Healthcare for London
The shape of things to come

Developing new, high-quality major trauma and stroke services for London

Report of the outcomes of consultation and recommended decisions for the Joint Committee of PCTs

20 July 2009
Contents

List of appendices .....................................................................................................................3
1 Introduction for the Joint Committee of PCTs ........................................................................4
Part A – The consultation and responses ..................................................................................5
2 Governance and responsibilities ...............................................................................................5
  2.1 Establishing a Joint Committee of Primary Care Trusts (JCPCT) .....................................5
  2.2 Establishing a Joint Health Overview and Scrutiny Committee (JHOSC) .......................6
  2.3 Appointment and responsibilities of key contractors ....................................................6
3 Developing the consultation and proposals in The shape of things to come ............................9
  3.1 Aims of the consultation strategy ....................................................................................9
  3.2 Pre-consultation engagement ..........................................................................................9
4 The shape of things to come – consultation material and activities ....................................10
  4.1 The consultation document and compact ......................................................................10
  4.2 Meeting the information needs of all consultees ............................................................10
  4.3 Activities .......................................................................................................................11
  4.4 The cost of consultation ...............................................................................................13
5 Response to consultation ....................................................................................................14
  5.1 The consultation in numbers .........................................................................................14
  5.2 Summary of Ipsos MORI consultation analysis .............................................................14
  5.3 Summary of Health Link report on traditionally under-represented groups ..................18
  5.4 Report by the Joint Health Overview and Scrutiny Committee .....................................19
  5.5 Response of the Patient and Public Advisory Group (PPAG) ........................................22
6 Health Inequalities and Equalities Impact Assessment ........................................................23
  6.1 Major trauma – main findings .......................................................................................23
  6.2 Stroke – main findings ..................................................................................................26
Part B – Decision-making .........................................................................................................29
7 Decision-making processes and criteria to be used by the JCPCT to agree future service provision arrangements .................................................................29
  7.1 Inputs into the decision-making process ........................................................................32
Part C .......................................................................................................................................33
8 Reports of the Clinical Advisory Group (CAG) ..................................................................33
Part D – Decisions on the future delivery of new major trauma and stroke services ..............34
9 Major trauma ........................................................................................................................35
  9.1 Major trauma – the case for change ..............................................................................35
  9.2 Major trauma – model of care ......................................................................................37
  9.3 Major trauma – number of major trauma centres ...........................................................40
  9.4 Major trauma – location of trauma centres ..................................................................44
10 Stroke ..................................................................................................................................50
  10.1 Stroke – the case for change .........................................................................................50
  10.2 Stroke – model of care .................................................................................................52
  10.3 Number of hyper-acute stroke units ............................................................................57
  10.4 Hyper-acute stroke units – location .............................................................................61
  10.5 Stroke units – Configuration .......................................................................................70
  10.6 TIA Services – configuration .......................................................................................76
11 Transition ............................................................................................................................80
  11.1 Major trauma ................................................................................................................80
  11.2 Stroke ............................................................................................................................80
12 Governance ..........................................................................................................................82
  12.1 Major trauma ................................................................................................................82
  12.2 Stroke .............................................................................................................................83
13 Recommendations ...............................................................................................................84
14 Glossary .................................................................................................................................85
List of appendices

1. Governance
   a. Remit of the Joint Committee of PCTs
   b. Joint Committee of PCTs meeting 27 January 2009 – minutes
   c. Joint Overview and Scrutiny Committee terms of reference

2. The consultation
   a. Consultation strategy
   b. Consultation document
   c. Communications activity report

3. Response to consultation
   a. Ipsos MORI consultation analysis
   b. Health Link report on traditionally under-represented groups
   c. Report of the JHOSC
   d. Integrated Impact Assessment – major trauma
   e. Integrated Impact Assessment – stroke

4. Decision-making
   a. Strategic coherence

5. Assessment of responses to consultation
   c. Commentary on consultation responses – major trauma
   d. Commentary on consultation responses – stroke

6. Evidence supporting deliverability proposals – major trauma
   a. Implementation and transition assurance
   b. Workforce
   c. Finance and Commissioning assurance Plan
   d. IT assurance
   e. Whole pathway – Prevention
   f. Whole pathway – Rehabilitation

7. Evidence supporting deliverability of proposals – stroke
   a. Deliverability
   b. Implementation and transition assurance
   c. Workforce assurance
   d. Finance and Commissioning assurance
   e. IT assurance
   f. Whole pathway assurance – Prevention and Rehabilitation

8. Recommendations
   a. Recommendations
   b. Major Trauma and Stroke Evaluation Assurance Plan
1 Introduction for the Joint Committee of PCTs

We are delighted to present this report to the JCPCT. It reflects much hard work by many colleagues across the NHS in London and has been enriched by the outcomes of the consultation. We believe it represents an historic opportunity for commissioners to take decisions which will lead to significant improvements in the quality of stroke and trauma care for Londoners.

The origins of our work in this area are well known. Lord Ara Darzi set out an ambitious vision for London’s health and healthcare services in *A Framework for Action*. This vision received considerable public support in a previous public consultation. One important element of *A Framework for Action* was the proposal to introduce new models of care for stroke and trauma. We have been privileged to lead the projects which have taken forward our work in these areas. At all times we have sought to adopt an inclusive approach – engaging with clinicians, service users, the public and the voluntary sector. We have also used relevant evidence and based our work on proven good practice. Our aim has been to ensure Londoners have stroke and trauma services which are truly world-class.

We are pleased the consultation provoked a strong response and have listened carefully to the issues raised. Overall we have received support for our proposals and many helpful points have been made which will inform our future plans.

The JCPCT meeting is a significant milestone – but not an end-point. The challenge ahead will be to make sure implementation of any decisions goes smoothly, and to ensure we achieve excellence along the whole care pathway.

We commend this report and the recommended decisions to the JCPCT and look forward to supporting your discussions on 20 July 2009.

* Rachel Tyndall, Senior Responsible Officer, Stroke
* Simon Robbins, Senior Responsible Officer, Major Trauma
* Healthcare for London

N.B.

1. This report is, in essence, a summary and should not be read in isolation. The associated appendices are an essential part of the decision-making process.

2. The use of quotes throughout the document is to illustrate issues. They do not necessarily reflect a balance of opinions or signify that Healthcare for London supports their sentiment.
Part A – The consultation and responses

2 Governance and responsibilities

2.1 Establishing a Joint Committee of Primary Care Trusts (JCPCT)

Following Consulting the Capital (the formal consultation on A Framework for Action) detailed proposals were developed to improve stroke and trauma care across London. Each workstream was led by a PCT Chief Executive and a Clinical Director. The proposals were developed on an inclusive basis with extensive engagement with clinicians, stakeholders, patients and the public. Considerable progress was made and a decision was taken to proceed to public consultation, necessitating the establishment of a Joint Committee of PCTs.

On 2 October 2008, the Healthcare for London programme office wrote to London PCT Chief Executives, and Chief Executives of PCTs and SHAs bordering London1, setting out proposals for a formal public consultation on acute stroke and major trauma services.

The letter proposed that a JCPCT (the committee) would be formed. PCTs in London and surrounding London for whom the implementation of the proposals might amount to a substantial variation or development for part or all of their population, were invited to join the committee (in line with Regulation 10(4) of NHS (Functions of Strategic Health Authorities and Primary Care Trusts and Administration Arrangements) (England) Regulation 2002). The purpose of the committee was to:

- approve the pre-consultation business case and documentation;
- relate formally to the Joint Health Overview and Scrutiny Committee which corresponding local authorities would be required to establish;
- receive the report on the outcome of consultation and consider the Health Inequalities Impact Assessment (HIIA); and
- make decisions on the models of care and delivery, taking into account the outcome of consultation, the Health Inequalities Impact Assessment and any other relevant information.

PCTs were asked to indicate whether they intended to participate in the public consultation, following appropriate discussion with their Overview and Scrutiny Committees, and patients’ fora.

A meeting of PCT representatives likely to join the Joint Committee of PCTs was held on 29 October 2008. The meeting was an opportunity to discuss the proposed Terms of Reference of the substantive JCPCT, and to discuss the appointment of a Chair.

---

1 Copying the letter to: CEs of London FTs; London NHS Trusts; London Ambulance Service; Regional Director of Public Health for London and Health Advisor to the Greater London Authority; Chief Executive of NHS Direct; NHS London, Chief Executive and Directors and the Mayor of London.
It was decided to establish a JCPCT (of all London PCTs and SW Essex PCT). Its first formal meeting was held on 27 January 2009. The meeting was held in public and elected:

- Richard Sumray as chair; and
- Sian Bates and Howard Freeman as vice-chairs

The remit of the Joint Committee of PCTs can be found in Appendix 1a and meeting notes for the 27 January 2009 meeting in Appendix 1b. The consultation commenced on 30 January 2009.

### 2.2 Establishing a Joint Health Overview and Scrutiny Committee (JHOSC)

On 7 October 2008, the Healthcare for London programme office wrote to Chief Executives, health OSCs and/or lead scrutiny officers of all Local Authorities in London and surrounding areas. Recipients were advised of the invitation issued to PCTs in London and PCTs in SHAs bordering NHS London to join a JCPCT.²

A meeting of the JHOSC which had been established for Consulting the Capital was held on 24 October 2008 at Islington Town Hall, where early discussion concerning the formation of a new JHOSC took place.

Councillor Mary O’Connor, Chair of the Consulting the Capital JHOSC, also raised the subject of a new JHOSC at a London Scrutiny Network Meeting on 21 November 2008 and council members were invited to an informal meeting on 17 December 2008.

A JHOSC was established to review the consultation on developing new, high-quality major trauma and stroke services in London and met formally for the first time on 4 February 2009.

The terms of reference of the JHOSC can be found in Appendix 1c.

### 2.3 Appointment and responsibilities of key contractors

#### 2.3.1 Independent analysis of the consultation

A tender was issued to nine companies on 31 October 2008, seeking an organisation to:

1. Independently assess and critique Healthcare for London communications and provide assurance that communications met a set of clear principles;

2. Establish structures that would advise the public on the consultation process and record consultees’ feedback:
   a) provide a freephone contact (staffed during usual office hours (ie 8.30 – 5.30pm and on answerphone at all other times);
   b) provide Freepost, email and fax addresses to answer queries and for receipt of consultation responses;
   c) establish a web presence with facility to receive consultation responses;
   d) liaise with Healthcare for London in order to respond to queries in a timely, informed way;

² Copying the letter to: Chief Executive, Greater London Authority; the Mayor of London; Senior Adviser, Mayor’s Office; Chief Executive, London Councils; CEs of PCTs in London and surrounding SHA areas, CEs in SHAs surrounding London, Members of the London Commissioning Group, NHS London Reconfiguration Team.
e) put a system in place to deal with late responses and complaints.

3. Assess responses to the consultation in an open, balanced and proportionate manner.

Interviews were held on 25 November 2008. The interview panel consisted of the former chair of the Patient and Public Advisory Group (PPAG); a JCPCT representative and Medical Director; the Senior Procurement Negotiator, Solent Supplies (tendering company) and the Consultation Delivery Manager, Healthcare for London.

Ipsos MORI was appointed to fulfil the role.

2.3.2 Traditionally under-represented groups

In addition to consulting with local traditionally under-represented groups as described in their plans of action, it was agreed that each PCT would supply a report on one of these meetings to a company that would compile an overall assessment of the views of traditionally under-represented groups across London.

A tender was issued to three companies on 8 January 2009 seeking an organisation to:

- review the responses of traditionally under-represented groups to the previous consultation, Consulting the Capital, which were relevant to stroke and major trauma services;
- identify traditionally under-represented population groups likely to have specific views (cross-checking with output from the Health Inequalities Assessment) on the incidence of, or treatment for, stroke or major trauma;
- design pro-forma materials to assist PCTs in conducting a small number of meetings with under-represented groups; and
- prepare a report based on the submissions from consulting PCTs on the views of traditionally under-represented groups.

Interviews were held on 12 February 2009 with two companies. The interview panel consisted of the Impact Assessment Lead, Healthcare for London; Head of Community Services, London Councils; Director of Communications, Healthcare for London; Consultation Delivery Manager, Healthcare for London. A PCT representative due to sit on the panel was unable to do so due to illness on the day.

Health Link was appointed to fulfil the role.

2.3.3 Mailing house

A tender was issued on 28 November 2008 to seek an organisation to provide mailing house (fulfilment) services for distribution of consultation materials during the consultation. Four companies responded.

Interviews were held on 9 January 2009. The interview panel consisted of Engagement Co-ordinator, Healthcare for London; Consultation Delivery Manager, Healthcare for London; and a representative from the finance directorate at Healthcare for London.

EC Group was appointed to fulfil the role.

2.3.4 Integrated Impact Assessment

The consultation and business case steering group considered the options for procurement and, following advice, used the NHS Purchasing and Supply Agency Consultancy Services
Framework Category 8 (Clinical Consultancy) to invite specialist bidder(s) within this framework to undertake the impact assessment.

Three consultancies in the above framework attended a Q&A briefing on 11 December 2008. Two of these submitted bids by the required date and were shortlisted for interview. An evaluation panel met on 16 January 2009 and interviewed the two bidders that had submitted bids.

The evaluation panel made a recommendation to the consultation and business case steering group to appoint Mott MacDonald working with the Public Health Action Support Team (PHAST) to undertake the impact assessments.

Mott MacDonald is a management, engineering and development consultancy working in the public and private sectors world-wide.

The Public Health Action Support Team (PHAST CIC) is a Community Interest Company social enterprise organisation. PHAST works on various projects with the public sector, charities and academic units. It has a small research and development team based in the Department of Primary Care and Social Medicine at Imperial College London funded by a research grant from PHAST. There is no connection between PHAST and Imperial College London in relation to PHAST’s work on this Integrated Impact Assessment.
3 Developing the consultation and proposals in *The shape of things to come*

### 3.1 Aims of the consultation strategy

The Healthcare for London programme office developed a consultation strategy (Appendix 2a) for the consultation. The aim was to develop a consultation that ensured:

- stakeholders were informed about, and could influence, the proposals;
- the consultation process was timely and legal;
- the resulting recommendations were the best options and included the best ideas from stakeholders;
- duplication of effort in consultation was avoided and existing knowledge and services utilised.

The consultation strategy was informed by PCT communications leads and autumn 2008 health fairs (see section 3.2 below) and lessons learnt from *Consulting the Capital*.

The consultation strategy was approved by the Joint Committee of PCTs.

### 3.2 Pre-consultation engagement

As part of pre-consultation engagement, the proposals for stroke and major trauma were discussed extensively with patients, clinicians and stakeholder groups.

During autumn 2008, a series of health fairs was held throughout London to feed back the results of *Consulting the Capital* to members of the public and discuss how the consultation was run. The health fairs provided an opportunity to discuss the proposed forthcoming consultation on stroke and major trauma.

At all times the development of proposals to improve stroke and trauma services has been characterised by active clinical engagement. Clinicians have taken the lead in identifying relevant evidence, specifying standards and designing care models and care pathways. Each project has a clinical director and an expert clinical group. They have also drawn on the expertise and advice of non-London clinicians as appropriate. Events have been held to share proposals and seek clinical consensus. And the London Clinical Advisory Group (CAG) has acted to enable strategic consistency and alignment with the overall Healthcare for London proposals.

The Gateway Review team acknowledged “a high degree of clinical engagement at all stages of the project, resulting in the development of a strong clinical case for change”.
4 The shape of things to come – consultation material and activities

4.1 The consultation document and compact

The consultation document (Appendix 2b) was considered by the Joint Committee of PCTs, the London Commissioning Group, the Patient and Public Advisory Group (PPAG), the JHOSC, and the London Ambulance Service. The questions in the consultation questionnaire were developed through cognitive testing by Ipsos MORI, working with five members of the public and five healthcare professionals.

In the first week of the consultation, the consultation document was emailed to 500 key stakeholders, and to PCT communications leads for distribution.

Two thousand detailed consultation documents were digitally produced in order to have them available early in the consultation. These documents were sent on 10 February to PCT Chief Executives, JCPCT members, PCT communications leads and to the JHOSC.

A compact consultation document was published, providing an overview of the issues being consulted upon, and directing people to further information if they were interested.

In all, 30,000 detailed documents and 114,000 compact documents were distributed.

All documentation was made available on the Healthcare for London website www.healthcareforlondon.nhs.uk

4.2 Meeting the information needs of all consultees

The compact consultation document was translated into 15 languages.

The compact document was also produced on tape, CD and Braille. Large print (18 point) versions of the detailed consultation document were created and made available in hard copy or electronic versions upon request.

The compact document and questionnaire were also produced in easy read and easy access versions, specifically for audiences with learning disabilities or aphasia (a communication impairment common in stroke survivors). The easy read was first tested on a group of people with learning disabilities to ensure readability. The easy access was developed with a group of aphasia sufferers, during a day-long workshop.

The detailed document, the compact and the translated versions were all made available on the website which, along with the online questionnaire, was designed to be fully accessible (the site exceeds the requirements specified in the NHS website guidelines).

A PowerPoint presentation was developed (including notes) and distributed to all PCTs. The PCTs were asked to adapt the presentation to give people an insight as to how the proposals might affect their local communities.

4.2.1 Travel times video

Ambulance travel times was a particular issue that PCT communications leads identified as being likely to be raised by members of the public. Two videos were commissioned to help explain some of the issues:
• The first video explained the role of the London Ambulance Service and featured interviews with London Ambulance staff and crew, clinicians and patients. The film aimed to demonstrate how quickly and safely London Ambulance Service can transport patients from the scene of an incident to central London/distant hospitals; the range of treatments paramedics can provide in an ambulance; some of the differences between stroke and major trauma patients; and plans for future care.

• The second showed three clips of live, unedited footage from the passenger seat of an ambulance on long-distance blue light calls from outer London pick-up points to central London at different times of the day. All the videos showed that a travel time substantially less than 30 minutes could be achieved.

4.3 Activities

The proposed start of consultation was announced in the Evening Standard on 23 January 2009 and the thelondonpaper on 5 and 9 February 2009; and a press release issued on 28 January.

The communications activity report (Appendix 2c) summarises the range of activity across London and in each PCT over the 14-week period. The report shows the large number of groups that were engaged, the opportunities for members of the public to become involved, and the key stakeholders that were informed. It is estimated that over 14,000 people attended meetings across the capital, in addition to the 13,000 people who visited health fairs. The consultation page on Healthcare for London’s website attracted 14,000 visitors.

4.3.1 Summary of key activities

During the first month of the consultation (February 2009) efforts concentrated on the distribution of consultation materials and briefing of key stakeholders. Around 1,000 organisations were contacted with a request to advertise the consultation on their websites and distribute the consultation document to staff and through networks. A pro-active media strategy was launched, to generate coverage and increase awareness.

March 2009 saw the launch of the pan-London events programme. Events were held with the following groups, reaching around 300 individual stakeholders:

• Labour, Conservative and Liberal Democrat MPs, Assembly Members and Peers;
• volunteers
• stroke and major trauma survivors, their representatives and carers;
• stroke survivors with aphasia;
• medical directors, nursing directors and PEC chairs (acute and PCT);
• clinicians and voluntary sector groups involved in developing the proposals;
• London councils, councillors and local authority senior officers;
• Healthcare for London Patient and Public Advisory Group;
• London Ambulance Service Patients Forum;
• LINks members;
• NHS London and Commissioning Support for London (CSL) staff.

PCTs held hundreds of local events and meetings. This enabled engagement with some of the above groups at a local level, as well as with staff, community forums, BME groups, other traditionally under-represented groups, and groups at risk of stroke or major trauma.

In March, the Chief Executive of the national charity The Stroke Association wrote to the 42 stroke clubs in London, enclosing consultation documents and encouraging a response to the consultation.
A marketing campaign began at the end of March. Highlights included:

- advertisements in publications and other activity targeting people aged over 55 years, Afro-Caribbean adults, and housebound older people;
- advertisements in thelondonpaper;
- promotional activity at four main London railway stations;
- launch of pages on ‘Facebook’ and ‘Twitter’ to utilise the growing influence of social activity.

In the final weeks of the consultation, activity included:

- distribution of consultation materials to meals on wheels providers, charities, libraries, councils, and PALS;
- production of a html flyer for distribution to NHS staff in London and surrounding SHAs
- emailing 450 external stakeholders, including charities and faith groups;
- contact made with key organisations expected to respond to consultation;
- health fair at City Hall.

