Improving Stroke and Major Trauma Services in London

Programme Brief for consideration by PCT Boards

September 2008

version 1.0
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Section 1 Introduction

Detailed proposals have been developed to significantly improve the care delivered to stroke (essentially a brain attack) and trauma patients across London. These improvements will be enabled by the introduction of new service delivery models and new care pathways. Work has progressed through active processes of clinical, public and patient engagement.

The proposed models of care embrace prevention, diagnosis, specialist acute treatment, acute rehabilitation and long term rehabilitation. This document specifically focuses on the need to conduct a public consultation on the specialist acute phase of care. This reflects the statutory requirement to consult on proposals to substantially vary or develop health services. The content of this document includes a summary of the case for change and a description of key pre-consultation, consultation and post consultation processes.

The proposals will:

- Enable greater prevention of stroke and trauma;
- Ensure the provision of high standards of care in the critical acute periods of treatment;
- Introduce effective processes of rehabilitation and recovery.

We aim to save over 1,000 lives a year, reduce disability and allow thousands of Londoners who experience trauma or a stroke to subsequently realise their full potential.

Section 2 Strategic Context

A Case for Change (March 2007) described how London needs to improve the health of Londoners, to make better use of primary care (for instance in prevention, diagnosis and rehabilitation), to centralise more specialised care, and to better use the NHS workforce and buildings.

Healthcare for London *A Framework for Action* (July 2007) and accompanying clinical pathway reports further developed the case for change and made specific proposals, for instance:

- the development of a stroke strategy and seven hyper-acute stroke centres;
- the development of trauma networks with three major acute centres.

Following *Consulting the Capital* (Nov 2007) the Joint Committee of PCTs accepted the clinical evidence (previously established and further supported by the Clinical Advisory Group (CAG)) and acknowledged the strong patient and public support (64 percent for specialised trauma centres, 67 percent for specialised stroke centres). However in the light of the CAG report it amended the proposed number of major trauma centres. The Committee agreed:

- to develop some hospitals to provide more specialised care to treat the urgent care needs of trauma (severe injury) patients – probably between three and six hospitals. The number and location of these hospitals should be subject to a further consultation by PCTs.

- to develop some hospitals to provide more specialised care to treat the urgent care needs of patients suffering a stroke (about seven hospitals in London providing 24/7 urgent care, with others providing urgent care during the day). The number and location of these hospitals should be subject to a further consultation by PCTs.

The proposed model of care for these services was described in *Consulting the Capital.* Patients will be transported to major trauma centres, and for stroke to hyper-acute centres, which have been designated as meeting the necessary clinical criteria.

Rehabilitation (and prevention) for patients is crucial. Both projects will clearly identify the pathway of care following acute admission and treatment. Personalised care plans will play a key role in supporting patients to regain mobility and recover to participate in a healthy life.

Section 3 The Case for Change

The clinical case for change for stroke and major trauma services is well established. The Clinical Advisory Group reviewed the evidence as part of *Consulting the Capital.* The consultation also established there was public support for change and the Joint Committee of PCTs therefore agreed on 12 June 2008 to develop some hospitals to provide more specialised care to treat the urgent care needs of stroke and major trauma patients. This section summarises this case.

3.1 Stroke Services

Stroke is the second most common cause of death and the single most important cause of physical disability in London. In 2007, stroke accounted for well over 4,400 deaths (both in and out of hospital) in the capital, of which nearly 25 percent may have been prevented. Nearly one percent of Londoners have suffered a stroke, and many of these have suffered more than one. The impact on hospital services is huge, with over 11,000 Londoners admitted to hospital with a stroke each year.

Most strokes are age-related. Over 75 percent occur in people over 65 years of age. However, the incidence is higher in black communities and tends to occur at a younger age than among white, European groups. Among London's black population, the incidence of stroke is 60% higher than that of the city's white population.

The poor quality of stroke services in England has been identified for many years, and in 1998 this led to the start of the Sentinel stroke audit. In 2006, figures for London showed that the very best two units in the capital were meeting the 12 key targets only 90 percent of the time. Some units' performance fall well below this benchmark and many figures worsened between 2006 and 2004. This has led to major inequalities in access to, and quality of, services in London.

Although a number of units in London have significantly improved their services since 2006, and more recently in response to the *National Stroke Strategy* and NICE guidelines, pan-London services need a step change improvement if patients are to have equality of access to the highest standard of care across the capital. The 2008 data has been recently published and shows improvement in a number of areas but still indicates that providers are some way off the requirements of the new service specification.

