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"

THURSDAY 5 MARCH 2009

London Borough of Redbridge, Council Chamber,
128-142 High Road, Ilford IG1 2DD

PRESENT:

Cllr Marie West - London Borough of Barking and Dagenham
Cllr Sachin Rajput - London Borough of Barnet
Cllr Carole Hubbard – London Borough of Bromley
Cllr Graham Bass - London Borough of Croydon
Cllr Greg Stafford - London Borough of Ealing
Cllr Ann-Marie Pearce - London Borough of Enfield
Cllr Christopher Pond - Essex County Council
Cllr Janet Gillman - London Borough of Greenwich
Cllr Robert Iggulden – London Borough of Hammersmith and Fulham
Cllr Vina Mithani – London Borough of Harrow
Cllr Ted Eden - London Borough of Havering
Cllr Mary O'Connor - London Borough of Hillingdon
Cllr Jon Hardy - London Borough of Hounslow
Cllr Christopher Buckmaster - Royal Borough of Kensington and Chelsea (Chairman)
Cllr Don Jordan – Royal Borough of Kingston Upon Thames
Cllr Helen O'Malley – London Borough of Lambeth
Cllr Filly K. Maravala – 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 Barrie Taylor - City of Westminster

ALSO PRESENT:

Officers:

Paranjit Nijher - London Borough of Barking and Dagenham
Jeremy Williams – London Borough of Barnet
Jacqueline Casson – London Borough of Brent
Shama Smith - London Borough of Camden
Simon Temerlies – City of London
Nigel Spalding - London Borough of Ealing
Tracey Anderson – London Borough of Hackney
Sue Perrin – London Borough of Hammersmith & Fulham
Rob Mack – London Borough of Haringey
Nahreen Matlib - London Borough of Harrow
Anthony Clements – London Borough of Havering
Deepa Patel – London Borough of Hounslow
Gavin Wilson – Royal Borough of Kensington & Chelsea
Joanne Tutt - London Borough of Lambeth

Julia Regan - London Borough of Merton
Iain Griffin - London Borough of Newham
Mike Emery - London Borough of Redbridge
Jilly Mushington - London Borough of Redbridge
Shanara Matin - London Borough of Tower Hamlets
Farhana Zia - London Borough of Waltham Forest

Others:
Rachel Barlow, Head of Operations for Surgery & Cancer, St Mary's Hospital
Prof. Peter Butler - Divisional Director, Trauma and Managed Networks, Royal Free Hospital
Pamela Chesters - Chair, Royal Free Hospital
Edward Donald, Director of Operations & Performance, St Mary's Hospital
Gill Gaskin, Consultant & Clinical Director of Medicine, St Mary's Hospital
Dr Lionel Ginsberg - Consultant Neurologist, Royal Free Hospital
Candace Imison - Deputy Director of Policy, The King's Fund
Cllr Kieran McGregor, London Borough of Enfield
Nicholas Miller, Healthcare for London
Michael Scott, Chief Executive, Westminster PCT
Prof. Steve Smith, Principal of the Faculty of Medicine, Imperial College and Chief Executive of Imperial College NHS Healthcare Trust
Andrew Way - Chief Executive, Royal Free Hospital

1. INTRODUCTORY REMARKS

Mr Mike Emery (Interim Head of Performance and Scrutiny, London Borough of Redbridge) welcomed everyone to the London Borough of Redbridge and made some 'housekeeping' announcements. He then led the meeting in a minute's silence to mark the recent death of Cllr Allan Burgess, who had been the London Borough of Redbridge's representative on the JHOSC.

2. APOLOGIES FOR ABSENCE

Apologies for absence were received from:
Cllr John Bryant (Camden)
Cllr Ken Ayres (City of London)
Cllr Jonathan McShane (Hackney
Cllrs Peter Tobias and Rory Vaughan (Hammersmith and Fulham)
Cllrs Gilli Lewis-Lavender and Sheila Knight (Merton)
Cllr Winston Vaughan (Newham)
Cllr Lufta Begum (Tower Hamlets)
Cllr Susie Burbridge (Westminster)

3. DECLARATIONS OF INTEREST

Cllr Carole Hubbard (Bromley) declared that she was an employee of Bromley PCT.
Cllr Greg Stafford (Ealing) declared that he was a member of the British College of Occupational Therapists.

