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Directorate of Representational and Political Activities

7 May 2009

THE SHAPE OF THINGS TO COME – DEVELOPING NEW, HIGH-QUALITY MAJOR TRAUMA AND STROKE SERVICES FOR LONDON

The BMA welcomes the opportunity to comment on Healthcare for London's consultation on the above.

In summary, the BMA is supportive of the proposals to deliver improved healthcare services to London where these changes are evidence-based and beneficial to patients. On this basis, we support the proposals to centralise services for major complex trauma broadly based in principle around the development of trauma networks and centres. We believe however that further consideration needs to be given to the workforce implications of this move and also major incident capacity.

In terms of the proposals to centralise stroke services, we believe that further evidence and planning is required to demonstrate unequivocally that it will benefit patient care.

With kindest regards.

Yours sincerely

S. Watson.

Sally Watson
Director of Representational and Political Activities

Encl.
BMA response to the *The shape of things to come – Developing new, high-quality major trauma and stroke services for London*

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BMA

THE SHAPE OF THINGS TO COME – DEVELOPING NEW, HIGH-QUALITY MAJOR TRAUMA AND STROKE SERVICES FOR LONDON.

BRITISH MEDICAL ASSOCIATION RESPONSE

Introduction

The BMA welcomes the opportunity to respond to Healthcare for London's (HfL) consultation document on *The shape of things to come – Developing new, high-quality major trauma and stroke services for London*. The BMA is a voluntary, professional association that represents all doctors from all branches of medicine across the UK. Over 100,000 practising doctors are members, as are nearly 20,000 medical students. The BMA is an independent trade union, a scientific and educational body and a limited company, funded largely by its members.

The BMA is supportive of the proposals to deliver improved healthcare services to London where these changes are evidence-based and beneficial to patients. The BMA's General Practitioners Committee and Central Consultants and Specialists Committee (CCSC) have developed some guiding principles for service reconfiguration[1] and this response is based in large part on these principles. In brief:

Reconfiguration must:
- Be evidence-based
- Enhance the standards of patient care across a health economy
- Be clinically-led in partnership with patients
- Be safe
- Include clear reporting of agreed outcome and financial data
- Include an impact assessment before a planned reconfiguration is implemented

Reconfiguration must not:
- Be driven purely by financial or political pressures
- Undermine existing services to the detriment of patient care

We are confident that you will share these principles as they are broadly similar to the five pledges made in Lord Darzi's report – *Leading Local Change*[2]. In this case, we believe that the proposals to centralise services for major complex trauma broadly based in principle around the development of trauma networks and centres is strong, evidence-based[3] and supported by emergency medicine consultants in London. Centres of this nature would clearly need to meet the targets for investigation and treatment within the time parameters and be supported by extensive transport links to maintain patient safety and build expertise. The BMA believes that for this group of patients, the benefits of specialist centred care can outweigh any detriments resulting from the increased travel distances to the centres.

This consultation addresses two very different clinical conditions, for which the evidence base is very different. As it stands, we feel that the case for the centralisation of stroke services requires further evidence and planning to demonstrate unequivocally that it will benefit patient care.

This response has been informed by the BMA's national branch of practice committees including the Consultants (CCSC), SAS and Public Health committees. It also reflects the views of the CCSC's Emergency Medicine subcommittee and is endorsed by the BMA's London Regional Council.

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[1] http://www.bma.org.uk/healthcare_policy/nhs_system_reform/jointstatementccscgpc280508.jsp
[2] *Our NHS Our Future: NHS Next Stage Review - Leading Local Change*, May 2008
[3] Freeman, J, Nicholl, J and Turner, J. (2006). Does size matter? The relationship between volume and outcome in the care of major trauma. *Journal for Health Services Research Policy*, 11, pp. 101-105.

Major trauma

As set out above, the BMA supports the proposals to centralise major trauma services. Whilst these proposals represent an enhancement of services for a small percentage of trauma patients[4], they must not however be used as a justification for the downgrading of existing A&E departments.

