Haringey Council

Agenda item:

Overview and Scrutiny Committee **On 1 December 2008** **[No.]**

Report Title:– **Acute Stroke and Major Trauma - Establishment of Pan London Joint Overview and Scrutiny Committee to Consider Changes to NHS Acute Services**	
Forward Plan reference number (if applicable): N/A	
Report of: Chair of Overview and Scrutiny Committee	
Wards(s) affected: **All**	Report for: **N/A**

1. Purpose

1.1 To report on the consultation process for proposals to develop NHS services for acute stroke and major trauma across and to agree, in principle, to Haringey's participation in a Joint Overview and Scrutiny Committee to respond to the proposals.

2. Introduction by Cabinet Member (if necessary)

2.1 N/A

3. Recommendations

To recommend the following to full Council on 9 January:

3.1 That Haringey participate in the proposed London-wide Joint Overview and Scrutiny Committee being established to respond to the forthcoming consultation document issued by the Joint Committee of PCTs on proposed changes to NHS services for acute stroke and major trauma.

3.2 That the Assistant Chief Executive (Policy, Performance, Partnerships and Communication Service) be delegated authority to agree the detailed terms of reference for how the Committee will operate in consultation with the Chair of Overview and Scrutiny Committee.

3.3 That Councillor Gideon Bull be appointed as the representative and a Committee Member from the Minority party as deputy representative from the London Borough of Haringey to the Joint Overview and Scrutiny Committee.

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4. Local Government (Access to Information) Act 1985

4.1 Background Papers:

The background papers relating to this report are:

Haringey Health Scrutiny Protocols

Healthcare for London: A Framework for Action

Improving Stroke and Major Trauma Services in London - Programme Brief for consideration by PCT Boards – Healthcare for London

These can be obtained from Robert Mack – Principal Scrutiny Support Officer on 020 8489 2921,
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5. Report:

5.1 *Healthcare for London; A Framework for Action* was published in July 2007 by NHS London. It was written for London NHS by Professor Lord Darzi and outlined what it was felt was need to improve the health of Londoners. Specific proposals for change were subsequently developed and outlined in the *Healthcare for London: Consulting the Capital* document, which were consulted on from November 2007. The consultation was led by a Joint Committee by London PCTs and, as part of this, a Joint Overview and Scrutiny Committee of the local authorities affected by the proposals was set up to respond.

5.2 Included within the consultation were proposals for:

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

5.3 The proposals were underpinned by a clinical case for change for stroke and major trauma services.

5.4 Following the consultation, the Joint Committee of PCTs accepted the clinical evidence and acknowledged the strong patient and public support (64 percent for specialised trauma centres, 67 percent for specialised stroke centres). The Joint Committee agreed:

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

5.5 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 sets of proposals will clearly identify the pathway of care following acute admission and treatment.

Stroke Services

5.6 Stroke is the second most common cause of death and the single most important cause of disability in London. In 2007, stroke accounted for over 4,400 deaths in London, of which it is estimated nearly 25 percent may have been preventable. Around one percent of people in London have suffered a stroke and many of these have suffered more than one. The impact on hospital services is considerable with over 11,000 admitted to hospital each year.

5.7 The majority of strokes are age-related, with over 75% occurring in people over 65 years of age. The incidence is higher within black communities and tends to occur at a younger age. The incidence of stroke is 60% higher in the black community than that of London's white population.

5.8 The poor quality of stroke services in England has been widely acknowledged. In 2006, figures for London showed that the two very best stroke units in London were meeting key targets only 90 percent of the time. The performance of some other units fell well below this level and many figures actually worsened between 2004 and 2006. This has led to inequalities in access to, and quality of, services.

5.9 Although a number of units in London have significantly improved since 2006, it is considered that pan-London services need substantial improvement if patients are to have equality of access to the highest standards of care. International comparisons of outcome measurements have provided further evidence of the need for change. Data from the Organisation for Economic and Cooperative Development (OECD) illustrates that the UK has achieved a 23% 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.

Major Trauma Services

5.10 Approximately 3000 people per year suffer a major trauma in London. 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. It is felt that services are insufficiently co-ordinated to provide the best care for patients.

5.11 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. 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 % whilst patients initially treated at a local hospital and subsequently transferred have an overall mortality of 19 %. It is estimated by the NHS that a network of trauma centres could save over 500 lives a year.

5.12 The Joint Committee of PCTs noted the 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% 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 % to 19 %;

5.13 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.