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.

4. MINUTES

RESOLVED: That the minutes of the meeting held on 4 February 2009 be approved as a correct record, subject to the inclusion of Nigel Spalding (Ealing) among the list of officers present.

5. PROGRAMME OF WITNESS SESSIONS

The Chairman, Cllr Buckmaster, reported that the London Health Observatory, which had been approached to fill the first Witness slot on the day's programme, had advised at a late stage that they considered it inappropriate to attend to give evidence (although they would be prepared to provide data). Although the support officers had worked hard to find a replacement, this had not proved possible in the limited time available. Consequently, Cllr Buckmaster suggested that the first part of the morning might usefully be devoted to considering the Programme of Witness Sessions.

Cllr Buckmaster reported that the support officers had made every attempt to locate a venue at a south London local authority for the present meeting, but to no avail. However, the next meeting, on 23 March, would be held at the London Borough of Lambeth. He advised that he had been approached by a number of Members who were keen that future meetings be held in central locations, to the convenience of the majority. Following a short discussion, it was

RESOLVED: That (following the meeting on 23 March) future meetings be held in central locations, wherever possible.

Cllr Buckmaster said that he would discuss with the support officers the venue for the meeting on 7 April, provisional arrangements having been made to hold it at the London Borough of Merton.

Consideration was given to the Programme of Witness Sessions. The support officers provided a brief oral update of recent developments in securing speakers for the forthcoming meetings.

The following suggestions for additional Witnesses and topics were made:

The Allied Health Federation
Details of how the scoring of hospitals was carried out - to be put to Healthcare for London (at a future meeting)
Dr Simon Tanner, Regional Director of Public Health
British Association of Stroke Physicians

A speaker able to give an international perspective
Royal National Orthopaedic Hospital

Cllr Buckmaster said that further suggestions for Witnesses were welcome.

Cllr Jordan said that he would forward to the Chairman details of the case in their favour made by Kingston Hospital, one of the 'unsuccessful' HASU Stroke hospitals. Cllr Buckmaster said that he considered it would be useful for the JHOSC to hear from at least one such 'unsuccessful' hospital. Also, all 'unsuccessful' hospitals should be written to, asking whether they wished to submit written evidence.

Cllr Sweden referred to the unsatisfactory position concerning the plans for revisions to stroke services in NE London, and advised that all affected Boroughs had been invited to a meeting at LB Waltham Forest on 31 March to consider the way forward. He would be pleased to forward the minutes of this meeting to the JHOSC. The Chairman said that it would be useful for a councillor from one of the affected NE London councils to report formally back to a future meeting of the JHOSC.

6. FINAL REPORT

The Chairman advised that it was the intention for the minutes of each evidence-gathering meeting to provide a substantive record of key points, without the need for a separate summary of each meeting being produced. It was intended that the first draft of the final report would be drafted by officers from Kensington and Chelsea, and Gavin Wilson would attend each meeting and note the points made.

The meeting on 7 May would allow an opportunity for discussion of the final report; however, if further amendments were needed, a further meeting of the JHOSC could be held.

7. WITNESS SESSION: KING'S FUND

The meeting received a presentation from Candace Imison (Deputy Director of Policy), King's Fund.

Ms Imison opened her presentation by referring to the fact that, unlike the case with some other areas of Health Service provision, there was a clear evidence base to support the reconfiguration of services for both Stroke and Major Trauma, on the basis of achieving a critical mass (of patients) capable of generating effective clinical outcomes.

In the case of Stroke, there was strong evidence of poor outcomes linked to lack of rapid access to diagnostics and rehabilitation. Big

improvements to individuals' lives could be effected by rapid interventions and good rehabilitation.

The NHS was to be applauded for proposing what was intended to be a comprehensive and coherent framework of provision. Within this framework, hospitals would continue to operate as part of interdependent clinical networks.

