

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



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

**Final report of the Committee
June 2009**

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

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Contents

Joint Foreword from the Chairman and Vice-Chairman	2
Background	4
Conclusions and Recommendations	6
List of Recommendations	7
General Comments	14
Stroke	24
Major Trauma	29
Appendix 1 - List of Witnesses attending the JHOSC	34
Appendix 2 - List of Written Submissions to the JHOSC	39
Appendix 3 - Glossary	41

N.B. Written submissions to the JHOSC and minutes of the 'Witness' meetings are available in a separate volume.

JOINT FOREWORD FROM THE CHAIRMAN AND VICE-CHAIRMAN



In 2007/08 for the first time all the London Boroughs came together with a Joint Health Overview and Scrutiny Committee (JHOSC) to consider the implications of Lord Darzi's proposals for improving health services in London.

Whilst those proposals were broadly welcomed by the first JHOSC, they were, at that stage, broad principles for the future. Now the NHS has come forward with detailed proposals concerning major trauma and stroke provision. A second JHOSC, comprising all London Boroughs and Essex County Council was formed to consider these proposals.

It is imperative that London is able to ensure that all its residents, over 7 million, are able to enjoy the best treatment available, wherever they live.

Scrutiny of these detailed proposals was always going to be a very different exercise from consideration of the general principles. However we have held six lengthy meetings over three months to hear from a range of witnesses and feel we are in a strong position to give our assessment of the plans for stroke and major trauma services in the capital.

While we all agree the direction of travel, it is perhaps not surprising that implementation and change raises some difficult issues, particularly for some London Boroughs. We recognise and appreciate these, but the JHOSC has tried at all times to provide a genuine pan-London response to the consultation exercise. Individual London Boroughs with their own local concerns for residents have made their own additional and specific responses.



Of course, having heard so much evidence, we do have questions and concerns. No democratic consultation can avoid these, and we have expressed them.

We believe that we have delivered a joint response which is thoughtful and, if critical in parts, is constructively critical.

At all times during our deliberations we have been guided by a genuine desire to seek what is best for London and we have not held our deliberations in a confrontational party political atmosphere. The JHOSC came together for the benefit of all the residents of London and neighbouring areas.

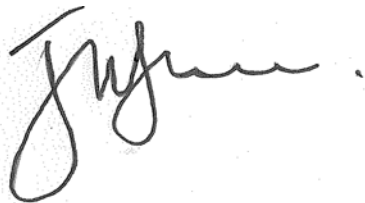
We have enjoyed the co-operation of NHS Trusts and Healthcare for London who have always sought to work with us, recognising our role as an essential part in the democratic consultation process.

This report would not have been possible without the commitment and hard work of officers from six London Boroughs, who have worked together as a team to provide exemplary administrative support to all our meetings.

We commend our report to all Londoners.

A handwritten signature in black ink, appearing to read 'Chris Buckmaster', with a large loop at the start and a horizontal stroke at the end.

Cllr Christopher Buckmaster (Chairman)

A handwritten signature in black ink, appearing to read 'Jonathan McShane', with a large loop at the start and a horizontal stroke at the end.

Cllr Jonathan McShane (Vice-Chairman)

BACKGROUND

This report presents the formal response of the Joint Health Overview and Scrutiny Committee (JHOSC) established to consider “*The shape of things to come*”, the consultation on developing high-quality major trauma and stroke services in London, undertaken by the Joint Committee of Primary Care Trusts (JCPCT) between January and May 2009.

The JHOSC was established under regulations governing joint authority health scrutiny, and comprised representatives from all of the London local authorities, as shown below:

Barking and Dagenham	Cllr Marie West
Barnet	Cllr Sachin Rajput
Bexley	Cllr David Hurt (<i>to 13 May 2009</i>)
	Cllr Ross Downing (<i>from 13 May 2009</i>)
Brent	Cllr Chris Leaman
Bromley	Cllr Carole Hubbard
Camden	Cllr John Bryant
City of London	Cllr Ken Ayers
Croydon	Cllr Graham Bass
Ealing	Cllr Greg Stafford
Enfield	Cllr Anne-Marie Pearce
Greenwich	Cllr Janet Gillman
Hackney	Cllr Jonathan McShane
Hammersmith & Fulham	Cllr Peter Tobias
Haringey	Cllr Gideon Bull
Harrow	Cllr Vina Mithani
Havering	Cllr Ted Eden
Hillingdon	Cllr Mary O'Connor
Hounslow	Cllr Jon Hardy
Islington	Cllr Paul Convery (<i>to 14 May 2009</i>)
	Cllr Martin Klute (<i>from 14 May 2009</i>)
Kensington and Chelsea	Cllr Christopher Buckmaster
Kingston upon Thames	Cllr Don Jordan
Lambeth	Cllr Helen O'Malley
Lewisham	Cllr Sylvia Scott
Merton	Cllr Gilli Lewis-Lavender
Newham	Cllr Winston Vaughan
Redbridge	Cllr Allan Burgess (<i>to 5 February 2009</i>)
	Cllr Ralph Scott (<i>from 5 February 2009</i>)
Richmond upon Thames	Cllr Nicola Urquhart
Southwark	Cllr Adedokun Lasaki
Sutton	Cllr Stuart Gordon-Bullock
Tower Hamlets	Cllr Lutfu Begum
Waltham Forest	Cllr Richard Sweden
Wandsworth	Cllr Ian Hart
Westminster	Cllr Susie Burbridge

The local authorities that provide social services in the Strategic Health Authorities neighbouring London were also invited to participate in the JHOSC. This reflected an invitation from the NHS for the PCTs in these areas to participate in the JCPCT. There was one appointment to the JHOSC:

- Essex County Council - Cllr Chris Pond.