Further consideration needs to be given to the workforce implications of this move as both are referenced only briefly in the document.[5] The proposal to have 24/7 specialist-led trauma teams will require a significant expansion in consultant numbers. To improve patient care, it will be important to ensure that the number of emergency medicine consultants in each emergency department reflects the workforce recommendations outlined by the College of Emergency Medicine[6]. Expansion will also be required in other specialties to ensure appropriate availability.

There is some evidence to suggest that processes and outcomes for other patients in the emergency department are worse during major trauma resuscitation. It is likely that this is due to the fact that resources are diverted away from them. On that basis and to reduce this risk, it is important that the major trauma resuscitation team is staffed separately and additionally to the general rotas in the emergency department.

There are a number of references to major incident planning in the document[7] and one of the reasons for recommending a four-network trauma system is the ability to respond to such incidents.[8] However, centralisation is not without its potential pitfalls. There may need to be significant excess capacity in the system to cope with the scenario whereby one of the major trauma centres had to close due, say, due to an MRSA outbreak. The BMA recognises that the fourth network may not be operational until 2012[9], but is concerned that the standards of patient care may suffer if the remaining three networks were not able to cope with the additional workload. We would be interested to know whether the NHS Department of Emergency Preparedness has considered this scenario?

The BMA believes that the case for trauma networks is supported by the evidence provided within the document. In terms of the two options that have the potential to deliver this model, we do not think it appropriate for the BMA to recommend a specific hospital setting over another. However, geography and speed of road transfer must be major considerations. The relationship between the centres and major road networks and airports – potential sites of major incidents - will clearly be crucial.

Stroke

The report states that currently only 10% of eligible patients are offered thrombolysis. The BMA believes that all Londoners with embolic stroke should have access to thrombolysis and so there is a need to increase the number of clinical settings that can offer this treatment. The proposals recognise that it is essential that hospitals should utilise existing stroke networks and 'ensure new services are of excellent quality'[10]. With this in mind, we are not aware of any evidence to suggest that acute stroke thrombolysis cannot be provided in a DGH, possibly as part of a network with telemedicine support**.** CT for acute stroke is already established in all major acute hospitals and they have twenty years of experience of thrombolysis for acute myocardial infarction. This more diffuse model, providing services closer to patients' homes, is likely to be more cost-effective and accessible. Indeed, this is model is currently being developed in Eastern SHA and South Central SHA, with most hospital trusts offering 24/7

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[4] Page 9, *The shape of things to come – Developing new, high-quality major trauma and stroke services for London.*

[5] Pages 23, 44, *The shape of things to come – Developing new, high-quality major trauma and stroke services for London.*

[6] *The Way Ahead 2008-2012*, College of Emergency Medicine.

[7] Pages 11, 15,17 and 22, *The shape of things to come – Developing new, high-quality major trauma and stroke services for London.*

[8] Page 17, *The shape of things to come – Developing new, high-quality major trauma and stroke services for London.*

[9] Page 22, *The shape of things to come – Developing new, high-quality major trauma and stroke services for London.*

[10] Page 36, *The shape of things to come – Developing new, high-quality major trauma and stroke services for London.*

thrombolysis services, or South Central SHA where several sites are being provided, which build on the current local services and expertise.[11] Furthermore, travelling times are significant in London, and a wider network of thrombolysis sites, is more likely to achieve timely intervention. Consequently, we feel that more than 8 clinical settings in London should have the ability to provide thrombolysis services.

Whilst we agree that 'for good urgent care for stroke patients, it is important to reach excellent-quality care, fast,'[12] the BMA is concerned by the fact that specialist stroke services will be concentrated on 8 sites with hyper-acute stroke units. These proposals make the assumption that everyone with symptoms suggestive of a stroke will be transferred by ambulance, that ambulance service will always correctly identify patients with a stroke and that, consequently, no patient with a stroke will attend A&E. In reality, it is likely that a significant number of patients (particularly the elderly with co-morbidities, those with co-existing neurological impairment and those with complex or unusual presentations) will continue to present at their nearest hospital, and so the lack of any proposals for secondary transfer is a concern. The case study on page 34 outlines the proposals for stroke care and the similarities to the care currently provided for people having a heart attack. We feel that this analogy is flawed however as it does not take into account the fact that more secondary transfers are likely to take place. As such, the BMA believes that those units that are currently providing an effective, high-quality acute stroke service should not prevented from continuing to doing so. As it stands, the 21 proposed local stroke units[13], which are concerned primarily with rehabilitation, will not be permitted to admit any acute stroke patients.

