 2010.

North East

The three providers in inner north east London (The Royal London, Newham and Homerton) went live on 1 October after having passed their go live assessments. The Trusts in outer north east London are on track to go live on 1 January 2010.

The hyper-acute stroke unit at The Royal London Hospital is due to go live starting in February 2010 and with full capacity in April 2010, and at Queen's is due to start opening capacity from April 2010.

South East

Stroke units at King's, St Thomas' and Lewisham are awaiting a go live assessment, although they have self-assessed as meeting the standards. Queen Elizabeth and Princess Royal are due to go live in the new year.

The hyper-acute stroke unit at King's College Hospital is due to go live starting in February 2010 and with full capacity in April 2010 and capacity is due to start opening at Princess Royal University Hospital during winter 2010/11. St Thomas' will be providing hyper-acute capacity during transition while Princess Royal is developing its hyper-acute service.

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South West
St Helier, Mayday, St George's and Kingston are all prepared to be assessed for go live.

The hyper-acute stroke unit at St George's is due to go live starting in February, with full capacity in April 2010.

4. Tariff
A London stroke tariff has been agreed. Healthcare for London delivered a series of workshops, one in each sector, to ensure that Trusts and PCTs were fully aware of the new tariff and how it would be accessed by Trusts. A formal acute commissioning guidance document which details the tariff and contracting rules is due to be published at the end of October.

5. London Ambulance Service
Since April 2009, the London Ambulance Service (LAS) has treated stroke calls as category A (immediately life-threatening) rather than category B (serious).

The 30-minute travel time to a hyper-acute stroke unit is an important component of a wider three-hour window within which to assess, treat and diagnose a stroke.

Ambulance times will be closely monitored by LAS to make sure people are arriving at specialist centres in time. The LAS will shortly be appointing a full-time member of staff whose role will be to analyse the service LAS offers to stroke patients (which will include arrival to the scene) and make recommendations (if required) to improve performance.

In addition, PCTs agreed last year to increased investment in the whole service, which is now beginning to reap rewards; by the end of this month, there will be almost 250 new emergency personnel on the road.

6. Rehabilitation
Stroke rehabilitation commissioning guidance is due to be published by the end of October, in order to inform the 2010/11 commissioning round. The guidance centres on the following key recommendations:

1. Every PCT should commission **inpatient rehabilitation** that is available for all stroke patients. This should start as soon as possible and continue for as long as required. This service must meet all of the performance standards as set out in the *London Stroke Strategy*.
2. Every PCT should commission a **community rehabilitation** service for stroke patients, delivered by staff with stroke specialist skills. Service configuration should be locally determined and the service must meet all of the performance standards.
3. Every PCT should commission an **early supported discharge** service for people who would benefit. This service should include staff with specialist stroke skills and must meet all of the performance standards.
4. Everyone who has had a stroke, and their carers, should have access to:
   - A **support worker** such as a family or carer support worker, community matron or stroke liaison nurse to provide:
     - navigation and advocacy;
     - a link with the inpatient and community rehabilitation teams, GPs and other care providers;

- A **designated person** from health or social care who is the key contact / keyworker for the patient and carer whilst in each setting, such as a therapist, nurse, social worker or other appropriate health professional. This role is locally defined in each setting and driven according to locally agreed policies.

5. For the first 12 months following stroke, all people who have had a stroke and their carers should have a **regular review** and assessment of ongoing medical, social and emotional needs as both an inpatient and in the community.

7. Prevention

Although it was initially within the scope of the project, Healthcare for London will not produce guidance on stroke prevention. Awareness of stroke has been raised greatly by the Department of Health's *FAST* campaign. In addition, the preventative measures for stroke are the same as for vascular disease, and align with general messages for healthy lifestyles, both of which are the subject of national campaigns.

Prevention is commissioned on a local level by each PCT. Networks provide support to this process, and Healthcare for London has given guidance to PCTs for completion of commissioning intentions for 2010/11.