The JHOSC held its first formal meeting on 4 February 2009. The meeting appointed the Chairman and Vice-Chairman from different political parties, and agreed the following terms of reference:

1. *To consider and respond to proposals set out in 'Shaping Health Services Together - Consultation on developing new, high-quality major trauma and stroke services in London' ("the consultation proposals"), with reference to any related impact assessments or other documents issued by or on behalf of 'Healthcare for London' in connection with the consultation;*
2. *To consider whether the consultation proposals are in the interests of the health of local people and will deliver better healthcare for the people of London and people travelling across the Greater London Authority (GLA) boundary, having due regard to cross-border issues;*
3. *To consider the 'Healthcare for London' consultation arrangements for the consultation proposals - including the formulation of options for change, and whether the formal consultation process is inclusive and comprehensive.*

Report format

The principal part of the report is formed of the JHOSC's **Conclusions and Recommendations**. This contains a section of *General Comments*, followed by sections on *Stroke* and then *Major Trauma*.

An Appendix contains a list of witnesses; a list of written submissions received; and a glossary.

A supplementary report (available separately to the main report) contains minutes of the 'witness' meetings, and the written submissions received.

Acknowledgements

The JHOSC would like to thank all of the witnesses who gave up their time to attend our meetings; the stakeholders and London Boroughs who submitted written evidence; the officers who provided advice and support; and the Boroughs that kindly hosted and provided hospitality for our meetings.

1.0 CONCLUSIONS AND RECOMMENDATIONS

Introduction

1.1 The JHOSC welcomes the opportunity to comment on the proposals in the consultation paper. The extension of time for the submission of our comments beyond the public consultation period is appreciated.

1.2 We consider that the criteria used to develop the proposals (sustainable and optimal quality; comprehensive coverage of the London population; and strategic coherence -‘best fit’) are fundamentally sound.

1.3 Having taken evidence from a wide range of informed bodies, we are able to support the direction of travel underlying the consultation paper: speedy access to 24/7 specialist care provided from a number of centres across London. The evidence we have heard over several months has demonstrated clearly that the proposed model is superior to the combined ‘daytime/out-of-hours’ model of delivering specialist care which the previous ‘Healthcare for London’ JHOSC favoured on the basis of information available at the time.

1.4 We welcome the greater emphasis now being given to stroke, which is the second highest cause of death and the most common cause of adult disability in London.

1.5 If the implementation of the proposed changes is managed well, and continued funding allows high-quality standards to be achieved and maintained, we would expect to see an end to the ‘postcode lottery’ of healthcare in relation to stroke and major trauma services in London that has existed for far too long.

1.6 The JHOSC is composed of democratically elected councillors who are in close touch with the views and wishes of people living in the local areas they represent. Its membership is drawn predominantly from councils' health scrutiny committees, and the JHOSC therefore represents a body of opinion with considerable experience of health matters. Additionally, a number of our members have had direct experience of working in the health service in various capacities. We have also taken evidence from clinicians and had the opportunity to ask searching questions about many areas of concern. However, we have taken the view that, as a body, we would not wish to in effect pass a clinical judgement on whether individual hospitals are equipped to deliver a particular service under the proposals. For this reason, we have generally refrained from referring to particular hospital trusts. We have tried to take a pan-London approach, and have left the London Boroughs individually to make their specific responses in relation to local concerns (see *supplementary report*).

1.7 It is probably fair to say that we started out with a considerable degree of scepticism at the proposed patient transfer times from scene to specialist

centre (30 minutes for stroke; 45 minutes for major trauma). However, when we heard from the London Ambulance Service, it was quite clear that their confidence in achieving these maximum travel times was very strong. On the relatively few occasions when these travel times might be exceeded, this must not fundamentally mitigate the overall benefit of transferring a patient directly to a centre which is able to offer expert clinical care.

2.0 RECOMMENDATIONS OF THIS JHOSC

For ease of reference, the recommendations that appear later in the main body of the report are set out below:

GENERAL

Implementation phase

1a) That a detailed action plan is drawn up which sets out effective measures for ensuring that the mutually supportive arrangements envisaged in the new networks are 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 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.

Staff recruitment and training

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 trauma networks.

5. 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.

6. That flexible working arrangements are explored, allowing opportunities for staff rotation within, and between, networks.

Resourcing

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

8. 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.

Prevention

9. 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.

Rehabilitation

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. 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. 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.

Hospital transfers

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.

Travel arrangements

15. 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'.

Cross-border co-ordination

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.

N.E. London

17. 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.

Communication with the public

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.

Health Impact Assessments

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 (HIA) consultants' study (which will focus on BME groups) are provided to the JHOSC for comment as soon as they are available.

20. That further 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.

Monitoring and Evaluation

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.

STROKE

General

22a) That the immediate eight HASUs should be seen as the minimum number, and the JCPT 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. 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.

Increasing the public's awareness of stroke

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.

Prevention

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.

Developmental needs

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.

