Joint Health Overview & Scrutiny Committee to review "Shaping Health Services Together - Consultation on developing new, high-quality major trauma and stroke services in London"

10am – 4.10pm Friday 24th April 2009

Venue: Council Chamber, Westminster Council House, Marylebone Road, London NW1 5PT

Contact officer: Joanne Tutt; jtutt@lambeth.gov.uk, 020 7926 2173

Committee Membership: attached.

Public Agenda

1. (10:00 A.M) WELCOME, INTRODUCTIONS AND APOLOGIES FOR ABSENCE (PAGES 1 - 2)

2. DECLARATIONS OF INTEREST

Any Member of the Committee, or any other Member present in the meeting room, having any personal or prejudicial interest in any item before the meeting is reminded to make the appropriate oral declaration at the start of proceedings. At meetings where the public are allowed to be in attendance and with permission speak, any Member with a prejudicial interest may also make representations, answer questions or give evidence but must then withdraw from the meeting room before the matter is discussed and before any vote is taken.

3. MINUTES (7 APRIL 2009)

To follow.

4. WRITTEN SUBMISSIONS FROM NHS TRUSTS (PAGES 3 - 20)

5. WITNESS PROGRAMME UPDATE

To follow.

6. .(10.10AM-11.00AM) WITNESS SESSION – SW LONDON STROKE CARE PILOT; PROFESSOR HUGH MARKUS

7. (11.00AM – 11.50AM) WITNESS SESSION – LONDON AMBULANCE SERVICE; MARK WHITBREAD, CLINICAL PRACTICE MANAGER – CARDIAC LEAD, NICK LAWRANCE, HEAD OF POLICY, EVALUATION AND DEVELOPMENT.

(11:50 - 12.00pm) Break.

8. (12.00PM-12.50PM) WITNESS SESSION – HEALTHCARE FOR LONDON, HEALTH IMPACT ASSESSMENT RESULTS; BASHIR ARIF, IMPACT ASSESSMENT LEAD, MATT MACDONALD, PUBLIC HEALTH ACTION SUPPORT TEAM

9. (12.50PM-1.10PM) – FEEDBACK FROM NE LONDON JHOSC – CLLR RICHARD SWEDEN, LB WALTHAM FOREST (PAGES 21 - 26)

(1.10pm – 1.45 pm Lunch)

10. (1.45PM – 2.30PM) WITNESS SESSION – TRAVEL WATCH; GAIL ENGERT, CHAIR OF LONDON TRAVEL WATCH SUB-COMMITTEE ON ACCESS TO TRANSPORT

11. (2.30PM – 3.15PM) WITNESS SESSION – HEALTHCARE FOR LONDON, TRAVEL MODELLING; MICHAEL WILSON, PROJECT MANAGER STROKE, SHAUN DANIELLI, PROJECT MANAGER TRAUMA, STEVE BLACK, SENIOR ANALYST

(3.15pm – 3.25pm break)

12. (3.25PM – 4.10PM) WITNESS SESSION – TRANSPORT FOR LONDON; CAROLE DAVIES, PRINCIPAL TRANSPORT PLANNER, JULIAN SANCHEZ, PRINCIPAL TRANSPORT PLANNER

[Each written report on the public part of the Agenda as detailed above:

(i) was made available for public inspection from the date of the Agenda;

(ii) incorporates a list of the background papers which (i) disclose any facts or matters on which that report, or any important part of it, is based; and (ii) have been relied upon to a material extent in preparing it. (Relevant documents which contain confidential or exempt information are not listed.); and

(iii) may, with the consent of the Chairman and subject to specified reasons, be supported at the meeting by way of oral statement or further written report in the event of special circumstances arising after the despatch of the Agenda.]

Exclusion of the Press and Public

There are no matters scheduled to be discussed at this meeting that would appear to disclose confidential or exempt information under the provisions Schedule 12A of the Local Government (Access to Information) Act 1985.

Should any such matters arise during the course of discussion of the above items or should the Chairman agree to discuss any other such matters on the grounds of urgency, the Committee will wish to resolve to exclude the press and public by virtue of the private nature of the business to be transacted.

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Agenda Item 1

PARTICIPATING AUTHORITIES

London Boroughs

	Appointed Member	Substitute Member(s)
Barking and Dagenham	Cllr Marie West	
Barnet	Cllr Sachin Rajput	
Bexley	Cllr David Hurt	Cllr Ross Downing
Brent	Cllr Chris Leaman	Cllr George Crane
Bromley	Cllr Carole Hubbard	Cllr Judi Ellis
Camden	Cllr John Bryant	Cllr Pat Callaghan
City of London	Cllr Ken Ayers	
Croydon	Cllr Graham Bass	
Ealing	Cllr Greg Stafford	Cllr Zahida Abbas Noori
Enfield	Cllr Ann-Marie Pearce	Cllr Vivien Giladi
Greenwich	Cllr Janet Gillman	Cllr Mick Hayes
Hackney	Cllr Jonathan McShane	Cllr Daniel Kemp
Hammersmith & Fulham	Cllr Peter Tobias	Cllr Rory Vaughan
Haringey	Cllr Gideon Bull	
Harrow	Cllr Vina Mithani	Cllr Margaret Davine
Havering	Cllr Ted Eden	
Hillingdon	Cllr Mary O'Connor	Cllr Judith Cooper
Hounslow	Cllr Jon Hardy	Cllr Felicity Barwood Cllr Ruth Cadbury
Islington	Cllr Paul Convery	Cllr Marisha Ray
Kensington and Chelsea	Cllr Christopher Buckmaster	
Kingston upon Thames	Cllr Don Jordan	
Lambeth	Cllr Helen O'Malley	
Lewisham	Cllr Sylvia Scott	Cllr Alan Hall
Merton	Cllr Gilli Lewis-Lavender	Cllr Sheila Knight
Newham	Cllr Winston Vaughan	Cllr Ted Sparrowhawk
Redbridge		Cllr Filly Maravala Cllr Ralph Scott
Richmond upon Thames	Cllr Nicola Urquhart	
Southwark	Cllr Adedokun Lasaki	Cllr Susan Elan Jones
Sutton	Cllr Stuart Gordon-Bullock	Cllr Jayne McCoy
Tower Hamlets	Cllr Lutfa Begum	Cllr Stephanie Eaton
Waltham Forest	Cllr Richard Sweden	
Wandsworth	Cllr Ian Hart	
Westminster	Cllr Susie Burbridge	