International comparisons of outcome measurements provide compelling evidence of the need for change. Data from the Organisation for Economic and Cooperative Development (OECD) illustrates that the UK has achieved a 23 percent reduction in stroke mortality over a 10 year period. Nevertheless, in spite of this decrease, the UK has the highest proportion of deaths due to stroke when compared with Australia, Germany, Sweden and the US and almost double to the number of deaths compared with our closest neighbour, France.

3.2 Major Trauma Services

It estimated that approximately 3000 people per year suffer a major trauma in London. We are close to getting final results from Healthcare for London analysis which will refine this number.

The standard of care delivered to the majority of trauma patients across the UK (including London) has been shown to be sub-standard in a number of crucial areas including provision of suitably experienced staff and correct clinical decision making. Services are insufficiently co-ordinated to provide the best care for patients. Patients transported directly to the most appropriate hospital (i.e. a trauma centre rather than a local hospital without proper trauma facilities) have been shown to have a mortality of 12 percent, whilst patients initially treated at a local hospital and subsequently transferred have an overall mortality of 19 percent. A network of trauma centres could save over 500 lives a year.

Currently two thirds of severely injured patients have to be transferred between hospitals as their local hospital does not provide the specialist care required. This increase in time to definitive care worsens outcomes for the severely injured.

The Healthcare for London Acute Care Working Group identified overwhelming evidence that severe trauma should be dealt with by a few specialised centres, for example:

- Patients with severe brain injury have their mortality risk reduced by 10 percent when treated in a trauma centre;
- Units with higher volumes of trauma care reduce patient mortality and length of stay, compared to smaller units; and
- Regionalisation of trauma care in Quebec resulted in a reduction in mortality from 52 percent to 19 percent;

Healthcare for London: A Framework for Action observes that the UK is almost alone amongst international comparators in not having a system of regional trauma centres. Data shows that current mortality for severely injured patients who are alive when they reach a hospital is 40 percent higher in the UK than in the US where regional trauma centres exist. The Royal College of Surgeons advocated the development of a systematic approach to trauma in 2000.

Section 4 The proposals – geographical scope

The proposal is that the consultation is run by all 31 London PCTs (each PCT commissions between two and four percent of the total). PCTs in neighbouring SHAs will be invited to join a Joint Committee of PCTs.

Section 5 The proposals – clinical scope

The consultation will cover:

Services for acute trauma care – explicitly the location and coverage of major trauma trauma (e.g. limb amputation, stab and gunshot wounds to the head, neck or chest, open skull fracture) and trauma (e.g. fractured hip or ankle) services in London.

Services for acute stroke care – explicitly the location of hyper-acute services and acute services and coverage in London.

5.2.1 Stroke

The stroke consultation will include configuration of specific hospital sites to provide equality of access to acute stroke services for adults in London. Whilst the documentation will include information on rehabilitation, community care and prevention these services are not being consulted upon. The information will be provided only to enable consultees to be better informed when making comments on acute services. Any local changes relating to these services will be locally managed.

There are three categories of configuration of hospital sites:

1) Hyper acute stroke units (HASU) – which provide the immediate response to a stroke, where the patient is stabilised and receives primary intervention, and where length of stay is typically no longer than 72 hours.
2) Stroke units (SU) – provide multi-therapy rehabilitation and ongoing medical supervision following a patient's stabilisation, where length of stay varies and will last until the patient is well enough for discharge to an acute inpatient setting.
3) Transient Ischaemic Attack (TIA) (mini-stroke) clinics – which provide rapid diagnostic assessment and access to a specialist within 24 hours for high risk patients following a TIA, and within seven days for low risk.

5.2.2 Major trauma

The major trauma consultation will cover the establishment of major trauma networks covering the whole of London. These networks will comprise a major trauma centre linked with a number of trauma centres all of which have proven ability to deliver care through a network-based model.

Major trauma centres will be proposed in specific identified hospitals (as will the trauma centres). They will have demonstrated their ability to provide a major trauma service through a process of evaluation of the quality of their clinical services. The location and coverage will be described in the consultation.

Each trauma network will consist of a major trauma centre, a number of trauma centres and a range of rehabilitation providers. This based on the network model developed and functioning in the United States through the American College of Surgeons.

The consultation will not include burns, prevention or rehabilitation. These will be addressed at a later date either through the Healthcare for London paediatric project or once the London trauma system is established.