Transfers from HASU

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.

Children and Young People

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.

MAJOR TRAUMA

General

30. 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. That the JCPCT advises 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. 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.

N.W. London

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. That local authorities serving N.W. London are consulted at an early stage on the proposals for a transition plan.

Skilled diagnostic care

35. 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. 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. That, as part of achieving high-quality rehabilitation after the initial principal clinical intervention, staff on wards should possess relevant neuro-training.

38. 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. 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.

3.0 GENERAL COMMENTS

(a) A smooth transition

3.1 The timetable for implementation of the proposals by April 2010 is a challenging one. It will be critically important to ensure that the transition period is managed well, and that the service to patients does not suffer. This is particularly important for stroke services, given the length of the transition period envisaged in the consultation paper.

3.2 The emphasis in that part of the consultation paper addressing stroke is on patients in critical need of acute treatment. This is important, but patients suffering from mini-strokes or transient ischaemic attacks (TIAs), appear to have been given less consideration.

3.3 We also comment later in some detail on the lack of a substantive focus on rehabilitation, which we find most regrettable. Good rehabilitation is absolutely essential to recovery, both for stroke and major trauma patients.

(b) Implementation timescale

3.4 There are a number of factors which make the April 2010 implementation date a challenging one.

i) Development needs

3.5 Some of the designated centres are recognised in the consultation paper to have "very significant development needs" if they are to attain the standards required. The proposals place considerable emphasis on those hospitals with particularly complex needs being supported by those with stronger services. In some cases, direct involvement in providing services could be required. The JCPT is "expecting collaboration" between centres which are close to one another. The success of the proposals will clearly be dependant on effective partnership working within networks.

We recommend:

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.

3.6 We would expect that the pressure on certain centres which are required to support other centres in their network – at the same time as developing their own specialist role - will be significant during the transitional phase. We note that the consultation paper itself acknowledges this point. The substantial increase in staff (in the case of stroke) will entail significant recruitment, teaching and training requirements.

2. We recommend 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.

3.7 There is also the proposal that some hospitals that failed to achieve specialist stroke centre status “play a significant role in transitional arrangements”. This would involve partnership working with designated hyper-acute stroke units (HASUs) and the provision of support for service development across London. We are concerned that the interim role of hospitals that were unsuccessful in their bids for specialist centre status may not prove realistic in practice.

3.8 We are aware that at least one of the hospitals that has not been designated under the proposals (Guy's and St Thomas'), has expressed reservations that implementing the proposals for eight HASUs may not be possible without causing a significant deterioration of clinical services in the short to medium term.

3. We recommend 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.

ii) Staff recruitment and training

3.9 The consultation paper recognises that a considerable number of suitably trained additional staff will be required – 200 additional therapists, and nearly 600 additional stroke nurses. However, it is unclear on what basis these figures have been derived, given that a detailed review of the stroke workforce is underway. Given that stroke is not generally regarded as an attractive specialism by nurses, achieving this level may well prove challenging.

3.10 The British Association of Occupational Therapists (BAOT) and the College of Occupational Therapists (COT) in their written evidence (*see Part B*) have drawn attention to the current low levels of therapy received by

stroke patients, emphasising that this shortfall in provision needs to be addressed, as well as the need for an appropriate level of additional staffing. Currently, we understand from the COT that there are severe difficulties reported in recruiting to the more senior therapist positions in London. We share these views. Building up expertise in stroke rehabilitation will take time and will require the presence of suitably experienced senior staff, to provide 'on the job' supervision, training and mentoring.

3.11 Achieving consistency in staffing levels across London is important, in order to ensure that the quality of stroke services does not vary. It would be sensible for the JCPCT to seek advice from the Royal College of Nursing (RCN) and the Allied Health Professionals Federation on staffing numbers required at designated stroke centres.

3.12 We note that until the designation process is complete, Trusts are not expected to commence recruitment of additional staff. However, we believe that Trusts should already be starting preparatory work, to allow them to launch recruitment campaigns as soon as the designation process is complete.

We recommend:

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.

3.13 Presently, there is no nationally recognised stroke training for specialist stroke staff. However, if implementation by April 2010 is to be achieved, it is imperative that suitable training is available.

5. We recommend that NHS London engages immediately with higher education bodies and the RCN 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.

3.14 There is a danger that the specialist units may have a magnet effect, drawing the more experienced and better trained staff away from other hospitals.

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

(c) Resourcing

3.15 An adequate level of resources is essential if specialist services which match or surpass the best examples of international practice are to be achieved and maintained. The financial climate has changed fundamentally since Prof. Lord Darzi's report, "*Healthcare for London: A Framework for Action*", was published in July 2007.

3.16 We note that the additional sums referred to in the consultation paper (£23 million per annum for stroke; £9 - 12 million per annum for major trauma) cover the acute end of care improvements, and do not include provision for rehabilitation. No additional provision has been identified for non-specialist units.

3.17 It is unclear whether these sums will be adequate to address all aspects of implementation, allowing for unforeseen circumstances, and possible areas of additional expenditure. Under-funding of the proposals could serve seriously to undermine Healthcare for London's aspirations to achieve world-class specialist care.

3.18 London Ambulance Service will need additional funding to enable it to prepare for its enhanced role under the proposals (e.g. additional ambulance journeys, more staff, and training). The need for additional and longer journeys must not impact negatively upon the service provided to other emergency patients.