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Update on major trauma implementation

1. Introduction

The purpose of this briefing is to provide a summary of the current project progress and describe a high level implementation timetable.

2. JCPCT Decision

The Joint Committee of PCTs (JCPCT) to commission their preferred option of 4 trauma networks. This provides major trauma services at; Royal London, St George's and Kings College Hospital commencing April 2010, and at St Mary's, Imperial with a later implementation date of Oct 2010.

3. Project Handover

Fionna Moore was appointed as the London Trauma Director from 1 October 2009. The final trauma project board took place on 21 September, when the responsibility for the project was formally handed over to the London Trauma Director working as part of the London Trauma Board.

4. Implementation Planning

To facilitate planning for April 2010 delivery the major trauma project has been working with the clinical and managerial trauma network leads and the London Ambulance Service. Each of the four major trauma centres have been submitting monthly implementation plans and risk logs which have been scrutinised by the London Trauma Director and the London Specialised Commissioning Group. The London Ambulance Service has also submitted monthly implementation plans.

4.1. Major Trauma Centres

Monthly meetings to discuss taking forward the work outlined within these plans have been taking place since April 2009 and will continue. The London Specialised Commissioning Group will commission major trauma centres and trauma networks and have been engaged throughout the implementation planning process. The aim of these planning meetings is to ensure that there is joint agreement of the timeframes and tasks that will need to be undertaken prior to the service becoming fully operational.

An external assessment of the MTCs readiness for implementation by the National Clinical Director for Trauma and the original chair of the evaluation panel will take place in January 2010. The London Trauma Board will be responsible for determining the suitability of each major trauma centre to be 'service ready' by April 2010 or October 2010 as appropriate.

4.1.1. Development of interim arrangements for North West London

The North West London Trauma Network has an agreed later implementation date of Oct 2010. A transition working group has been set up which will develop the interim arrangements for the North West for the period between the April 2010 implementation date and the later go-live date for this network.

4.2. Implementation planning for Trauma Centres

A number of trauma centres sit within each trauma network. During the monthly implementation planning meetings for major trauma centres with the London Trauma Director, described above, each centre also provides updates on the

development of their network and progress to date. This includes aspects such as developing plans for governance of the network and protocols for repatriation.

In December 2009 each trauma network, with representatives from each trauma centre, will present a summary of current progress to date and remaining challenges for the implementation of the trauma centre criteria to a panel comprising of the following; Fionna Moore, LSCG and a representative of the relevant Sector Acute Commissioning Unit (SACU).

Further progress meetings will take place during 2010 – 2011 when additional support for the development of Trauma Centres will be provided. Each SACU will be responsible for commissioning trauma centres within the network.

4.3. Implementation planning for the London Ambulance Service

The London Ambulance Service has identified those elements of work which it needs to complete in order to deliver patients effectively to the appropriate centre. A triage protocol has been drawn up and agreed which will help crews to perform this function. All staff will need to be trained in the use of the triage protocol and training is underway. In addition a clinical co-ordination desk will be established which will give support to crews in decision-making as well as a real time overview of where trauma patients are being taken in London. The London Ambulance Service has implementation plans against all the tasks that need to be achieved by April 2010. Meetings to discuss delivery against these objectives and meetings to discuss commissioning arrangements with the LAS commissioning team, are held on a monthly basis.

4.4. Major incident planning across trauma networks

The Department of Emergency Preparedness is linking in with each trauma network to establish network major incident plans. These plans will form a revised section of the pan-London major incident plan, which will link in with the LAS clinical co-ordination desk.

4.5. Agreement of all adjacent PCTs/SHAs

The Healthcare for London project team is continuing to hold regular discussions with adjacent PCTs and SHAs to agree clear pathways for trauma patients from areas adjacent to London into major trauma centres and back to their local hospital, and also to ensure that these arrangements are reflected in local agreements with commissioners and out-of- London ambulance services.