The process by which clinical quality and other factors which were used to determine the options for consultation will be made explicit in the consultation document.

Section 6 Benefits of Change

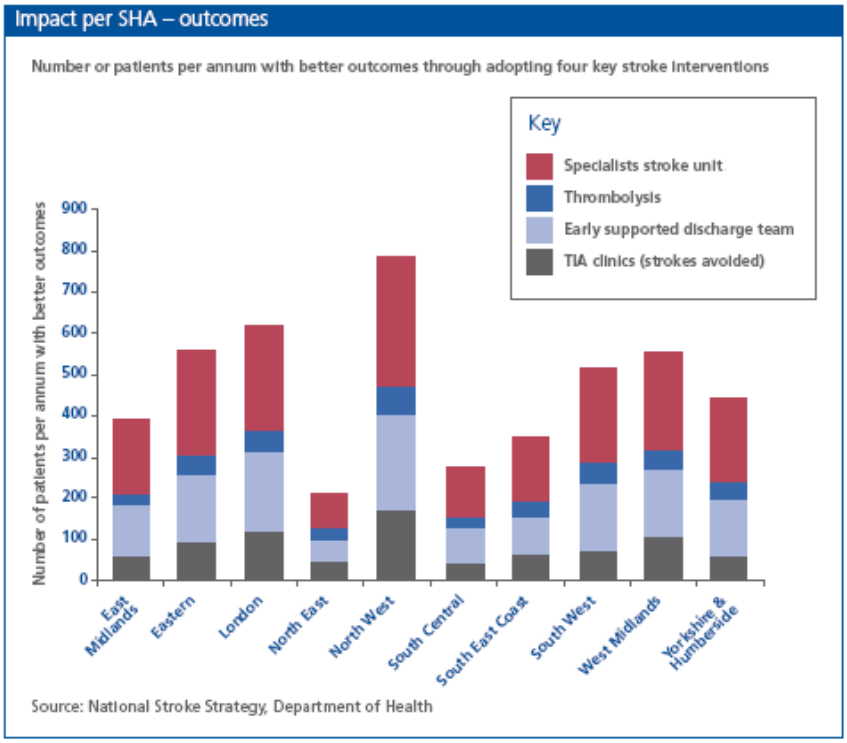
6.1 Stroke

Measures of success are being developed using the detailed service specification that has been developed for the London Ambulance Service / HASU / SU / TIA services. These will give a clear timescale about when they will be achieved.

Measures will need to be developed for the following benefits:

1) Awareness of stroke to increase, resulting in more people being treated urgently following a stroke;
2) Increase in the number of patients able to be thrombolysed by ensuring people get to a specialist hospital as quickly as possible;
3) More patients receiving high dependency care in the first 72 hours following a stroke;
4) More patients receiving thrombolysis following a stroke resulting in more patients having a good outcome (independent or minimal help required) at three months from onset;
5) More patients receiving their total hospital care in a stroke unit, resulting in a greater number of patients having a good outcome at three months from onset;
6) More patients assessed as high risk following a TIA to be assessed by specialist TIA clinic within 24 hours, thus reducing the risk of a major stroke; and
7) Stroke patients to receive earlier assessment from community rehabilitation providers so as to plan transfer into community more effectively.

The graph below shows the benefits for all SHAs of introducing the four key stroke interventions recommended in the *National Stroke Strategy*.



Notes:Transient Ischaemic (lack of blood supply) Attacks (TIA).
Thrombolysis a stroke treatment used to reduce the severity and impact of stroke, increasing potential recovery.

6.2 Major trauma

A trauma system for London would:

- Reduce mortality and disability;
- Improve communication and collaboration between hospitals providing care;
- Provide a higher quality service which is faster, providing the right care, with better clinical outcomes, and improved patient satisfaction; and
- Improve equality of access.

A trauma system would minimise the time to definitive care by delivering patients straight to the most appropriate facility rather than taking them to the nearest hospital and transferring them.

The benefits of introducing a regionalised trauma system reach beyond the improvement of patient outcomes. Whilst not part of this consultation, a system-wide prevention strategy would reduce the number of people suffering severe injury. The majority of injuries are preventable, consisting mainly of motor vehicle accidents and falls. A pan-London approach to prevention has the potential to save a significant number of lives and the burden of injury.

The establishment of a London-wide trauma system made up of networks would facilitate more effective educational programmes for all those involved in trauma care and therefore improve the skills of clinicians and other staff. Rotation of staff between centres would support the retention of skills across the network and encourage a culture of co-operation.