Throughout the consultation, the programme office worked closely with the Joint Health and Overview Scrutiny Committee (JHOSC) offering briefings to witnesses to help them prepare for JHOSC sessions.

Interest in the consultation remained fairly constant throughout the first 12 weeks with an average of around 700 visitors a week to the consultation page on the website, which then peaked during the last two weeks to over 4000.
4.3.2 Health fairs

In consultation with PCT communications leads, the Healthcare for London programme office developed a health fair 'package' that could be used across London. This included display panels, furniture, consultation documents and marketing material. To support PCTs in delivering the health fairs, two staff from event management contractor, Tribe, worked at each event to assist with promotion and management of the events. Healthcare for London programme staff also supported all health fair events.

Tribe delivered and set up the health fair in at least one location in every London borough between 28 February and 25 April. This corporate approach ensured that common information was presented at all meetings and roadshows – although PCT staff who manned the stand were encouraged to describe the local context.

Based on lessons learnt from the previous consultation, Consulting the Capital, the Healthcare for London programme team also developed a mobile unit, particularly targeted at PCTs who had difficulty holding a static health fair in high-traffic areas. Ten events using the mobile unit took place in town centres and supermarket car parks. One event was held in a market, attracting over 1,200 visitors.

Many PCTs offered a range of activities to make the event more engaging, such as activities for children and free health checks (such as blood pressure and cholesterol checks). PCTs used advertising and flyers to raise awareness and increase the number of visitors. Most of the health fairs benefited from a representative from the London Ambulance Service being on hand to explain the role of paramedics in the proposals and allay fears over travel times.

The health fairs were seen as a great success by both the public and PCT members, with 13,000 visitors in total (an average of 300 visitors per event.) The health fairs (or ‘roadshows’) held during the first consultation Consulting the Capital had fewer visitors – around 100 people per event on average. The increase in the number of visitors in this consultation suggests that the formula for delivering this type of event had improved.

4.4 The cost of consultation

The projected spend to 20 July 2009 is £1.2 million. This includes costs of the Healthcare for London communications team supporting the consultation, printing and publishing, translations and alternative format information, venues, advertising, roadshows, the cost of the response analysis and the Integrated Impact Assessment.
5  Response to consultation

The response to the consultation is provided in three main documents:

- Ipsos MORI consultation analysis of individual and organisational responses (Appendix 3a) – summarised in section 5.2 below.
- Health Link report on traditionally under-represented groups (Appendix 3b) – summarised in 5.3 below.
- Report by the Joint Health Overview and Scrutiny Committee (Appendix 3c) – summarised in 5.4 below.

Further relevant information is available in the:
- Integrated Impact Assessments (Appendices 3d and 3e);
- the report of the Patient and Public Advisory Group (PPAG); and
- individual and organisational responses to the consultation.

The JCPCT should also consider assessments of the responses to consultation which have been made by:
- the Clinical Advisory Group (see Section 8);
- individual PCTs; and
- the stroke and major project boards (Appendices 5c and 5d).

5.1  The consultation in numbers

Many thousands of people took the opportunity to be involved:

- 14,000 individual visitors to the website;
- 13,000 visitors to roadshows;
- over 14,000 people attended meetings arranged in PCT areas and by the programme office.

And a great many decided to make their views known. Approximately:

- 8,100 individual responses to the consultation questionnaire;
- 200 organisational responses to the consultation questionnaire;
- 1,300 people involved in traditionally under-represented consultation groups;
- 1,000 people and organisations wrote, phoned, or emailed comments;
- 4,000 people signed petitions.

5.2  Summary of Ipsos MORI consultation analysis

(The full report is available in Appendix 3a)

Respondents were able to respond by:

- completing the consultation questionnaire – postal and online forms;
- sending a letter or comments by post;
- emailing, telephoning and faxing.
Ipsos MORI also examined feedback obtained at meetings and events undertaken by PCTs and the Healthcare for London programme office.

5.2.1 Major trauma

What did we say in *The shape of things to come*?

Under the proposals, every Londoner would be within 45 minutes’ ambulance journey of a major trauma centre. Major trauma centres would provide 24/7 specialist emergency care for people with life-threatening injuries. These would be linked to local trauma centres based at A&E units across the capital, which would care for patients who have less serious injuries as well as providing ongoing treatment and rehabilitation for all patients.

We proposed establishing three or four trauma networks. Three options were presented for establishing trauma networks in London:

- Option 1 (preferred option)
  Four trauma networks with major trauma centres at The Royal London Hospital, King’s College Hospital, St George’s Hospital, and St Mary’s Hospital.

- Option 2
  Four trauma networks with major trauma centres at The Royal London Hospital, King’s College Hospital, St George’s Hospital, and The Royal Free Hospital (instead of St Mary’s Hospital).

- Option 3
  Three trauma networks with major trauma centres at The Royal London Hospital, King’s College Hospital, and St George’s Hospital.

Analysis of consultation responses, Ipsos MORI

The following text is extracted from the executive summary found at the front of the full Ipsos MORI report.

Key stakeholder organisations expressed support for the development of four major trauma centres, although there were some organisations who favoured the three-centre approach. Whilst there was a general consensus on the location of three of the four proposed centres, there was a difference of opinion amongst key stakeholder organisations as to whether the fourth centre should be located at St Mary’s Hospital or at the Royal Free Hospital.

At the aggregate level, 51% of individual respondents supported the preferred option of four major trauma centres which included St Mary’s Hospital, The Royal London Hospital, King’s College Hospital and St George’s Hospital. The majority (89%) of respondents from Barnet favoured the second option of four major trauma centres with The Royal Free Hospital replacing St Mary’s Hospital.

There was support from key travel organisations that ambulances would be able to meet the 45 minutes’ journey time as laid out in the proposal. However, this was caveated with the warning that travel conditions are likely to become more difficult in the future.

Ensuring good coverage and location were the prime concerns of individual respondents.

“The BMA believes that for this group of patients (trauma), the benefits of specialist centred care can outweigh any detriments resulting from the increased travel distances to the centres.”

*British Medical Association*
5.2.2 Stroke

What did we say in *The shape of things to come*?

With the introduction of specialist stroke services, all people who have a stroke would be taken to a new hyper-acute stroke unit within 30 minutes’ ambulance journey. At a hyper-acute stroke unit, patients would receive expert care for the first 72 hours, including immediate access to a brain scan and clot-busting drugs, if appropriate. Patients would then be cared for in a local stroke unit for continued treatment and rehabilitation closer to home.

Hyper-acute stroke care should be delivered in no more than eight sites across London. This would optimise the number of patients treated at each site, and ensure expert teams are available 24 hours a day – improving survival and reducing disability. More than 20 stroke units will provide ongoing care once a patient is stabilised, including multi-therapy rehabilitation. Transient ischaemic attack services will provide rapid assessment and access to a specialist – within 24 hours for high-risk patients, or within seven days for low-risk patients.

We recommended the creation of eight new hyper-acute stroke units at:

1. Charing Cross Hospital, Hammersmith
2. King’s College Hospital, Denmark Hill
3. Northwick Park Hospital, Harrow
4. Queen’s Hospital, Romford
5. St George’s Hospital, Tooting
6. The Princess Royal University Hospital, Orpington
7. The Royal London Hospital, Whitechapel
8. University College Hospital, London

Several other hospitals showed they could meet future standards for hyper-acute stroke units and were put forward as alternatives to the preferred configuration.

The Royal London Hospital OR St Thomas’ Hospital
Charing Cross Hospital OR Chelsea and Westminster Hospital
King’s College Hospital OR St Thomas’ Hospital
Northwick Park Hospital OR Barnet Hospital
St George’s Hospital OR Mayday University Hospital
University College Hospital OR The Royal Free Hospital

Analysis of consultation responses, Ipsos MORI

The following text is from the executive summary found at the front of the full Ipsos MORI report.

Over 70% of individuals responding were in agreement with the proposal as to how stroke care would be provided in the future and agreed that eight hyper-acute stroke units would provide the best urgent care for stroke patients in London. The major concerns with the proposed eight hyper-acute stroke units related to their location and the risks to ensuring patients get urgent medical attention.

Whilst there was general support for the focus on specialist stroke care from key stakeholder organisations, some expressed concerns that the evidence base for the acute stroke care proposals was not as compelling as that for specialist major trauma centres.

There was concern from some organisations with regards to the proposed location of hyper-acute stroke units (HASUs), particularly in terms of provision in outer London.
boroughs. The need for more outer London coverage was mentioned by those organisations representing residents in Barnet and Enfield. However, there was agreement from transport organisations that the proposed 30-minute Blue Light travel time could be met.

Three in five (61%) respondents were in favour of the proposed configuration of hyper-acute stroke units and three-quarters (75%) were in agreement with the proposed configuration of stroke units and TIA services. Alternative locations for the units were the most frequently mentioned reason for disagreement with the proposed configuration.

“We are impressed by the evidence provided and the clinical criteria upon which decisions in the strategy are based.”

The Stroke Association

5.2.3 Decision-making – process and criteria

What did we say in The shape of things to come?

To ensure the best options for delivering new services were included in this consultation, the committee developed the following criteria:

- **sustainable and optimal quality** – to ensure all providers are able to deliver services to the highest standards;
- **comprehensive coverage of the London population** – to ensure all residents can access services in acceptable times;
- **strategic coherence or ‘best fit’** – to ensure opportunities are pursued to bring important acute services together where there is benefit in doing so.

Analysis of consultation responses, Ipsos MORI

The following text is extracted from the executive summary, found at the front of the full Ipsos MORI report.

Organisations were broadly supportive of the criteria Healthcare for London proposes to use in order to decide how to provide services in the future. The need to provide equitable services across London was recognised by many of the key stakeholder organisations as an important goal. There was an emphasis on the need to be clear about travel times, as this is one of the key public concerns.

Three-quarters of individual respondents agreed with the criteria on which decisions will be made after the results of the consultation are presented to the Joint Committee of PCTs. The importance of travel times and being transported to the hospital quickly, were the most commonly mentioned reasons offered by respondents to explain their agreement or disagreement with the consultation criteria.
5.3 Summary of Health Link report on traditionally under-represented groups

(See Appendix 3b)

Health Link was commissioned to identify relevant traditionally under-represented groups, guide PCTs in their conduct of consultation meetings, and assess responses from meetings (see 4.3 for details). Article 13 (which also bid for this work) were commissioned to organise and run meetings when it became apparent that some PCTs would be unable to do so themselves.

PCTs and Article 13 consulted with 46 groups – a total of 1,294 people. This included two consultations with members of the Hindu community and members of the Sikh community which each involved about 300 people. Other groups consulted ranged in size from four to 60 people, with an average of 28. PCTs and Article 13 produced 47 reports.

Health Link’s report concludes that “Compared with our earlier consultation with traditionally under-represented groups in relation to A Framework for Action, this consultation on The shape of things to come has demonstrated much more substantial support for the recommendations.”

Nevertheless, there were doubts and reservations raised:

- **Loss of services**
  The fear that the new services will result in hospital closures and a reduction in access to hospital services persists.

- **Families and friends**
  The new pattern of services may mean that some patients will be in hospitals further away from their homes than is the case at present. Concern about how families, friends and carers will cope with this has persisted through both consultations. Low incomes, disability and older age could make visiting difficult for some people.

- **Travel times**
  A persisting anxiety is about ambulance travel times. In particular, participants were concerned about the impact that increased overall times would have on patients’ conditions and whether the London Ambulance Service can consistently meet the target times. The shape of things to come addressed concerns with evidence that the benefits of improved treatment outweigh the increase in travel time anticipated, and the ambulance service’s own records indicate that the target times will be achieved. A number of groups remained sceptical, particularly about meeting the target times.

- **Carers**
  The role of carers received attention in Consulting the Capital. The PCTs consulted groups of carers in this consultation, but generally the carers commented on the proposals in general, rather than in their own role as carers.

- **Paramedic skills**
  A number of groups commented on the crucial role that paramedics will play in the new arrangements. In Consulting the Capital some groups expressed scepticism about the skills of paramedics. The shape of things to come notes the importance of relevant skills for paramedics and the ambulance service more widely, and indicates that further training is being put in place.
• **Communication**
  A number of groups have referred to the continuing importance of clear communication in plain English, with interpreting and translation as necessary.

• **Long-term illness or disability:** Groups recognised that patients being treated in the new centres for major trauma or stroke will sometimes have long-term illness or disability and were concerned that staff in the centres need to be aware of the conditions of individual patients and take account of these in their treatment.

• **Groups vulnerable to prejudice or stigma**
  Discrimination and prejudice may occur in relation to culture, religion, race, gender, sexual orientation, gender reassignment and age. For some religious groups, as an example, there are specific requirements in relation to end-of-life care. Groups with learning difficulties, mental health problems felt that they are sometimes subjected to discrimination and prejudice within the NHS.

• **Capacity**
  Some groups raised concerns about the capacity of the new services to meet the demands, with one noting that major trauma centres could themselves become targets for terrorists in a concerted attack.

5.4 **Report by the Joint Health Overview and Scrutiny Committee**

(The full report is available in Appendix 3c)

The supplementary report of the committee: *Minutes of ‘Witness’ Meetings; written submissions to the JHOSC*, is available from the Healthcare for London Programme Office.

5.4.1 **General comments**

The JHOSC delivered its final report to the JCPCT on 10 June 2009. The report states that:

“Having taken evidence from a wide range of informed bodies, we are able to support the direction of travel underlying the consultation paper: speedy access to 24/7 specialist care provided from a number of centres across London. The evidence we have heard over several months has demonstrated clearly that the proposed model is superior to the combined ‘daytime/out-of-hours’ model of delivering specialist care which the previous ‘Healthcare for London’ JHOSC favoured on the basis of information available at the time.”

The JHOSC

“..Welcome[s] the greater emphasis now being given to stroke, which is the second highest cause of death and the most common cause of adult disability in London,” and believes that:

“If the implementation of the proposed changes is managed well, and continued funding allows high-quality standards to be achieved and maintained, we would expect to see an end to the ‘postcode lottery’ of healthcare in relation to stroke and major trauma services in London that has existed for far too long.”

The JHOSC heard evidence presented on the robustness of travel times:

“‘It is probably fair to say that we started out with a considerable degree of scepticism at the proposed patient transfer times from scene to specialist centre (30 minutes for stroke; 45 minutes for major trauma). However, when we heard from the London Ambulance
Service, it was quite clear that their confidence in achieving these maximum travel times was very strong. On the relatively few occasions when these travel times might be exceeded, this must not fundamentally mitigate the overall benefit of transferring a patient directly to a centre which is able to offer expert clinical care."

The JHOSC raised a number of specific issues and made detailed recommendations for consideration by the JCPCT. These include:

- **Implementation of the changes**
  Detailed plans (including contingency) should be prepared – that set out how the transfer to new services will be achieved – especially how mutual support will be encouraged. Services should not be closed before adequate replacements are provided.

- **Staff recruitment**
  This should be a key priority for the NHS which should investigate flexible working and work in partnership with higher education bodies and the Royal College of Nursing and the Allied Health Professionals Federation.

- **The focus on acute provision**
  Future consultations should address the whole pathway more thoroughly. The JHOSC would like to see more work on a long-term strategy to promote healthy living to prevent strokes and major trauma; and more work to address the challenges of joint working to provide high-quality rehabilitation – particularly involving the Association of Directors of Adult Social Services (ADASS) and London Councils. This would assist the goal of ensuring consistency of access and quality. The JHOSC would also like an early involvement of hospital social work teams in planning longer-term pathways and encourages the NHS to build upon the success of the FAST campaign and work with local authorities in order to reduce the number of strokes.

- **Investment in enhanced community-based resources**
  An assessment of joint financial incentives should be undertaken.

- **Hospital transfers**
  Clear clinical and administrative protocols should be in place before new systems go live, and there should be appropriate monitoring. This not only includes transfers between HASUs and stroke units and major trauma and trauma centres, but also between local hospitals and specialist centres.

- **Travel arrangements**
  Specialist centres should draw up travel plans.

- **Cross-border co-ordination**
  More joint working with adjacent PCTs and ambulance services should occur – in particular to ensure transfer protocols are agreed and implications for visitors can be assessed.

- **Communications**
  It will be important that patients feel comfortable with, and understand, the care pathway. Particular attention needs to be given to the needs of BME communities.

- **Monitoring and evaluation**
  Attention should be focused on the quality of the service, the patient experience, and the effect on other services and staff (recruitment and retention) in all hospitals.

- **Training**
  Adequate resources should be made available for the training of paramedics, and of staff
in hospitals not providing a major trauma centre or HASU, to ensure appropriate
immediate care and transfer when necessary.

5.4.2 Stroke

- The number of HASUs
  The JHOSC recommended that eight HASUs is seen as a minimum and should be
  regularly reviewed as the number of people arriving at a HASU with stroke-like symptoms
  – but who have not had a stroke; self-referrals; and undiagnosed strokes; becomes
clearer.

- Standards
  Standards must not be compromised during transition and new services must be
delivering high standards and able to cope with demand before existing services are
changed.

- Telemedicine
  Lessons should be learnt from health systems which have successfully applied
telemedicine.

- Bed spaces
  Sufficient capacity must be in place. The number of beds should not limit the time
available (and needed) for some patients in a HASU or stroke unit – either by too few beds
being provided or by utilisation of stroke beds by general patients.

- Rehabilitation
  The needs of children and young people and how these will be met should be considered.

5.4.3 Major trauma

- Proposed fourth major trauma centre
  Commitment should be made that the proposed fourth major trauma centre will become
operational as soon as possible.

- Neuro-rehabilitation services
  All, not just some, PCTs should provide multi-specialist rehabilitation services.
5.5 Response of the Patient and Public Advisory Group (PPAG)

(The following text is the full report)

The Healthcare for London Patient and Public Advisory Group (PPAG) welcomes the fact that nearly 11,000 responses were received to the Healthcare for London consultation on stroke and major trauma from a diverse range of individuals and organisations. The group, which has 27 individual members appointed through an independent recruitment process, acts as the patient voice in the development of the Healthcare for London programme.

The group notes that the majority of respondents to the consultation expressed support for the proposals to improve stroke and major trauma services in the capital:

- 73% of respondents agreed with the proposed model of stroke care comprising hyper-acute stroke units, local stroke units and TIA units;
- 71% agreed that hyper-acute stroke units would provide the best urgent care for stroke patients and 61% agreed with Healthcare for London’s preferred locations for eight HASUs;
- 87% of respondents were in favour of establishing four major trauma centres.

Noting the very high number of responses received from some geographic areas of London, the group would like to stress that number of responses alone should not unduly influence the outcome of the consultation; decisions that affect the health of Londoners should be made on the basis of the ideas and views of respondents, solid data and clinical evidence.

The group, whilst generally supporting the proposals, has a number of concerns regarding:

- The importance of rehabilitation services, and the need to develop fully integrated rehabilitation care pathways including high quality nursing care;
- The importance of a prevention strategy, particularly for stroke, and the lack of detail for a prevention care pathway;
- The need to carefully manage patient transfers between specialist centres and hospitals providing follow-on care;
- The potential travel difficulties (time, distance and cost of travel, particularly car parking charges), that some people may experience when visiting a partner, relative or friend in a major trauma centre or hyper-acute stroke unit;
- Planning for future congestion problems and the impact this could have on travel times.

The group believes that the Healthcare for London proposals for new stroke and major trauma services have the potential to improve the lives of many Londoners. However, the group recognises the challenges of successful implementation, which will require detailed plans.

The Patient and Public Advisory Group wishes to remain informed of all developments and to be closely involved with and to monitor the implementation of new stroke and major trauma services in London.
6 Health Inequalities and Equalities Impact Assessment

(The full reports are available in Appendices 3d and 3e)

Health inequalities and equality impact assessments are powerful planning tools that support decision makers. They can help ensure policies, strategies and/or plans are designed in ways to maximise the beneficial effects, and minimise adverse effects, on health and inequalities.

The Integrated Impact Assessments are specific to the major trauma and acute stroke services. The work builds on, but does not duplicate the previous assessment, namely the Health Inequalities Impact Assessment (HIIA)/Equalities Impact Assessment that was conducted as part of Consulting the Capital.

Mott MacDonald, working with the Public Health Action Support Team, were contracted to provide independent integrated impact assessments consisting of prospective:

- Health inequalities and equalities impact assessments
- Modified Environmental Impact Assessment (EIA) consisting of travel access and carbon assessments.