Ms Imison underlined the importance of a good framework being put in place for the evaluation of the proposed changes. She also referred to the resource commitments underpinning the proposals, and suggested that it would be prudent to monitor their implementation.

The relationship between hospitals and the London Ambulance Service (LAS) was a key one, and the support of LAS in making the proposed changes work well would be critical. Feedback from the LAS on how new arrangements were working would be important.

Ms Imison said that her fundamental concern with the Stroke proposals was that the model proposed by Prof. Roger Boyle (National Clinical Director for Heart Disease) had not been adopted.

The model proposed in the consultation paper certainly provided rapid access to a scan (and thrombolysis if required), but it also involved transfer - within a short period of time - of a patient from a hyper-acute stroke unit (HASU) to another hospital (for continuing care and rehabilitation) in many cases. This transfer might have an adverse impact on the patient's condition, and she suggested strongly, therefore, that the proposed model be evaluated before it was introduced.

Effective protocols would be needed covering the transfer of patients between HASUs and Stroke Units at other hospitals, as potentially this could be an area of operational difficulties (e.g. HASU bed provision could become overloaded if transfer arrangements did not work smoothly, threatening the quality of patient care).

Ms Imison recommended, therefore, that the proposed model of Stroke provision be tested in one part of London before it was considered for implementation across the capital, and suggested that S.W. London (where St George's Hospital had been the centre of a Stroke network for a number of years) might be appropriate. However, this trialling should not delay the introduction of rapid access to scans, treatment and rehabilitation at other hospitals within existing service configurations. She also referred to the example of Surrey PCT, which encouraged all hospitals in its area to provide rapid access to scans and thrombolysis, (and trained a broader range of health professionals to provide thrombolysis), and suggested that the JHOSC might wish to investigate this further.

Following her presentation, Ms Imison responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

On the question of the removal of existing major Stroke services from a hospital, Ms Imison said that the loss of access for local people would need to be balanced against the improved quality of care received under the reconfiguration proposals in the consultation paper.

Good co-ordination of services across London's boundaries was likely to present challenges, but it would be very important to get this right. The LAS and ambulance services from surrounding out-of-London areas would need to co-operate closely. Ms Imison reiterated that the role of paramedics was a crucial one.

Reference was made to the increased number of ambulance journeys (from HASUs to Stroke units at other hospitals) and the implied need for additional vehicles and ambulance staff.

The likely organisational difficulties around bed availability arising from inter-hospital transfers were again noted, and the idea of 'ring-fenced' beds for Stroke patients was noted as likely to be impracticable.

Ms Imison envisaged that the deployment of staff within a Stroke network might be operated in a fairly flexible fashion, rather than having individuals necessarily attached to a particular hospital, and she referred to joint appointments as one such possibility. On the basis of her experience of the model of provision in S.W. London, she estimated that NHS London was not that far away from having adequate numbers of staff for the proposed eight HASUs.

Good integration of Stroke services provided by NHS and social care teams was clearly of considerable importance, and could offer significant benefits to patients. Ms Imison considered that, compared to other parts of the country, in London there had been a relative under-investment in intermediate and support care. However, continued rehabilitation in a community setting (with Stroke treatment relatively close to people's homes) was important.

The HASUs clearly had the potential to develop into powerful centres within the Health Service in London, and it might be appropriate to monitor their operation within a year or so of becoming operational.

As regards the impact of the Stroke proposals on relevant Health Service staff, Ms Imison considered that where hospitals lost thrombolysis, this could have a de-skilling effect. However, she did not consider that general stroke care (ie other than the initial period of rapid assessment/treatment) was likely to be taken away from district general hospitals. It would be important to ensure that existing professional skills in relation to Stroke were retained at these hospitals.

On the question of international examples of more effective Stroke treatment than presently existed in the UK, Ms Imison said that the consultation proposals should introduce comparable rapid diagnostic/treatment, which should deliver better outcomes in London.