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.

3.19 Some Trusts have voiced concerns that detailed financial appraisals were not sought in the assessment of bids for specialist centre status. If this is indeed the case, it is somewhat surprising given the scale of the proposals. Trusts which were unsuccessful in their bids are likely to feel that a thorough assessment of their case could not have been achieved without a detailed financial analysis.

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.

(d) Prevention

3.20 The focus of the consultation proposals is heavily upon achieving clinical outcomes, with a lesser emphasis upon rehabilitation and longer-term care. However, the evidence we have heard has served to underline the crucial role of prevention in the broader healthcare context.

3.21 Increasing the public's awareness of healthy lifestyles (in the case of stroke) and tackling the root causes of reckless behaviour, particularly

among younger men (in the case of major trauma) is crucial. The benefits to society, individuals, and in terms of long-term cost-effectiveness, cannot be over-emphasised.

3.22 Evidence shows that time devoted to helping people re-assess their lifestyles after a first stroke, is effective and helps reduce the risk of a subsequent, possibly fatal stroke.

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.

(e) Rehabilitation

3.23 We understand that the immediate treatment phase was intended to be the focus of the consultation paper, and we note that the additional sums referred to in the consultation paper do not include provision for rehabilitation and long-term care.

3.24 Given the significance of rehabilitation throughout the care pathway - in the case of both major trauma and stroke - in terms of benefiting a patient's recovery, we regret that it was not given far greater emphasis in the consultation proposals.

3.25 The role of longer-term care and support beyond the initial principal clinical intervention is clearly a critical one. Once a patient has had the initial clinical treatment, recovery in a ward where nursing and auxiliary staff (e.g. therapists) are suitably trained (in relation to stroke, or major trauma) is needed.

3.26 In the case of stroke, the consultation proposals concentrate on immediate clinical treatment. However, initial rehabilitative care - in the form of occupational therapy - has an important role to play in the acute phase of treatment within the first 48 hours. There is insufficient emphasis on the necessary after-care following transfer from a HASU to a local hospital, and then discharge into the community.

3.27 We therefore consider the omission of substantive comments on rehabilitation to be a serious one, in terms of developing an effective model of care. We would have expected to have seen the role of rehabilitation, including the role of intermediate care, developed as an integral part of the consultation proposals.

We recommend:

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.

3.28 Effective integration of Health and Social Care services is essential. A joined-up multi-disciplinary approach is required, in order that the transition from hospital to community is managed well, and the right care is provided for the individual concerned on a continuing basis. The provision of good-quality information about continuing care is needed. Support for local day centres, or 'Stroke Clubs', which provide valuable support for the longer-term needs of discharged patients, is to be encouraged.

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.

3.29 The JHOSC notes that the consultation paper states, "Some PCTs may need to invest more in rehabilitation". This recognition is to be welcomed, and we look forward to this increased investment being made. A similar need exists to fund the social services of local authorities if rehabilitation is to be successful. The care pathway extends through critical care, ongoing hospital care and support in the community.

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.

3.30 We note that the JCPCT's response (July 2007) to the former JHOSC's recommendations on health and social care matters stated that "We are keen to explore relevant approaches such as integrated planning, joint commissioning and pooled budgets".

We recommend:

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 .

(f) Hospital transfers

3.31 Traditionally, transfers between hospitals (and from hospital to community-based care) have not been an area of strength, with management and administrative arrangements failing to deliver as intended. This can result in distress to the patient (and their relatives, friends and carers), and can adversely affect recovery.

3.32 It is important that the proposed new arrangements for transfer from specialist centres to District General Hospitals (DGHs), and from DGH to community, operate smoothly from inception. Patients need to be transferred at the clinically correct time, and robust protocols will need to be in place to ensure smooth transfers between hospitals, and an adequate bed base to cope with demand. Patients and their carers should have arrangements explained clearly to them.

14. We recommend:

a) 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';

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

(g) Travel arrangements

3.33 One impact of the proposals will be that relatives, friends and carers will have to travel greater distances to a hospital destination that they may well be unfamiliar with, rather than travel to their local DGH. Although we recognise that the number of journeys may well be small (given the generally short period of patient stay for the initial specialised treatment), this factor needs to be taken into account.

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'.

(h) Cross-border co-ordination

3.34 The consultation paper recognises that London's health services do not operate in geographical isolation. This has been a theme which the JHOSC has returned to throughout its deliberations.

3.35 It is essential that the new arrangements to deliver better care for stroke and major trauma patients take account of the population catchments of those areas just outside London's boundaries. The responses of some witnesses were not as encouraging on this critical point as we would have hoped.

3.36 We were pleased to receive evidence from Transport for London and London TravelWatch that modelling had been undertaken on visitor journey times to the new specialist centres, with satisfactory results. However, it has to be recognised that these units will also serve areas beyond the GLA boundary.

We recommend:

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.

(i) N.E. London

3.37 It is regrettable that a major public consultation on restructuring services across London should have been initiated without including comprehensive recommendations on stroke for N.E. London.

3.38 In the circumstances, the JHOSC has been unable to take full account of the concerns of all its constituent members in relation to one area of London. Our scrutiny exercise in that respect is therefore incomplete, as the recommendations from Healthcare for London are not comprehensive for the whole of London.

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.

