Office of the
Trust Special Administrator
of MSFT

Mid Staffordshire NHS
NHS Foundation Trust

# The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust

## Trust Special Administrators' Final Report

## Volume Three

## Supporting information and analysis

December 2013

Office of the
Trust Special Administrator
of MSFT

# The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust

## Trust Special Administrators' Final Report

## Volume Three

## Supporting information and analysis

Presented to Parliament pursuant to s.65I of the National Health Service Act 2006

Any enquiries related to this publication should be sent to tsapublic@midstaffs.nhs.uk.

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# The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust

## Annex 3.1: Local CCG strategies

Published April 2013

NHS
Stafford and Surrounds
Clinical Commissioning Group

...First class healthcare

Commissioning Prospectus
2013 - 2014

## Foreword

As Chair of the Stafford and Surrounds Clinical Commissioning Group (CCG), I am privileged to share with you our Commissioning Prospectus for 2013/2014. The Prospectus demonstrates how clinicians will use their close relationship with patients and partners to focus on the key health challenges in Stafford and its surrounding villages, use tax payers money efficiently and, most importantly of all, deliver improved health outcomes for our residents.

The CCG was authorised as a statutory body in April 2013 and since then I have taken some time to reflect on how our CCG will be able to deliver these promises. One might be tempted to say that now isn't the right time to "give GPs the reins". However, I believe that this document will convince readers that unless GPs and the patients they serve are at the heart of the commissioning process we cannot maintain the current rates of health improvement.

The NHS is subject to the same financial pressures as all other organisations. By working with skilled managerial staff, using robust evidence and, where necessary, taking bold decisions, the people of Stafford and its villages can expect to gain longer, healthier lives.

Where possible we will work with our community to deliver the services they need in a way that is most acceptable to them. However, we may not always be able to deliver their preferences and when we cannot we will listen to challenges and share our reasons.

Finally, the Stafford health community has been much in the spotlight and no one can fail to understand the importance of ensuring patients receive high quality care. This is care that is safe and reliable, makes best use of innovation in technology and systems, avoids waste and works to prevent disease and its impact on people's lives.

These are my words but they are not enough. Throughout this document you will see the words of many experts. The experts are our patients and residents. It is their words which will convince the readers that the plan is the right plan for Stafford and Surrounds.

Dr Margaret Jones
Chair,
Stafford &
Surrounds CCG

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## Our Vision

The people of Stafford and its surrounding villages receive first class health care leading to a high quality patient experience and excellent outcomes.

## Introduction

The objective of this Prospectus is to 'tell the story' of the health needs of the people of Stafford and its surrounding villages.

It sets out the key health priorities for our population, describes the standards that local people can expect from the services we commission on their behalf and provides information how the budget for these services will be spent.

The Prospectus explains how the views of the population have been, and will continue to be heard, and demonstrates how we will work with key partners to address health inequalities and deliver improved health outcomes for our population.

We are committed to working closely with the Health & Wellbeing Board to ensure a coordinated approach to promoting the health and wellbeing of residents in Stafford and surrounds.

## Who are we?

Clinical Commissioning Groups (CCGs) are groups of General Practitioners (GPs) that are responsible for planning and designing local health services in England. They will do this by 'commissioning' or buying health and care services including:

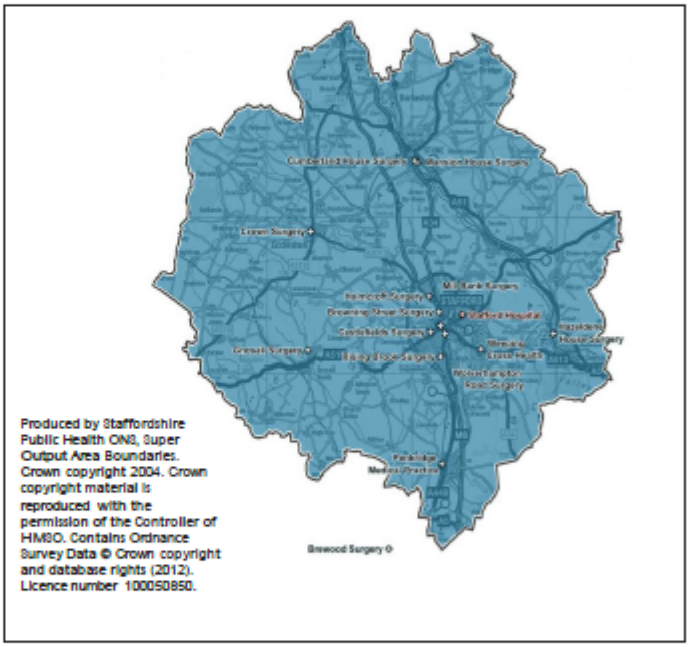
- Planned hospital care
- Urgent and emergency care
- Rehabilitation and Community health services
- Mental health and learning disability services