As regards whether the proposals for Major Trauma could respond adequately to a major incident (e.g. terrorist attack), and could deliver on proposed ambulance transfer times (45 minutes), Ms Imosen said that she understood that the proposals for four Major Trauma networks had widespread clinical support. In practice, this model of provision had been practised in London for a number of years. She referred to the good record of NHS London in responding to major incidents, and did not feel that provision for a major incident ought to be a significant driver in determining the number of Major Trauma networks.

The Chairman thanked Ms Imison for her presentation and for responding to Members' questions. Ms Imison kindly agreed to respond to any further evidence-based questions from Members (sent to the Chairman, or Julia Regan or Gavin Wilson of the supporting officers).

8. ROYAL FREE HOSPITAL WITNESS SESSION

The meeting received a presentation from Andrew Way (Chief Executive), assisted by Pamela Chesters (Chair), Prof. Peter Butler (Divisional Director, Trauma and Managed Networks), and Dr Lionel Ginsberg (Consultant Neurologist), Royal Free Hospital (RFH).

Mr Way opened his presentation by welcoming the initiative taken by Healthcare for London in putting forward proposals intended to improve care for stroke and trauma patients in London. He pointed out that the RFH had been one of the first hospitals to operate a HASU (nearly two years previously). Also, being a 'trauma black spot' in London, the Trust had a lot of experience in responding to the needs of trauma patients.

It was important to realise that the RFH - as with other major hospital trusts in London - had a catchment for patients which extended outside the capital's boundaries (in the RFH's case, into Hertfordshire and part of Bedfordshire). In considering whether having eight HASUs and four MT centres was the appropriate level of provision, it was crucial, therefore, to consider the *actual* population which was presently covered, and to not de-stabilise unnecessarily existing service provision.

The RFH had long ago recognised the particular clinical strengths of UCLH, and had developed an alternate unique provider model based on one care pathway for heart attack and Stroke. This combined pathway provided outcomes of a high quality, but under the evaluation

criteria for the service reconfigurations proposed by Healthcare for London, the service would be lost.

Mr Way said that having to give priority to dealing with the considerable disruption caused by the inadequacies of the new Cerner IT system had affected the strength of RFH's bid.

Mr Way referred to the fact that the RFH had proposed an alternate catchment arrangement for four Major Trauma Centres (MTCs) that recognised the strength of the Royal London Hospital, but took account of the broader catchment of the RFH. However, this option had not been put forward by Healthcare for London for public consultation.

Although RFH's service proposal would be ready for implementation by the end of 2010, the consultation paper had chosen to show them (along with St Mary's) as ready by 2012, and the Trust felt that this portrayed their preparedness in an inaccurate manner.

The RFH had not been asked to submit any detailed financial appraisal, and on this basis (and assuming this was the case with other hospitals) Mr Way could not see how any realistic financial evaluation of the proposals was possible. However, it was surely essential to have a detailed picture of the financial costs and benefits for the proposed major changes in services.

Following his presentation, Mr Way and colleagues responded to a number of questions from Members. Additional or supplementary points to those covered earlier, are set out below.

On the question of whether the four MTCs proposed in the consultation paper represented the right level of provision, Prof. Butler said that if account was taken of the Home Counties catchment, he believed that five MTCs would be more appropriate.

On the optimum number of HASUs, Dr. Ginsberg referred to the need for a flexible approach, since although around eight HASUs might be a sensible level of provision in the short or medium-term, in time he could envisage that many district general hospitals could provide specialist Stroke care.

Based on population projections, Mr Way estimated that if patients from Home Counties were taken into account, the figure of 1,600 MT patients per year for London could rise to over 2,000 per year. He pointed out that under the consultation proposals, the RFH would no longer be able to operate with its existing catchment of MT patients.

Dr. Ginsberg confirmed that the hospital's decision to combine heart and Stroke treatment had been primarily due to the similarity in care pathways, rather than having been resource-driven. He was unable to say how many such combined heart/stroke centres would be needed to

cover London, since this modelling had not been done. The JHOSC agreed that it would be helpful for Healthcare for London to undertake this modelling, and advise the JHOSC of the results.