The Integrated Impact Assessments have considered which groups are likely to be affected and the impact on these groups. The assessment also considered the impact on the six equality groups – age, disability, faith, gender, race and sexual orientation – as defined in legislation. A further equality group was also added – people living in deprived areas in London. This was due to their susceptibility to socio-economic disadvantage and poorer health outcomes when compared to the general population.

The full Integrated Impact Assessments describe the mitigating actions that are proposed to address the negative impacts. These actions are also considered in Appendix 8a – recommendations.

The following summaries are extracted from the full Integrated Impact Assessments.

6.1 Major trauma – main findings

This assessment largely highlights that major trauma tends not to be closely associated with any of the statutory equality groups. Young men are the principal presenters. Geography is a far more relevant factor as most major trauma occurs in the central and inner London areas. However, it is worth noting that socio-demographic data collected for major trauma events are insufficiently complete.

The overall IIA finding is that the service proposals for major trauma would benefit the population of London by providing them with better access to specialist care.

6.1.1 Positive impacts

i. Evidence, both nationally and internationally, has demonstrated that transporting patients to centres staffed by specialist clinicians, with expertise in treating particular incidents and equipped with state of the art equipment, would improve clinical outcomes and quality of care in major trauma.

ii. The proposals for reform are generally welcomed and are seen likely to yield positive health outcomes for all Londoners, providing equality of care at the point of delivery. For patients travelling by blue light ambulance or helicopter, these proposals would help to smooth and reduce inequalities; everyone with a major trauma would go to a
specialist major trauma centre, whatever their socio-economic background or geographical location.

iii. It was considered that the option most likely to result in positive impacts is Option 1, based around four major trauma centres at The Royal London, King’s College, St George’s, and St Mary’s hospitals. This was supported by the majority of stakeholders and had fewer negative or carbon consequences than Options 2 and 3. Access was also better for Option 1.

iv. Patient access by blue light ambulance: all patient journeys to the major trauma centres from within London would be within the required target of 45 minutes according to London Ambulance Service information. The overall numbers of patients affected by longer travel times (over 30 minutes) are likely to be small due to the high proportion of major trauma events which occur in central areas of London, where the major trauma centres are clustered. Those areas that are over 30 minutes away have low densities of population and few numbers of BAME groups and socially deprived individuals.

v. Public transport: access for Option 1 is better than Options 2 or 3, with high Public Transport Accessibility Levels (PTALs); three of the proposed major trauma centres have a PTAL score of 6 (excellent) with the remaining site having a score of 4 (good).

vi. Private car: 100% of Londoners should be able to reach a major trauma centre within 60 minutes; and 70% can reach a centre within 30 minutes by car.

6.1.2 Negative impacts

Whilst there is general consensus about the ability of Healthcare for London’s proposals for major trauma services to improve health outcomes, there are also some potentially negative impacts. Whilst it is important to address these in implementing the changes, it must be noted that the positive benefits in terms of equal access to high quality care and improved clinical outcomes, outweigh the negative aspects. The key negative issues are summarised below:

Lack of pathway, network and capacity planning
   i. The main concern is that the whole care pathway, including rehabilitation, has yet to be as fully developed as the acute element. Without robust and transparent step-down and discharge arrangements there is a risk of system blockages.

   ii. There are worries about the level of co-ordination between different PCTs and local authorities that would be needed to ensure that cross-boundary networks can be delivered. Service delivery in London is already highly complex and the proposals would create new boundaries to manage, across which many patients would need to be transferred. Excellent co-ordination would be required along the pathway if the major trauma centres are not to clog up.

Access and carbon emissions
   iii. Major trauma victims would mostly be transported to hospitals unfamiliar to them, which are some distance away from their homes and/or friends and family. This could be particularly disorientating for more vulnerable members of the community.

   iv. Carers, relatives and visitors using cars – and particularly public transport – would require longer and more complex journeys to visit loved ones in a major trauma centre. Increased travelling time is likely to have disadvantages in terms of emotional stress and anxiety. These effects could also impact upon equality groups to a greater extent due to their propensity to use public transport when compared to the general
population. Black, Asian and Minority Ethnic (BAME) and socially-deprived communities, which tend to be clustered in central London where public transport links are good, may not be too adversely affected; however, the large populations of older people living in outer London areas, which are less well-served by public transport links, are likely to experience particular disadvantages.

v. Any of the three options for major trauma would lead to an increase in carbon emissions – this would be expected as ambulances would travel further to central hospitals. The increases in emissions are expected to result in an increase of approximately 200 tonnes per annum for Options 1 and 2 and approximately 250 tonnes per annum for Option 3, compared to the baseline position. However, this increase is considered small when compared to carbon emissions from NHS road transport in London; 250 tonnes per annum represents 0.05%.

Potential discrimination against equalities groups
vi. There are some concerns that the proposed major trauma centres may be less able to meet the cultural needs of certain faith or ethnic groups. It is assumed that staff at local A&Es are more experienced in dealing with beliefs or customs of their surrounding community.

North west London
vii. There are perceived issues for outer north west London where distance would be greater to a major trauma centre, whichever option is selected by JCPCT. In addition, if a four-centre option is chosen, the centre serving this area of London would take longest to be established, giving inferior access in the interim to residents in north west London, and exaggerating geographical inequalities for patients.
6.2 Stroke – main findings

It is very evident from the review for stroke services that certain equality groups within London are more susceptible to experiencing a stroke than the general population. The most obvious trend is that between older people and stroke. Nationally about 80% of strokes occur in people over 65 years. The figures for London are similar: figures received by London Ambulance Service suggest that the over 65s account for over 80% of stroke occurrences. In addition to older people, socially-deprived communities and Black, Asian and minority ethnic groups are also susceptible to stroke and people with learning disabilities or mental health problems are also ‘at risk’ groups. As such, these groups could stand to benefit significantly from the expected improvements in clinical outcomes.

There is also an important issue of geography to consider. When comparing stroke in inner and outer London boroughs, the greatest numbers of strokes occur in outer boroughs, where higher numbers of older people reside.

All areas in London should be a maximum of 30 minutes away from a HASU by blue light ambulance. In many cases this would mean Londoners would face a longer journey than at present. However, as patients would be transported to very specialist centres, rather than their local A&E, the positive clinical outcome should outweigh this negative impact for patients.

6.2.1 Positive impacts

The overall IIA finding is that the service proposals for stroke services would benefit the population of London by providing them with better access to specialist care. In particular:

   i. evidence, both national and international, has demonstrated that transporting patients to centres staffed by specialist clinicians, with expertise in treating strokes and equipped with state-of-the-art equipment, improves clinical outcomes and quality of care;

   ii. the proposals for reform are generally welcomed and are expected to yield positive health outcomes for all Londoners, providing equality of care at the point of delivery;

   iii. according to London Ambulance calculations, all patient journeys to HASUs from within London would be within the required target of 30 minutes. Patient travel by blue light ambulance acts to smooth inequalities, meaning that everyone across London has access to good clinical services;

   iv. the national FAST campaign on stroke awareness provides a good platform from which to launch the new stroke proposals and develop a public awareness programme targeted at the specific sections of London’s population most prone to experiencing a stroke and at local populations at PCT level.

---

3 This figure represents hospital admission journeys for probable strokes. It does not include presenters not taken to hospital by ambulance.
6.2.2 Negative impacts

Whilst there is general consensus about the ability of Healthcare for London’s stroke services proposals to improve health outcomes, there are also some potentially negative impacts. The key issues are summarised below:

Lack of pathway and network planning
i. Probably the greatest vulnerability in the proposals is that the whole care pathway, including rehabilitation, has yet to be as fully developed as the acute element. At present, an agreed approach to rehabilitation has not been signed off, which places in jeopardy the ability to discharge patients to community rehabilitation services in jeopardy;

Access and carbon emissions
ii. There may be particular issues for some outer London boroughs where distance to the HASUs would be greater, whichever decision on the options is taken by the JCPCT;

iii. acute stroke sufferers could be transported to hospitals unfamiliar to them, which are some distance away from their homes and/or friends and family. This could be particularly disorientating for more vulnerable members of the community;

iv. carers, relatives and visitors using cars (and particularly, public transport) are likely to require longer and more complex journeys to visit loved ones in a HASU. Increased travelling time is likely to have disadvantages in terms of emotional stress and anxiety. These effects may also impact upon equality groups to a greater extent due to their propensity to use public transport when compared to the general population. BAME and socially-deprived communities – which tend to be clustered in central London where public transport links are good – may not be too adversely affected; however, the large populations of older people living in outer London areas, which are less well-served by public transport links, are likely to experience disadvantage;

v. the stroke proposals would lead to an increase in carbon emissions – around 100 tonnes per annum compared to the baseline position. However, this increase is considered small when compared to carbon emissions from NHS road transport in London (0.02%).

Potential discrimination amongst equalities groups
vi. There are some concerns that the proposed HASUs may be less able to meet the cultural needs of certain faith or ethnic groups. It is assumed that staff at local hospitals are more experienced in dealing with beliefs or customs of their surrounding community;

vii. There is the perceived potential for negative impacts on other services or hospitals. For example, patients receiving other types of care at designated HASU hospitals may be unintentionally deprioritised with regard to access to clinicians or scanning equipment. Another risk is staff at other hospitals (those without HASU status) becoming demotivated as a result of the service changes.
For decision

The JCPCT is asked to accept the following reports:

1. Ipsos MORI report on the consultation process and responses
2. Health Link report on traditionally under-represented groups
3. Joint Health Overview and Scrutiny Committee report and commissions Healthcare for London prepare a response
4. Integrated Impact Assessment for major trauma
5. Integrated Impact Assessment for stroke

The JCPCT is asked to confirm:

6. that the consultation process was appropriate and met all the requirements of a valid consultation.
Part B – Decision-making

7 Decision-making processes and criteria to be used by the JCPCT to agree future service provision arrangements

The following section is a paper which was presented to the JCPCT on 7 July 2009:

1. Introduction
The public consultation on proposals to improve the quality of London’s acute stroke and trauma care concluded on 8 May. The consultation document set out the case for change, proposed new models of care and described preferred and alternative configuration options. In formulating and agreeing the options for inclusion in the consultation process the JCPCT utilised three criteria:

- sustainable and optimal quality; to ensure all providers are able to deliver services to the highest standards;
- comprehensive coverage of the London population; to ensure all residents can access services in acceptable times;
- strategic coherence (see Appendix 4a); to ensure opportunities are pursued to bring important acute services together where there is a benefit in doing so.

2. Purpose of the paper
To recommend, for adoption by the JCPCT:

- the decision-making processes it will adopt to agree future service provision arrangements;
- the specific criteria it will utilise to determine the future service delivery configuration.

3. Principles
We recommend that the JCPCT will adopt an approach which:

- is shaped around the objective of improving quality and clinical outcomes;
- enables equitable outcomes across London;
- takes proper account of the responses made to the consultation, the Integrated Impact Assessment (IIA) and other relevant information;
- is based on relevant evidence, clinical advice and authoritative good practice.

4. Decision-making process

4.1 The case for change
The consultation document sets out a case for change which indicates the requirement for significant development in acute stroke and trauma services across London.

The JCPCT will receive a report which will appraise the extent to which the responses to the consultation, the Integrated Impact Assessment (IIA) and other relevant information challenge the case for change. The report and recommendations will have
been endorsed by stroke and trauma project boards, the expert clinical panels and the Healthcare for London Clinical Advisory Group prior to presentation to the JCPCT. Should the case for change be significantly challenged, the report will make recommendations regarding the associated implications.

4.2 Models of care
The consultation document described new models of care for stroke and trauma necessary to deliver required quality standards. The JCPCT will receive a report which will appraise the extent to which the responses to the consultation, the IIA and any other relevant information challenge the proposed models of care. The report and the recommendations it includes will have been endorsed by the stroke and trauma project boards, the expert clinical panels and the Clinical Advisory Group. Should the models of care be significantly challenged, the report will make recommendations regarding the implications.

4.3 Service delivery configuration
The consultation document sets out a preferred configuration for the future delivery of major trauma centres, hyper-acute stroke units (HASUs), stroke units and TIA clinics. Alternative configuration options are described for major trauma centres and hyper-acute stroke units.

The JCPCT will receive a report with appropriate supplementary information, analysis and data which recommends either:

- a decision to approve the preferred option, and the reasons for so doing;
- a decision to approve an alternative option and the specific rationale to justify that decision.

In developing the report, an appraisal will be made of the extent to which the responses to the consultation, the IIA, and other relevant information (for example, implementation plans) conclude that an option other than the preferred option should be recommended in light of a consideration against the agreed criteria. The report and any recommendation included within will be endorsed by the Stroke and Trauma Project Board and, where appropriate, the Clinical Advisory Group and external clinical advice.

5. Criteria
As stated in 1 above the JCPCT utilised three criteria in formulating and agreeing options for inclusion in the consultation process. The consultation document invited views on the use of these criteria in the post-consultation decision making processes.

The use of the criteria was supported – 75% of all responses. This rises to 85% if responses of ‘don’t know’ and ‘did not answer question’ are excluded. In a recent meeting, the JCPCT also indicated a requirement for the criteria to pay appropriate attention to:

- deliverability of new standards;
- affordability and use of resources.
Four criteria are proposed as follows:

5.1 Sustained and optimal quality of provider services
We recommend that the assessment of configuration options will be based on:

a) compliance with the agreed models of care. Configurations which do not comply with the model of care should not be approved;
b) the outcomes of the external evaluation of proposals made by trusts to develop major trauma and acute stroke services. This evaluation took account of existing facilities and resources but particularly focussed on the capability and capacity to develop services to enable delivery in line with the defined specification at an appropriate future date. This evaluation was conducted as part of the process to develop options for consultation and remains an important reference point as final decisions are made;
c) implementation plans: implementation plans are being prepared for all proposed major trauma and acute stroke unit sites. They will take account of a range of issues – including equipment, workforce and transitional considerations. The JCPCT should not include sites in the approved configuration which do not have satisfactory implementation plans;
d) capacity and resilience: it is critical that the agreed configuration has appropriate capacity to meet anticipated demand. For major trauma, consideration should also be given to appropriate resilience and major incident planning aspects;
e) network effectiveness: the approved configuration needs to demonstrate how effective network arrangements should support the model of care (for example, in terms of issues such as patient transfers).

5.2 Equitable access to specialist services for London’s population
We recommend:

a) for major trauma: all Londoners must have access to a major trauma centre in 45 minutes;
b) for hyper-acute stroke units: all Londoners must have access to a HASU in 30 minutes;
c) for stroke units: stroke unit configuration should recognise the long-term nature of care provided and the benefits of minimising travel time for carers and relatives.

5.3 Strategic coherence
We recommend that a configuration will be approved which:

- enables a colocation of hyper-acute stroke units with major trauma centres;
- ensures all major trauma and hyper-acute stroke services are located on hospital sites which could be significant providers of specialist acute services (major acute hospitals) in the future.

5.4 Affordability and efficient use of resources
We recommend configuration options will only be approved if there is assurance of affordability. The relative costs of alternative options will be considered but there will be a recognition of the fundamental objective of optimising quality and outcomes.
6. Weighting
We recommend all criteria will be considered equally carefully by the JCPCT as it takes decisions regarding options for decision and that the JCPCT should satisfy itself that options included in the decisions meet all four criteria.

For decision

The JCPCT is asked to:

7. agree the decision-making criteria and agree that they will be applied to support decision-making.

7.1 Inputs into the decision-making process

Whilst the JCPCT should be mindful of all the responses to the consultation, the key inputs used in the following pages are:

- Ipsos MORI consultation analysis of individual and organisational responses (Appendix 3a);
- Health Link report on traditionally under-represented groups (Appendix 3b);
- Report by Joint Health Overview and Scrutiny Committee (Appendix 3c);
- Integrated Impact Assessments (Appendices 3d and 3e);
- The response of the Patient and Public Advisory Group (PPAG) (Section 5.5);
- Reports of the Clinical Advisory Group agreed at its meeting of 26 June (Appendices 5a and 5b);
- Commentary on consultation responses by the project boards (Appendices 5c and 5d). Both of these reports has been informed by clinical expert panels and authoritative external clinical advice;
- Evidence supporting deliverability proposals (Appendices 6 and 7).

“They need to look at maximising the greater good by providing fair and equal services for all people living in the city, and not be influenced by localism.”

View of under-represented group in Health Link report

“the PPAG would like to stress that number of responses alone should not unduly influence the outcome of the consultation; decisions that affect the health of Londoners should be made on the basis of the ideas and views of respondents, solid data and clinical evidence.”

Patient and Public Advisory Group
Part C

8 Reports of the Clinical Advisory Group (CAG)

(The full reports are available in Appendices 5a and 5b)

The Clinical Advisory Group (CAG) informs the development of the Healthcare for London programme. The CAG chairs report to PCTs and the Strategic Health Authority through the interim board of Commissioning Support for London and the NHS London board.

The CAG has 32 members from a broad mix of professions, specialties, care settings and geography to ensure it can speak with authority, knowledge and expertise on an appropriate breadth of health issues.

The CAG has advised the project boards throughout the consultation.

At its meeting of 26 June 2009, the CAG received and discussed an assessment of responses which had been made to the consultation. Members also took account of any additional significant evidence or information that had come to light during the consultation. The CAG report reflects the outcome of these discussions.

The CAG considered a range of relevant issues regarding the proposals for major trauma and stroke, which arose from stakeholder responses to the public consultation, the Joint Health Overview and Scrutiny Committee (JHOSC) report and the Integrated Impact Assessment (IIA). The CAG made a number of recommendations for consideration by the JCPCT. These recommendations and CAG views on challenges are incorporated into relevant sections later in this report.

The CAG was supportive of the proposals to improve stroke and trauma care. It agreed that the case for change and the model of care remain valid for stroke and major trauma and supported the proposals to designate eight hyper-acute stroke units and four major trauma centres.

The CAG also agreed with the proposals for local stroke units and TIA services.

For decision

The JCPCT is asked to accept the:

8. report of the Clinical Advisory Group
Part D – Decisions on the future delivery of new major trauma and stroke services

This section of the report recommends decisions that will enable improvements in new major trauma and stroke services across London:

<table>
<thead>
<tr>
<th>Section 9</th>
<th>Major trauma</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.1</td>
<td>The case for change</td>
</tr>
<tr>
<td>9.2</td>
<td>Model of care</td>
</tr>
<tr>
<td>9.3</td>
<td>Number of major trauma centres</td>
</tr>
<tr>
<td>9.4</td>
<td>Location of major trauma centres</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Section 10</th>
<th>Stroke</th>
</tr>
</thead>
<tbody>
<tr>
<td>10.1</td>
<td>The case for change</td>
</tr>
<tr>
<td>10.2</td>
<td>Model of care</td>
</tr>
<tr>
<td>10.3</td>
<td>Number of hyper-acute stroke centres</td>
</tr>
<tr>
<td>10.4</td>
<td>Location of hyper-acute stroke centres</td>
</tr>
<tr>
<td>10.5</td>
<td>Configuration of stroke centres</td>
</tr>
<tr>
<td>10.6</td>
<td>Configuration of TIA services</td>
</tr>
</tbody>
</table>
9 Major trauma

9.1 Major trauma – the case for change

9.1.1 What did we say in *The shape of things to come*?

There are about 1,600 major trauma cases each year in London (0.1% of all A&E cases) with most injuries occurring in central London.

In London and the UK, the quality of care delivered to most patients is poor. The *National Confidential Enquiry into Patient Outcome and Death* in 2007 found that over half of patients receive sub-standard care. Few of London's hospitals are set up to provide highly-specialised care for major trauma patients, and services are often poorly co-ordinated.

International comparisons show London is lagging behind other major cities in its treatment of trauma patients. Death rates for severely injured patients who are alive when they reach a hospital is 40% higher in the UK than in some parts of the US.

9.1.2 Views and issues raised in relation to the case for change

(Please see Appendix 5c for a fuller list of key issues and responses)

| **Ipsos MORI analysis and responses to consultation** | Respondents agreed that specialist, expert trauma care would save lives and reduce disability. Stakeholders also supported the principles of the major trauma proposals, and welcomed the focus on improving services in this area. |
| **JHOSC** | The JHOSC emphasised the need to ensure that all residents are able to enjoy the best treatment available, wherever they live. |
| **Traditionally under-represented groups** | Groups welcomed the focus on improving services in this area.  
The case for change was not challenged by respondents. |
| **Impact Assessment (IIA)** | The IIA supported the case for change. It stated:  
“Evidence, both nationally and internationally, has demonstrated that transporting patients to centres staffed by specialist clinicians with expertise in treating particular incidents and equipped with state of the art equipment will improve clinical outcomes and quality of care”. |

9.1.3 Project board's consideration of views and issues raised

(Please see Appendix 5c for a fuller list of key issues and responses)

The clinical expert panel that advised the major trauma project agreed that no new evidence had emerged in recent months to challenge the case for change.
It was therefore agreed by the major trauma project board that the case for change remains valid.