The links and co-operation present in a trauma system would ease the activation and implementation of the Major Incident Plan with hospitals having recognised roles within it. With the introduction of a trauma system the number of people surviving injury and returning to normal social and economic functioning would be increased.

In general, success can be measured by a decrease in mortality and morbidity for major trauma cases across London. Specific success criteria will be established as the trauma system is developed over coming months.

Section 7 Governance of the projects

7.1 Stroke

The Senior Responsible Officer (SRO) for the project is Rachel Tyndall, Chief Executive of Islington PCT. She is accountable to the London Commissioning Group (LCG) for delivery of the project and is supported by a project board of Healthcare for London project officers and a Clinical Director – Chris Streather, Renal Physician, Medical Director and the Director of Strategy at St George's;

The stroke project board is advised by three panels:

- Clinical Expert Panel – comprising healthcare professionals representing the end-to-end stroke pathway – including public health professionals, GPs, stroke physicians, nurses, therapists, social care representatives and the voluntary sector from a range of organisations and hospitals across London.
- Patient Panel – one part of engagement with stroke patients and survivors is through the stroke patient panel. The membership includes representation from the Stroke Association, Connect and Crossroads, and access to their patient and carer groups.
- Commissioning and Finance Panel – comprising commissioning and finance representatives of each of the Collaborative Commissioning Groups (CCG) in London, and cardiac and stroke network leads. This panel meets monthly.

7.2 Major Trauma

The Senior Responsible Officer (SRO) for the project is Simon Robbins, Chief Executive of Bromley PCT. He is accountable to the LCG for delivery of the project and is supported by a project board of Healthcare for London project officers and a Clinical Director – Matt Thompson, Professor of Vascular Surgery at St George's, University of London.

The major trauma project board is advised by three panels:

- Clinical Expert Panel – comprising clinicians from every speciality involved in delivering trauma care and from a range of hospitals across London. E.g. therapies, trauma, rehabilitation, ambulance service, public health, A&E, paediatrics, orthopaedic surgery, neurosurgery, anaesthetics, intensive care, ward and A&E nursing, physiotherapy, radiology, social services, maxillo-facial surgery, blood transfusion, plastic surgery, GP, psychiatry and major incident planning.

- Patient Panel – The major trauma project is engaging with patients via the major trauma project patient panel. Representation includes: British Institute for Brain Injured Children; Brain Injury Rehabilitation Trust; Brain Injury Rehabilitation Trust; Child Brain Injury Trust; Headway; Royal Hospital for Neuro-disability; Spinal Injuries Association; and Healthcare for London Patient and Public Advisory Group member, two major trauma patients and a carer of a major trauma patient.

- Commissioning and Finance Panel – comprising commissioning and finance representatives of each of the Collaborative Commissioning Group (CCGs) in London, as well representation from the London Specialist Commissioning Group and three members from PCTs surrounding London.

Section 8 Developing the Options for Consultation

8.1 Stroke

The project is developing a strategy that covers prevention and awareness, acute care and rehabilitation and community care. This will be issued in early October.

Interested NHS providers will be producing expressions of interest to provide three types of acute stroke care:

1) Hyper acute stroke unit
2) Stroke unit
3) TIA clinics

The acute designation documents will be based on service specifications and performance standards, developed with the projects' various expert panels.

An external panel of clinicians from outside of London will be appointed to evaluate the proposals and produce a long list of potential provider sites for each type of service. Following the initial evaluation, an option or options for configuration of the acute stroke service will be identified.

The stroke project has completed an analysis of the number of patients that are expected to attend London hospitals with a suspected stroke. In addition we have modelled the travel time of patients attending all the hospitals on the fringes of London.

The prevention workstream and the rehabilitation and community care workstream have also been developed with a significant level of engagement with clinicians, commissioners and patient representatives and stroke survivors.

8.2 Major Trauma

Trauma networks are expected to cover a population of between one and a half and three million people (Royal College of Surgeons, Better Care for the Severely Injured 2000). This means that, based on an approximate population of eight million people in London plus patients referred in from neighbouring PCTs, between three and six networks will be required.

A preliminary phase of designation produced five potential trauma networks. These networks have been liaising with providers in neighbouring out-of-London PCTs to ensure that there is joined up trauma care for those patients living around the peripheries of London. We expect bids from each of these networks.

