London Ambulance Service NHS
NHS Trust

Healthcare for London: The Shape of Things to Come

The response of
London Ambulance Service NHS Trust

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Introduction

This paper constitutes the London Ambulance Service (LAS) response to *'The shape of things to come: Developing new, high-quality major trauma and stroke services for London*' (TSOTTC).

It describes the LAS's views on providing the best care for major trauma and stroke patients. It sets out the implications for the ambulance service of the Healthcare for London proposals and proposes the LAS contribution to making them a reality.

1. The principle of specialisation

The London Ambulance Service supports the principle of concentrating specialist care services so that each centre sees enough patients to develop an expertise in the area of care.

Since April 2006 the LAS has bypassed local A&E Departments in order to convey patients who have experienced an ST elevation myocardial infarction (STEMI) to cardiac catheter centres. As a result, in London STEMI patients receive treatment from highly experienced staff, equipped 24/7 to provide specialist care. These centres offer primary percutaneous coronary intervention (PCI), a procedure for which international studies have provided evidence of improved survival rates for patients, when compared to adminstering treatment locally.[1]

2. Major trauma

The LAS supports the regionalisation of trauma care using networks to provide the best care for our patients. Major trauma represents less than 0.1% of the calls to which we respond; however these patients often have very complex needs which evidence suggests are best met in a specialist unit.

The LAS are already in a good position to implement these changes. We actively engage with HfL and the trauma networks in the development of the proposals. We also have a strong relationship with the Helicopter Emergency Medical Service (HEMS) with whom we will continue to work closely in the provision of pre-hospital trauma care.

A network approach for trauma enables our staff to continue transporting injured patients to their nearest trauma centre, while ensuring the most severely injured are conveyed directly to a major trauma centre with the capacity, equipment and experienced staff available 24/7 to provide specialist treatment to patients with complex injuries.

[1] "Long-term Outcome of Primary Percutaneous Coronary Intervention vs Prehospital and In-Hospital Thrombolysis for Patients With ST-Elevation Myocardial Infarction." Stenestrand, Lindback, Wallentin. Journal of the American Medical Association, October 11 2006.

The configuration of trauma networks outlined in HfL's preferred option (The Royal London, Kings College Hospital, St Georges Hospital ad St Mary's Hospital) provides good coverage for London, particularly as most major trauma occurs in central London. The LAS are confident that all London patients would be within a 45 minute blue light ambulance journey of these four hospitals.

The provision of four major trauma centres provides resilience in the event of a major incident, ensuring that the severely injured can still be catered for in the event that one of the major trauma centres is unavailable. However, the throughput of patients in a major trauma centre is imperative to its success. We do have concerns regarding the number of major trauma patients four centres would see and the impact this would have on their capacity to sustain their skills.

In order for St Mary's Hospital to meet the requirements required for designation as a major trauma centre, this hospital would not be online to receive major trauma patients until 2012. Robust interim arrangements are required to ensure that the patients within St Mary's network are effectively provided for during this period.

The effective triage of patients to the most appropriate destination will be vital to the success of these plans. The LAS has been engaging with HfL and the trauma networks to ensure a pan-London approach is taken to appropriate triage and patient destination criteria. For instance, trauma centres with neurological facilities will still receive "isolated" head injuries and we will need to ensure LAS staff are trained to facilitate this.

Our staff are already trained in how to treat patients with trauma. However, to support the new system, we will need to equip crews with the skills to make decisions around the most appropriate destination for patients, as outlined in 2.7.

The regionalisation of trauma services has resource implications for the LAS. Conveying our patients to a major trauma centre will result in increased job cycle times. Additional resources will be required to ensure that this does not impact on the rest of our patients.

The movement of services from one hospital to another will increase the number of transfers which will be required, especially from hospitals in outer London. LAS recommend that this future demand is forecast and planned for.

3. Stroke

This section addresses the HfL proposals for stroke patients.

As the only NHS Trust with responsibility for delivering services to patients across London, LAS are currently able to convey some patients to genuine centres of excellence. At these locations 24/7 access to CT scans, consultant opinion, thrombolysis (where appropriate), and other services are reducing mortality and morbidity among stroke patients. However, in many areas there is simply no such out of hours provision and patients can wait up to 48 hours after

arriving in A&E before assessments are carried out. This situation is unacceptable.