The JHOSC felt that it would be useful for details to be provided by Healthcare for London of the prevalence of Stroke in the 10-15 mile band outside London, to complement the information known for the capital. It also considered that a commentary from the RFH would be helpful on this sought information.

If the RFH was not chosen as the fourth MTC, Mr Way said that he would expect patients in certain parts of London (e.g. South Barnet) to be disadvantaged. However, overall, the proposals in the consultation paper should certainly be to the benefit of Londoners. Nevertheless, the view taken by the RFH was that in arriving at sensible final service reconfigurations, account must be taken not only of the best clinical pathways for patients living in London, but also for those in the immediate catchment area outside the city.

Reference was made to the very positive responses of the London Ambulance Service, and clinicians, to the RFH's combined heart/stroke care pathway. Given the time which it often took for evaluation of new services to be carried out in the NHS, the RFH believed that evaluation of their combined service should be undertaken, in order to see whether it might be a model that could be applied more widely.

In terms of the strength of its case over St Mary's to provide a fourth MTC, the RFH considered that it had all the necessary facilities (with the exception of a CT scanner) based on one site, with a very strong group of clinicians able to provide a 24/7 service by the end of 2010. However, some additional skills and personnel would be required, though these were likely to be small in number.

As regards an evaluation of the combined heart/stroke model, there was no model within the UK with which it could be compared. However, elements of the combined service (e.g. transfer time from accident to treatment) had been the subject of comparison with other leading hospitals.

Having eight HASUs was a proposal made by Healthcare for London based on achieving a 'critical mass' of patients per HASU, but would involve some de-commissioning of acute stroke services currently provided by some hospitals. This would have an impact in terms of longer transit times for some local patients, and under-utilisation of skills of staff affected. Most parts of London would have access to an 'inner' and an 'outer' HASU, except SW London (where St Georges would have a key role in provision) and N. Central London (where there was no 'outer' partner to UCLH).

With reference to a higher figure of up to fourteen HASUs, RFH recognised that, based on existing clinical expertise and capacity, eight was probably a realistic level of provision for the time being. However, in the longer-term, having a larger number was a possibility. The Trust had explored the model of some HASUs providing 24/7 provision, whilst some operated as daytime providers, and recognised that this was an alternative model which might address issues of local provision and travel.

In response to an enquiry from Ms Chesters regarding whether the JHOSC would consider Healthcare for London proposals to de-commission a particular service, or whether this would be a matter for the local OSC concerned, Cllr Buckmaster referred to the specific terms of reference of the JHOSC in relation to responding to the present consultation exercise, launched in January. It would be for a local OSC to consider 'calling in' a particular subsequent proposal affecting service provision, although in terms of the role of a pan-London JHOSC in such circumstances, this was an area which had yet to be clarified.

In terms of the desirability of transferring an ill patient, after 72 hours' care in a HASU, to a Stroke Unit at a local hospital, this was a possibility under the model of provision proposed in the consultation paper, with a limited number of HASUs. In that context, delivering all treatment required for a Stroke patient in one hospital was clearly preferable. However, it was important to note that the consultation proposals referred to HASUs providing treatment "for the first 72 hours - or until a patient is stabilised".

From a logistical point of view, the administrative challenge of arranging transfers between HASUs and Stroke Units at a local hospital was recognised as an issue by the RFH, and a significant bed base would be required. Nevertheless, the advantages of a Stroke patient receiving expert care within the first critical 72 hours at a HASU should not be lost sight of.

In some concluding remarks, Ms Chesters referred again to the strengths of the RFH in terms of their capacity to provide a fourth MT centre, and underlined that the proposals for service reconfiguration should take account of the catchment from areas immediately outside London's boundaries. The overall cost of the proposals to the NHS and the areas where value for money would result from the proposed changes, were important areas for clarification. The RFH would be pleased to provide any further information which the JHOSC might require.

