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.

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		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.

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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.

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		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.

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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

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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

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	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

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	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

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• 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.

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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.

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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

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	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

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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**

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	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.