Health Scrutiny chairmen for social services authorities covering the areas of all the non-London PCTs to whom NHS London wrote in connection with 'Healthcare for London' were contacted (December 2008) concerning participation in the proposed JOSC. As of 23.01.09, those authorities who have indicated a preference for participation are as follows:

Essex – Cllr Christopher Pond

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West Middlesex University Hospital NHS Trust

TRUST MANAGEMENT OFFICE

21 April, 2009

020 8321 5604

020 8321 5434

E MAIL Jacqueline.docherty@wmuh.nhs.uk

Julia Regan,
Scrutiny Manager, Stronger Communities Team,
9th Floor, Merton Civic Centre,
London Road,
Morden, Surrey,
SM4 5DX

Dear Julia

Re: The shape of things to come – developing new, high quality major trauma and stroke services for London

Thank you for your letter dated 20th March 2009, in which you requested a view from the West Middlesex University Hospital NHS Trust on the proposals for the development of major trauma and stroke services in London.

In relation to trauma, we fully support the development of major Trauma Centres in London in order to ensure that this relatively small patient group is provided with the most effective, high quality care. As a local provider of services, already working with our more specialist neighbouring hospitals, we do not envisage the designation of trauma services to have a significant impact either on the Trust or on the travelling times of our patients.

In relation to stroke services, we welcome the proposal to further develop our stroke unit and TIA services to meet the full requirements of the Healthcare for London specification for a Stroke Unit. Indeed, we have already designated a ward to stroke care to ensure all patients are provided with optimal treatment and have in place detailed plans to enable our services to continue to develop. We did not select to bid to be a Hyper Acute Stroke Unit as we believe that this specialist service is best provided in an environment where it can be supported by the full range of services provided within a large teaching hospital environment with specialist and tertiary services

In relation to the provision of Hyper Acute stroke care, our bid was submitted in partnership with Imperial who planned to provide this service from their Charing Cross site. This represented the closest unit for our local population to access. However, we are concerned that within the consultation documentation it is noted that if Imperial are successfully designated as a trauma centre, then Hyper Acute Stroke services will be relocated from Charing Cross to be adjacent to the Trauma Centre on the St Mary's site. This would not be an optimal location for our patients and under this scenario we would wish to support Chelsea and Westminster's designation in order to maintain services as locally as possible for our patients.

Clearly, the selected configuration for the Hyper Acute Stroke Units will impact on the size of Stroke Unit required at the West Middlesex. We will continue to work closely with our health care partners including acute providers and the London Ambulance Service to ensure that we have sufficient bed capacity to manage demand.

We will be responding to the Healthcare for London consultation with these views.

I hope that this response is helpful to your discussion. If you require any further information, please do not hesitate to contact me.

Kind regards

Jacqueline Docherty
Chief Executive

Trust Board Paper No:

Ealing Hospital NHS
NHS Trust

09/03/01

TITLE OF REPORT: Response to the Healthcare for London consultation on developing new, high-quality major trauma and stroke services in London "The shape of things to come"

FOR APPROVAL

DATE: March 2009

DIRECTOR RESPONSIBLE:

AUTHOR: Dr Jenny Vaughan, Consultant Neurologist and Lead Clinician for Neurology and Julie Lowe, Chief Executive

SUMMARY:

This paper provides background information on the consultation on changes to stroke services across London. It recommends that the Board does not support the recommended options within the consultation.

The proposed changes to major trauma services are covered in a separate paper.

RELATIONSHIP WITH THE BOARD ASSURANCE FRAMEWORK:

A1 – Provide accessible high quality and responsive services to meet the needs and expectations of our diverse population.

SPECIFY ANY ADDITIONAL COSTS OR LOSS OF INCOME AND HOW THIS WILL BE RESOURCED:

Whilst the prime reason for the stroke bid was not financial there are, nevertheless, costs associated with losing stroke services, as there would also be with a successful bid.

It is estimated that direct income of c. £1.5m would be lost if stroke is no longer provided at Ealing, losing a £600k contribution to fixed costs and overheads. Variable costs associated with this income are only £100k, whilst the remaining

£800k is in semi-fixed ward costs. Therefore the net loss to the Trust will be between £0.6m and £1.4m.

A successful stroke unit bid has an increased cost of between £1.2m and £1.7m attached to it (associated with additional staff and therapy costs), although this is based on provisional changes to stroke income tariffs which Healthcare for London have said may be subject to further review.