All those trauma networks passing the clinical evaluation stage of the designation process will move to the options evaluation stage. Between November and December 2008, the major trauma project team will conduct options development and evaluation which will involve a comparative analysis of all possible configurations of trauma networks across London.

There will be a workshop run by an external agency in September comprising 20 members of the general public who will be consulted on the eight factors selected for the options evaluation and their relative importance to each other.

Section 9 Consultation – governance and timing

The proposal is to run the consultation in line with Sections 242 and 244 of the NHS Act 2006.

Department of Health guidance for reconfiguration of services recommends that:

- Public and patients need to be reassured that change is necessary and that it will improve the care their receive;
- No major service change should happen except on the basis of need and sound clinical evidence;
- Change should only be initiated when there is clear and strong clinical basis for doing so; consultation should proceed only where there is effective and early engagement with the public, clear evidence of improved outcomes for patients and resources available to enable new facilities to open alongside old ones closing; and
- The case for change should be led by clinicians and subjected to independent clinical assessment prior to consultation.

9.1 The plans

The current project plans allow for public consultation on stroke and trauma to run for 12 weeks, from 5 January 2009 to 30 March 2009. Therefore the consultation should be run 'as if it is one consultation'. This would mean:

- A single set of meetings (reducing administrative burden)
- A single set of consultation materials (reducing costs of roadshows, publications and advertising, minimising confusion to the public and best enabling the public to understand the whole health economy)

However a joint consultation would not mean that the two parts were inextricably linked. So, for instance, a delay in the options appraisal of one part would not necessarily delay the start of consultation for the other. The JCPCT would have the power to direct different specific communications activity for each of the two parts of the consultation.

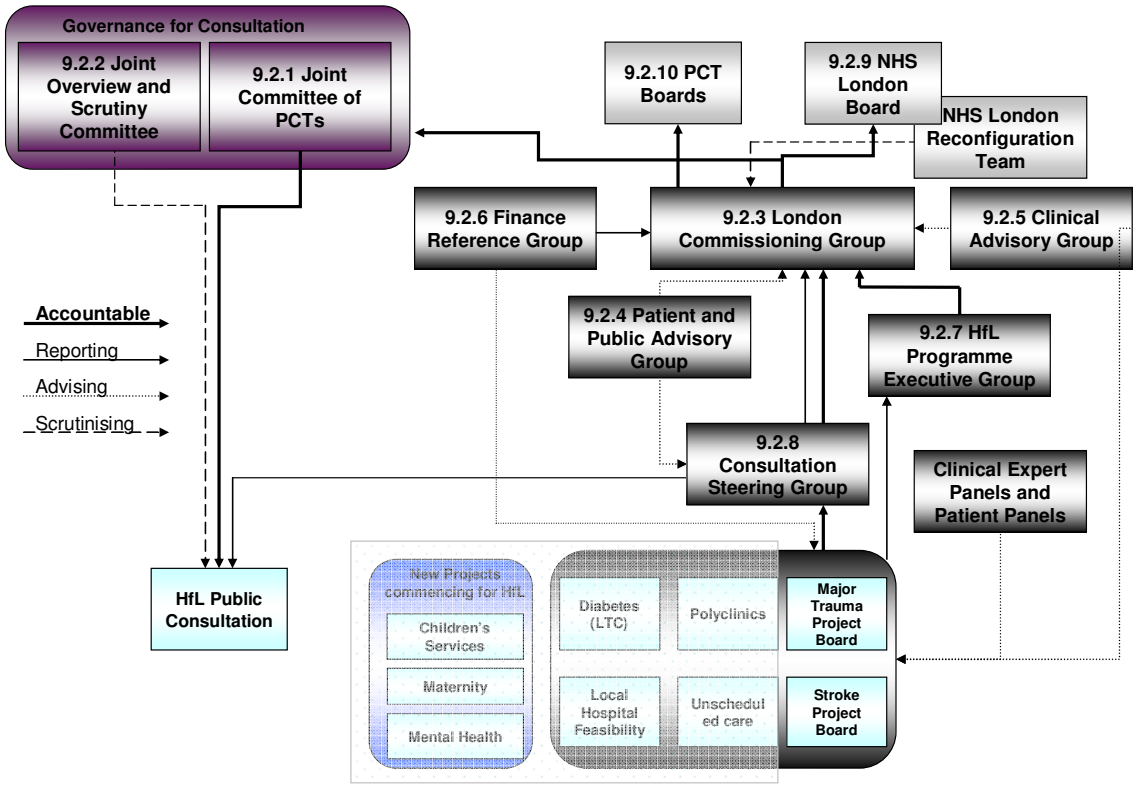
The consultation steering group (with appropriate input from the LCG, CAG, and PPAG) will develop a public consultation document and associated materials that explains the consultation and seek to elicit public views as well as their option preferences.

