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

WEDNESDAY 4 FEBRUARY 2009

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

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

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

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

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

1. APPOINTMENT OF CHAIRMAN

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

RESOLVED:

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

2. APPOINTMENT OF VICE-CHAIRMEN

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

3. APOLOGIES FOR ABSENCE

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

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

4. DECLARATIONS OF INTEREST

Cllr Carole Hubbard (Bromley) declared that she was an employee of Bromley PCT.
Cllr Jonathan McShane (Hackney) declared that he was an employee of the NHS in Southwark.
Cllr Vina Mithani (Harrow) declared that she was an employee of the Health Protection Agency.
Cllr Mary O'Connor (Hillingdon) declared that she was chairman of the London Health Commission.

5. PROPOSED TERMS OF REFERENCE

RESOLVED: That the proposed Terms of Reference be agreed.

6. PROPOSED OPERATIONAL ARRANGEMENTS

RESOLVED:

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

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

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

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

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

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

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

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

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

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

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

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

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

RESOLVED:

3) That the proposed Rules of Procedure be agreed.

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

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

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

RESOLVED:

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

7. THE CONSULTATION PAPER

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

d) <u>Don Neame, HfL Director of Communication</u>

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

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

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

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

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

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

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

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

The meeting finished at 1.21pm.

Chairman