The report recognises that 'stroke patients need fast access to high-quality scanning facilities.[14] This suggests that designated stroke units will have sufficient CT capacity and/or MR capacity with modern machines. These will need appropriate staffing, and there will need to be good radiological staffing with expertise in reporting of neurological imaging. Hyper-acute stroke units will require an even greater level of radiology support.

As with the proposed sites for the trauma centres, we do not think it appropriate for the BMA to endorse a specific model for the delivery of hyper-acute stroke services. However, we seek reassurance that if hyper-acute stroke services are to be centred on a small number of sites as currently proposed, then these sites will remain designated on a geographical basis, rather than trust-specific, basis.

Transient ischaemic attack (TIA) services
These services must be provided as a network, if not at every acute site. As set out above, patients are likely to present to any A&E department and so a clear referral pathway, following initial assessment, must be developed so that all patients can access prompt investigation and appropriate treatment. Those patients who transpire to have acute stroke will need immediate transfer to a thrombolysis centre, whereas those with genuine TIAs will require urgent investigation and follow-up. All of these proposals are clearly predicated on a significant expansion in the number of stroke consultants.

Transfer of acute patients
This report, as with several of the reports related to the Next Stage Review and the SHA visions also omits to discuss the necessary development of a properly-funded and supported critical care transfer system. Although there is outline cover in some areas of the country for paediatrics, this is often stretched. For adults, and the majority of patients attending with trauma or stroke will be adult, there is no formalised transfer infrastructure. Indeed the only way of ensuring rapid transfer is to denude the level of medical and often nursing or practitioner cover, in the transferring hospital to undertake the transfer. Many of the reforms suggested, and these reforms in particular, are fundamentally flawed without urgent attention to the area of safe, quality inter-hospital transfer as found in several other countries.

[11] Page 4, *The shape of things to come – Developing new, high-quality major trauma and stroke services for London.*
[12] Question 5, page 38, *The shape of things to come – Developing new, high-quality major trauma and stroke services for London.*
[13] Page 39, *The shape of things to come – Developing new, high-quality major trauma and stroke services for London.*
[14] Page 27, *The shape of things to come – Developing new, high-quality major trauma and stroke services for London.*

Conclusion

The BMA is supportive of the proposals to deliver improved healthcare services to London where these changes are evidence-based and beneficial to patients. With this in mind, we believe that the proposals to centralise trauma services should be taken forward although further consideration needs to be given to major incident capability, including the development of planned excess clinical capacity, and the geography of the proposed units. There are also significant workforce implications associated with this model and we would be happy to be involved in the further detailed work required in this area.

We do not however believe that all of the proposals for stroke services meet the BMA's guiding principles for service reconfiguration or the pledges made in Lord Darzi's report – *Leading Local Change.*[15] Without further evidence, the BMA is not convinced that the concentration of hyper-acute stroke services in 8 centres will enhance the standards of patient care, utilise existing expertise or provide best value for money. Further consideration needs to be given to the fact that a significant number of patients will continue to present themselves to their nearest A&E departments. Currently the proposals do not address the possibility of secondary transfers taking place.

The BMA believes that stroke units that are currently providing and continue to provide an effective, high-quality acute stroke service should not be prevented from continuing to do so. With this in mind, thrombolysis services should be made available in a greater number of settings where safety and quality can be proven. The 21 proposed local stroke centres should have the capacity to treat acute stroke patients where necessary.

In terms of TIA services, clear referral pathways must be developed so that all ambulatory patients can access prompt investigation and appropriate treatment. Those units that are already providing high-quality TIA services should not be prevented from continuing to do so.

[15] *Our NHS Our Future: NHS Next Stage Review - Leading Local Change*, May 2008