HOW THIS POLICY/PROPOSAL RECOGNISES EQUALITY LEGISLATION:
N/A

LEGAL IMPLICATIONS:
N/A

COMMUNICATION/CONSULTATION AND PATIENT & PUBLIC INVOLVEMENT:

Public consultation is currently taking place.

RECOMMENDATION(S):
The Board is asked to:

1. Support the attached response to the consultation document which recommends locating a SU and TIA service on the Ealing site.
2. Mandate the Executive team to continue to work towards a stroke unit and TIA service at Ealing.
3. Highlight concerns to a range of local partners via the Executive team and senior clinicians.
4. Consider potential partners who might be willing to provide and manage an SU on the Ealing site.

EALING HOSPITAL NHS TRUST

REPORT TO TRUST BOARD – 26 March 2009

Response to the Healthcare for London consultation on developing new, high-quality major trauma and stroke services in London "The shape of things to come"

1. Summary

1.1. This paper provides background information on the consultation on changes to stroke services across London. It recommends that the Board does not support the recommended options within the consultation.

1.2. The proposed changes to major trauma services are covered in a separate paper.

2. Introduction

2.1. Healthcare for London (HfL) published a public consultation document outlining its plans for the future of stroke and trauma care in London. This is attached at appendix 1. If the preferred options described in the document are implemented, the existing Stroke Unit at Ealing Hospital will be closed.

3. Background

3.1. Stroke is a major public health challenge across the world. It is the second most common cause of death in the United Kingdom, and one of the leading causes of disability. There have been significant advances in stroke care over the last two decades, driven by the Royal College of Physicians' clinical guidelines on stroke, and by the biannual National Sentinel Stroke Audit. This has led to the establishment of Stroke Units (SUs) in virtually every major hospital in the United Kingdom, and thereby to significant decreases in mortality and morbidity attributable to stroke. In the last five years several centres have introduced thrombolytic ('clot-busting') treatment for acute stroke. The decision whether to give this treatment is complex, and the infrastructure required to deliver treatment within the required 3 hour time-window is extensive; a consensus view has emerged therefore – both within London and more generally across the UK – that this treatment is best centralised in a small number of Hyperacute Stroke Units (HASUs).

3.2. These plans were first outlined by Lord Darzi in his review of health services in London, published in 2007. Lord Darzi's guiding principle in this review was 'centralise where necessary, localise where possible'. This principle applies to stroke services. Patients will be taken to HASUs for initial assessment and treatment, before being returned to their local hospital for ongoing medical treatment and rehabilitation in the local Stroke Unit (SU). This ties in well with Department of Health policy, outlined in the Green Paper *Our Health, Our Care, Our Say*, which emphasises the importance of delivering care locally.

3.3. The current HfL proposals envisage 7 or 8 such centres in London. Within North West London HASUs are proposed at North West London Trust (Northwick Park site) and Imperial College Trust (Charing Cross site). Stroke units and TIA services are proposed at Hillingdon, Chelsea and Westminster and West Middlesex as well as co-located with the HASUs.

4. Stroke is a major problem for Ealing residents

4.1. Figures produced for NHS Ealing indicate that 170 people died from stroke in Ealing in 2006/7; that year there were also approximately 1600 admissions for stroke-related conditions, with admissions from Southall wards running at twice the national levels. Approximately 4000 people in Ealing have had a stroke at some time, so there is an existing population who experience problems with speech, mobility and daily life activities as a result of stroke.

5. The current Ealing Hospital stroke unit

5.1. The hospital currently has a 12 bedded stroke unit (which at times increases to as many as 18 beds). The community arm of the service is based at Clayponds Hospital (and managed by the provider arm of NHS Ealing), where there are 18 beds for continued rehabilitation of which approximately 12 are occupied by stroke patients. The multidisciplinary team consists of a consultant stroke physician, five junior doctors, a stroke specialist nurse, nurses, physiotherapists, occupational therapists, speech and language therapists, dieticians, psychologists, and rehabilitation assistants. The stroke service receives significant support from three consultant neurologists, radiologists (one of whom has a particular interest in neuro-imaging), and a vascular surgeon. The SU has recently been refurbished to a high standard, with dedicated ceiling mounted hoists, and a gymnasium for patient rehabilitation.

6. Stroke services at Ealing have improved significantly year-on-year

6.1. The results of the National Sentinel Stroke Audit show that the performance of the Ealing Hospital SU has improved steadily over recent years. The most recent report, based on our performance in 2008, puts Ealing in the top 25% of SUs in the country for the total process score. We perform in the top 25% in four of the nine key performance indicators. We also demonstrate excellence in previously unaudited areas such as secondary prevention of stroke and discussion of risk factors with patients. There remain areas in which further work is necessary (early assessment by occupational therapists), but overall the Audit demonstrates a SU that is providing excellent care to its patients. These results reflect the efforts of clinical staff on the SU, and also the success of recent new initiatives to improve the organization of stroke and TIA care at Ealing Hospital. For example, a neurovascular clinic was established in April 2008, providing a consultant-delivered Transient Ischaemic Attack (TIA) (sometimes referred to as a "mini stroke") service for low-risk patients, to complement the in-patient investigation and management of high-risk patients. This has led to an increase in the referrals to our vascular surgeon, who now performs approximately 20 carotid endarterecetomies at Ealing Hospital each year, with excellent results and very low levels of morbidity or mortality. Comparative data with other units is due to be published in April 2009.