9.1.4 Clinical Advisory Group assessment

The CAG reviewed the relevant information and agreed that the case for change remains valid.

9.1.5 Summary

In Consulting the Capital (the London-wide consultation carried out in 2007/08) respondents gave very strong support to the proposals to change major trauma services. The case for change was accepted. Whilst the case for change was therefore not specifically presented as a question in this consultation, there was strong support for changing the arrangements for delivering care. The project board and the CAG reaffirmed that the case for change remained valid.

For decision

The JCPCT is asked to agree that:

9. the case for change for major trauma is valid.
9.2 Major trauma – model of care

9.2.1 What did we say in *The shape of things to come*?

A limited number of trauma networks in London were proposed. Each network would have:

- a major trauma centre providing immediate treatment to people with the most serious injuries 24 hours a day, seven days a week. After initial treatment, patients would be transferred to local hospitals for ongoing care;
- local trauma centres based at A&E departments to treat people with less severe injuries, and to provide high-quality ongoing treatment and rehabilitation for all patients.

All Londoners would be within 45 minutes’ ambulance journey of a major trauma centre.

9.2.2 Views and issues raised in relation to the model of care

(Please see Appendix 5c for a fuller list of key issues and responses)

| Ipsos MORI analysis and responses to consultation | The proposal to establish trauma networks in London, giving patients direct access to dedicated specialists and treatment, was supported. Respondents generally recognised that patients are more likely to receive better treatment if they are taken immediately to a specialist trauma centre rather than to their nearest hospital. |
| JHOSC | The JHOSC took evidence from a wide range of informed bodies and is “able to support the direction of travel underlying the consultation paper: speedy access to 24/7 specialist care provided from a number of centres across London”. |
| Traditionally under-represented groups | Respondents expressed general support for the proposals, though some expressed concern or raised questions about capacity, funding, and affordability of the proposals. |
| Integrated Impact Assessment (IIA) | The overall assessment is “that the service proposals for major trauma will benefit the population of London by providing them with better access to specialist care. In particular, evidence (both nationally and internationally) has demonstrated that transporting patients to centres staffed by specialist clinicians with expertise in treating particular incidents and equipped with state-of-the-art equipment will improve clinical outcomes and quality of care”. |

9.2.3 Project board’s consideration of views and issues raised

(Please see Appendix 5c for a fuller list of key issues and responses)

The clinical expert panel which advised the major trauma project board agreed that no new evidence had emerged in recent months to challenge the proposed model of care.

It was therefore agreed by the project board that the model of care remains valid.
9.2.4 Clinical Advisory Group assessment

The CAG reviewed the relevant information and agreed that the model of care remains valid.

Affordability and efficient use of resources

The financial assessment of the costs of implementing the proposed new model of care was outlined in the pre-consultation business case. The costs relate to the acute care pathway. Costs for improving prevention of major trauma and improving community-based rehabilitation are outside the scope of this consultation and will be addressed by PCTs.

System impact

- The estimated additional recurrent cost to PCTs of a four-centre configuration is estimated at £13.9m per annum; the comparable costs of a three- and five-centre option are £11.4m and £16.4m respectively;
- the proposed major trauma centres have put forward arguments that the costs are understated. Nevertheless, further dialogue has not resulted in a sufficiently strong case for changing the estimated cost figures presented in the pre-consultation business case (PCBC);
- PCTs are committed to investing in major trauma services.

Cost benefit

- Although no contemporary research on cost/benefit measurement was available, a number of papers indicated that the cost per quality-adjusted life year (QALY)\(^4\) associated with major trauma activity is c£3,000. This is well within the cost-effectiveness threshold used by the National Institute of Clinical Excellence (£20,000-£30,000) and the Department for Transport's 'Value of preventing a fatality' (which is equivalent to a value per QALY of £38,000). This indicates that investing in a major trauma system is cost-effective and that there is a net economic benefit from the recurrent investment proposed.

Commissioning arrangements

- The London Specialised Commissioning Group (LSCG) has developed proposals to commission major trauma services to support the 2010/11 contracting process and ensure the anticipated benefits are delivered;
- LSCG will also consider risk sharing arrangements to balance the activity and costs risk between acute trusts and PCTs;
- transitional arrangements to enable the designated centres to establish the new services will need to be considered.

Impact on providers of services

- Acute trusts are expected to support any capital costs from their capital financing arrangements;
- for those acute trusts losing activity, the overall impact is likely to be minimal;
- acute trusts will be expected to explore all avenues to increase productivity, reduce costs, and maximise opportunities from economies of scale.

\(^4\)A QALY is a measure of disease burden that takes into account both the quantity and the quality of life lived. It is used in assessing the value for money of a medical intervention.
9.2.5 Summary

*Consulting the Capital* 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.”

Whilst consultation respondents were not specifically asked their view on the model of care, responses to the consultation showed strong support for the model.

In its original assessment of the proposals prior to consultation the National Clinical Advisory Team (NCAT) found there “was clear evidence that dedicated major trauma teams with a higher patient throughput save lives compared with smaller units.”

PCTs are committed to investing in major trauma services. The proposed model of care is cost-effective and the total additional cost of the new model of care represents around 0.1% of PCT allocations. (See Appendix 6c).

The project board and the CAG agreed that the proposed model of care is valid.

**For decision**

**The JCPCT is asked to agree that:**

10. the proposed model of care for major trauma is valid.
9.3 Major trauma – number of major trauma centres

9.3.1 What did we say in *The shape of things to come*?

We proposed establishing three or four trauma networks. Three options were presented for establishing trauma networks in London:

- **Option 1 (preferred option)**
  Four trauma networks with major trauma centres at The Royal London Hospital, King’s College Hospital, St George’s Hospital, and St Mary’s Hospital.

- **Option 2**
  Four trauma networks with major trauma centres at The Royal London Hospital, King’s College Hospital, St George’s Hospital, and The Royal Free Hospital (instead of St Mary’s Hospital).

- **Option 3**
  Three trauma networks with major trauma centres at The Royal London Hospital, King’s College Hospital, and St George’s Hospital.

In developing proposals it was concluded that two centres would not be able to cope with the number of major trauma patients and there would be insufficient capacity to cope with a major incident. Five or more centres would risk not treating the required number of patients needed to achieve better outcomes for patients.

Three or four centres would provide each major trauma centre with enough patients to become truly world-class, whilst also being able to cope with the anticipated number of patients, respond to a major incident and effectively manage networked trauma centres across London. A four-centre option was preferred as, on balance, it better satisfied the agreed criteria.

9.3.2 Views and issues raised in relation to the number of trauma centres

(Please see Appendix 5c for a fuller list of key issues and responses)

| Ipsos MORI analysis and responses to consultation | The vast majority (87%) of respondents supported the preferred options that included four major trauma centres (options 1 and 2). Option 3 with three trauma networks was the least popular option with just 2% supporting this option. The fact that either St Mary’s Hospital or The Royal Free Hospital would establish their major trauma centre at a later date to the other three appears not to be a concern for the public or stakeholders who would prefer to establish a major trauma centre in north west London even if that means a delay in the service. Both Barts and the London NHS Trust and King’s Health Partners supported three major trauma centres and associated networks, believing that there is a risk that the total caseload will not be sufficient to support a fourth major trauma centre and that it would add considerable cost with little or no clinical benefit. King’s Health Partners suggested an alternative configuration of three trauma networks, with major trauma centres at St Mary’s, King’s College and The Royal London hospitals. The Royal London and Spinal Injuries Association suggested limiting the development of a London trauma system to three centres by 2010, with |

---
the possibility of expanding to a fourth major trauma centre at a later stage. The London Ambulance Service expressed some concern about the potentially low caseload in each centre created by four major trauma centres. Some organisations emphasised the need for networks to be of a manageable (small) size.

A few stakeholders argued for five trauma networks – proposing all five centres under consideration.

<table>
<thead>
<tr>
<th>JHOSC</th>
<th>The JHOSC argued that:</th>
</tr>
</thead>
<tbody>
<tr>
<td>“Whilst there are arguments that three major trauma centres might be adequate clinically to provide the necessary services for London, we believe that four is the appropriate number. Firstly, this is because the new structure must be able to cope with occasional peaks and secondly, because public perception is important: it would be wrong to create a situation where very large numbers of people felt that they were disadvantaged by not having a major trauma centre in their area.”</td>
<td></td>
</tr>
</tbody>
</table>

| The JHOSC commented that: |
| “On the basis of the evidence we have heard, it would appear that centralisation with experienced clinical staff will improve services for major trauma patients, and that four major trauma centres is the right number to achieve coverage of the capital.” |

| The JHOSC was concerned that a public commitment for the fourth major trauma centre is made so that in the event of any future reductions in funding to the NHS, the fourth centre is not ‘sacrificed’ and that the fourth major trauma centre becomes operational as soon after April 2010 as is feasible. |

| Traditionally under-represented groups | The majority of groups expressed a preference for four networks. Some groups raised concerns about the capacity of the new services to meet demand, especially in a major incident. |

| Impact Assessment | The assessment revealed virtually unanimous agreement for four major trauma centres as opposed to three. |

### 9.3.3 Project board’s consideration of views and issues raised

(Please see Appendix 5c for a fuller list of key issues and responses)

In the view of the major trauma project board, there was no new evidence presented that successfully challenged the original proposal. This was that, overall, four major trauma centres was the best option for Londoners.

Whilst three trauma networks would give higher numbers of patients at each major trauma centre (potentially improving clinical outcomes) four networks would provide greater capacity to cope with the expected numbers of patients and would be easier to manage than three networks. Furthermore, NHS London’s Department of Emergency Preparedness assessed that four trauma networks would best support major incident handling. The major trauma project board recognises that the number of major trauma centres appropriate for London will need to consider economies of scale for workforce. There is a balance to strike between
providing acceptable access for patients to this service whilst ensuring that expected caseload enables the best possible clinical outcomes.

An alternative configuration of three trauma networks (King’s, St Mary’s and The Royal London) could create considerable capacity strain for the two networks established in 2010 and increase travel times until the third major trauma centre was fully ready for operation, resulting in possible inequalities in patient care.

The project board confirmed its view that five major trauma centres would not provide the necessary caseload to deliver good clinical outcomes.

9.3.4 Clinical Advisory Group assessment

The CAG looked at the evidence, views and challenges regarding the possibility of three, four or five major trauma centres, and considered the project board’s assessment

On the consideration of affordability, the CAG expressed the view that a four major trauma centre system would be more cost-effective (in the context of reducing mortality rates and increasing the opportunity for patients to return to full functionality) than the status quo of no centralised trauma care.

The CAG was assured that the project recognised the additional complexity created by the delayed implementation of a fourth major trauma centre and that this aspect was mitigated by the implementation planning and monitoring currently being carried out.

The CAG raised the issue of out-of-London patient flows, which can be expected to be taken to London major trauma centres when the system is operational. The CAG recommended that this potential increase in patient volume be taken into account when assessing the resilience of a potential configuration.

The CAG also discussed relevant matters including the establishment of networks and capacity – paying particular attention to resilience considerations.

The CAG reviewed and accepted the assessment that five major trauma centres would not provide the necessary caseload to deliver good clinical outcomes.

The CAG considered the relevant facts and supported the proposal to designate four major trauma centres for London.

9.3.5 Summary

In its assessment of the original proposals, NCAT found that whilst three major trauma centres might be adequate, there is not sufficient coverage of north west London or adjacent areas. The team concluded that a four-centre option was preferable, and would give better geographical coverage and capacity for all major trauma care in London.

Assessing the benefits of three or four trauma networks against the criteria

1. Sustainable and optimal quality:
   a) both the three- and four-centre options comply with the model of care. The three-centre option would enable higher patient activity at each major trauma centre and therefore might be expected to deliver better clinical outcomes;
   b) there would be more pressure on capacity with a three-centre option
   c) the four centre option provides greater assurance of resilience – particularly in the event of a major incident;
   d) the four centre option would provide greater likelihood of effective network development.
2. Equitable access to specialist services:
a) both options will provide coverage for the whole of London, though four trauma networks would provide slightly better coverage than three trauma networks.

3. Strategic coherence:
All sites offer the opportunity to bring important acute services together.

4. Affordability and efficient use of resources:
The estimated additional recurrent cost to the system of a three-centre configuration is £11.4 million p.a. The estimated additional recurrent cost to the system of four networks is £13.9 million p.a. PCTs are committed to investing resources in major trauma services.

The project board considers that a four-centre option delivers the optimum balance between costs and benefits.

The majority of respondents to the consultation, the project board and the Clinical Advisory Group supported the case for four major trauma centres.

The graphic below summarises the advantages and disadvantages of three or four trauma networks. Whilst the project team has indicated an illustrative position for each indicator, the approach is purely qualitative. The graphic is provided as an aid to review the criteria in the round – rather than a quantitative scale.

Summary of assessment against the JCPCT criteria: three major trauma networks versus four

<table>
<thead>
<tr>
<th>JCPCT criterion</th>
<th>3 MTCs</th>
<th>4 MTCs</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustained and optimal quality of provider services</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Compliance with the agreed models of care</td>
<td></td>
<td>Three MTCs would best comply with the model of care advocating a small number of specialised units to improve clinical outcomes</td>
<td></td>
</tr>
<tr>
<td>Outcomes of the external evaluation</td>
<td></td>
<td>Potential major trauma centres in the North and North West scored lower in the bid evaluation than the other three potential MTCs in Option 3</td>
<td></td>
</tr>
<tr>
<td>Implementation plans</td>
<td></td>
<td>Implementation plans and monitoring against progress are in place for all potential MTCs</td>
<td></td>
</tr>
<tr>
<td>Capacity and resilience</td>
<td></td>
<td>Critical mass is more favourable for a 3-MTC system, but there are significant concerns over resilience. A 4-MTC system would create more manageable capacity in each MTC and increased ability to respond to major incidents.</td>
<td></td>
</tr>
<tr>
<td>Network effectiveness</td>
<td></td>
<td>A 4-MTC system is easier to implement and produces networks of manageable size in relation to the number of trauma centres</td>
<td></td>
</tr>
<tr>
<td>Equitable access to specialist services</td>
<td></td>
<td>100% of major trauma incidents in London would be covered within 45 minutes for both the 3-MTC and 4-MTC options. More patients would have shorter journeys in a 4-MTC system.</td>
<td></td>
</tr>
<tr>
<td>Strategic coherence</td>
<td></td>
<td>Both 3- and 4-MTC configurations would enable the consolidation of specialised services</td>
<td></td>
</tr>
<tr>
<td>Enables colocation of MTC and HASU</td>
<td></td>
<td>All potential MTC sites could be significant providers of specialist acute services</td>
<td></td>
</tr>
<tr>
<td>Ensures MTCs are located on hospital sites which could be significant providers of specialist acute services</td>
<td></td>
<td>The baseline costs for the new model of care are affordable at 0.1% of PCT allocations. The estimated recurrent cost of a 3-MTC configuration is estimated to be £2.5m lower than that of a 4-MTC configuration.</td>
<td></td>
</tr>
</tbody>
</table>
For decision

The JCPCT is asked to agree that:

11. a four-network major trauma system should be designated.

9.4 Major trauma – location of trauma centres

9.4.1 What did we say in The shape of things to come?

St Mary’s Hospital (option 1) was identified as the preferred option over The Royal Free Hospital (option 2) for the fourth major trauma centre.

The St Mary’s Hospital option would enable greater coverage of London by 2010 – more Londoners would have access to an established trauma system. This is because the Royal London Hospital could extend its networked coverage further with this option. It would also mean St Mary’s Hospital would:

- manage a smaller number of trauma centres which are already aligned through existing clinical networks and relationships, easing challenges in delivering services by 2012;
- be better placed to deal with major incidents, as advised by NHS London’s Department for Emergency Preparedness. This is due to transport and road-access issues and its proximity to high-risk areas such as central London and Heathrow.

9.4.2 Views and issues raised in relation to the configuration – location of trauma centres

(Please see Appendix 5c for a fuller list of key issues and responses)

Based on the recommendation for four trauma networks (see section 9.3) only options 1 and 2 are considered below.

<table>
<thead>
<tr>
<th>Ipsos MORI analysis and responses to consultation</th>
<th>Over 50% of respondents supported option 1, with four major trauma centres at The Royal London Hospital, King’s College Hospital, St George’s Hospital and St Mary’s Hospital.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Thirty-six per cent of respondents supported option 2, with four major trauma centres at The Royal London Hospital, King’s College Hospital, St George’s Hospital and The Royal Free Hospital. These responses were concentrated in north London. Nearly nine in ten respondents in Barnet supported this option. The only other areas to favour this option were Enfield (49%) and Haringey (47%). One petition was received in support of option 2.</td>
</tr>
<tr>
<td></td>
<td>When asked why they considered their chosen option would present the best option, the majority of questionnaire responses relate to the accessibility of the hospitals proposed.</td>
</tr>
</tbody>
</table>
Stakeholders representing an area (such as local councils) generally supported the proposal with the hospital nearest to that area.

The Royal Free Hospital argued that it was a better choice than St Mary’s Hospital due to its proximity to the M1, A1, Brent Cross and Hampstead Heath. It argued that it had the infrastructure in place, the majority of key people in post and all requisite services on site.

Barnet Council argued that existing clinical networks and referral arrangements with The Royal Free Hospital would be lost if patients were taken to The Royal London Hospital.

Some stakeholders stated that The Royal London Hospital has the required expertise and capacity to take the leading role in the London trauma system while newly-established major trauma centres develop.

Concerns were raised through letters, emails and phonecalls regarding the coverage of north London.

*It seems obvious that the Royal Free Hospital, the major hospital in the north of London, should be developed to be the centre for major trauma.*

*Female, Barnet resident*

<table>
<thead>
<tr>
<th>JHOSC</th>
<th>The JHOSC intentionally did not comment on the best location of a major trauma centre.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Traditionally under-represented groups</td>
<td>The majority of groups supported option 1. Reasons for preferring option 1 or option 2 were usually about how well the hospitals were spread around London; transport links; the nearness of a hospital to a particular group; and familiarity with; or approval or disapproval of, a particular hospital.</td>
</tr>
<tr>
<td>Integrated Impact Assessment (IIA)</td>
<td>It was considered that the option most likely to result in positive impacts is option 1, based around four major trauma centres at The Royal London, King’s College, St George’s and St Mary’s hospitals. This was supported by the majority of stakeholders and had fewer negative or carbon consequences than options 2 and 3. Access was also better for this option.</td>
</tr>
</tbody>
</table>

### 9.4.3 Project board's consideration of views and issues raised

(Please see Appendix 5c for a fuller list of key issues and responses)

The strongest differentiator between the Royal Free Hospital and St Mary’s Hospital is that the location of the fourth major trauma centre directly impacts on the ability of the new London trauma system to maximise the coverage of the Royal London Hospital. Stakeholders have widely acknowledged that the Royal London Hospital has the required expertise and capacity to take a leading role in the London trauma system while the newly-established major trauma centres develop.

The two possible major trauma centres in the north/north west of London have the biggest development needs and therefore should not be overburdened by covering too large an area if another option can be considered. Similarly, the Royal London Hospital has experience of
developing successful networks, specifically for trauma, and would be best placed to take on responsibility for managing the most trauma centres.

The assessment of the Royal Free and St Mary's hospitals in relation to resilience in the event of a major incident was conducted by NHS London’s Department for Emergency Preparedness and produced a marginal advantage in favour of St Mary’s Hospital.

The view that the Royal Free Hospital currently has all the services up and running was not shared by the evaluation panel, which identified gaps which would need to be filled to meet the designation criteria in full by 2012 (for example on-site maxillofacial services).

The evaluation panel also identified gaps in services that would need to be addressed by St Mary’s Hospital. Whilst it is recognised that the creation of a neurosurgery unit is a challenge for St Mary’s Hospital, the implementation plans provided by Imperial Healthcare NHS Trust demonstrated the ability to meet the designation criteria by 2012.

The project board considered that whilst there was divided opinion on whether St Mary’s Hospital or The Royal Free Hospital should be designated the fourth major trauma centre, there was little evidence presented that the four trauma networks with major trauma centres at The Royal London Hospital, King’s College Hospital, St George’s Hospital and St Mary’s Hospital would not be the best option for London – and this option was supported by the majority of stakeholders responding to the questionnaire.