The consultation steering group will commission various impact assessments e.g. Health, equalities, travel time and environmental. The assessments will be made:

- during the planning and development of proposals but when clinically and financially viable options are established (so as not to waste money on assessments that are otherwise unviable); but
- the results will need to be made available during the consultation period, so that consultees can consider the assessments when making their views known.

9.2 Governance Arrangements

The diagram below shows the proposed governance structure for the consultation. In essence this is the same as for *Consulting the Capital*, with an additional 'Consultation Steering Group' established to coordinate all the strands of the consultation.



9.2.1 Joint Committee of PCTs (JCPCT)

The proposal is to establish a single JCPCT with one member for each constituent London PCT. Members should be voting members of relevant PCT Boards. Places for interested PCTs out of London will be allocated once any interest is known. The JCPCT will:

- Approve the pre-consultation business case and consultation documentation for improving the acute phase of adult services for stroke and major trauma;
- Relate formally to the Joint Overview and Scrutiny Committee which corresponding local authorities would be required to establish;
- Receive the report on the outcome of the consultation;
- Consider the impact assessments and any other relevant material;
- Take decisions on the issues being consulted upon, taking into account the outcome of consultation, the impact assessments and any other relevant material.

9.2.2 Joint Overview and Scrutiny Committee

Healthcare for London will write to London Scrutiny Committees and neighbouring councils' scrutiny committees inviting them to form a Joint Overview and Scrutiny Committee (JOSC).

9.2.3 London Commissioning Group

The consultation will be overseen by the London Commissioning Group (LCG). A review is being conducted as to the fitness for purpose of the LCG to meet the needs of Healthcare for London.

9.2.4 Patient and Public Advisory Group

The Director of Communications and the Stakeholder Manager are currently in discussion with Michael English, the previous Chair of the London Committee of PPIFs, to agree membership of a new PPAG.

9.2.5 Clinical Advisory Group

The Clinical Advisory Group (CAG) was established to advise and support the Healthcare for London programme.

9.2.6 Finance Reference Group

Will provide an external point of reference specifically around the development of the pre-consultation business case.

9.2.7 Programme Executive Group

The Programme Executive Group (PEG) consists of members of the Healthcare for London programme office and project managers. It will be necessary for the PEG to be informed of the progress of the consultation and vice-versa to ensure synergies and opportunities for joint working are exploited.

9.2.8 Consultation Steering Group

The Consultation Steering Group (CSG) will manage the consultation process, for including the development of the pre-consultation business case and consultation materials, commissioning of the impact assessments and implementation of the plan.

The Programme Board will include:

- David Sissling (Programme Director, Healthcare for London), Programme Chair
- Don Neame (Director of Communications, Healthcare for London)
- Nicole Millane (Head of Communications Implementation, Healthcare for London)
- Jo Sheehan (Finance Manager, Healthcare for London)
- Helen Cameron (Programme Manager, Healthcare for London)
- Simon Robbins (Senior Responsible Officer, Major Trauma and Joint SRO for the consultation)
- Professor Matt Thompson (Clinical Lead, Major Trauma)
- Tim Daly / Shaun Danielli (Project Manager, Major Trauma)
- Dr Rachel Tyndall (Senior Responsible Officer, Stroke and Joint SRO for the consultation)
- Chris Streather (Clinical Lead, Stroke)
- Kevin Hunter (Project Manager, Stroke)
- Alastair Finney (NHS London)
- Lisa Anderton (NHS London)

The group will meet at least monthly.

9.2.9 NHS London Reconfiguration Team

NHS London Reconfiguration Lead will need to be satisfied that the organisations involved have the capability and capacity in terms of staff, skills, resources and project management arrangements in place to:

- Develop robust, evidence-based proposals;

- Undertake the process of involvement and consultation;
- Implement their plans (including consultation) within a manageable timeframe;
- Handle communications and media relations; and
- Provide strong leadership

The Reconfiguration Lead has indicated that the consultation will require a Gateway Review, and an independent clinical review.