(j) Communication with the public

3.39 The JCPT has mounted a public consultation exercise which has aimed to achieve a widespread understanding of the proposed changes in healthcare for Londoners.

3.40 Nevertheless, the JHOSC has concerns that the message underlying the rationale for the proposals has not been communicated effectively to the general public – i.e that getting as speedily as possible to specialist clinical care (likely to be located further away than the local DGH) will provide superior care than the existing practice of being taken to the nearest local A&E department.

3.41 Also, the consultation paper itself could usefully have focused more directly upon the patient's experience throughout the new care pathways. A simple, step-by-step explanation of what a patient could expect would have been a helpful central focus.

We recommend:

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.

(k) Health Impact Assessments (HIAs)

3.42 We were pleased to be advised that the remit of the HIAs would extend beyond statutory equalities issues, and would include traditionally under-represented groups, and deprived communities. It is useful that as well as identifying impacts on particular groups, Mott MacDonald/Public Health Action Support Team (PHAST) will identify solutions in their final report.

3.43 We note the significantly greater incidence of stroke within BME groups (e.g. 60% higher in black African and black Caribbean populations than in the white population).

We recommend:

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.

3.44 We are concerned that the timetabling of the HIAs means that the conclusions in the final report will not be available for the JHOSC to consider before it submits its own report. Additionally, the timescale of the proposals affecting N.E. London (referred to above) means that the HIAs are unable to take into account the final outcome of proposals affecting one region of the capital.

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.

I) Monitoring and Evaluation

3.45 The consultation proposals are far-reaching in reshaping services in London, and there is clearly a need for their implementation to be carefully scrutinised.

3.46 The consultation paper envisages that, as new services are delivered from April 2010, the quality of services will improve over the initial twelve months. Effective monitoring of the new care pathways will be crucial. Good quality information from hospitals, the London Ambulance Service and ambulance services adjoining the capital, will be essential.

We recommend:

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.

4.0 STROKE

a) General

4.1 The JHOSC has received no definitive evidence from witnesses to suggest that the proposal for an immediate minimum of eight HASUs (with a maximum 30-minute 'scene to specialist centre' journey-time by blue-light ambulance) is not of the right order to address anticipated patient numbers.

4.2 Some of the evidence did point to the possibility that more than eight HASUs might be needed in response to future demand. Guy's and St Thomas' NHS Foundation Trust has submitted written evidence to us which expresses concern that eight HASUs may be insufficient to cope with peaks of A&E demand, or an unexpected drop in HASU capacity (if one unit's attention had to be devoted to an outbreak of infection, for example). The Trust also considers that co-location with major trauma centres could exacerbate pressures, contrary to the statement on page 4 of the compact version of the consultation document issued by Healthcare for London.

4.3 The evidence suggests that there is no consensus over the optimum number of patients per year for a HASU, in the absence of a highly similar international model for comparative purposes; no detailed estimates of predicted patient flows for individual HASUs were provided. The experience of the stroke pilot in S.W. London (based around St George's Hospital) is that up to 20% of admissions for specialist treatment turn out, on diagnosis, to be non-stroke in nature. As the location of emergency specialist treatment centres becomes well-known to the public, more people are likely to arrive other than by blue-light ambulance. Many of these patients will have missed the '3 hour window' for thrombolysis, but would still benefit from the specialist care provided at the HASU. Stroke patients often deteriorate after admission, and their condition can be very unstable. This has implications for bed availability, where patients stay longer than 72 hours.

4.4 Another factor which came through strongly in the evidence presented to us was the critical importance of speed in a stroke victim receiving the correct diagnosis and treatment, and in promoting a more full recovery. We heard that, for those patients for whom thrombolysis treatment is appropriate, the sooner they receive it, the better. Patients have a one-in-two chance of a full recovery if thrombolysis is administered in the first 90 minutes following a stroke, compared to a one-in-eight chance after three hours. The aim should always be to shorten the '3 hour window' (without compromising the patient's care or well-being), given the deterioration in a stroke victim's condition that takes place as the minutes pass.

We recommend:

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.

4.5 Clinical excellence is essential, but the public has to be assured that with the removal or reduction of services in a particular geographic area, they will not suffer, but in fact have enhanced provision. Fears expressed by a number of Boroughs (*see supplementary report*) need to be addressed robustly if public support is to be secured.

4.6 The period of development of the new networks will be critical, and the pressures on designated HASUs, and the continuing role of some de-designated hospitals during this time has already been referred to. The JHOSC considers it to be absolutely essential that patient care does not suffer as a result of a shortfall in provision, in the period of transition following the introduction of the proposals.

We recommend:

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.

4.7 The experience from the stroke pilot in S.W. London illustrates the improvements in healthcare that can be achieved by attaining higher rates of thrombolysis. It also demonstrates that a 24/7 model of providing specialist stroke care is superior to one combining day-time at one hospital and out-of-hours treatment at another.

4.8 The JHOSC heard conflicting views about the role that telemedicine might play in London. However, although the use of telemedicine is still in

development in this country, (operating at St Thomas's Hospital since June 2007, and across Surrey), it appears that it could have a significant role to play in the future, bringing a number of benefits. We would therefore have expected that the proposals for stroke might have referred to the development and potential role of telemedicine.

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.

b) Increasing the public's awareness of stroke

4.9 The DoH's recent 'FAST' campaign appears to have been successful in increasing public awareness of the signs of stroke and what action needs to be taken.