CCG boards are made up of GPs from the local area, at least one registered nurse and one secondary care specialist doctor. All GP practices have to belong to a Clinical Commissioning Group.

Stafford & Surrounds Clinical Commissioning Group (SAS CCG) was authorised in April 2013 following a year of shadow working as a sub-committee of South Staffordshire Primary Care Trust. The CCG is working closely with our patients to improve health outcomes by commissioning high quality, evidence based services.

The CCG currently has 14 GP practices serving a population of approximately 144,000 residents.

**Stafford and Surrounds CCG Practice Locations**



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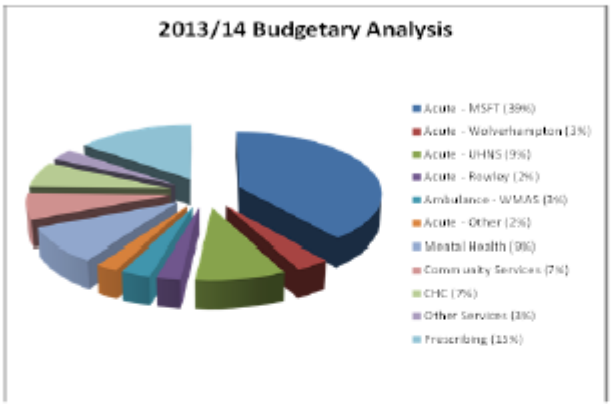
Of the 14 practices, 12 are within the Stafford District (representing approximately 126,000 patients) with the remaining two practices, Brewood and Penkridge, in the South Staffordshire District

The CCG, which falls within the Prospering UK cluster as defined by the Office of National Statistics, faces a number of challenges, not least the special administration of the main acute provider – Mid Staffordshire NHS Foundation Trust.

## How we spend our money?

The CCG spends the majority of its £154m clinical budget on acute hospital care (59%), followed by prescribing (15%), mental health (8%) and community services (7%). The table below shows the budgetary analysis by service area.




## Our Values

The CCG has a strong clinical focus and a good record of engagement with partners, which is reflected in our values. These are:

- Quality First.
- Prevention of ill-health.
- Decisions driven by the views and involvement of our patients.
- Integration with a wide range of Partners.
- Openness and honesty in all that we do.
- Contribution of all our members and staff.

## Our Enduring Goals

Our Enduring Goals will enable the CCG to prioritise its work and investments. By March 2022, the CCG will achieve five enduring goals:

1. A reduction of 10% in levels of obesity against the expected prevalence
2. A reduction in the proportion of people with undiagnosed disease from 30% to 10%
3. A 'levelling up' of health outcomes so all residents experience the same health outcomes
4. A reduction in excess winter deaths of 50%
5. A reduction of 50% in unplanned admissions to Hospital for people with Long Term Conditions

## The Challenges

The Population of Stafford and its surrounding villages are well educated, affluent and in good health. Men live six months longer and women live nine months longer than the England average.

The population is aging and has a rural element that is above the Staffordshire average (31%). Like other parts of Staffordshire, the expected prevalence shows a significant number of people may be undiagnosed or unrecorded on disease registers.

In the main, the local population has lower levels of smoking and obesity than the rest of the country and childhood obesity is below the county and national average. However, there are pockets of deprivation where health outcomes are less favourable.

There is one ward in Stafford (Littleworth) that is in the 10% most deprived in England and three wards in the top 20% of most deprived (Penkside, Highfields and Western Downs) where teenage pregnancy and smoking during pregnancy is higher and breast feeding is lower than the England average.