9.3 Timeframes

High level consultation plan:

Task/Deliverable/Outcome	Date
LCG PCT CEs approve Programme Brief	12 September 2008
Complete first draft consultation document (CD) and pre-consultation business case (PCBC)	29 September 2008
Shadow JCPCT meet to accept remit	29 October 2008
LCG review first draft CD & PCBC	7 October 2008
CAG review first draft CD & PCBC	17 October 2008
SHA Board briefing	w/c 1 Dec or 8 Dec 2008
JCPCT	Mid November (TBC)
JCPCT	26 November 2008
Stroke & Major Trauma options identified	1 December 2008
Present consultation options to CAG	2 December 2008
Stroke & Major Trauma Business Case Complete	8 December 2008
LCG approve final drafts of CD and PCBC	12 December 2008
JCPCT approve CD and PCBC in public	16 December 2008
SHA Board approve CD & PCBC	17 - 21 December 2008
Notify JOSC & key stakeholders of consultation start	18 December 2008
Brief JCPCT of consultation start	5 January 2009
Consultation start date	5 January 2009
Consultation end date	29 March 2008
JCPCT discuss initial responses in private	2 April 2009
Consultation response evaluation end date	16 June 2009
JCPCT discuss final analysis in public	2 July 2009
Options approved	2 July 2009

Additional JCPCTs to be held in private, to monitor and direct the consultation, are expected in February, March, May and June.

9.4 Measures of success

The success of the consultation will be measured by:

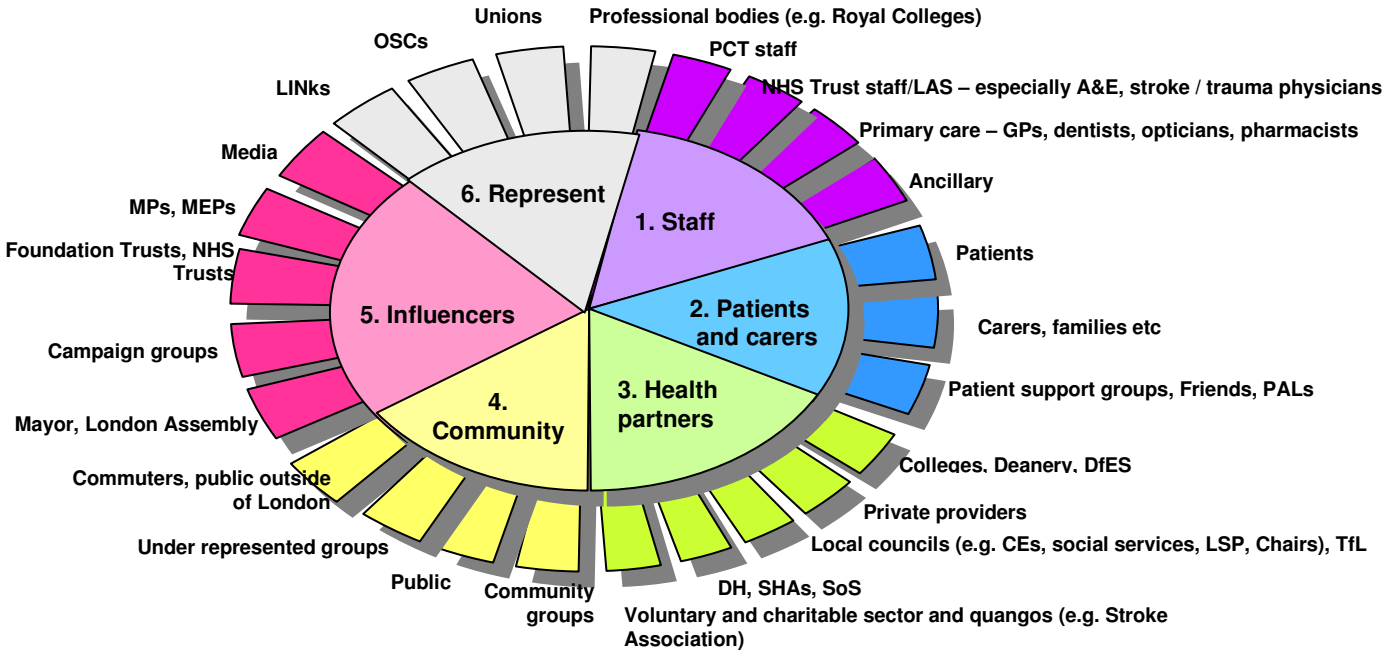
- Number of respondents to the consultation (compared to other consultations);
- Respondents' views on quality of proposals;
- Meeting milestones and time plan and adherence to action plan;
- Engagement with traditionally under-represented groups;
- Public and stakeholder awareness of the issues;
- Positive engagement with questions posed - relevance of views expressed and the improvements they have on the recommendations; and
- No grounds for judicial review.

