

Healthcare for London
The shape of things to come

**Response to the Joint Health Overview and
Scrutiny Committee**

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Foreword

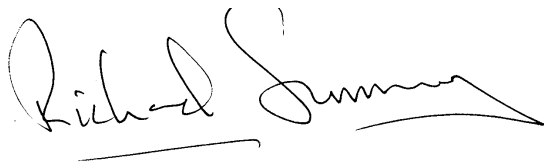
On behalf of the Joint Committee of Primary Care Trusts (JCPCT) may I thank you for your comprehensive and considered report on *Healthcare for London: The shape of things to come*.

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.

A handwritten signature in black ink, appearing to read 'Richard Sumray', with a horizontal line underneath.

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 stroke 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/