9. <u>ST MARY'S HOSPITAL WITNESS SESSION</u>
(see powerpoint slides appended to these minutes)

Witnesses were:

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

Members were informed that Imperial College NHS Healthcare Trust was the largest NHS Trust in England, with over a million patient contacts a year and an annual turnover of over £850 million. It was proud of its health outcomes and had the lowest hospital standardised mortality rates in the UK. It was also the UK's first academic health science centre.

The Trust had five hospitals, of which St Mary's was Healthcare for London's preferred option for the fourth MTC (in preference to the Royal Free). St Mary's had also been identified as one of the recommended hospitals to provide a Stroke Unit and transient ischaemic attack services.

Professor Smith and his colleagues made the following points in support of its bid to be designated a MTC:

- The Trust already had considerable experience and expertise in major trauma and was a national leader in resuscitation practice;
- The Trust had a patient pathway that aimed to stabilise the patient at the injury scene (specialists sent to site by car or helicopter) and then transfer them to the MTC or one of a network of trauma centres that was supported by the MTC ;
- St Mary's made geographical sense in relation to the location of the other proposed MTCs and its proximity to Whitehall and Heathrow (potential major incident targets);
- St Mary's was accessible from London's major transport arteries
- St Mary's was judged to be ahead of the Royal Free on five of the criteria (slide 6 refers);
- The Trust's highly regarded academic unit enabled them to keep at the forefront of medical developments.

In relation to the Trust's capacity to provide Stroke services, Professor Smith stressed the Trust's low stroke mortality rate and the high rating it was given in the Royal College of Physicians' organisation audit.

In response to a question about start dates, Professor Smith said that the Trust would be able to provide a fully functioning MTC by October 2010, and agreed that he had been puzzled by April 2012 having been set by Healthcare for London as an alternative to the April 2010 start date, given that the Trust could comply sooner.

In reply to questioning about Stroke services and the location of patients, the Trust witnesses stressed that their bid had been submitted

in partnership with a group of hospitals in North West London and that they would be working together to ensure that high quality was maintained 'across the patch'. Michael Scott, Chief Executive, Westminster PCT, added that the PCT was making a major investment in Stroke prevention, assessing and addressing underlying causes, and that the improved rehabilitation services should reduce the need for social care services for Stroke patients.

Witnesses were quizzed as to whether they thought the proposed number of MTCs and HASUs was right, and what the implications of opting for a different number would be:

- In relation to MTCs, the Trust witnesses replied that international experience suggested that a minimum of 400 cases annually per centre was needed for maintaining professional expertise. Therefore four centres would be right for London. The PCT witness said he was content with four MTCs, as it was best for doctors to have regular clinical experience of major trauma; also having five would be too expensive. It was suggested that the JHOSC should ask Healthcare for London if adding in patients from the Home Counties would justify the inclusion of a fifth MTC.
- In relation to Stroke services**,** witnesses said that increasing the number of HASUs from 8 to 16 would be too many to maintain clinical expertise – for example it would reduce the number of thrombolysis patients at St Mary's from 200 to 100, providing too low a number for any individual doctor.

In reply to a question about the patient welfare and bed availability concerns raised about moving patients from HASUs to Stroke Units, the witnesses explained that the 72 hours cited in the consultation document was an average based on clinical experience. Some patients would go straight home from HASUs; some would transfer to Stroke Units within 72 hours; and some would take longer to be stable enough for transfer. The Trust was working with its Stroke network to develop a transfer protocol, and would have a network stroke board to oversee the movement of patients and ensure that this happened at the "clinically correct time".

Further points were made in reply to specific questions:

- The Trust had considered combining Stroke and heart pathways in the way that the Royal Free Hospital had, and had ruled it out;
- In relation to the feasibility of some hospitals providing a 9-5 service for Strokes and some a 24-hour service, the Trust has done some modelling on this and had found that a minority of Strokes occurred between 9am and 5pm - so those hospitals would be unable to achieve a critical mass of experience;
- Trauma surgeons would develop a second speciality that they could practise, as well as looking after other surgical patients and emergency cases.

The Chairman thanked the St Mary's Hospital representatives for their presentation and for responding to Members' questions

The meeting finished at 4.32 pm.

Chairman