7. Further developments are planned to achieve future high standards that will be required of SUs

7.1. The National Stroke Strategy, published by the Department of Health in 2008, sets high standards for the future management of stroke services in the UK. This has been taken on board by HfL, who have required every SU to demonstrate how it will achieve the necessary standards by April 2011 at the latest. Considerable support will be required throughout London to meet these standards, but this is a challenge for which Ealing Hospital is prepared. As a concrete example, the radiology department has recently purchased a new MDCT scanner, which will provide ever more rapid access to state-of-the-art brain imaging for stroke and TIA patients.

8. The Trust's response to the designation process

8.1. HfL asked Trusts to express an interest in becoming a HASU, Stroke Unit (SU) and/or TIA service in September 2008. Ealing expressed an interest in a Stroke Unit and a TIA service. Interest was not expressed in a HASU

on the basis that the Trust could not realistically provide a 24/7 thrombolysis service given the level of investment this would require for a small number of patients and the fact that HASUs are probably best sited within tertiary centres. A copy of the Trust's bid is attached at appendix 2. These bids were then evaluated and a copy of the evaluation report is attached as appendix 3. On 8th January 2009 the Chief Executive wrote to express concern about the process and a copy of this letter is attached as appendix 4. A meeting was held with the Medical Director, Director of Operations, Consultant-Neurologist and Consultant-Elderly Caree on 19th January 2009 with Rachel Tyndall, Chief Executive of NHS Islington and Senior Responsible Offficer (SRO) for stroke. At the meeting Rachel agreed to review the process and evaluation. A copy of her response was received on 6th March 2009 and is attached as appendix 5.

9. What would happen if the Ealing stroke unit were closed?

9.1. 350 patients each year are managed in the Ealing SU. Of these approximately 250 are found to have had a stroke or TIA. Current plans envisage that these patients will have their initial assessment carried out at a HASU (either Charing Cross or Northwick Park) but then they will returned to their local Stroke Unit within 72 hours. It is not clear who will look after the patients currently managed at Ealing Hospital. The HfL consultation document states that the patient capacity currently supplied by Ealing Hospital is 'not required'. HfL have indicated at recent meetings that final decisions on capacity have not in fact yet been made, and that designated SUs will be asked to provide information on how many beds they will provide. In reality if there is no Stroke Unit at Ealing, Ealing residents will be sent from the HASU to Hillingdon or West Middlesex for SU care, even when they have had no previous contact with these hospitals. The proposed HASUs at Charing Cross and Northwick Park have already expressed concerns about their ability to repatriate Ealing residents in a timely fashion if there is no SU at Ealing Hospital. If patients cannot be moved away from the HASUs efficiently, then they may have to close to new admissions, and the London Ambulance Service would then have to take patients to HASUs in other parts of London.

9.2. If there is no SU at Ealing, then this will have serious implications for the running of other local services, both in the hospital and in the community. There are specialist acute services and procedures available at EHT which will be under threat if the SU is removed. These include acute surgery (especially vascular) and coronary angiography. Patients undergoing these procedures are at an increased risk of stroke and the removal of an on-site SU means that if they suffer stroke as a complication their treatment

then optimal subsequent management may be compromised. If a patient does have a stroke whilst in the hospital, they will be unable to access immediate stroke care, which significantly worsens outcome, and they will then have to be transferred away from Ealing for further management. Access to key therapists (speech and language therapists, physiotherapists and occupational therapists) will also be impaired,as they will not be available on site.

10. Alternative options

10.1. The bid was based on a SU and TIA service located at Ealing Hospital and managed by the Trust. This remains the preferred option. However, rather than provide no service on the Ealing site, it might be possible to consider providing space on the Ealing site that is managed by one of the sites that is accredited.

11. The Financial Impact of removing stroke services from Ealing Hospital

11.1. Whilst the prime reason for the stroke bid was not financial there are, nevertheless, costs associated with losing stroke services, as there would also be with a successful bid.

11.2. It is estimated that direct income of c. £1.5m would be lost if stroke is no longer provided at Ealing, losing a £600k contribution to fixed costs and overheads. Variable costs associated with this income are only £100k, whilst the remaining £800k is in semi-fixed ward costs. Therefore the net loss to the Trust will be between £0.6m and £1.4m.

11.3. A successful stroke unit bid has an increased cost of between £1.2m and £1.7m attached to it (associated with additional staff and therapy costs), although this is based on provisional changes to stroke income tariffs which Healthcare for London have said may be subject to further review.

12. Conclusion

12.1. No clear evidence has been produced by HfL to justify their proposals to i) decommission the current successful SU at EHT or ii) non-designate our current TIA service. Stroke care at Ealing is currently of a standard which meets the needs of the population it serves. The self-assessment suggested that the Trust could meet the standards required of a modern stroke unit and TIA service. The evaluation downgraded the self-assessment scores but the reasons for this remain unclear. The most recent National Sentinel Stroke audit shows Ealing Hospital is delivering

care that places it in the top 25% of all Trusts nationwide, and has made major improvements since the last audit. It is expected that when the full results of this independent national audit are made public in the near future, Ealing Hospital's position will be very favourable when compared with other Trust's in the NW London area. NHS Ealing's own study looking at stroke needs of their population (drafted before the recent audit results became available), attached as appendix 6, showed that in many areas Ealing Hospital's performance was equivalent to neighbouring North West London hospitals over a range of different indices.