4.10 Given the great importance of speed in a stroke victim receiving the right treatment, stroke recognition and knowing who to contact to get that treatment is of critical importance. The clearest possible description of symptoms is valuable to ambulance control centre staff receiving a telephone call. This applies equally to 'mini-strokes' or TIAs. GPs in particular need to be well trained in stroke recognition.

4.11 There are many ways in which someone with stroke symptoms (or someone acting on their behalf) might choose to seek help (e.g. by contacting/visiting a GP-led health centre; a 'walk-in' centre; an urgent care centre; an A&E department; an out-of-hours telephone number; or NHS Direct).

4.12 The evidence we have heard has underlined a particular need for TIAs to be recognised better, in order that prompt action can be taken to deal with them. At present, the public may be less certain in identifying TIA symptoms than with a full-blown stroke, and more inclined not to seek treatment (perhaps because they feel the symptoms are too mild to bother a GP or other health professional with). The message to all concerned must be that TIAs *must* be taken seriously.

We recommend:

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.

c) Prevention

4.13 As mentioned earlier, we would have liked to have seen a considerably greater emphasis on prevention in the consultation proposals. As well as providing healthcare that matches or surpasses the best international practice, it is right that individuals should be encouraged to take a greater responsibility for their own health. This is likely to come more sharply into focus in years to come, as pressure on Government funding streams increases and more emphasis is placed on healthy lifestyle choices.

We recommend:

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.

d) Developmental needs

4.14 As highlighted earlier, the consultation proposals are premised heavily upon various hospitals being supported to a considerable degree in the initial period of changeover, in order to play the part envisaged for them, and to achieve suitable geographical coverage across London. Particularly taking account of the fact that the majority of stroke patients live in the outer areas of London, it will be important to ensure that there is no inequality in access to service provision.

4.15 The proposals state that “there would have to be very strong and intensive support in place to drive the development of hyper-acute stroke services on certain sites”. Four designated HASU sites are identified as having “very significant development needs”. These are matters of concern if the April 2010 timescale is to be achieved.

4.16 We therefore note the considerable task facing some hospitals, within a challenging timeframe. Our firm view is that the introduction of improvements in stroke care within a demanding timescale must not be at the expense of

other hospital services suffering. We would therefore question whether a 'big bang' approach of having eight HASUs by April 2010 would be appropriate, if this were to be at the expense of existing centres of stroke excellence being downgraded. A more flexible approach, retaining hospitals with good mortality rates (*see details in supplementary report*) while other designated HASUs address their very significant development needs, would surely be more appropriate.

We recommend:

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.

e) Transfers from HASU

4.17 People recovering from stroke must receive specialist care. Staff at HASUs and Stroke Units who deal with stroke patients must be trained to deal sensitively with their specific needs. Good communication of a patient's needs on transfer is essential.

4.18 There has been some concern expressed at our meetings at the idea of patients being transferred to a local Stroke Unit after the period of 72 hours referred to in the consultation paper. However, we do recognise that the proposals state that patients will stay in a HASU for a 72-hour period or until their condition is stable.

We recommend:

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.

f) Rehabilitation

4.19 In earlier comments, we highlighted our concern that the consultation proposals fail to address in adequate detail the role of rehabilitative care in the patient's pathway to recovery, and made a number of recommendations. We also commented upon the need for sufficient numbers of trained therapists, if the proposals to deliver high-quality care are to work as intended.

4.20 Although rehabilitation is generally regarded as a longer-term support, the starting point actually lies in the acute phase. For example, occupational therapists need to be available to provide cognitive and perceptual screening. Patients need access to daily rehabilitation. Arrangements at this stage may need to be made for early supported discharge, and the involvement of therapists is crucial, to ensure that continuing care in the community is provided.

4.21 Earlier, we drew attention to concerns expressed by the British Association of Occupational Therapists and the College of Occupational Therapists (COT) at the possible difficulties in recruiting adequate numbers of suitably qualified therapists to match the requirements of the new healthcare arrangements. They have also drawn attention to the need, when planning staffing levels, to take account of the fact that occupational therapists may not be available on site, due to their undertaking home visits, which take a significant amount of time.

NOTE: Recommendations on rehabilitation are contained in section 3.0, General Comments, earlier in the report.

g) Children and Young People

4.22 The consultation proposals fail to address the particular care needs of children and younger people. However, the numbers are not insignificant: approximately 1 in 10 of those under the age of 55 who suffer a stroke each year is under the age of 30. Recovery and rehabilitation from stroke present particular challenges for younger survivors.

29. We recommend:

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

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

5.0 MAJOR TRAUMA

a) General

5.1 On the basis of the evidence we have heard, it would appear that centralisation with experienced clinical staff will improve services for major trauma patients, and that four major trauma centres (MTCs) is the right number to achieve coverage of the capital. In accordance with the principle of achieving strategic coherence or 'best fit', the merit of co-location of the proposed fourth MTC with a HASU is asserted.

5.2 Whilst there are arguments that three MTCs might be adequate clinically to provide the necessary services for London, we believe that four is the appropriate number. Firstly, this is because the new structure must be able to cope with occasional peaks and secondly, because public perception is important: it would be wrong to create a situation where very large numbers of people felt that they were disadvantaged by not having an MTC in their area.