Section 10 Communications

The consultation communications are planned to be managed in a similar way as *Consulting the Capital* – the original consultation on *A Framework for Action.*

The communications aspect of the consultation will be managed by the Director of Communications and staff in the Programme Office, most of whom had experience of managing Consulting the Capital. The team has been strengthened by the addition of a public affairs manager and a media manager.

Clinicians will present the proposals wherever possible to ensure consultees are clear that the proposals are based on sound clinical arguments.



We expect the cost of the consultation to be less than £1 million, similar to the cost of *Consulting the Capital* – with a more focused consultation agenda, but a wider geographical coverage and potentially more interest and more responses to analyse.

Section 11 Pre-consultation Business Case

The pre-consultation business case will build upon this programme brief and will include the following areas (for both major trauma and stroke):

- The case for change
- The objectives to be achieved
- Description of current model of care
- Proposals – a description of how the options were selected, a description of each option, the case for and against each option, the recommended option – if there is one
- Reference to impact assessments
- Financial analysis of options
- Transition & implementation – timescales to implementation, phasing, implementation arrangements for commissioners etc

11.1 Financial Implications

The business case for both services will identify the current and proposed costs of commissioning these services for each option. In addition, it will also identify potential income changes to current providers on a pan-London basis as services relocate.

The scope of the financial analysis has yet to be finalised. In overall terms, the pre-consultation business case will include an analysis of activity and financial flows of the current acute pathway and the proposed options.

11.1.1 Stroke

The estimated current spend by PCTs on acute stroke services is approx £70m. Based on total PCT allocations of London PCTs of £10bn, this accounts for approx 0.7% of PCT allocations. It is expected that investment will be required to deliver the proposed enhanced service across the acute and rehabilitation part of the care pathway.

11.1.2 Major Trauma

The major trauma project is undertaking work to determine the financial implications of establishing a major trauma system for London. The current spend by London PCTs on acute care is difficult to ascertain as there are no discrete Healthcare Resource Groups (HRGs). Early indications are that PCTs currently spend approx £30 – £40 million on the acute care pathway. This represents 0.3% -0.4% of the total London PCT allocations. It is expected that establishing major trauma networks will require investment by PCTs. This investment will be required to support new acute care services and increased support to patients requiring intensive rehabilitation.

11.2 Workforce Implications

11.2.1 Workforce for London

NHS London is developing a workforce strategy which will be produced on 16 Sept. *Workforce for London* addresses key issues facing staff moving from hospitals to the community, employment flexibility, and the continuing development of a workforce which reflects the diversity of London. The engagement and involvement of staff in delivering service changes will be a key part of the strategy.

This is a high-level ten year strategy setting out, for the first time, a holistic view of the shape of the clinical workforce in London's NHS health economy.

11.2.2 Training

The proposals will affect staff of the London Ambulance Service (LAS) who will be asked to take a greater level of responsibility in decision-making on treating and transferring patients. The LAS has agreed that changes in their workforce would be required, including improved training for all paramedics. *Consulting the Capital* recommended investment in training of LAS staff.

11.2.3 Stroke

A detailed stroke workforce review has commenced which will be aligned with the NHS London workforce strategy. In the meantime the expected workforce requirements for the acute stroke pathway are being modelled and costed. These are detailed in the stroke service specifications (HASU, SU and TIA Clinic). In addition training requirements are being developed for each element of the pathway.

11.2.4 Major Trauma

There will be a positive effect on the workforce through the establishment of a London trauma system. By delivering care through networks there will be increased opportunities for staff to gain skills and experience along the whole patient pathway.

National data indicates that severe injuries comprise a very small percentage (less than 0.1%) of the A&E workload. Thus, the change in workload for each A&E department will be negligible. Based on estimates from the Royal London Hospital, there are approximately 3000 major trauma patients per year across London. Given that there are 34 A&E departments in London, this will see an average of 88 less admissions per A&E department per year – less than two per week.

The workforce implications will be fully scoped to ensure any impact is anticipated and changes are planned. Specifically there may be shortages of some generic and specialist rehabilitation staff.

Specialisation of trauma services will lead to changes in staff roles, and experience will be passed on through a thorough training and development programme involving rotation of staff and training positions as well as formal training developments.