12.2. There is real concern that the capacity issues caused by the removal of the SU at Ealing Hospital cannot be managed by other local providers. There is also a significant potential adverse impact on other services provided by the Trust.

13. Recommendation

13.1. The Board is asked to:

- Support the attached response to the consultation document which recommends locating a SU and TIA service on the Ealing site.
- Mandate the Executive team to continue to work towards a stroke unit and TIA service at Ealing.
- Highlight concerns to a range of local partners via the Executive team and senior clinicians.
- Consider potential partners who might be willing to provide and manage an SU on the Ealing site.

Dr Jenny Vaughan, Consultant Neurologist and
Lead Clinician for Neurology

Julie Lowe, Chief Executive

March 2009

Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors Meeting

Wednesday 8th April 2009

(BDA/07/xxx)

King's Health Partners response to Healthcare for London Consultation 'The shape of things to come - developing new, high quality major trauma and stroke services for London'

Status:	A Paper for *Decision*
History:	*No previous history*

Martin Shaw
Director of Finance

Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors Meeting

8th April 2009

A paper prepared by Jackie Parrott / Marian Ridley,
Joint Directors of Partnership & Planning
and presented by Martin Shaw, Director of Finance

King's Health Partners response to Healthcare for London Consultation 'The shape of things to come - developing new, high quality major trauma and stroke services for London'

1.0 Introduction

1.1 Members of the Board will be aware that NHS London's *Framework for Action*, published in 2007 and consulted upon in 2008, signalled an intention to improve the quality of trauma and stroke services for the London population by rationalising these specialist services into fewer centres.

1.2 Following a process in the latter half of 2008 when Trusts were invited to bid to provide trauma and stroke services, the attached consultation document was published at the end of January 2009, setting out Healthcare for London's proposed future configuration of trauma and stroke services, and some alternative options. The consultation is being led by a Joint Committee of the 31 primary care trusts in London and NHS South West Essex (the JCPCT).

1.3 It is proposed that the Trust should respond jointly with King's College Hospital NHS Trust, under the auspices of King's Health Partners. The closing date for responses to the consultation is the 8th May, however since the proposals in the consultation document have important implications for the Trust and for King's Health Partners, we wish to submit our joint response before the closing date so that we ensure appropriate profile for the issues of concern to us.

1.4 The Council of Governors will be briefed on the issue and have an opportunity to discuss it at the Service Strategy Working Group on the 16th April, and their views will inform the final draft.

2.0 Draft response

2.1 Attached is the draft response, which has been developed by Maggie Hicklin, Divisional Director and other Trust colleagues, together with colleagues at King's College Hospital. Both trusts are supportive of the underlying aims and objectives of Healthcare for London's proposals for delivering high quality stroke and trauma in London, but have concerns about some of the proposed changes, particularly in relation to stroke services. These concerns are set out in the attached draft.

2.2 The Board will also be mindful of recent discussions on the future role of the St. Thomas's site and its importance as a Major Acute Hospital serving central London. In that context our Corporate Development team have been commissioned to do some modelling of the locations of major trauma centres. We believe that this will, in addition to supporting the designation of King's College Hospital as a Major Trauma Hospital serving south east London, support the case for recognition of the importance of the St Thomas' site as a

Major Acute Hospital, as the site providing the most comprehensive coverage of central London populations and strategically important locations. St Thomas' would be the ideal site to be brought into play for purposes of overall London-wide resilience, linked with King's College Hospital.

2.3 This work is not yet completed, but we hope to update the Board at its meeting. Subject to the outcome of this analysis, the views of the Board and of King's Health Partners colleagues, our conclusions from this work may be used to supplement the final version of our joint response to this consultation.

3.0 Recommendation

The Board of Directors is asked to:

- **Support the line taken in the attached joint draft response to the consultation**
- **Note that further changes to the draft will be agreed with King's College Hospital NHS Foundation Trust before submission to the JCPCT.**

Martin Shaw
Director of Finance **1st April 2009**

DRAFT

Annex

King's Health Partners' Response to Healthcare for London Consultation

Current Position

We are strongly supportive of the underlying aims and objectives of HfL's proposals for delivering high quality stroke and trauma care in London, the overall model in principle and its feasibility.

Currently the organisation of stroke and trauma services in London fails to provide high quality of care for the majority of the population and it is evident that most of the current good services are located around the centre of the city leaving much of suburban London with poor quality provision.

Within Trauma we support the adoption of the 3 Major Trauma Centres and the subsequent networks of trauma centres (with the possibility of a fourth centre in April 2012). We will continue to develop King's Health Partners trauma service with the designation of King's as the MTC whilst providing clinical and managerial support to all our network partners.

Within Stroke we support the principle that the HASU designation process should take both journey time and quality of service into account, however, the plan as currently proposed raises significant uncertainties about the feasibility of implementing it without causing a significant deterioration of clinical services in the short to medium term.

The professional consultation exercise undertaken by HfL during the development of their stroke plans came out strongly in favour of a larger number of smaller HASUs (around 12-14 HASUs each with 10-15 beds) as opposed to a smaller number of larger units.

King's and St Thomas' have a long history of collaboration on Stroke services and this will inevitably increase as a result of the successful accreditation of King's Health Partners as an Academic Health Sciences Centre. Currently King's and St Thomas' hospitals are consistently two of the highest scoring units in the National Sentinel Stroke Audit.