5.3 We note that, under the proposals, the intention is for the Royal London Hospital to play a leading role, extending its coverage to parts of North and North West London.

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.

5.4 We have heard some evidence to suggest that when a major trauma case involving a small number of people (perhaps three or four) is being dealt with at London's existing MTC, clinical resources are diverted away from other areas of care. Thus there is merit in having a number of MTCs.

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.

5.5 The aim should be to achieve a seamless pathway of care for major trauma victims. The proposals seem to place most emphasis on the provision of the essential immediate treatment of patients, with little emphasis on subsequent transfer of patients to local hospitals and the necessary rehabilitation required.

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.

b) N.W. London

5.6 The JHOSC has heard from both hospitals identified as potential sites for the fourth MTC. Both have indicated that they would be ready to become operational as the fourth MTC considerably in advance of the proposed April 2012 implementation date. We therefore find it surprising that the consultation paper should not have reflected this.

5.7 There is also a lack of clarity surrounding the criteria, methodology and weighting used in the assessment process, since no details have been published. This has made it impossible for us to come to an informed view on the location of the fourth MTC. We find this unfortunate. We draw the disappointing conclusion that little weight has been given to financial issues and costs/benefits.

5.8 Given the preparedness of both potential fourth MTCs to deliver services in advance of April 2012, we are strongly in favour of a fourth MTC becoming operational before that date, where it has demonstrated a capacity to do so.

We recommend:

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.

5.9 The consultation paper states that a transition plan for handling major trauma cases in N.W. London will need to be developed.

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

c) Skilled diagnostic care

5.10 The role of LAS paramedics will be critical in ensuring that, as far as possible, only those with an appropriate level of injuries are taken to a MTC. We understand that work is already in hand on the development of an effective triage tool for use by LAS staff at the scene of an incident.

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.

5.11 Major trauma cases triaged at scene as less serious will be taken to a Trauma Centre at a DGH. In some cases, it may be that the assessment upon arrival at hospital is that transfer to a MTC is required, given the nature of the injuries.

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.

5.12 The proposal for trauma networks to develop staff rotation plans (to ensure that the maximum number of staff are trained in managing major trauma cases) is supported.

5.13 The consultation paper proposes that a London Trauma Office be established to oversee all trauma care in the capital, and provide guidance to trauma networks. One of its functions will be to develop a training and development programme.

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.

5.14 Whilst the consultation paper identifies a need for nearly 600 additional 'stroke' nurses, it fails to quantify the number of extra nursing staff in relation to major trauma. However, during the period of consultation, Healthcare for London has advised that the numbers of additional nurses "will not be significantly large".

5.15 We are aware of the current severe shortage of nurses in London. It would have been helpful if an estimate of additional nurses required for major trauma had been included in the consultation paper.

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.

5.16 Specialised neuro-rehabilitation is provided across London by a consortium, operating through nine specialist providers. At present, the provision of multi-specialist rehabilitation across London is patchy. The specialised neuro-rehabilitation services need to be linked into the work of the Trauma networks.

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.

5.17 The evidence submitted by King's Health Partners (see Appendix) has suggested a model of three MTCs different from that proposed by Healthcare

for London. We have restricted our comments to those proposals which are the subject of formal consultation.

Appendices

Appendix 1: Witnesses attending the JHOSC

Appendix 2: List of written submissions to the JHOSC

Appendix 3: Glossary

N.B. A supplementary report to the main report is available separately. This contains:

- a) Minutes of the 'Witness' meetings**
- b) Written submissions**

Appendix 1: Witnesses attending the JHOSC

4 February 2009: Royal Borough of Kensington and Chelsea

'Stroke and major trauma' consultation paper

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

5 March 2009: London Borough of Redbridge

The King's Fund

- Candace Imison, Deputy Director of Policy

The Royal Free Hospital

- Prof. Peter Butler, Divisional Director, Trauma and Managed Networks
- Pamela Chesters, Chair
- Dr Lionel Ginsberg, Consultant Neurologist
- Andrew Way, Chief Executive

St Mary's Hospital

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

23 March 2009: London Borough of Lambeth

The Royal College of Nursing (RCN)

- Bernell Bussue, Regional Director, RCN
- Gillian Cluckie, Clinical Nurse Specialist, Stroke Care
- Alan Dobson, RCN Adviser in Nursing Practice, Acute and Emergency Care
- Heather Jarman, Nurse Consultant, Emergency Department, St. George's Hospital NHS Trust

The Royal London Hospital Trauma Centre

- Prof. Karim Brohi, Professor of Trauma Sciences, Barts and the London NHS Trust
- Graham Simpson, Director of Strategy, Royal London Hospital

Headway (The Brain Injury Association)

- Annie Clacey, Regional Director, Headway UK
- Norman Keen, Vice-Chair, Headway East London

Association of Directors of Adult Social Services (ADASS)

- Simon Williams, ADASS

7 April 2009: London Borough of Camden

The Stroke Association

- Joe Korner, Director of Communications, Stroke Association
- Peter Rawlinson, Trustee, Stroke Association

Age Concern

- Lynn Strother, Lead on Policy and Voice for Age Concern London; and Director, Greater London Forum for Older People

Londonwide Local Medical Committees (LMC)