The project board received a letter from Professor Keith Willett, National Clinical Director for Trauma Care, who stated that:

“In reality, there is little to choose between the citing of the fourth centre at St Mary’s or the Royal Free and, therefore, a pragmatic decision has to be made based on the designation criteria and geographic locations.”

No evidence was presented that any other hospital was a viable alternative to those already under consideration.

9.4.4 Assessment of options against the criteria – factors that determine whether an option should be discounted or which influences the decision on the best option

There are no factors that provide a reason why any option should be discounted.

The following factors have been used to compare the relative merits of:

- option 1, with major trauma centres at The Royal London Hospital, King’s College Hospital, St George’s Hospital and St Mary’s Hospital, and;
- option 2, with major trauma centres at The Royal London Hospital, King’s College Hospital, St George’s Hospital and The Royal Free Hospital.

1. Sustained and optimal quality
   a) Both options comply with the agreed models of care;
   b) External evaluation of proposals: Both options include The Royal London, King’s College and St George’s which all submitted bids that indicated the hospitals could establish major trauma centres that exceeded the required clinical standards by 2010. The Royal Free and St Mary’s submitted bids of exactly the same quality and showed they could meet the required clinical standards by 2012 (up to two years later than the three networks led by King’s College, St George’s and The Royal London hospitals);
c) Implementation: the independent bid evaluation panel judged that The Royal London, King’s College and St George’s hospitals have the capacity and capability to enable delivery in line with the defined specification by April 2010, and St Mary’s or The Royal Free hospitals by April 2012. However both St Mary’s and The Royal Free hospitals have now indicated that they could go live in 2010 – and this is reflected in their implementation plans. The St Mary’s Hospital option would maximise the expertise and capability of The Royal London Hospital to deliver care to the greatest population.

Implementation plans have been prepared for all five potential sites, taking account of a range of issues including equipment, workforce and transitional considerations, and for the London Ambulance Service. These are an assessment of progress against all the criteria for designation. They focus particularly on criteria which were passed on an aspirational basis (i.e. services were not currently in place but would be delivered by the agreed implementation date). Each plan also indentifies risks for implementation, the level of risk and strategies for mitigation.

There are no factors identified in the plans for any of the hospitals which would impact on any decision made by the JCPCT.

The advice from Workforce for London is that there is no evidence either presented in the consultation or emanating from the work of the project teams and Workforce for London that currently which would impact on any decision made by the JCPCT.

No factors have been identified in the proposed IT support systems and infrastructure of the trauma system which would impact on any decision made by the JCPCT;

d) Both options have appropriate capacity to meet anticipated demand. However, the St Mary’s Hospital option has a slight advantage in resilience and in the case of a major incident;

e) Network effectiveness: both options have effective network arrangements in place to support the model of care. The Royal Free Hospital would have a bigger network of trauma centres to manage, and would therefore be more challenging to implement and sustain.

2. Equitable access to services
   a) Both options will ensure that all Londoners have access to a major trauma centre in 45 minutes. The St Mary’s Hospital option would ensure more coverage of London by April 2010 and marginally better overall travel times.

3. Strategic coherence
   a) The Royal London, King’s College and St George’s hospitals are all proposed as hyper-acute stroke units. The St Mary’s option would provide more of a challenge to colocation than the Royal Free Hospital option. Neither The Royal Free nor St Mary’s hospitals are proposed as a hyper-acute stroke unit, though The Royal Free Hospital is an alternative to University College Hospital which is the preferred option for a hyper-acute stroke unit. However, should Charing Cross Hospital be designated a hyper-acute stroke unit, and St Mary’s Hospital be designated as a major trauma centre, a plan would be developed to realise the benefits of future colocation on the St Mary’s site. St Mary’s Hospital and Charing Cross Hospital are both part of Imperial Healthcare NHS Trust;

   b) all centres are proposed to be located on hospital sites which could be significant providers of specialist acute services in the future.
4. Affordability and efficient use of resources
   a) The costs identified represent PCT costs and reflect investment in the model of care. The location of these services has no impact on the cost to PCTs.

Appendix 6 is provided in order to give reassurance to the committee of deliverability of the proposals.

9.4.5 Summary

The majority of respondents to the consultation and the project board support option 1.

The Integrated Impact Assessment considered that option 1 was most likely to result in positive impacts.

The graphic below summarises the advantages and disadvantages of option 1 (with St Mary’s Hospital) and option 2 (with The Royal Free Hospital). Whilst the project team has indicated an illustrative position for each indicator, the approach is purely qualitative. The graphic is provided as an aid to review the criteria in the round – rather than a quantitative scale.

**Summary of assessment against the JCPCT criteria: location of fourth major trauma centre at St Mary’s Hospital or the Royal Free Hospital**

<table>
<thead>
<tr>
<th>JCPCT criterion</th>
<th>4 MTCs incl. St Mary’s</th>
<th>4 MTCs incl. Royal</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustained and optimal quality of provider services</td>
<td></td>
<td></td>
<td>Both configurations would equally comply with the model of care</td>
</tr>
<tr>
<td>Compliance with the agreed models of care</td>
<td></td>
<td></td>
<td>St Mary’s and the Royal Free hospitals obtained the same score in the bid evaluation</td>
</tr>
<tr>
<td>Outcomes of the external evaluation</td>
<td></td>
<td></td>
<td>Implementation plans and monitoring against progress are in place for all potential MTCs</td>
</tr>
<tr>
<td>Implementation plans</td>
<td></td>
<td></td>
<td>The 4th MTC at St Mary’s would have a more manageable number of patients than the Royal Free due to a smaller catchment area and offers moderately increased ability to respond to major incidents</td>
</tr>
<tr>
<td>Capacity and resilience</td>
<td></td>
<td></td>
<td>The 4th MTC at St Mary’s would produce a network of more manageable size in North West London, by allocating the greatest number of TCs to the Royal London</td>
</tr>
<tr>
<td>Network effectiveness</td>
<td></td>
<td></td>
<td>Implementation plans and monitoring against progress are in place for all potential MTCs</td>
</tr>
<tr>
<td>Equitable access to specialist services</td>
<td></td>
<td></td>
<td>100% of major trauma incidents in London would be covered within 45 minutes for both 4-MTC options. Marginally more patients would have shorter journeys with the 4th MTC at St Mary’s.</td>
</tr>
<tr>
<td>Strategic coherence</td>
<td></td>
<td></td>
<td>Both options would enable the consolidation of specialised services. Colocation would be easier to realise for the configuration with the Royal Free as the 4th MTC.</td>
</tr>
<tr>
<td>Enables colocation of MTC and HASU</td>
<td></td>
<td></td>
<td>All potential MTC sites could be significant providers of specialist acute services</td>
</tr>
<tr>
<td>Ensures MTCs are located on hospital sites which could be significant providers of specialist acute services.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Affordability and efficient use of resources</td>
<td></td>
<td></td>
<td>Commissioning costs to PCT are the same for both options</td>
</tr>
</tbody>
</table>
For decision

The JCPCT is asked to agree that:

12. major trauma centres should be commissioned at: The Royal London Hospital, King’s College Hospital, St George’s Hospital and St Mary’s Hospital.
10 Stroke

10.1 Stroke – the case for change

10.1.1 What did we say in *The shape of things to come*?

In London, stroke is the second-highest cause of death and the most common cause of adult disability. More than 11,000 people having a stroke are admitted to London hospitals each year – one person every hour – and one in six people dies.

The UK has the highest proportion of deaths due to stroke compared with Australia, Germany, Sweden and the US – and almost double the deaths occurring in France. Clinical evidence shows that patients are 25% more likely to survive or recover from a stroke if they are treated in a specialist centre.

In London there are big differences in the quality of stroke care. Rates of death in different hospitals vary considerably – and people in outer London have the most limited access to high-quality stroke services.

10.1.2 Views and challenges to the case for change

(Please see Appendix 5d for a fuller list of key issues and responses)

| Ipsos MORI analysis and responses to consultation | Respondents were not asked their view on the case for change. However, the case for change was not challenged by respondents. Key stakeholder organisations generally supported the focus on specialist stroke care. |
|--------------------------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------- | |
| JHOSC                                             | The JHOSC welcomed the greater emphasis on stroke, stating that: “if the implementation of the proposed changes is managed well, and continued funding allows high-quality standards to be achieved and maintained, we would expect to see an end to the ‘postcode lottery’ of healthcare in relation to stroke and major trauma services in London that has existed for far too long.” |
| Traditionally under-represented groups            | Respondents were not asked their view on the case for change. However, the case for change was not challenged by respondents. |
| Integrated Impact Assessment (IIA)                | The IIA concludes that the clinical case for change is strong and that stroke proposals will improve clinical outcomes, standards and equality of care. |
10.1.3 Project board’s consideration of views and issues raised

(Please see Appendix 5d for a fuller list of key issues and responses)

Despite the general improvements in stroke services between the Sentinel Audits of 2006 and 2008 the capital is still failing to provide high-quality specialist care for all stroke patients. The need to improve stroke services in London was explicitly accepted by many respondents to the consultation and the stroke project board has not seen evidence of a substantial challenge.

The clinical expert panel which advised the stroke project board agreed that no new evidence had emerged in recent months to affect the case for change.

It was therefore agreed that the case for change remains valid.

10.1.4 Clinical Advisory Group assessment

The CAG reviewed the relevant information. The CAG considered that no new evidence had emerged in recent months to affect the case for change and agreed that the model of care remains valid.

10.1.5 Summary

In Consulting the Capital (the London-wide consultation carried out in 2007/08) respondents gave very strong support to the proposals to change stroke services. The case for change was accepted. Whilst the case for change was therefore not specifically presented as a question in this consultation, there was strong support for changing the delivery arrangements.

The project board and the CAG reaffirmed that the case for change remained valid.

For decision

The JCPCT is asked to agree that:

13. the case for change for stroke is valid.
10.2 Stroke – model of care

10.2.1 What did we say in The shape of things to come?

Three new stroke services were proposed:

- Hyper-acute stroke units will provide the immediate response to a stroke for the first 72 hours, or until a patient is stabilised. The units will be open 24 hours a day, seven days a week (24/7). Anyone having a stroke in London will be taken to one of eight units to have a brain scan and, if appropriate, receive clot-busting drugs within 30 minutes of arriving at the hospital;
- more than 20 stroke units will provide ongoing care once a patient is stabilised, including multi-therapy rehabilitation. This care may be provided in the same hospital as the hyper-acute unit, or in a hospital nearer to a patient’s home;
- transient ischaemic attack (TIA or mini-stroke) services will provide rapid assessment and access to a specialist – within 24 hours for high-risk patients, or within seven days for low-risk patients.

All Londoners would live within 30 minutes’ ambulance drive of world-class specialist stroke services. People should be assessed, diagnosed and treated within 30 minutes of arriving at hospital. This gives Londoners the best chance of receiving clot-busting treatment (if appropriate) within the ideal window of opportunity: the first three hours after having a stroke.

10.2.2 Views and issues in relation to the model of care

(Please see Appendix 5d for a fuller list of key issues and responses)

<table>
<thead>
<tr>
<th>Ipsos MORI analysis and responses to consultation</th>
<th>Over 70% of respondents agreed with how stroke care could be provided in the future. Key stakeholders also supported the model of care.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>A few stakeholders expressed concerns that the evidence-base for stroke care proposals was not as compelling as that for major trauma.</td>
</tr>
<tr>
<td></td>
<td>A review of alternative models of care was suggested, including the hub and spoke model (whereby all centres offer thrombolysis during working hours but only the hub does so out-of-hours and at weekends) and greater use of telemedicine.</td>
</tr>
<tr>
<td></td>
<td>The BMA argued that thrombolysis should be provided in every district general hospital and some respondents questioned whether patients who may not benefit from thrombolysis should go to a hyper-acute stroke unit.</td>
</tr>
<tr>
<td></td>
<td>Homerton University Hospital NHS Foundation Trust referred to: \“.. a trade-off between treating the 15% who might benefit and disadvantaging the 85% who will be treated further from home than they otherwise would\” \“.</td>
</tr>
<tr>
<td>JHOSC</td>
<td>The JHOSC took evidence from a wide range of informed bodies and is: \“able to support the direction of travel underlying the consultation paper: speedy access to 24/7 specialist care provided from a number</td>
</tr>
</tbody>
</table>
The JHOSC heard conflicting views about the role of telemedicine but stated that it would have expected the proposals to have referred to the development and potential of this form of treatment.

In addition the JHOSC wrote that:

“The evidence we have heard over several months has demonstrated clearly that the proposed model is superior to the combined day-time/out-of-hours model of delivering specialist care which the previous Healthcare for London JHOSC favoured on the basis of information available at the time.”

The JHOSC advised that there should be a maximum referral time target of 24 hours from identifying a TIA to access to a specialist.

<table>
<thead>
<tr>
<th>Traditionally under-represented groups</th>
<th>Respondents expressed general support for the proposals, though some expressed concern or raised questions about capacity, funding and affordability of the proposals.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Integrated Impact Assessment (IIA)</td>
<td>The IIA stated that evidence, both nationally and internationally, has demonstrated that transporting patients to centres staffed by specialist clinicians with expertise in treating strokes and equipped with state of the art equipment would improve clinical outcomes and quality of care”.</td>
</tr>
</tbody>
</table>

10.2.3 Project board’s consideration of views and issues raised

(Please see Appendix 5d for a fuller list of key issues and responses)

There is evidence that higher rates of thrombolysis are achieved when patients are taken to a 24/7 specialist centre rather than units providing only a partial service, or a service without 24/7 coverage by stroke experts.

Some respondents queried whether it was right that all patients be transported to a HASU if only a small percentage (those suitable for thrombolysis) would benefit. Clinical advisers to the project board have advised that hyper-acute stroke units will benefit all patients, not just those receiving thrombolysis. Hyper-acute stroke units will provide all stroke patients with emergency assessment from specialists in acute stroke, brain-imaging, and a high-dependency unit environment of physiological monitoring with active intervention that aims to stop worsening brain damage.

HASUs will provide rapid specialist assessment, access to a CT scan within 30 minutes of arrival, 24/7 monitoring in a high-dependency bed, and a multi-disciplinary specialist team on call 24 hours a day. HASUs will provide stroke patients with immediate admission into a specialist care bed. The continuous physiological monitoring (of blood pressure, heart rate, oxygenation, blood glucose) that will be carried out under this model is essential. Monitoring will be supported around the clock by expertise in interpretation and assessment of the stroke mechanism. Expert nursing, available 24/7, is necessary to monitor and react to the physiological changes that can result in worsening brain damage.

In addition, as with heart attacks, thrombolysis is likely to be the first step in the development of more effective, specialist treatment for stroke. In future, it is likely that care will be more interventional – such as the use of intra-arterial thrombolysis and stents. These, and other
developments, will need to be supported by more sophisticated approaches. This will not be possible at every hospital with an A&E department. Clinical advisors feel that in this regard the proposed model has some ‘future-proofing’.

The use of telemedicine was proposed by some respondents in order to offer facilities at more hospitals and therefore provide care for patients (either self-presenting or misdiagnosed) who have had a stroke and arrive at a hospital not designated as a HASU. However clinicians have advised that face-to-face care from a clinical expert represents best practice. In London, the density of population and hospital facilities would allow all patients to receive prompt face-to-face care from stroke specialists in a dedicated hyper-acute stroke unit. The stroke clinical expert panel considered that telemedicine could have a role as an adjunct to the hyper-acute model, and Healthcare for London will look at ways of building on the expertise that providers, particularly St. Thomas’ Hospital, have built up in this area.

The board considered the response from an independent review, which was commissioned to look at the issues raised during consultation and the project board’s draft commentary. The review team, made up of Professor Roger Boyle, National Director for Heart Disease and Stroke; Dr Damian Jenkinson, National Clinical Lead for Stroke Improvement; and Professor Gary Ford, Director of the UK Stroke Research Network concluded that:

“We are reassured by the overwhelming response in favour of redesigning how the hyperacute services are arranged in London.

In general, we are happy that the case for change remains valid and that the proposed model is right both in terms of overall numbers of HASUs and acute stroke units for a city the size of London and the incidence of stroke currently.”

There was no evidence presented that the proposed model of care would not provide the best stroke care for Londoners.

10.2.4 Clinical Advisory Group assessment

The CAG reviewed the issues raised by the consultation, the proposed responses of the project board and other relevant information.

The project board advised the CAG that there is evidence that higher rates of thrombolysis are achieved when patients are taken to a 24/7 specialist unit. The conclusion of the south west London pilot of a hub and spoke model for thrombolysis confirmed this. The CAG agreed with this view.

The CAG agreed with the view that, whilst the use of telemedicine has been beneficial in more dispersed populations, face-to-face timely care from a clinical expert represents best practice.

The project board advised CAG that the proposed model of centralising specialist stroke care will deliver the best clinical outcomes for patients in London in future. The CAG agreed with this view but noted the importance of emphasising the particular context in London that made this the desired model rather than those operating in other areas.

On the challenge of whether all patients will benefit from hyper-acute stroke care, the CAG considered an article published in the British Medical Journal5 questioning the current emphasis on hyper-acute stroke care to improve access to thrombolysis. The project board informed the CAG that the article assumed that the benefits of hyper-acute stroke care are limited to the delivery of thrombolysis. The project board emphasised that all patients will

benefit from emergency assessment by specialists in acute stroke, and physiological monitoring with active intervention in a high-dependency unit. The CAG agreed with this view.

The CAG agreed that the proposed model of care for stroke remains valid.

10.2.5 Affordability and efficient use of resources

The financial assessment of the costs of implementing the proposed new model of care was outlined in the pre-consultation business case. The costs relate to the acute care pathway. Costs for improving the prevention of strokes and improving community based rehabilitation are outside the scope of this consultation and will be addressed by PCTs.

System impact

- The additional recurrent cost is estimated at £23.5m per annum to deliver the acute stroke care pathway of which £20.4m is for acute hospitals (£10.4m for HASUs and £10m for stroke units and £3.1m for other system costs). PCTs are committed to providing the additional funds;
- provider implementation plans indicate that the phasing of the estimated cost to PCTs is (2009/10: £4m; 2010/11 £19.5m; 2011/12: 20.4m);
- PCTs have committed to investing in acute stroke services. Plans for 2009/10 and service plans for 2010/11 will reflect these additional costs;
- reduced admissions (and therefore consequent costs) should be possible in the future as a result of prevention strategies and improved TIA services.

Cost benefit

- Cost-effectiveness measures used in the National Stroke Strategy (NSS) indicate that the NSS proposals delivered value for money. The cost of the proposal is consistent with costs calculated in the National Stroke Strategy;
- the NSS calculated a cost per quality-adjusted life year (QALY) of £2,500. This is well within the cost-effectiveness threshold used by the National Institute of Clinical Excellence (£20,000-£30,000) and the Department for Transport’s ‘Value of preventing a fatality’ (which is equivalent to a value per QALY of £38,000).

Commissioning arrangements

- PCTs retain ultimate responsibility for commissioning stroke services though the commissioning arrangements which will be delegated to sector acute commissioning units (SACUs)
- a tariff approach has been devised to reflect the new model of care. This involved splitting the existing tariff into two elements: a tariff for the HASU component based on bed-days and a tariff for the SU element based on spells;
- it was noted that the Department of Health is considering basing the national stroke tariffs on a ‘best practice’ approach. As such, the ‘London’ tariff approach would become convergent with the national tariff and is likely to be short-term. In addition, future stroke tariffs will be subject to the same requirements to drive up productivity as those that apply to any other service;
- transitional tariff arrangements have been developed to support the phased implementation of the proposal.
Impact on provider of services

- The maximum income loss for acute trusts no longer providing stroke services is approximately two per cent (of overall income). The maximum income gains for those acute trusts taking on additional service are approximately 1.5 per cent (of overall income);
- acute trusts are expected to support the capital costs from their capital financing arrangements;
- acute trusts will be expected to explore all avenues to increase productivity, reduce costs, and maximise opportunities from economies of scale.

In conclusion, there is a clear health benefit case to proceed. The costs initially calculated by the project are still considered to be reasonable and are in line with those presented in the NSS. The tariff and contracting mechanism that has been constructed will support the new system.

10.2.6 Summary

A new model of care for stroke was described in Consulting the Capital (the London-wide consultation carried out in 2007/08). The JCPCT agreed:

“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 proving urgent care during the day). The number and location of these hospitals should be subject to a further consultation by PCTs.”