Our Response to the Consultation

The case for a small number of large trauma units is accepted and the location of King's supports the 45 minute journey time target. The same case for very large HASUs is less compelling. There is no evidence that eight large HASUs with twenty beds each will provide better clinical outcomes than a larger number of medium sized units.

Designation of a small number of HASUs raises concerns about resilience, both in terms of the stroke service and in terms of A&E capacity and capability. To achieve the sort of door to needle times and thrombolysis rates that the best units are currently achieving requires a seamless pathway from A&E to HASU with rapid access to scanning in A&E. London has experienced major problems this winter with A&E departments struggling to manage peak capacity resulting in failure to meet performance targets, delays in unloading ambulances and requests for diverts. There have also been significant bed problems, which have had a knock on effect on elective activity and on the ability of community services to cope with supported discharges.

There is real concern that with only eight hyper acute stroke units there may be insufficient reserve to cope with peaks of A&E demand or an unexpected drop in HASU capacity if one unit had to reduce activity, say to manage an outbreak of infection or a staffing crisis.
The co-location of HASUs with trauma units will exacerbate the pressure on those hospitals and is likely to cause capacity issues at each stage of the pathway, A&E, imaging and beds. East London will be particularly vulnerable and, under HfL's preferred model, will be reliant on

King's College Hospital to provide high quality HASU services. It is likely to take some years for Bromley, the Royal London and Queen's Hospitals to be brought up to speed.

In the medium term until those units are well established, a very short door to needle time in central London will mitigate against a slightly longer journey time from areas with no provision. St. Thomas' already has the expertise to support the overall objectives of the consultation. St Thomas' Hospital is currently achieving door to needle times of as low as 12 – 17 minutes. Given the shortage of high quality HASU provision, and the fact that many Londoners do not currently have timely access to thrombolysis treatment, we challenge the proposal to reduce high quality provision in central London with the closure of the St Thomas' Unit, which is regarded as a centre of national and international excellence.

We have major concerns about the use of a rigid sector model to plan the provision of clinical services in London. Central London poses a particular health challenge, with the population requiring urgent and emergency care changing rapidly as people move in and out of London for work, travel and social events. Any resultant service should take account for the visiting as well as the resident population.

Ensuring adequate clinical capacity during the three to five year period when the proposed units are being developed will be difficult:

- There will be no incentive for existing units to increase capacity during this time if they are not designated as long term providers.

- The designated units are unlikely to be able to meet demand in the required time frame.

- King's College Hospital would be the only existing provider in South East London and would need a 30 bed HASU to provide the necessary capacity. This would require an additional 80 nursing staff and with about 3,000 acute admissions per year would require a significant increase in the medical establishment and substantial capital investment.

- The same problem is likely to arise in other sectors. Being able to manage a HASU of 30 beds will be heavily dependent on there being effective stroke units with sufficient capacity to receive local patients within 72 hours of admission. Many of the stroke units are not yet at a stage where this level of service is likely to be deliverable and there will need to be a considerable investment both financially and in terms of education and training support to help these units reach a level where they sustain a comprehensive stroke service.

- Of the eight HASUs being proposed for designation by HfL, four were regarded as currently providing high quality HASU care, the remaining four require varying levels of support and development to achieve the standards set out in the designation process.

- In addition, the designation of only King's as a provider of HASU care is detrimental to maximising the benefits of the Academic Health Sciences Centre.

Identified Risks

There are a number of significant risks we have identified with the current proposal for the distribution of stroke services:

- There is a national shortage of trained specialists (nurses, physicians and therapists). Thus the feasibility of a rapid and radical development of specialist stroke care with a

large increase in capacity for hyper acute care in centres that are currently vestigial is unlikely to be delivered without significant investment and without strong support from the existing high quality stroke units, of which King's and St Thomas' are leaders in the field.

- There is a real danger of destroying existing high quality care without putting in the required capacity and quality into outer London. The flow of patients from Kent into South East London has not been adequately factored into planning. There is no experience in the UK of such large units, their cost effectiveness and the pressures they may put on diagnostic and therapeutic processes in hospitals.

- The result may be gaps in service provision and a lack of cohesive pan-London coverage for Londoners and visitors to London.

- It is short-sighted to be taking clinical capacity together with capacity for development, education and training out of the system at this early stage and we believe that adequate consideration has not been given to these issues.

- The four units that are already providing high quality care will themselves have major training requirements for their large increase in staffing and will be challenged to achieve the necessary internal change. Providing support to other developing units at a time of substantial increase in the workforce and the consequent teaching and training required will further hamper the development of the proposed units.

- The proposal to de-commission the existing hyperacute units will have an impact on the quality of care for other patient groups at St Thomas' Hospital. A significant number of patients have a stroke whilst in hospital undergoing treatment for other conditions, most notably heart disease. These are usually patients who have a stroke in the post operative period and are often complex cases requiring critical care facilities. Under the proposed HfL model, these patients would no longer be treated for their stroke at St Thomas but would have to be transferred to King's College Hospital, which will add unnecessary delay and a complicated transfer to the patient pathway. The same will be true of other centres.

- Stroke research is a major Department of Health priority as evidenced by the development of the Stroke Research Network. The proposed model my hamper the recruitment of patients into clinical trials as major research active centres will be excluded from hyperacute research. Follow up of patients, after moving patients back to their base hospital, will be more complex.