5. Performance Monitoring and Management

Performance monitoring of the London Trauma System will be undertaken through the collection of data to the Trauma Audit Research Network (TARN) This data will be collated by the London Trauma Office to give an overview of the performance of networks and the system. A performance framework has been drafted and is currently being finalised.

A performance monitoring and quality improvement group will be established to provide peer support in relation to the performance of the trauma networks. This is part of the governance structure. Performance will be monitored through quarterly performance review meetings with each Trauma Network. Any serious performance issues which are not addressed through these channels would be escalated to the LSCG Board and the SACU JCPCTs.

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6. Ongoing workstreams

Workstreams are in place on;

- Prevention
  A proposal for the future composition for a prevention strategy for London was outlined in a separate paper submitted to the JCPCT as part of the assurance documentation. This work will be taken forward by the project and the strategy forms part of the new governance framework. The estimated timeframe for completion of this work is March 2010.

- Rehabilitation
  Two expert advisers were recruited to continue the work on the development of a trauma rehabilitation pathway and strategy. This work will be taken forward by the project as a rehabilitation sub-group of the clinical steering group. This group will continue the development of the rehabilitation model including piloting the rehabilitation pathway.

Other workstreams are in place taking forward work on education and training, IT issues, trauma centres and research

Agenda Item 5

London Borough of Barnet
North London Business Park
Oakleigh Road South
London
N11 1NP

October 16th 2009

Dear Councillor Buckmaster,

I am writing to you in my role as Chairman of the Barnet Health Overview & Scrutiny Committee. You will no doubt be familiar with me as the primary Barnet representative on the 'Stroke and Trauma' JHOSC which you chair.

At its meeting on September 14th 2009, Barnet's Health OSC considered the response from Healthcare for London on the results of its consultation. Whilst the committee affirmed its agreement with the principles of building a network of Hyper-Acute Stroke and Major Trauma units across the capital, it expressed several concerns over both the consultation, and the accuracy of the stated 'blue light' ambulance times contained therein.

The committee is concerned that effective consultation was not carried out by Healthcare for London. Awareness of the proposals and consultation was low, with it being necessary for the Leader of Barnet Council to send a letter to every resident in the borough to elicit a proper response.

Following this initiative, the response in Barnet was by far the highest of any London borough, comprising some 8,600 responses and 27% of the total for the capital as a whole. The committee is concerned that this was dismissed as "atypical" by IPSOS MORI and did not influence the final choice of locations for Hyper-Acute Stroke or Major Trauma Centres where it ought to have done.

Furthermore, the committee is also concerned that given the large distances involved, the 'blue light' travel times from the borough to the nearest Stroke and Major Trauma Centres are likely to be unrealistic, potentially falling outside the 30 and 45 minutes 'gold standard' journey times.

Therefore, the London Borough of Barnet Health Overview & Scrutiny Committee believes that the Joint Health Overview & Scrutiny Committee, to whom it would appear powers have been delegated to, should refer the decisions made by Healthcare for London regarding the Reconfiguration of

Stroke and Major Trauma Services to the Secretary of State on behalf of the London Borough of Barnet for the following reasons:

1. **A lack of effective consultation by Healthcare for London.**

2. **That it was necessary for the Leader of Barnet Council to send a letter to every resident in the borough to elicit an effective response to the Healthcare for London consultation further to paragraph 1(i) above.**

3. **That not enough weight was given to the overwhelming response from Barnet residents when considering the results of the Healthcare for London consultation.**

4. **Uncertainty over the estimated 'blue light' travel times to the proposed sites of the Stroke and Major Trauma Centres.**

I therefore request that discussion of the above be placed on the agenda for the JHOSC meeting scheduled for 28th October 2009.

Yours sincerely,

Councillor Sachin Rajput
Chairman of Barnet Health Overview & Scrutiny Committee
Barnet Representative on Pan-London JHOSC on Stroke/Major Trauma