- Dr Paddy Glackin, LMC Secretary
- Dr Tony Grewal, LMC Secretary

24 April 2009: City of Westminster

S.W. London 'Hub and Spoke' Stroke Care Pilot

- Prof. Hugh Markus, Lead Clinician for Stroke Services, St George's NHS Healthcare Trust

London Ambulance Service (LAS)

- Nick Lawrence, Head of Policy Evaluation and Development, LAS
- Mark Whitbread, Clinical Practice Manager, LAS

Health Impact Assessments

- Bashir Arif, Impact Assessment Lead, Mott MacDonald
- Peter Gluckman, Public Health Action Support Team (PHAST)

London TravelWatch

- Gail Engert, Chair, Access to Transport Committee, London TravelWatch
- Vincent Stops, London TravelWatch member

Travel Modelling

- Steve Black, Senior Analyst, Healthcare for London (HfL)
- Shaun Danielli, Project Manager, Trauma, HfL

- Michael Wilson, Stroke Project, HfL

Transport for London (TfL)

- Andrew Gonsalves, Transport Planner, TfL
- Julian Sanchez, Principal Transport Planner, TfL

7 May: London Borough of Hammersmith and Fulham

NHS Surrey Stroke Pilot

- David Davis, Stroke Lead, S.E. Coast Ambulance Service
- Felicity Dennis, Network Manager, Surrey Heart and Stroke Network
- Eddie Hunter, Longsight Consultants
- Dr Carl Long, Clinical Lead for Stroke, Surrey Heart and Stroke Network
- Kay Mackay, Director of Strategy and Service Delivery, NHS Surrey
- Dr Bhaskar Mandal, Consultant Stroke Physician, Ashford and St Peter's Hospitals NHS Trust
- Helena Reeves, Communications Director, NHS Surrey

British Association of Stroke Physicians (BASP)

- Dr Tim Cassidy, BASP

Different Strokes

- Jeffy Wong, Regional Co-ordinator, London, Different Strokes

Regional Director of Public Health

- Dr Simon Tanner, Regional Director of Public Health

NHS London

- Simon Milligan, Senior Finance Lead, Healthcare for London
- Jo Sheehan, Finance Lead, Healthcare for London

Appendix 2: List of Written Submissions to the JHOSC

London Boroughs

- LB Barnet: Supporting the Vulnerable in our Community Overview & Scrutiny Committee
- LB Brent
- LB Bexley: Health and Adult Social Care Overview & Scrutiny Committee
- LB Camden: Health Scrutiny Committee/Executive Member, Adult Social Care and Health/Camden Stroke Local Implementation Team
- City of London: Community and Children's Services Health Scrutiny Sub-Committee
- LB Croydon
- LB Ealing: Health, Housing and Adult Social Services Scrutiny Panel
- LB Enfield: Scrutiny Members attending JHOSC
- LB Hackney: Health in Hackney Scrutiny Commission
- LB Hammersmith and Fulham
- LB Harrow: Overview and Scrutiny Committee
- LB Hounslow: Adults Health and Social Care Scrutiny Panel/Council's Executive
- RB Kensington and Chelsea: Overview and Scrutiny Committee on Health
- RB Kingston upon Thames: Health Overview Panel
- LB Lambeth: Health and Adult Services Scrutiny Sub-Committee
- LB Newham: Mayor of Newham (on behalf of: Newham Health Scrutiny Commission/Cabinet/Chief Officers/NHS Newham (including Newham Community Health Services) /Newham University Hospital Trust/Newham Stroke Board)
- LB Redbridge: Health Scrutiny Committee
- LB Waltham Forest: Health, Adults and Older People's Overview & Scrutiny Sub-Committee
- LB Wandsworth: Health Overview & Scrutiny Committee
- Westminster City Council: appointed member to JHOSC
- London Councils.

Key stakeholders, professional organisations and other interested parties

- British Association of Stroke Physicians
- Camden Local Involvement Network
- Chelsea and Westminster Hospital NHS Foundation Trust
- College of Occupational Therapists

- Dr David Goldhill
- Ealing Hospital NHS Trust
- Epsom and St Helier University Hospitals NHS Trust
- Greater Manchester Association of PCTs
- Guy's and St Thomas' NHS Foundation Trust
- Hillingdon Hospital NHS Trust
- King's Health Partners (comprising King's College London and Guy's and St Thomas', King's College Hospital and South London and Maudsley NHS Foundation Trusts)
- Kingston Hospital NHS Trust
- Richmond LINK response
- Transport for London
- West Middlesex NHS Trust
- Whipps Cross University Hospital NHS Trust

Appendix 3: Glossary

A&E	Accident and Emergency
BME	Black and Minority Ethnic
COT	College of Occupational Therapists
DGH	District General Hospital
DoH	Department of Health
FAST	Stroke recognition test: <u>F</u> acial weakness? <u>A</u> rm weakness? <u>S</u> peech problems? <u>T</u> ime to call 999.
GLA	Greater London Authority
HASU	Hyper-acute Stroke Unit
HIA	Health Impact Assessment
HfL	Healthcare for London
JCPCT	Joint Committee of Primary Care Trusts
JHOSC	Joint Health Overview and Scrutiny Committee
LAS	London Ambulance Service
LINK	Local Involvement Network
MTC	Major Trauma Centre
PHAST	Public Health Action Support Team
PCT	Primary Care Trust
RCN	Royal College of Nursing
TfL	Transport for London

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