King's Health Partners Recommendation

The consultation aims to improve the quality of care for acutely ill patients in London. King's Health Partners supports the proposals for the development of major trauma centres. We believe that the ambition for high quality services for stroke is more likely to be achieved if there is a more careful phased implementation rather than the proposed big bang approach.
The bids submitted by King's Health Partners proposed the running of a joint AHSC service with the sharing of medical staff between King's and St Thomas' hospitals. Our recommendations are:

1. The AHSC, rather than King's College Hospital alone should be designated to provide HASU, SU and TIA services, ensuring that south east London has the flexibility, capacity and resilience required to meet the demand.

2. South East London requires 30 HASU beds and we would initially envisage providing them at King's and at St Thomas' Hospitals. We believe that this is achievable within the timescale required and plans are in place to recruit and train staff to deliver this. We would work to one set of clinical protocols and implement a single patient pathway, a joint consultant rota with the advantage that implementation, whilst challenging, would be achievable and would provide resilience.

3. We have successfully installed telemedicine at St Thomas' Hospital and this has been an important factor in achieving door to needle times of less than 20 minutes (most recently 12 – 17 minutes). We are currently installing the same service into King's College A&E and believe that telemedicine could be used as a valuable asset to support Bromley in eventually delivering the required performance.

4. King's Health Partners is committed to supporting the development of a HASU for the population of Bromley (and part of Kent) and we are in discussion with Bromley about what that support might look like. We would expect to review the number and organisation of beds provided by the AHSC in 3-5 years time or when the Bromley HASU unit is delivering the required capacity and quality.

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MINUTES OF A MEETING OF THE JOINT HEALTH OVERVIEW & SCRUTINY COMMITTEE
Waltham Forest Town Hall, Walthamstow
Tuesday 31 March 2009 (10.05 am – 12.25 pm)

Present: Councillor Richard Sweden (London Borough of Waltham Forest) in the Chair

Councillors representing London Borough of Barking & Dagenham: John Denyer, Mrs D Hunt and Marie West

Councillors representing London Borough of Havering: Ted Eden and Fred Osborne

Councillors representing London Borough of Redbridge, Filly Maravala and Ralph Scott

Councillor representing London Borough of Waltham Forest: Alan Siggers

Councillor representing Essex County Council: Chris Pond (observer status)

Co-opted Members: Neil Collins was in attendance.

Councillor Peter Herrington (Waltham Forest) was also in attendance.

Apologies for absence were received from Malcolm Wilders (co-opted Member). Apologies were also received from Councillor Christopher Buckmaster, Kensington & Chelsea and Councillor Winston Vaughan, Newham who wished to thank the Committee for their invitation to attend on his occasion.

Also present were:

Heather O'Meara, Chief Executive, NHS Redbridge and lead officer for the Case for Change review and Ruth Osborn, Head of Communications at NHS Waltham Forest. Apologies were received from Adrienne Noon, Head of Communications, NHS Redbridge.

No Member declared an interest in the business considered

The Chairman advised those present of action to be taken in the event of emergency evacuation of the Town Hall becoming necessary.

9 MINUTES

The minutes of the meeting of the Joint Committee held on 27 January 2009 were confirmed as a correct record and were signed by the Chairman.

10 PRESENTATION ON HEALTHCARE FOR LONDON CONSULTATION

The Chairman welcomed the NHS officers to the meeting and explained that several Members were also involved with the pan-London Joint Health Overview and Scrutiny Committee. The pan-London Committee had begun scrutinising the Healthcare for London proposals and had been informed that elements of the plans for stroke services affecting North East London would not be finalised until July 2009 due to the Case for Change review of services in this area. The Outer North East London Committee had therefore requested presentations to be given both on the general Healthcare for London consultation and on the Case for Change review of North East London services.

The lead officer confirmed that she was the sector chief executive for acute commissioning for the whole of Outer North East London. As regards trauma, there was already a regional trauma centre at the Royal London Hospital and the Healthcare for London proposals would mean little difference to existing services in this area. Acute trauma cases were relatively few in number and so the proposal was to have 3-4 specialist centres for London in order that trauma consultants and other specialist staff could see enough cases to keep their skills at the required level. Officers added that Queen's Hospital would be the local centre for the trauma network (led by the Royal London) rather than King George. Waltham Forest residents would continue to be treated at Whipps Cross (other than the most serious cases which would go to the Royal London). Thu for example the most serious victims of a knife crime incident in Waltham Forest would go to the Royal London while those with non-life threatening injuries would be taken to Whipps Cross.

There was a need to change stroke services as current death rates were too high and care levels not good enough. Work was also underway to prevent strokes occurring and the current advertisements for the FAST stroke awareness test were an example of this. It was noted that part of Havering was a hotspot for stroke and that the four outer London boroughs had the majority of strokes in North East London.

The current consultation proposed having hyper acute stoke centres at the Royal London and Queen's. The lead officer accepted that more improvement was needed for Queen's to effectively host a hyper acute unit. Work was underway with BHRT to address this and an additional neurological consultant had now been appointed. Relevant proposals on further stroke services for North East London would be brought to the Joint Committee of Primary Care Trusts in May 2009. Detailed mapping of ambulance journey times had been undertaken which had informed decisions about the locations of stroke centres. It was emphasised that the model used was future proof and took

account of expected population changes over the next 10-15 years. There was also a need to consider the length of hospital stay in order to allow more people to be treated.