In its assessment, NCAT stated that the proposals:

"if implemented appropriately and adequately resourced, will undoubtedly greatly improve stroke care for the people of London.”

The proposals are in line with those set out in the National Stroke Strategy, published by the Department for Health in 2007.

Alternative models of care such as a hub and spoke model (perhaps supported by telemedicine) or different pathways for patients who might not benefit from thrombolysis, have been considered by the project board, by the Clinical Advisory Group and by an independent panel. Having weighed the merits of these alternatives, their consistent advice is that the proposed model of care is the best solution for London.

Analysis indicates that the proposed model of care is affordable, cost-effective and offers a net economic benefit. (See Appendix 7c). The additional recurrent cost is estimated at £23.5m per annum to deliver the acute stroke care pathway, and PCTs are committed to providing the additional funding.

The refined model of care proposed in The shape of things to come has received considerable support and has been endorsed by the project board, the CAG and authoritative external clinical advisors.

For decision

The JCPCT is asked to agree that:

14. the model of care for stroke is valid.
10.3 Number of hyper-acute stroke units

10.3.1 What did we say in *The shape of things to come?*

Hyper-acute stroke care should be delivered in no more than eight sites across London. This would optimise the number of patients being treated at each site, ensure expert teams are available 24 hours a day – improving survival and reducing disability – and mean all Londoners would be within a 30-minute blue light ambulance drive of a hyper-acute stroke unit.

Fewer than eight hyper-acute stroke units would not be able to meet the specified requirements in terms of capacity and travel times.

10.3.2 Views and issues raised in relation to the number of hyper-acute stroke units

(Please see Appendix 5d for a fuller list of key issues and responses)

<table>
<thead>
<tr>
<th>Ipsos MORI analysis and responses to consultation</th>
<th>Seventy-one per cent of respondents (individuals and organisations) agreed that eight hyper-acute stroke units would provide the best urgent care for stroke patients in London.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Whilst some organisations expressed concern whether eight units would provide effective coverage of London, key stakeholders (including London Councils and the London Ambulance Service) agreed with the proposal for eight hyper-acute stroke units. The Stroke Association, whilst agreeing that eight hyper-acute stroke units was the minimum required, recommended keeping the number of units under review in case more were needed in the future.</td>
</tr>
<tr>
<td></td>
<td>A number of respondents argued that there should be many more hyper-acute units, with all centres with a stroke unit having the ability to manage the acute part of treatment.</td>
</tr>
<tr>
<td></td>
<td>During consultation meetings, the number of HASUs was the subject of much debate. Some argued there should be more than eight units, while others supported the idea of eight.</td>
</tr>
<tr>
<td>JHOSC</td>
<td>The JHOSC found no definitive evidence that an immediate minimum of eight HASUs is:</td>
</tr>
<tr>
<td></td>
<td>“not of the right order to address anticipated numbers.”</td>
</tr>
<tr>
<td></td>
<td>It recommended the eight HASUs should be seen as the minimum number and that the JCPCT regularly reviews this number and increases the number if demand justifies it.</td>
</tr>
<tr>
<td>Traditionally under-represented groups</td>
<td>Most groups consulted supported the proposed number of HASUs.</td>
</tr>
<tr>
<td>Integrated Impact Assessment (IIA)</td>
<td>The assessment did not challenge the capacity planning data underpinning the proposals. Although the team had some concerns about capacity modelling, it was reassured that the number of HASUs was taken into account in the drafting of the stroke service proposals.</td>
</tr>
</tbody>
</table>
The IIA team is of the view that the proposals are expected to improve access, and hence outcomes, for patients from deprived areas and equality groups in comparison to current services, and that eight HASUs appears to be the right number to deliver these outcomes.

10.3.3 Project board’s consideration of views and issues

(Please see Appendix 5d for a fuller list of key issues and responses)

A number of factors were taken into account when determining the optimal number and location of hyper-acute stroke units and stroke units:

1) capacity of hospitals – the units need to provide the right number of specialist beds in the right locations. London needs about 130 hyper-acute unit beds and 550 stroke unit beds. This is based on an analysis of the number of patients expected to attend London hospitals with a suspected stroke.

2) units need to be provided in the right places to ensure all Londoners can get to the right care within 30 minutes’ blue light ambulance journey;

3) teams providing complex care to greater numbers of patients have better outcomes; therefore, fewer, larger units are likely to provide better care for stroke patients.

Consulting the Capital concluded that, where necessary, services should be centralised. The Healthcare for London project team therefore developed a proposal in which high-quality care could be delivered with as few HASUs as possible. This proposal is in line with this broad consensus view of the delivery of specialist services.

The project board believes that fewer than eight hyper-acute units would not achieve the 30-minute access standard. However, more than eight units would reduce the number of patients seen at each unit, and so reduce the benefits of centralising specialised care. The difficulties of meeting the standards set for a HASU at a greater number of units would also incur increased costs. An additional HASU, over and above the eight proposed, would not add sufficient value in terms of travel times and increased quality to be optimal.

A small number of units is crucial, not just to give a critical mass of patients, but to ensure a critical mass of expertise, staff and equipment. The delivery of high-quality hyper-acute care is dependent upon the availability of highly-skilled staff 24 hours a day. In principle, units with smaller numbers of patients could provide the same levels of specialist staffing and equipment, but would face challenges in maintaining staff skills and expertise. Across London there would also be an increased challenge in recruiting sufficient medical staff (each HASU needs to be supported by at least six consultants working to provide 24/7 cover as well as a full on-site team including stroke-experienced middle-grade doctors) in meeting the very exacting standards set for a HASU (including 24/7 urgent availability of sophisticated imaging and interpretation) and in affordability for providers (since many costs would be fixed).

Some respondents have argued that an increased number of units would reduce journey times and therefore benefit patients receiving thrombolysis. Introducing more units would not make a dramatic difference to travel times. The advantages achieved by marginally shortening journey times will be outweighed by the increased rates of thrombolysis and the shorter door-to-needle times likely to be achieved in a model based on a small number of specialist centres. In addition, as discussed above, the benefits of adequately staffed hyper-acute care could not practically be achieved in a large number of units, and shorter journey times would therefore not be an advantage.
The project board is confident that the configuration described can achieve access to hyper-acute care for all Londoners within 30 minutes by blue light ambulance.

As stated previously, the project board received the view from the independent review (the review team made up of Professor Roger Boyle, National Director for Heart Disease and Stroke; Dr Damian Jenkinson, National Clinical Lead for Stroke Improvement; and Professor Gary Ford, Director of the UK Stroke Research Network) that:

\textit{In general, we are happy that the case for change remains valid and that the proposed model is right both in terms of overall numbers of HASUs and acute stroke units for a city the size of London and the incidence of stroke currently.}

The clinical expert panel agreed that the factor of fundamental importance was that all Londoners will be within 30 minutes of a HASU.

The project board concluded that there was no evidence presented that demonstrated that eight hyper-acute stroke units would not be the best option for Londoners.

10.3.4 Clinical Advisory Group assessment

The CAG looked at the evidence, views, and challenges, and considered the project board’s response.

The CAG agreed that eight hyper-acute stroke units would provide the best urgent care for stroke patients in London. The CAG noted the challenges that could be expected in staffing a higher number of HASUs than those in the preferred option.

10.3.5 Assessment of proposal against the criteria – factors that determine whether an option should be discounted or which influence the decision on the best option

No factors have arisen during consultation that show eight HASUs are not the right number of HASUs.

Using the criteria developed, the merits of eight hyper-acute stroke units are assessed below:

1. Sustainable and optimal quality: eight HASUs would provide better clinical outcomes and have the capacity to accommodate all stroke patients. More than eight units would reduce the number of patients seen at each unit, reducing the benefits of providing specialised care, and would be more challenging to equip and staff;

2. Equitable access to specialist services: a number of combinations of eight HASUs could provide enough units to ensure that everyone could access specialist stroke care within 30 minutes. Less than eight units would be unable to provide the required capacity. More than eight HASUs would only marginally improve travel times for some of the population of London. The advantages associated with a relatively small reduction in travel times would be outweighed by the risks associated with the dilution in specialist capability which would occur as the number of HASUs increased.

3. Strategic coherence: the establishment of eight HASUs is entirely consistent with the overall strategic direction – to develop a limited number of major acute hospitals providing excellent specialist acute care. All sites offer the opportunity to bring important acute services together.

4. Affordability and efficient use of resources; PCTs are committed to investing funds to improve stroke services. Eight HASUs are affordable within existing resources.
of the proposal is consistent with costs calculated in the National Stroke Strategy. Cost-effectiveness measures used in the National Stroke Strategy (NSS) indicate that the NSS proposals delivered value for money. A new tariff has been calculated to support the new model of care (see Appendix 7d). In the short term, the cost per case for commissioners is not affected by the number of HASUs. However, it is expected that providers will achieve economies of scale in a system with a higher number of beds in each location and therefore a lower number of HASUs in total.

10.3.6 Summary

There were a few responses proposing fewer than eight HASUs.

Some respondents and key stakeholders suggested many more HASUs, but a greater proportion proposed that eight was a minimum and that more should be considered either now or at a later date.

The majority of responses to the consultation, the project board, the Clinical Advisory Group and the independent review all affirmed support for eight HASUs.

It is, of course, entirely appropriate that the number of HASUs is kept under review and the JCPCT should note the recommendations (Appendix 8a) and Evaluation Assurance Plan (Appendix 8b) which suggest regular monitoring of HASUs with a view to quickly addressing any issues that might arise.

A qualitative illustration of the advantages and disadvantages of eight HASUs against more than eight is shown graphically below. The graphic is provided as an aid to review the criteria in the round – rather than indicating a quantitative scale.

<table>
<thead>
<tr>
<th>JCPCT criterion</th>
<th>8 HASUs</th>
<th>More than 8 HASUs</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sustained and optimal quality of provider services</td>
<td><img src="image" alt="Graph" /></td>
<td>More than 8 HASUs have less critical mass and would be harder to staff with specialist staff</td>
<td>More than 8 HASUs have less critical mass and would be harder to staff with specialist staff</td>
</tr>
<tr>
<td>Equitable access to specialist services</td>
<td><img src="image" alt="Graph" /></td>
<td>A greater number of HASUs would have a small benefit in travel times for some Londoners</td>
<td>A greater number of HASUs would have a small benefit in travel times for some Londoners</td>
</tr>
<tr>
<td>Strategic coherence</td>
<td><img src="image" alt="Graph" /></td>
<td>The more hospitals that provide HASU services, the less likely they are to match the strategic coherence criteria</td>
<td>The more hospitals that provide HASU services, the less likely they are to match the strategic coherence criteria</td>
</tr>
<tr>
<td>Affordability and efficient use of resources</td>
<td><img src="image" alt="Graph" /></td>
<td>In the short-term, the cost per case for commissioners is not affected by the number of HASUs. However, it is expected that economies of scale will be achieved in a system with a higher number of beds in each location and therefore a lower number of HASUs in total</td>
<td>In the short-term, the cost per case for commissioners is not affected by the number of HASUs. However, it is expected that economies of scale will be achieved in a system with a higher number of beds in each location and therefore a lower number of HASUs in total</td>
</tr>
</tbody>
</table>

For decision

The JCPCT is asked to agree:

15. to commission eight hyper-acute stroke units in London.
10.4 Hyper-acute stroke units – location

10.4.1 What did we say in The shape of things to come?

We recommended the creation of eight new hyper-acute stroke units at:

1. Charing Cross Hospital, Hammersmith
2. King’s College Hospital, Denmark Hill
3. Northwick Park Hospital, Harrow
4. Queen’s Hospital, Romford
5. St George’s Hospital, Tooting
6. The Princess Royal University Hospital, Orpington
7. The Royal London Hospital, Whitechapel
8. University College Hospital, London

Several other hospitals showed they could also meet future standards for hyper-acute stroke units and were put forward as alternatives to the preferred configuration.

The Royal London Hospital OR St Thomas’ Hospital
Charing Cross Hospital OR Chelsea and Westminster Hospital
King’s College Hospital OR St Thomas’ Hospital
Northwick Park Hospital OR Barnet Hospital
St George’s Hospital OR Mayday University Hospital
University College Hospital OR The Royal Free Hospital

The advantages and disadvantages of the preferred site and the ‘paired’ alternative site were weighed against three criteria and set out in the consultation document:

The Royal London Hospital or St Thomas’ Hospital
St Thomas’ Hospital showed it could meet future standards and could provide services to people in north east London. The Royal London Hospital would need more support in meeting future standards for stroke care – however, its location gives better journey times for stroke, and it is proposed as a major trauma centre with neurosurgery services. The Royal London Hospital is the preferred site for the hyper-acute stroke unit.

Charing Cross Hospital or Chelsea and Westminster Hospital
Both hospitals showed they could equally meet future standards. However, Charing Cross Hospital is the preferred site for the hyper-acute stroke unit as it would be colocated with neurosciences facilities and gives better travel times.

Should Charing Cross Hospital be designated as a hyper-acute stroke unit and St Mary’s Hospital be designated as a major trauma centre, a plan would be developed to realise the benefits of future colocation on the St Mary’s site. This would be the responsibility of the relevant commissioners and Imperial Healthcare NHS Trust which runs both St Mary’s and Charing Cross hospitals. Clinical standards of these services would need to be at least the same, if not higher, than the current proposed configuration. All planning and associated decision-making processes would be informed by appropriate stakeholder engagement.

King’s College Hospital or St Thomas’ Hospital
Both hospitals currently provide first-class stroke care and showed they could equally meet future standards. King’s College Hospital is the preferred site for the hyper-acute stroke unit as it provides better access for the population of south east London. In addition, King’s
College Hospital offers greater alignment with the strategic criteria and has on-site neurosciences facilities. We strongly expect that King’s College Hospital and St Thomas’ Hospital will work closely together in shaping and delivering stroke services for the population they serve. This is particularly the case in light of their developing partnership as an emerging Academic Health Science Centre.

**Northwick Park Hospital or Barnet Hospital**
Both hospitals showed they could equally meet future standards. Northwick Park Hospital provides better travel times and its location better reflects existing patient flows. Northwick Park Hospital is the preferred site for the hyper-acute stroke unit.

**St George’s Hospital or Mayday University Hospital**
St George’s Hospital scored higher on ability to meet future standards than Mayday University Hospital. There is no overall advantage in travel times between the hospitals. St George’s Hospital is proposed to be the site for a major trauma centre with neurosciences facilities. It is therefore the preferred site for the hyper-acute stroke unit.

**University College Hospital or The Royal Free Hospital**
University College Hospital scored higher on ability to meet future standards than The Royal Free Hospital. While The Royal Free Hospital would give better travel times, University College Hospital is our preferred site for the hyper-acute stroke unit. We strongly expect University College Hospital and The Royal Free Hospital will work closely together in support of the hyper-acute stroke unit, reflecting their proposed partnership agreement as an Academic Health Science Centre. The Royal Free Hospital is a potential major trauma centre. The JCPCT will take account of the benefits of colocation in determining its decision.

In reviewing the options for the population of north London, we also considered Barnet Hospital. Both University College Hospital and The Royal Free Hospital scored higher on ability to meet future standards than Barnet Hospital. Though Barnet Hospital has a slight advantage on travel times, it is not our preferred site.

**10.4.2 Views and issues relating to the location of hyper-acute stroke units**

(Please see Appendix 5d for a fuller list of key issues and responses)

| Ipsos MORI analysis and responses to consultation | Sixty-one per cent of respondents were in favour of the proposed configuration of hyper-acute stroke units. Of those respondents who disagreed (either with the number of HASUs or the proposed configuration) 44% proposed The Royal Free Hospital and 36% Barnet Hospital. *(N.B. more than one response was allowed.)* Other alternative sites (St Thomas’, Chelsea and Westminster, and Mayday University hospitals) were each mentioned by four per cent or fewer respondents to this question. Many key stakeholders were supportive of the recommendations. Some stakeholders (and particularly those representing residents in Barnet and Enfield) expressed concern that there was inadequate coverage of outer London boroughs, given the high incidence of stroke in these areas. In responding to the questionnaire, of those that disagreed with the proposed configuration or number of HASUs, the need for better coverage in North London was mentioned by 19% of respondents. |

---

62
People writing letters, emails or telephoning most frequently expressed support for the Royal Free Hospital (29% of all comments received) followed by support for Barnet Hospital (21% of all comments received.)

Six petitions were received supporting HASUs at Mayday, The Royal Free and Barnet hospitals, respectively.

<table>
<thead>
<tr>
<th>JHOSC</th>
<th>The JHOSC intentionally did not comment on the location of HASUs.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under-represented groups</td>
<td>Most groups that expressed a preference supported the configuration of HASUs. Some suggestions for alternative locations were made.</td>
</tr>
</tbody>
</table>
| Integrated Impact Assessment (IIA) | The IIA found that the proposed HASUs were well located to serve the majority of elderly, BAME populations and high-deprivation communities.  
| | The IIA also considered that having a HASU that services a certain geographic area is more important than its exact location within that area.  
| | The IIA assessed public transport access to HASUs and in each case concluded that the preferred option offered better access that the alternative. |

10.4.3 Project board’s consideration of views and issues raised

(Please see Appendix 5d for a fuller list of key issues and responses)

The project board advises the JCPCT that the preferred configuration would ensure that everyone could access specialist stroke care within 30 minutes by ambulance.

Although concern has been expressed that too many HASUs are proposed for central London the proposed hyper-acute stroke services at Princess Royal University Hospital, Queen’s Hospital, Northwick Park Hospital and St George’s Hospital will ensure equitable coverage for outer London.

The clinical expert panel agreed that access to a HASU for all Londoners within 30 minutes by blue light ambulance is essential.

Concern was expressed about more difficult journeys for visitors. The project board noted that the review of the south west London network pilot gave reassurance in that:

- patients and carers did not seem concerned about where patients received treatment, only that it was the best treatment available;
- the additional travel caused by patients' admission to the hub hospital did not appear to have caused problems for families and friends.
The project board looked at views expressed in consultation about the proposed location of HASUs.

**Whipps Cross Hospital**
Whipps Cross Hospital was not offered as an alternative to the preferred option. Whipps Cross Hospital submitted a bid to provide HASU services, but did not meet the bid assessment requirement. In the absence of any bids from north east London providers meeting the bid criteria, Queen’s Hospital and the Royal London Hospital were identified as the most appropriate locations for HASUs. These providers were chosen to meet the population need for stroke services across north east London, optimise access to services, and meet the strategic coherence requirements.

Although local MPs suggested that Whipps Cross should be considered as a HASU, very few consultation respondents raised this issue.

**St Thomas’ Hospital**
St Thomas’ Hospital was described in the consultation document as an alternative to both Royal London and King’s College hospitals.

Approximately four per cent of respondents who disagreed with the preferred option expressed support for St Thomas’ Hospital, generally promoting St Thomas’ Hospital as an additional HASU rather than arguing it offered benefits relative to the Royal London or King’s College hospitals. All drew attention to the quality of the stroke service currently provided at St Thomas’ Hospital.

While the bid for St Thomas’ Hospital was of high-quality, the project board recommends eight hyper-acute stroke units as the best option for Londoners (for the rationale for a HASU configuration comprising eight hospitals (see 10.3 above). In this context only one of the hospitals of each paired alternative described in the consultation is required to meet capacity requirements and to enable access for all Londoners within 30 minutes blue light ambulance (King’s College Hospital or St Thomas’ Hospital; the Royal London Hospital or St Thomas’s Hospital). The project board did not consider that compelling evidence had been submitted suggesting that St Thomas’ Hospital should be an additional HASU or preferred as a HASU to the Royal London Hospital or King’s College Hospital.

The project board recommends that if the preferred option is adopted services be provided at St Thomas’ Hospital while other units develop. St Thomas’ Hospital would have a vital role in providing transitional support for south east London. This is in line with the proposals for transition set out in section 11.

The opportunities for collaboration within the Academic Health Science Centre (Kings Health Partners) were also advocated and are supported.
Charing Cross
There was strong support for a hyper-acute stroke unit at Charing Cross Hospital. However, concerns were expressed about a future movement of the services to St Mary’s Hospital. St Mary’s did not bid to provide HASU services. The preferred option is for a HASU at Charing Cross Hospital. However, the development of plans to realise the benefits associated with a colocation with major trauma services at St Mary’s Hospital are envisaged. Such planning processes would necessarily be detailed and would require appropriate local engagement and public consultation.