Potential Benefits of Changes

Stroke

5.14 Measures of success are currently for the following proposed developments:

- Awareness of stroke resulting in more people being treated urgently following a stroke
- Increase in the number of patients able to be clot busting drugs by ensuring people get to a specialist hospital as quickly as possible
- More patients receiving high dependency care in the first 72 hours following a stroke
- More patients receiving clot busting drugs following a stroke resulting in more patients having a good outcome
- More patients receiving all their hospital care in a stroke unit resulting in a greater number of patients having a good outcome
- 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
- Stroke patients to receive earlier assessment from community rehabilitation providers so as to plan transfer into community more effectively.

Major trauma

5.15 It is intended that 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.

5.16 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.

5.17 It is considered that there will be additional benefits gained through introducing a regionalised trauma system. Whilst not part of this consultation, it is felt that it would assist the development of a system-wide prevention strategy to reduce the number of people suffering severe injury. The majority of injuries are considered to be preventable, consisting mainly of motor vehicle accidents and falls. A pan-London approach to prevention is felt to have the potential to prevent a significant number of deaths and injuries.

5.18 The establishment of a London-wide trauma system made up of networks could also 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 assist the activation and implementation of the Major Incident Plan with hospitals having recognised roles within it.

Consultation on Proposed Changes

5.19 Consultation on the proposed changes will be run by all 31 London PCTs and PCTs in neighbouring strategic health authorities through the establishment of a Joint Committee of PCTs.

5.20 The consultation will cover:

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

- Services for acute trauma care and the location and coverage of major 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.

5.21 The stroke consultation will include the 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 people to be better informed when making comments on acute services. Any local changes relating to these services will be locally managed.

5.22 There will be three categories of configuration of hospital sites:

- Hyper acute stroke units (HASU) providing 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;

- Stroke units (SU) providing 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.

- Transient Ischaemic Attack (TIA) (mini-stroke) clinics providing 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.

5.23 The major trauma consultation will cover the establishment of major trauma networks for 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.

5.24 Major trauma and trauma centres will be proposed in specific identified hospitals. They will all 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.

5.25 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.

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

Consultation Programme

5.27 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.

5.28 The current plans are for public consultation on stroke and trauma to take place for 12 weeks, from 5 January 2009 to 30 March 2009. The consultation will be run as if it is one consultation. This will mean that there will be a single set of consultation materials and meetings.

5.29 A single Joint Committee of PCTs (JCPCT) will again be established to lead the consultation with one member for each constituent London PCT. 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.

Establishment of JOSC

5.30 Healthcare for London has invited all London Boroughs to consider establishing a Joint Overview and Scrutiny Committee (JOSC) to respond to the consultation. Boroughs will only have the legal power to scrutinise the report as part of the JOSC and not individually.

5.31 The large scale changes proposed will clearly constitute substantial variations or development to services for all London Boroughs, as defined under Section 7 of the Health and Social Care Act 2001, and it is also possible that the changes will also constitute substantial variations or developments to some local authorities outside of London. It is therefore likely that will be a statutory duty for all such local authorities affected to establish and participate in a JOSC. Preliminary discussions on the setting up of a JOSC have already taken place between NHS London and the London Scrutiny Network (LSN).

5.32 The reconfigurations are likely to have significant implications for Haringey residents, particularly those who may be unfortunate enough to have an acute stroke or be a victim of major trauma, as well as relatives/carers. The number of Haringey residents that suffer a stroke is comparatively high and it is a particular issue amongst the black community. It is therefore recommended that Haringey agree to participate in the JOSC. Due to the large number of local authorities potentially involved, representation will be limited to one per Borough and it is therefore recommended that the Chair be appointed as Haringey's representative.

5.33 It is likely that the work of the JOSC will have been undertaken within the consultation timetable of the Joint Committee of PCTs but it is possible that there may be some limited scope for flexibility. However, the timescale is likely to be tight and it therefore may not be possible to get the approval of full Council to the terms of reference for the JOSC, as required within the Constitution, before the work of the JOSC begins. It is therefore recommended that the power to agree this be delegated to officers in consultation with the Chair of Overview and Scrutiny Committee.

6. Legal and Financial Implications

6.1 There are no obvious financial implications for the Council. The legal implications have been described above in the body of the report.

7. Chief Financial Officer Comments

7.1 There are no direct financial implications arising from the establishment of a Pan London JOSC. However, any future proposals and recommendations that the JOSC may make should be considered for financial implications as they arise.

8. Head of Legal Services Comments

8.1 The legal implications have been described above in the body of the report

9. Equalities Implications

The JOSC will, as part of its work, need to consider carefully the equalities implications of the proposals and, in particular, the Equalities Impact Assessment undertaken by the Joint Committee of PCTs. As previously mentioned, stroke levels are disproportionately high amongst the black population.

7. Consultation

The JOSC will also wish, as part of their consideration, to satisfy themselves that the PCTs have consulted appropriately with relatives and stakeholders.