As regards West Essex, stroke cases in Epping and Harlow would go to Queen's whilst the rest of the West Essex PCT area would use Whipps Cross or the Royal London. Some acute trauma cases from further into Essex would be taken to the Princess Alexandra Hospital in Harlow.

Once the hyper acute units were implemented, CT scans would be available from them on a 24:7 basis as well as a number of other services for the early stages of stroke such as thrombolysis. Thus patients were likely to receive better health outcomes by being taken to a specialist stroke centre, even allowing for a longer journey time. The same principle applied for acute trauma cases. The lead officer added that the modelling had shown that 3-4 centres would be enough to cope, even with a major incident affecting London. Cutting edge centres such as this would be likely to attract staff and there were currently a number of unemployed therapists in London so recruitment was unlikely to be a major problem. Staff communication whether by NHS staff trained in the UK or elsewhere was an important issue and the lead officer noted the Committee's concerns in this area. Work on implementation of the agreed centres would commence after the consultation and the hyper acute stroke units would be in operation by April 2010.

Some Members felt that smaller specialised stroke units could be used in areas of higher population but felt that stroke patients should go first to a hyper acute unit. Prevention services and those for transient ischaemic attacks would be made available on an individual borough basis.

The proposals would allow meeting of a target to commence treatment of a stroke within three hours although CT scans only took in the region of 15 minutes to administer and the results were available instantly. Scans would not be given in all cases, clinical guidance would be followed on this. There were also incidences of younger people suffering strokes, often due to risk factors such as ethnicity or childhood obesity. The lead officer was uncertain how childhood stroke would be addressed and if there was any role for example Great Ormond Street Hospital and agreed to find out and update the Committee on this.

The Committee noted that the consultation contained a lack of proposals for stroke services in associated areas such as disabled aids and adaptations, speech therapy and prevention of stroke. The lead officer responded that this would be picked up via the already in progress work around care outside hospital in North East London. The lead officer was unaware of any complaints regarding a lack of disabled adaptations in Outer North East London.

It was emphasised that hyper acute stroke units would not just offer scanning and drugs but would consist of a multi-disciplinary team including physiotherapy, swallowing assessments, speech and language therapy and

nurses with specialist skills. A Member commented that staff at the speech therapy unit at Queen's Hospital were very committed and enthusiastic.

The Committee **noted** the presentation.

11 PRESENTATION ON MAKING HEALTHCARE FOR LONDON HAPPEN IN NORTH EAST LONDON – THE CASE FOR CHANGE

The lead officer explained that these proposals applied to the eight North East London boroughs. This exercise was not a formal consultation but outlined the next steps in implementing Lord Darzi's vision in the community. The current healthcare landscape in North East London was not financially sustainable, particularly when the level of historic debt was taken into account.

It was emphasised that the proposals were not a repeat of the previous Fit for the Future review but aimed to deliver care in the most appropriate setting within the available financial and staffing resources. A group of 40-50 local consultants, GPs, nurses and therapists were involved in drawing up the proposals.

The review would look at the following areas:

- Urgent surgery
- Urgent medicine
- Children's services
- Maternity and newborn services
- Specialist services
- Planned care

Formal consultation would commence in July 2009. The consultation period would be expanded due to people being on holiday. The lead officer emphasised that the planned changes were driven by clinicians in order to improve clinical outcomes and reduce inequalities in the system. The consultation would include the type of stroke services provided in each North East London hospital but the lead officer said she would check with the Joint Committee of Primary Care Trusts how this would link with the wider Healthcare for London consultation.

The Committee raised concern about the financial situation in the North East London health sector. The lead officer clarified that there had not been a further topslice of funding but London PCTs had agreed not to ask for the return of the topsliced monies taken three years ago. Trusts with historic debt were able to apply to have this written off, provided they could demonstrate financial sustainability. The lead officer denied that a North East London hospital would have to close as a result of the review.

Members felt that the public were being involved in the review at too late a stage and that this may disengage people. There were also concerns raised about the differing methodologies used in the Case for Change and Healthcare for London consultation exercises. The lead officer replied that the

Case for Change clinical advisory group was testing its work against Healthcare for London principles.

The lead officer was uncertain at this stage precisely what services would be affected by the Case for Change review (other than the broad areas outlined above). There was a lot of capacity to run the health system better. It was necessary to manage long-term conditions better which would lead to less people having to enter hospital. It was also important to reduce numbers of primary care patients attending at A & E.

The Committee thanked the lead officer for her input to the meeting and **noted** the presentation.

12 COMMITTEE'S TERMS OF REFERENCE

Members noted that no legal comments on the proposed terms of reference had been received from any of the Boroughs. It was agreed that an amendment would be made to paragraph 4 to include Thurrock District Council and Brentwood Borough Council having the right to nominate a Member with observer status to the Committee.

Subject to the above addition and some minor typographical changes, the Committee agreed to adopt the terms of reference with immediate effect.

13 COMMITTEE'S WORK PROGRAMME

It was noted that the Committee would be likely to have to undertake a full scrutiny of the Case for Change proposals once the consultation period commenced in July. Other suggestions for the work programme would be circulated by officers outside the meeting.

14 URGENT BUSINESS

It was **agreed** that the minutes would be agreed by the Committee by e-mail on this occasion in order that they could be forwarded as soon as possible to the pan-London Committee for their information.

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