Barnet Hospital
A considerable number of respondents from Barnet and other parts of north central London expressed concern about the proposals. Thirty six per cent of respondents who disagreed with the preferred option of a HASU at Northwick Park Hospital proposed Barnet Hospital as an alternative. Around 19% suggested that north London needed better coverage. Many argued that a hyper-acute stroke unit needed to be located locally to meet the needs of the local population. However, the approach and the model of care are driven by the provision of timely access to high-quality care for all Londoners. The location of HASUs therefore needs to be determined on a pan-London basis.

There was also a perception amongst respondents that the proposed HASUs are too distant from the home of many residents of Barnet and Enfield. However analysis continues to indicate all residents of London, including those in north London will be able to access a hyper-acute stroke unit within 30 minutes’ blue light ambulance travel time with the preferred option.

The methodology utilised to determine travel times was also challenged. An alternative modelling approach was proposed by Barnet and Chase Farm hospitals. The project board carefully considered this and the further analyses of travel times for residents of north London undertaken by the project team. The project board is confident that the adopted approach is robust and that, if the preferred hospitals are chosen to provide HASU services, all Enfield and Barnet residents will have access to a unit within 30 minutes blue light ambulance. The project board is reassured by the support offered by the London Ambulance Service, Transport for London and a range of other stakeholders.

Mayday University Hospital
The challenge from residents and stakeholders centred around the belief that Mayday University Hospital should provide a HASU as well as St George’s Hospital in order to provide extra capacity and reduce travel times. Around two per cent of respondents who disagreed with the preferred option supported a HASU at Mayday University Hospital; and over 1,000 people signed petitions to retain a HASU at Mayday University Hospital. However, the capacity provided within the preferred option has been assessed as sufficient to meet the needs of Londoners without the need for extra HASUs. Although additional HASUs could provide modest reductions in travel times, all Londoners will be within 30 minutes’ blue light ambulance travel time of a HASU under the preferred option.

St Helier Hospital
Sutton Council suggested St Helier Hospital as a HASU. However St Helier Hospital did not submit a bid to be designated a HASU, and was not considered to be a HASU on this basis.
The Royal Free Hospital

The Royal Free Hospital was identified as an alternative to University College Hospital. Around 44% of the respondents who disagreed with the preferred option for hyper-acute stroke units, proposed The Royal Free Hospital. This view was consistently expressed by respondents for Barnet and north London.

The prevailing view amongst these responses was that The Royal Free Hospital is less distant and is the hospital associated with established patient flows. However the approach and the model of care are driven by the provision of timely access to high-quality care for all Londoners. The location of HASUs therefore needs to be determined on a pan-London basis. The preferred option took account of a number of factors including quality (as indicated by the external evaluation).

The travel time methodology was challenged. This issue is discussed in relation to Barnet Hospital (above). Analysis continues to indicate that all residents of London, including those in north London, will be able to access a hyper acute stroke unit within 30 minutes’ blue light ambulance travel time with the preferred option.

It is significant to note that the response from The Royal Free NHS Trust expressed support for a facility at University College Hospital with strong collaboration between the two hospitals as part of the developing Academic Health Science Centre.

North Middlesex University Hospital

North Middlesex University Hospital NHS Trust felt that the large population and high incidence of stroke in outer London and the areas surrounding the hospital and concern about travel times, made a case for the hospital to be considered as a HASU site.

North Middlesex University Hospital was not offered as an alternative to the preferred option. North Middlesex submitted a bid to provide HASU services but did not meet the bid assessment requirement, and additional HASU capacity is not required in this area. Travel-time modelling shows that if the preferred option is chosen, all Londoners will have access to a unit within 30 minutes’ blue light ambulance. The accuracy of these travel times is supported by both the London Ambulance Service and Transport for London.

10.4.4 Hyper-Acute Stroke Units: assessment of proposal against the criteria – factors that determine whether an option should be discounted or which influence the decision on the best option

There are no factors presented that provide a sufficient reason why the preferred option should be discounted.

Using the criteria developed, the merits of the preferred locations of hyper-acute stroke units are assessed below:

1. Sustainable and optimal quality
   a) The proposed configuration of HASUs complies with the agreed model of care.
   b) External evaluation of proposals: implementation and transition plans take into account the outcomes of the evaluation of bids.
   c) Oversight of the implementation of the new stroke model in London will be provided by the London stroke project board. A London stroke clinical director is being appointed to ensure there is strong clinical leadership for the future development and implementation of the new stroke system across London.
Each of the London cardiac and stroke networks has provided assurance that the plans of the preferred providers in their sector will meet the required quality standards and are actively managing risks associated with implementation – including those associated with ensuring an appropriate workforce is in place.

If the JCPCT opts for a decision in favour of the preferred option, assurance is therefore provided that this option is deliverable and plans are in place to support its implementation. If the JCPCT opts for a decision other than the preferred option, such an assurance is not provided, but this does not suggest that alternatives would not be just as deliverable once similar implementation and transition plans had been developed.

An assessment of the workforce requirements indicates that whilst there are gaps between the current and future medical workforce requirements these can be addressed. An action plan has been developed. For the non-medical workforce, NHS London’s People and Organisational Development team has assessed that there is sufficient workforce supply in the system to meet the staffing requirements of the stroke pathway – although recruitment is a risk that needs to be addressed and the numbers of staff required may have an impact on other services, including increasing expenditure on agency staff in these areas.

d) Capacity planning has been undertaken to match anticipated demand with capacity at each provider.

e) Network effectiveness: the existing stroke and cardiac networks are demonstrating their effectiveness in supporting both commissioners and providers. All networks have identified managerial and clinical leadership. Pan-London oversight is enabled through a board co-ordinating the work of the networks.

2. Equitable access to specialist services
   a) the preferred configuration will ensure that everyone can access specialist stroke care within 30 minutes by blue light ambulance.

3. Strategic coherence
   a) all sites in the preferred option could be significant providers of specialist acute services in the future. If the preferred option recommended for major trauma is chosen by the JCPCT, colocation with major trauma centres at St George’s Hospital, The Royal London Hospital and King’s College Hospital is achieved and a plan will be developed to realise the benefits of future colocation with the fourth major trauma centre (St Mary’s Hospital).

4. Affordability and efficient use of resources
   a) The costs calculated represent PCT costs and reflect investment in the model of care. The location of these services has no impact on the costs to PCTs.

Appendix 7 is provided to give reassurance to the committee of deliverability of the proposals.

10.4.5 Summary

The JCPCT carefully considered the potential locations for HASUs prior to the launch of consultation; and determined the preferred option using their three criteria. In identifying the preferred option they recognised that a number of alternative hospitals had shown that they could meet the future standards, and that these were difficult decisions.
Sixty-one per cent of respondents were in favour of the proposed configuration of hyper-acute stroke units.

Although concerns were raised about whether all Londoners would be within 30 minutes of a HASU by blue light ambulance, the JHOSC and the IIA accepted the view that the preferred option would deliver this level of access. This view has also been supported by the London Ambulance Service and Transport for London.

The IIA found that the proposed HASUs were well-located to serve the majority of at risk populations.

During consultation a majority of respondents supported the preferred option, but a number of respondents advocated other hospitals or suggested additional sites for HASUs. These views are summarised above (except in relation to Chelsea and Westminster Hospital because few responses expressed support for Chelsea and Westminster Hospital and no challenges were raised which would cause a change to the preference for Charing Cross Hospital).

In each case the evidence supporting the case for an alternative or additional HASU has been considered. Having weighed the views and evidence the project board recommends that the preferred option remains as described in the consultation document (see 10.4.1 above).

This therefore means that:

- The Royal London Hospital is preferred rather than St Thomas’ Hospital in light of access and strategic coherence considerations.

- Charing Cross Hospital is preferred rather than Chelsea and Westminster Hospital in light of access considerations and colocation with neurosciences.

- King’s College is preferred rather than St Thomas’ Hospital in light of access and strategic coherence considerations.

- Northwick Park Hospital is preferred rather than Barnet Hospital in light of access and patient flow considerations.

- St George’s Hospital is preferred rather than Mayday University Hospital in light of quality and strategic coherence considerations.

- University College Hospital is preferred rather than the Royal Free Hospital in light of quality considerations.

During the course of consultation, commissioners have engaged with Imperial Healthcare NHS Trust on the issue of whether colocation of stroke and major trauma services would be possible on the St Mary’s Hospital site. The north west London sector chief executive has stated that:

“While a co-location on the St Mary’s site would require very detailed further planning we can assure the JCPCT that it is a feasible proposition and could be progressed within an appropriate timeframe. We are clear that any such development would need to be subject to public consultation processes.”

The NCAT agreed that the proposed distribution of HASUs would lead to the best access for all Londoners.
For decision

16. The JCPCT is asked to agree that:

eight hyper-acute stroke units should be commissioned at:

- Charing Cross Hospital, Hammersmith
- King’s College Hospital, Denmark Hill
- Northwick Park Hospital, Harrow
- Queen’s Hospital, Romford
- St George’s Hospital, Tooting
- The Princess Royal University Hospital, Orpington
- The Royal London Hospital, Whitechapel
- University College Hospital, London

In taking this decision the JCPCT understands that commissioners will develop a plan to realise the benefits of future colocation on the St Mary’s Hospital site. This would be the responsibility of the relevant commissioners and Imperial Healthcare NHS Trust which runs both St Mary’s and Charing Cross hospitals. Clinical standards of these services would need to be at least the same, if not higher, than the current proposed configuration. All planning and associated decision-making processes would be informed by appropriate stakeholder engagement and public consultation.
10.5 Stroke units – Configuration

10.5.1 What did we say in *The shape of things to come?*

We recommended developing 21 stroke units at:

- Barnet Hospital, Barnet
- Charing Cross Hospital, Hammersmith
- Chelsea and Westminster Hospital, Fulham
- King’s College Hospital, Denmark Hill
- Kingston Hospital, Kingston upon Thames
- Mayday University Hospital, Croydon
- National Hospital for Neurology & Neurosurgery (part of University College Hospital), Bloomsbury
- North Middlesex Hospital, Edmonton
- Northwick Park Hospital, Harrow
- Queen Elizabeth Hospital, Woolwich
- Queen’s Hospital, Romford
- St George’s Hospital, Tooting
- St Helier Hospital, Carshalton
- St Mary’s Hospital, Paddington
- St Thomas’ Hospital, Waterloo
- The Hillingdon Hospital, Uxbridge
- The Princess Royal University Hospital, Orpington
- The Royal Free Hospital, Hampstead
- The Royal London Hospital, Whitechapel
- University Hospital Lewisham
- West Middlesex Hospital, Isleworth

The external evaluation panel assessed St Helier Hospital, Queen Elizabeth Hospital, Queen’s Hospital, The Royal London Hospital and The Princess Royal University Hospital as needing significant support to develop their local stroke unit services. However, stroke units at these sites are necessary to meet demand for stroke beds and provide local services.

We proposed that five hospitals currently providing acute stroke services do not do so in the future: Ealing Hospital, Southall; The Whittington Hospital, London; Queen Mary’s Hospital, Sidcup; Central Middlesex Hospital, Park Royal Hospital and Chase Farm Hospital, Enfield.

Local NHS organisations in north east London were leading a general review of acute services. So, whilst hyper-acute stroke units (and associated stroke units and TIA services) were proposed at The Royal London Hospital and Queen’s Hospital, proposed locations of other stroke and TIA services were not included in the consultation proposals.

10.5.2 Views and issues relating to the number and location of stroke units

(Please see Appendix 5d for a fuller list of key issues and responses)

<table>
<thead>
<tr>
<th>Ipsos MORI analysis and responses to consultation</th>
<th>Seventy-five per cent of respondents were in agreement with the proposed configuration of stroke units.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Twenty-three per cent of those respondents that disagreed with the proposal suggested the need to include other hospitals. Twelve per cent of those that disagreed with the proposals supported maintaining the stroke unit at Ealing Hospital. Organisations representing Ealing and residents felt that the decision not to continue providing stroke care locally would detract from the service currently provided in that area.</td>
</tr>
<tr>
<td></td>
<td>Concerns were also raised about the capacity of Barnet Hospital to act as a stroke unit for Barnet and Enfield residents, with no stroke provision at Chase Farm.</td>
</tr>
<tr>
<td></td>
<td>Around five per cent of the respondents who wrote a letter, email or</td>
</tr>
</tbody>
</table>
telephoned were opposed to the closure of the stroke unit at Ealing Hospital.

Seven petitions were received. Four of these were each supported by about 30 people. However three petitions with a total of just over 2,000 signatures supported a stroke centre at Ealing.

**JHOSC**

The JHOSC intentionally did not comment on the location of stroke units but commented that it felt that north east London stroke units should have been included in the recommendations.

**Traditionally under-represented groups**

Most groups consulted expressed support for the locations of the 21 stroke units, often because a local hospital was included. Some suggestions for alternative locations were made.

**Integrated Impact Assessment (IIA)**

No commentary on the location of stroke units, except regarding travel for families, friends and carers. However, the IIA has not identified any overwhelming evidence to suggest that the alternative options provide any substantive benefits above the preferred options in relation to equalities. Where local equalities issues remain, the application of measures, particularly those relating to access, should help to mitigate any negative impacts.

### 10.5.3 Project board’s consideration of issues raised

(Please see Appendix 5d for a fuller list of key issues and responses)

Whilst the vast majority of residents and stakeholders supported the proposals for new, higher-quality stroke services, the project board recognised the concerns of residents whose local hospital would not be providing stroke services in the future. However, the board considered the individual situation of each hospital and concluded that there was enough capacity planned into the system to provide an excellent service to all residents – wherever they lived.

**Chase Farm Hospital**

Some respondents suggested that there should be a stroke unit at Chase Farm Hospital. However Chase Farm Hospital did not submit a bid. Extra beds are not required in the north of London, with capacity at locations such as Barnet and North Middlesex hospitals.

**Whittington Hospital**

Some respondents suggested that there should be a stroke unit at The Whittington Hospital. However The Whittington Hospital did not meet the bid assessment requirement. Extra beds are not required in the north of London, with capacity at locations such as Barnet and North Middlesex hospitals.

**Ealing Hospital**

Twelve per cent of people who did not agree with the proposed configuration of stroke units suggested the need for a unit at Ealing Hospital. Concerns raised centred around there being insufficient capacity in other units and alternative units being too far away.
Capacity planning undertaken by Healthcare for London and agreed with the network indicates that sufficient beds will be available to meet the needs of Ealing residents (and residents of north west London in general) using the JCPCT’s preferred option (at Hillingdon, West Middlesex, Northwick Park and Charing Cross hospitals).

The board agreed that wherever services are provided for Ealing residents, they should be culturally and linguistically appropriate.

The IIA states that people around Ealing and Central Middlesex have good access to other units, and therefore, are likely to be less affected in transport access.

**Queen Mary’s Hospital**
The bid from Queen Mary’s Hospital to provide SU and TIA services did not meet the required standard.

Following the endorsement of the Secretary of State of the *A Picture of Health* service strategy for south east London, Queen Mary’s Hospital will change in nature and will no longer provide emergency care services. The loss of the supporting acute medical services means that Queen Mary’s Hospital would no longer be a suitable location for acute stroke services.

**10.5.4 Stroke units: assessment of proposal against the criteria – factors that determine whether an option should be discounted or which influence the decision on the best option**

There are no factors presented that provide a reason why any option should be discounted.

Using the criteria developed, the merits of the proposed locations of hyper-acute stroke units are assessed below:

1. **Sustainable and optimal quality**
   a) The proposed configuration of stroke units complies with the agreed model.
   b) External evaluation of proposals: implementation and transition plans take into account the outcomes of the evaluation of bids.
   c) Implementation plans are prepared for all sites, taking account of a range of issues including equipment, workforce, and transitional considerations. Each of the London cardiac and stroke networks has provided assurance that the plans of the preferred providers in their sector will meet the required quality standards and are actively managing risks associated with implementation – including those associated with ensuring an appropriate workforce is in place.

   If the JCPCT opts for a decision in favour of the preferred option, assurance is therefore provided that this option is deliverable and plans are in place to support its implementation. If the JCPCT opts for a decision other than the preferred option, such an assurance is not provided, but this does not suggest that alternatives would not be just as deliverable once similar implementation and transition plans had been developed.

   d) Capacity planning has been undertaken to match the amount of activity and capacity at each provider.

   e) Network effectiveness: the existing stroke and cardiac networks are demonstrating their effectiveness in supporting both commissioners and providers. All networks have identified managerial and clinical leadership. Pan-London oversight is enabled through a co-ordination of the work of the networks.
2. Equitable access to specialist services
   a) the preferred configuration will ensure that everyone can access local stroke care facilities.

3. Strategic coherence
   a) the stroke unit proposals have been developed through a commissioning-led process. PCTs across London are reviewing acute services and are ensuring alignment between the emerging outcomes of those reviews and the proposed configuration of stroke units.

4. Affordability and efficient use of resources
   a) the preferred configuration is affordable and takes account of existing resources. The cost of the proposal is consistent with costs calculated in the National Stroke Strategy. Cost-effectiveness measures used in the National Stroke Strategy (NSS) indicate that the NSS proposals delivered value for money. A new tariff has been calculated to support the new model of care. The location of stroke units has no impact on the cost to PCTs.

Appendix 7 is provided in order to give assurance to the JCPCT of deliverability of the proposals.

10.5.5 Specific sector considerations

North east London
At the time of launching the consultation, local NHS organisations in north east London were leading a general review of acute services. This meant that whilst there was clarity that (under the preferred option) hyper-acute stroke units, stroke units and TIA services would be provided at The Royal London Hospital and Queen's Hospital, Romford, the proposed locations of other stroke and TIA services in north east London hospitals were not clear. It was expected that local NHS organisations in north east London would make specific proposals for local stroke services of the highest quality in line with the work emerging from their local review – and that these would be submitted to the Joint Committee of PCTs for consideration. These proposals are shown below:

‘North East London NHS recommends that at this point in time there should be no change to the location of stroke units in the sector. Stroke Units with TIA services will therefore continue to be provided at Whipps Cross, Homerton and Newham and these hospitals will be required to meet the standards set out by Healthcare for London. The bid from Newham Hospital did not meet the bid overview requirement, however the sector recommend continuing to commission stroke services from Newham Hospital to ensure that appropriate local access and sufficient capacity is available. This would not be possible without providing stroke care at Newham. The network has reviewed and assured plans for implementation at all of these hospitals. No further consultation needs to take place at this time because this does not represent a change from the current configuration of services.

King George’s Hospital does not currently admit acute stroke patients and is not needed to provide access or capacity.

If, following the review of acute services, there is an emerging view that the role of certain hospitals should change, then this will be consulted on locally, and plans for stroke care would be part of that consultation.
North East London Cardiac and Stroke Network is able to provide assurance that the HASU providers in the preferred option and SUs and TIA services at Whipps Cross, Homerton and Newham have robust plans in place to provide services.'

**North west London**
The JCPCT is recommended to approve stroke unit facilities serving north west London at Charing Cross Hospital, Chelsea and Westminster Hospital, Northwick Park Hospital, St Mary's Hospital, Hillingdon Hospital, and West Middlesex Hospital.

However, during the course of the consultation it has become apparent that stroke unit capacity is required above that originally planned. Whilst this could be provided by the above hospitals, a review will be carried out to assure commissioners that this is optimal and sustainable. It is possible that this review will recommend the commissioning of stroke unit capacity at an additional site beyond those listed above. Such a recommendation would need, necessarily, to be in line with the outcomes of the ongoing review of acute services. An appropriate engagement and consultation process will be observed as necessary.

**10.5.6 Summary**
Seventy-five per cent of respondents were in favour of the proposed configuration of stroke units.

The key issue for respondents to the location of stroke units was whether there was a local unit – the argument did not focus around clinical quality or other issues. Residents feel strongly that they do not want to lose local services. Nevertheless, despite claims that nearby units would be unable to cope, these views were not supported by evidence or the modelling.

