Guy's and St Thomas' NHS
NHS Foundation Trust

Board of Directors Meeting

Wednesday 8th April 2009

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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'

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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**

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.