LAS also understand that, whilst our workload focuses on the emergency care offered to stroke patients, the whole pathway for all stoke patients needs improving if Londoners are to receive world class care. With this in mind LAS fully support the approach to implement better services for both stroke and TIA, and to focus on public education and rehabilitation of patients as well as emergency care.

By playing a key role in initiatives such as the South West London Stroke Pilot, LAS have proven their eagerness to help address current shortcomings in the system and are keen to implement a single pathway for all FAST+ patients within London. This is because, despite the success of pathways like those in South West London, the presence of different protocols for stroke patients in various parts of London causes difficulties for LAS.

LAS fully support the proposals of developing eight Hyper Acute Stroke Units to which all FAST+ patients will be conveyed for initial treatment and assessment. Establishing eight centres will ensure that each unit receives enough patients to make it viable whilst keeping journey times to a reasonable length, especially for those FAST+ patients who will benefit from thrombolysis whose journey is therefore time critical.

The locations suggested by TSOTTC are in the right place to ensure that LAS can reach them within thirty minutes of leaving a patient's home, as stipulated as part of a gold standard, three-hour, call-to-needle time.

LAS have confidence that some of the HASU sites nominated could deliver stroke care to the standards required almost immediately. However, as the bid document acknowledges, there are several sites which will require a much longer lead in time to deliver the required level of care. LAS are pleased that assistance will be offered to these sites from other trusts with established stroke expertise, but are conscious of the likely impact of a staggering the introduction of improvements across London. Separate protocols in different areas dilute the effectiveness and public understanding of the benefits which could be delivered by a genuine pan-London pathway.

Regardless of the timings for 'go live' with each HASU, the transition from current to future levels of provision will need to be carefully scoped, planned and implemented. A key concern for LAS is the roll out of services where one HASU's go-live date may lag significantly behind (i.e. up to two years) it's neighbour. Should such a situation arise, decisions about which patients should be conveyed to the new up and running HASU which were based solely on postcodes would be difficult for LAS to support. In the event that there is a lack of capacity within the system for a significant period of time, LAS would support defining patient eligibility based around need and their potential to benefit from the services offered. For instance, rather than open up the stroke pathway to half the residents of a sector, a better clinical case could be made for making all residents within a sector eligible, if they could be conveyed to that HASU within three hours of on-set of symptoms.

The suggested sites for stroke units appear to offer a good distribution of centres to allow patients to undergo rehabilitation close to their homes and/or families. The LAS believe that each HASU should set up protocols to transfer patients to stroke units by a Patient Transport Service (PTS) provider, as these journeys will not fall under the LAS's A&E contract.

LAS do not differentiate between stroke or TIA and therefore will convey all FAST+ patients to the nearest HASU, even those whose symptoms have begun to subside. With this in mind LAS support the provision of TIA clinic as a mandatory requirement for HASUs.

Compared to major trauma, there is relatively little in the way of extra training which LAS staff will require:

- Crews are already trained in FAST
- A new version of our call prioritisation software has already been implemented which now categorises FAST+ patients with onset of symptoms within 2 hours as Category "A" (target response: 8 minutes). Previously they would have received a Category "B" response, the target for which is 19 minutes.
- LAS staff are already familiar with the concept of conveying patients further to receive definitive care having implemented the UK's first model which diverts STEMI patients to one of eight Heart Attack centres rather than their local A&E
- In order to implement LAS's part of the pathway, a communications exercise is required to brief staff.

Conveying patients longer distances to HASUs means that resources which would have responded to calls will not be in their usual area and will take longer to return. Given that HfL's proposals are designed to treat the c11,500 patients who have a stroke in London each year, the majority of whom will be conveyed to a HASU via ambulance, it is imperative that LAS are funded to cover the extra journey times if a high level of service is to be sustained for the rest of the population. Without this extra funding, both for the fully rolled-out model and to cover any interim arrangements, LAS will not be able to offer the level of care required to support both FAST positive patients and the rest of London's health needs.

4. Conclusion

This paper has described the view of the London Ambulance Service on '*The shape of things to come: Developing new, high-quality major trauma and stroke services for London*.' The London Ambulance Service is in fact key to the successful realisation of the vision in the document.