The project board agreed that no challenge had required it to take a different view than the original preferred configuration.
For decision

17. The JCPCT accepts the recommendation of the north east London commissioners regarding continuing providing stroke services in that sector. The JCPCT is asked to agree that:

stroke units should be commissioned at:
- Barnet Hospital, Barnet
- Charing Cross Hospital, Hammersmith
- Chelsea and Westminster Hospital, Fulham
- Homerton University Hospital, Hackney
- King’s College Hospital, Denmark Hill
- Kingston Hospital, Kingston upon Thames
- Mayday University Hospital, Croydon
- National Hospital for Neurology & Neurosurgery (part of UCH), Bloomsbury
- Newham General Hospital, Newham
- North Middlesex Hospital, Edmonton
- Northwick Park Hospital, Harrow
- Queen Elizabeth Hospital, Woolwich
- Queen’s Hospital, Romford
- St George’s Hospital, Tooting
- St Helier Hospital, Carshalton
- St Mary’s Hospital, Paddington
- St Thomas’ Hospital, Waterloo
- The Hillingdon Hospital, Uxbridge
- The Princess Royal University Hospital, Orpington
- The Royal Free Hospital, Hampstead
- The Royal London Hospital, Whitechapel
- University Hospital Lewisham, Lewisham
- West Middlesex Hospital, Isleworth
- Whipps Cross University Hospital, Leytonstone
10.6 TIA Services – configuration

10.6.1 What did we say in *The shape of things to come*?

We recommended developing TIA services at:

- Barnet Hospital, Barnet
- Charing Cross Hospital, Hammersmith
- Chelsea and Westminster Hospital, Fulham
- King’s College Hospital, Denmark Hill
- Kingston Hospital, Kingston upon Thames
- Mayday University Hospital, Croydon
- University College Hospital, Euston
- North Middlesex Hospital, Edmonton
- Northwick Park Hospital, Harrow
- Queen Elizabeth Hospital, Woolwich
- Queen’s Hospital, Romford
- St George’s Hospital, Tooting
- St Helier Hospital, Carshalton
- St Mary’s Hospital, Paddington
- St Thomas’ Hospital, Waterloo
- The Hillingdon Hospital, Uxbridge
- The Princess Royal University Hospital, Orpington
- The Royal Free Hospital, Hampstead
- The Royal London Hospital, Whitechapel
- University Hospital Lewisham, Lewisham
- West Middlesex Hospital, Isleworth

Queen’s Hospital, The Princess Royal University Hospital, Queen Elizabeth Hospital and West Middlesex Hospital would need more support to develop TIA services.

As described above, local NHS organisations in north east London were leading a general review of acute services. So, whilst hyper-acute stroke units (and associated stroke units and TIA services) were proposed at The Royal London Hospital and Queen’s Hospital, Romford, proposals for locations of other stroke and TIA services were not included in the consultation proposals.

10.6.2 Views and issues relating to the number and location of TIA services

(Please see Appendix 5d for a fuller list of key issues and responses)

<table>
<thead>
<tr>
<th>Ipsos MORI analysis and responses to consultation</th>
<th>Seventy-five per cent of respondents were in favour of the proposed configuration of TIA services. The BMA stated that hospitals providing TIA services currently should continue to do so.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td><em>The London Ambulance Service do not differentiate between stroke or TIA services and therefore will convey all FAST patients to the nearest HASU, even those whose symptoms have begun to subside. With this in mind the London Ambulance Service supports the provision of TIA clinics as a mandatory requirement for HASUs.</em></td>
</tr>
<tr>
<td></td>
<td><strong>London Ambulance Service</strong></td>
</tr>
<tr>
<td>Respondents who disagreed with the recommended configuration of TIA services were asked why and 19% cited the need to include other hospitals.</td>
<td></td>
</tr>
<tr>
<td>JHOSC</td>
<td>The JHOSC considered that there should be greater emphasis on services for people suffering a TIA.</td>
</tr>
<tr>
<td>Traditionally under-represented groups</td>
<td>Most groups supported the configuration of TIA services.</td>
</tr>
<tr>
<td>---------------------------------------</td>
<td>------------------------------------------------------</td>
</tr>
<tr>
<td>Integrated Impact Assessment (IIA)</td>
<td>No commentary on configuration of TIA services. However the creation of HASUs and TIA services are expected to lead to particular improvements in clinical outcomes and benefits for patients requiring thrombolysis.</td>
</tr>
</tbody>
</table>

10.6.3 Project board’s consideration of views and issues raised

Whilst the vast majority of residents and stakeholders supported the proposals for new, higher quality TIA services, the project board recognised the concerns of residents whose local hospital would not be providing TIA services in the future. However, the board considered that there was enough capacity planned into the system to provide an excellent service to all residents – wherever they lived.

Ealing Hospital

Eleven per cent of people who did not agree with the proposed configuration of TIA services suggested the need for a unit at Ealing Hospital. Concerns centred around alternative units being too far away.

However, under the proposed model, a TIA service can only be provided where a HASU or stroke unit is located.

10.6.4 TIA services: assessment of proposal against the criteria – factors that determine whether an option should be discounted or which influence the decision on the best option

There are no factors presented that provide a reason why any option should be discounted.

Using the criteria developed, the merits of the proposed locations of TIA services are assessed below:

1. Sustainable and optimal quality
   a) The proposed configuration of TIA services complies with the agreed model.
   b) External evaluation of proposals: each of the London cardiac and stroke networks has provided assurance that the plans of the preferred providers in their sector will meet the required quality standards and are actively managing risks associated with implementation – including those associated with ensuring an appropriate workforce is in place.
   c) Implementation plans are prepared for all sites, taking account of a range of issues including equipment, workforce, and transitional considerations.

Each of the London cardiac and stroke networks has provided assurance that the plans of the preferred providers in their sector will meet the required quality standards and are actively managing risks associated with implementation – including those associated with ensuring an appropriate workforce is in place.
If the JCPCT opts for a decision in favour of the preferred option, assurance is therefore provided that this option is deliverable and plans are in place to support its implementation. If the JCPCT opts for a decision other than the preferred option, such an assurance is not provided, but this does not suggest that alternatives would not be just as deliverable once similar implementation and transition plans had been developed.

d) The infrastructure and staffing for TIA services will be incorporated into stroke units.

e) Network effectiveness: the existing stroke and cardiac networks are demonstrating their effectiveness in supporting both commissioners and providers. All networks have identified managerial and clinical leadership. Pan-London oversight is enabled through a co-ordination of the work of the networks.

2. Equitable access to specialist services
   a) The preferred configuration will ensure that everyone can access local TIA services.

3. Strategic coherence: the TIA service proposals have been developed through a commissioning-led process. PCTs across London are reviewing acute services and are ensuring alignment between the emerging outcomes of those reviews and the proposed configuration of stroke and TIA units (see below).

4. Affordability and efficient use of resources
   a) the preferred configuration is affordable and takes account of existing resources. The cost of the proposal is consistent with costs calculated in the National Stroke Strategy. Cost-effectiveness measures used in the National Stroke Strategy (NSS) indicate that the NSS proposals delivered value for money. A new tariff has been calculated to support the new model of care. The location of TIA services has no impact on the cost to PCTs

Appendix 7 is provided in order to give reassurance to the JCPCT of deliverability of the proposals.

North east London and north west London
Please see section 10.5 (stroke units) above. In north east London commissioners propose no change in the location of TIA services which should continue to be provided at Whipps Cross, Homerton and Newham hospitals.

TIA provision will follow the pattern for stroke provision and would therefore be considered in any north west London review (see 10.5.5 above)

10.6.5 Summary

Seventy-five per cent of respondents were in favour of the proposed configuration of TIA services.

The key issue for respondents to the location of TIA services was whether there was a local service – the argument did not focus around clinical quality or other issues. Residents feel strongly that they do not want to lose local services. Nevertheless, despite claims that nearby units would be unable to cope, these views were not supported by evidence or the modelling.
The project board agreed that no challenge had required it to take a different view than the original preferred configuration.

For decision

18. The JCPCT accepts the recommendation of the north east London commissioners regarding continuing providing stroke services in that sector. The JCPCT is asked to agree that:

TIA services should be commissioned at:

- Barnet Hospital, Barnet
- Charing Cross Hospital, Hammersmith
- Chelsea and Westminster Hospital, Fulham
- Homerton University Hospital, Hackney
- King’s College Hospital, Denmark Hill
- Kingston Hospital, Kingston upon Thames
- Mayday University Hospital, Croydon
- University College Hospital, Euston
- Newham General Hospital, Newham
- North Middlesex Hospital, Edmonton
- Northwick Park Hospital, Harrow
- Queen Elizabeth Hospital, Woolwich
- Queen’s Hospital, Romford
- St George’s Hospital, Tooting
- St Helier Hospital, Carshalton
- St Mary’s Hospital, Paddington
- St Thomas’ Hospital, Waterloo
- The Hillingdon Hospital, Uxbridge
- The Princess Royal University Hospital, Orpington
- The Royal Free Hospital, Hampstead
- The Royal London Hospital, Whitechapel
- University Hospital Lewisham, Lewisham
- West Middlesex Hospital, Isleworth
- Whipps Cross University Hospital, Leytonstone
11 Transition

11.1 Major trauma

If an option of four major trauma centres is approved by the JCPCT, the trauma network in north west London would have a later implementation date. A plan will be drawn up to enable the transition from a system of three trauma networks to a system of four. This plan will detail the arrangements for north west London for the period between the April 2010 implementation date for three trauma networks and the later go-live date for the fourth network. It will ensure residents of north west London will have an appropriate major trauma service during this period. The organisations that would need to be included in devising the plan include:

- Providers in the north west
- The London Ambulance Service
- The London trauma director
- The London Specialist Commissioning Group (LSCG)
- The Acute Commissioning Unit (ACU) for the north west
- Local authorities
- Barts and the London NHS Trust
- St George’s Healthcare NHS Trust
- Kings College Hospital NHS Foundation Trust

Once agreed, the plan will be submitted to the London trauma board and commissioners for agreement and ongoing monitoring.

11.2 Stroke

The introduction of new stroke services has been planned using a phased approach, based on agreed transition principles. This is particularly important for HASUs in hospitals which have not provided HASU-type services previously in order to support the step change in provision of services and recruitment of adequate staffing.

11.2.1 Stroke units

Full stroke unit capacity will be in place before expanding HASU bed numbers in order that patients can be transferred to an appropriate local stroke unit. Stroke unit opening is planned to commence in October 2009 and full new stroke unit capacity is planned to be available from the end of January 2010. In this period beds will continue to be provided in units which will then be decommissioned. This will maintain necessary capacity until these beds are no longer needed.

11.2.2 Hyper-acute stroke units

Opening of hyper-acute beds is planned to take place in phases. Development of services at Queen’s Hospital, Romford and Princess Royal University Hospital, Orpington will take longer. It is proposed that in addition to the HASUs in the preferred option, additional transitional capacity for south east London is provided by St Thomas’ Hospitals.

In the period to 1 February 2010: All patients will continue to go to their existing acute stroke provider. Northwick Park HASU will develop a thrombolysis service for their existing local
catchment area. Charing Cross, University College, The Royal London, Kings and St George’s hospitals will continue to provide thrombolysis and hyper-acute care as now.

From 1 February: The rollout of HASU bed capacity will commence with all HASUs (except Queen’s and Princess Royal University hospitals) providing enough capacity for all patients potentially eligible for thrombolysis in their new catchment areas. All patients who are not eligible for thrombolysis will continue to go to their existing acute stroke care provider.

From 6 April: All HASUs (except Queen’s and Princess Royal University hospitals) will open full HASU capacity for all patients in their new catchment. Queens will begin to provide thrombolysis as appropriate from April 2010 and gradually increase its HASU capacity until full capacity is reached by October 2010.

From October 2010: Princess Royal University Hospital will begin to provide thrombolysis as appropriate and gradually increase its HASU capacity until full capacity is reached by summer 2011 at the latest. At this time transitional capacity at St Thomas’ Hospital will no longer be required.

11.2.3 TIA services

Until new TIA services are established, existing pathways of care will be maintained. The TIA service ‘go-live’ date is synchronised with stroke unit (SU) opening as some high-risk TIA patients will need to be admitted to an SU.

In those parts of London where there are already two high-quality existing stroke services in close proximity, discussions should take place – supported by commissioners and the SHA if necessary – as to how they can work better together to improve services for patients even further, albeit with the physical facilities located on one site only.

NCAT
12 Governance

12.1 Major trauma

12.1.1 Pan-London arrangements

The London trauma director will ensure there is strong clinical leadership for the future development and implementation of the London trauma system. The London trauma director will be key in designing how future clinical input is harnessed and future pan-London protocols and standards are drafted.

Once the London trauma director is appointed, new governance structures will be set up as the Healthcare for London project is disestablished. In order to support the London trauma system and director, a London trauma office will be established. This will be the co-ordination function of the London trauma system and will comprise managerial support, information analysis and financial support.

The London trauma director will sit on a London trauma board that will act as the formal link between providers and commissioners.

12.1.2 Commissioning and performance management

The London Specialist Commissioning Group (LSCG) will take responsibility for the commissioning of major trauma centres and trauma networks, which includes the implementation monitoring of the major trauma centres and trauma networks. The London trauma director will provide guidance to the LSCG to ensure implementation planning is clinically relevant.

Trauma centres will retain current commissioning arrangements through a host PCT, although in line with all acute services, this is likely to move to sector-based acute commissioning.

Performance monitoring will take place through the London trauma office, whilst the performance management function (delivery of outcomes against contract) will be undertaken by the LSCG.

12.1.3 Networks (including delegated responsibilities)

The trauma networks will have their own governance structures and systems for developing local protocols. The network management function, which will reside with the major trauma centre of each network, will be commissioned by the LSCG in addition to the clinical functions of the major trauma centre.

Networks will hold responsibility for monitoring and improving the performance of the major trauma networks, and will feed into the London trauma board.

12.1.4 Governance and accountability arrangements

Oversight of the implementation of the new trauma model in London will be provided by the London trauma board. The LSCG will be represented on the board, which will have the authority to review milestones and agree changes to implementation timeframes where necessary.
12.2 Stroke

12.2.1 Pan-London arrangements

The London stroke clinical director, working closely with the cardiac and stroke networks and providers, will ensure there is strong clinical leadership for the future development and implementation of the new stroke system across London.

It is proposed that the clinical director will be supported by the London stroke programme manager who will ensure London-wide co-ordination of implementation and transition. It is also proposed that five project managers work in the stroke networks to bring the disciplines of formal project management to implementation and transition, including governance, planning, reporting and risk management. This will ensure that implementation is driven in a controlled way and with an effective grip at both sector and pan-London levels.

12.2.2 Commissioning and performance management

PCTs are responsible for commissioning acute stroke services but are expected to delegate this responsibility to the sector acute commissioning units.

Prevention, rehabilitation and long-term care will continue to be commissioned on a local level by each PCT.

12.2.3 Networks (including delegated responsibilities)

Stroke networks were established by (and with funding from) the Department of Health in response to the National Stroke Strategy, to review and organise delivery of stroke services across the care pathway. Membership of stroke networks is broad and includes PCTs, local authorities, NHS provider trusts, ambulance services, voluntary sector providers and representatives, and representation of individuals who have had a stroke.

The networks are central to the commissioning process, and in London, a formal relationship between networks and commissioners is being established. The stroke networks will have delegated authority to lead implementation in each sector.

12.2.4 Governance and accountability arrangements

Oversight of the implementation of the new stroke model in London will be provided by the London stroke project board which includes the five stroke network chairs. The stroke networks will be held to account by the project board, which in turn reports to the London Commissioning Group.

Once the project board judges that implementation is securely established, and that any major risks have been resolved, the project board will transfer accountability for pan-London oversight to the board of London stroke networks.
13 Recommendations

Associated to the decision-making process is the opportunity to listen to comments on how the proposals could be improved or amended.

In this consultation Healthcare for London has been fortunate in receiving a wealth of suggestions which will improve the development and delivery of major trauma and stroke services across the capital. The key recommendations are listed in Appendix 8a.

In addition, the JCPCT has indicated that it would like assurance that the new services will be properly evaluated to ensure that the predicted benefits are realised and taxpayers receive value for their money. An evaluation assurance plan is attached in Appendix 8b.

<table>
<thead>
<tr>
<th>Recommendation</th>
</tr>
</thead>
<tbody>
<tr>
<td>The JCPCT is asked to agree the recommendations contained in Appendix 8a and commissions Healthcare for London to take appropriate action to ensure the recommendations are acted upon.</td>
</tr>
</tbody>
</table>
### Glossary

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>A&amp;E</td>
<td>Accident and Emergency</td>
</tr>
<tr>
<td>ACU</td>
<td>Acute Commissioning Unit</td>
</tr>
<tr>
<td>Acute</td>
<td>In this document, acute refers to emergency or urgent reatment provided in hospital</td>
</tr>
<tr>
<td>ADASS</td>
<td>Association of Directors of Adult Social Services</td>
</tr>
<tr>
<td>AHSC</td>
<td>Academic Health Science Centre</td>
</tr>
<tr>
<td>BAME</td>
<td>Black and Asian Minority Ethnic</td>
</tr>
<tr>
<td>BLA</td>
<td>Blue Light Ambulance</td>
</tr>
<tr>
<td>BMA</td>
<td>British Medical Association</td>
</tr>
<tr>
<td>BME</td>
<td>Black and Minority Ethnic</td>
</tr>
<tr>
<td>BMJ</td>
<td>British Medical Journal</td>
</tr>
<tr>
<td>CAG</td>
<td>Clinical Advisory Group</td>
</tr>
<tr>
<td>CE</td>
<td>Chief Executive</td>
</tr>
<tr>
<td>Clinician</td>
<td>A medical professional who is engaged in the care of patients, such as doctors, nurses and therapists</td>
</tr>
<tr>
<td>CSL</td>
<td>Commissioning Support for London</td>
</tr>
<tr>
<td>CT scan</td>
<td>The X-ray technique most commonly used to examine the brain</td>
</tr>
<tr>
<td>DGH</td>
<td>District General Hospital</td>
</tr>
<tr>
<td>DoH</td>
<td>Department of Health</td>
</tr>
<tr>
<td>EqIA</td>
<td>Equalities Impact Assessment</td>
</tr>
<tr>
<td>EIA</td>
<td>Environment Impact Assessment</td>
</tr>
<tr>
<td>Haemorrhagic stroke</td>
<td>A stroke caused by a burst blood vessel bleeding into the brain or into the surrounding areas</td>
</tr>
<tr>
<td>HASU</td>
<td>Hyper-acute stroke unit</td>
</tr>
<tr>
<td>Health fair</td>
<td>Events where PCT staff promoted the consultation. Health fairs took place in shopping centres, libraries and other public areas.</td>
</tr>
<tr>
<td>HfL</td>
<td>Healthcare for London</td>
</tr>
</tbody>
</table>
Health Inequalities Impact Assessment

Integrated Impact Assessment

Independent research company appointed by Healthcare for London to receive and analyse the responses to the consultation

The most common type of stroke (around three-quarters of all strokes) where blood flowing to the brain is blocked by a clot or when blood vessels become too narrow

Joint Committee of Primary Care Trusts

Joint Health Overview and Scrutiny Committee

London Ambulance Service

London Specialised Commissioning Group

Term used to describe the most severe, life-threatening injuries, or multiple injuries. It can include arm or leg amputations, severe knife and gunshot wounds, and major spinal or head injuries

Major Trauma Centre

Major Trauma network

National Clinical Advisory Team

National Health Service

National Stroke Service

A process which aids the recovery from a brain injury

Term used for the group of specialist neurological services in a hospital

Overview and Scrutiny Committee

Patient Advice and Liaison Service

Primary Care Trust

Professional Executive Committee

Patient and Public Advisory Group

Public Transport Accessibility Levels

Quality-adjusted life year

A process to support the best recovery possible after an injury or illness

Sector Acute Commissioning Units
<table>
<thead>
<tr>
<th>SHA</th>
<th>Strategic Health Authority</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stakeholder</td>
<td>A person, group, organisation that affects or can be affected by an organisation's actions</td>
</tr>
<tr>
<td>Stroke</td>
<td>A type of brain injury. There are two types of stroke; ischaemic or haemorrhagic</td>
</tr>
<tr>
<td>SU</td>
<td>Stroke Unit</td>
</tr>
<tr>
<td>Telemedicine</td>
<td>The diagnosis and treatment of patients at a distance using medical information, such as x-rays or television pictures.</td>
</tr>
<tr>
<td>TFL</td>
<td>Transport for London</td>
</tr>
<tr>
<td>Thrombolysis</td>
<td>A type of treatment using drugs to break up a blood clot. It is used to treat patients who have an ischaemic stroke</td>
</tr>
<tr>
<td>TIA</td>
<td>Transient Ischaemic Attack – a temporary lack of blood to part of the brain which causes short term problems</td>
</tr>
<tr>
<td>Trauma</td>
<td>Injuries such as a fractured hip or ankle or minor head injury</td>
</tr>
</tbody>
</table>