Other areas where the District performs worse than the Staffordshire average are Carer's Support, winter deaths and accidental injuries.

Within the area, there is both a male prison and female prison with a total population of almost a thousand prisoners.

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## The Challenges (cont)

There has been a stark rise in emergency admissions of 15%, against a national increase of 7%, over the past five years. Alcohol related admissions are also increasing, although they remain below the national average.

Quality Outcomes Framework (QOF) data highlights a high prevalence of cancers. Higher prevalence is associated with age; however, analysis shows that even when adjusted for age, incidence of prostrate, colorectal and breast cancer is higher than anticipated.

The CCG faces a well publicised challenge relating to its main acute hospital, Mid Staffordshire NHS Foundation Trust (MSFT), which has been the subject of an independent public enquiry following significant safety concerns.

In January 2013, the Contingency Planning Team reported that MSFT was no longer clinically or financially viable and is now under the administration of the Trust Special Administrator (TSA). Following a consultation period, the TSA will make recommendations to the Secretary of State around the future of the organisation and services it provides. The overall priority for the CCG is to ensure the delivery of consistently high quality care in the most appropriate place and the most efficient way.

## Giving Patients a Say

The CCG recognises the importance of engaging the local community in shaping the service priorities and how they will be delivered. It regularly works with Staffordshire Healthwatch, as well as community organisations such as the South Staffordshire Network for Mental Health and the Carer's Association.

Within the CCG, each GP practice group has a Patient Participation Group (PPG) which links into a district-wide PPG, creating a two-way flow of information with the CCG. In addition, the CCG has a lay member whose role is to champion patient and public engagement at Board level.

**"The bottom line for the NHS is not money but the care we give to people."**

*Stafford Resident, Town Centre Vox Pop, July 2012*

In March 2013, the CCG launched Conversation Staffordshire in partnership with Staffordshire Healthwatch and Engaging Communities. The ongoing project aims to engage with the whole population in a more responsive and accessible way using technology and innovation where appropriate.

## Our Track Record

Building on the foundations of Practice Based Commissioning (PBC); the CCG has a track record of delivery:

### Commissioning for Safety

In response to issues raised by patients, it became evident that the Stroke service at MSFT was not compliant with national standards. The CCG led the process to reconfigure services to Specialist Centres. Public Health data now shows that 120 lives have been saved since the changes were introduced.

### Provision of Care Closer to Home

The CCG has redesigned a number of services including Diabetes, ENT Triage and Treatment, Dermatology, Falls, Glaucoma Triage, and Stroke ensuring that more care is delivered in the community setting, enhancing access, and improving service quality and cost efficiency.

The redesign of Respiratory & Heart Failure Services, Intermediate Care Services and the Children's Community Nursing Service has reduced attendances and readmissions to hospital

## Everyone Counts – SAS CCG Delivery Plan – 2013/14

| Programmes | Transformation Schemes | Outputs |
|---|---|---|
| **Planned Care**<br>The CCG is an outlier in relation to the National and ONS median for elective admissions and above ONS median for 1st OPA.<br>A strategy for the reconfiguration of planned care pathways has been agreed with local providers.<br>This will undergo review following the outcomes of the monitor report at MSFT | - Better care pathways and GP to consultant communication reducing growth in hospital referrals and subsequent treatments.<br>- Reduction in outpatient follow-ups and face to face consultations.<br>- Optimisation of treatment at the appropriate time avoiding unnecessary interventions | - Reduction in first outpatient attendance<br>- Reduction in elective admissions, removing unnecessary steps and improving patient experience<br>- Improved follow-up ratios avoiding unnecessary appointments<br>- Reduction in procedures of low clinical value |
| **Unplanned Care**<br>The CCG is an outlier in relation to the National and ONS median for non-elective admissions<br>There is a local agreement to transform the emergency and urgent care system. This will include the development of an ambulatory care unit, review of MIU's, GP OOH's and a model for integrated and social care. The CCG is also exploring the introduction of a GP enhanced LES to reduce unnecessary hospital admissions | - EUCS – modernising services which are sustainable and of high quality across the health economy. Implementation of NHS 111, AEC model, review of MIU's and ICT/social care model<br>- Nursing homes – targeted support to nursing homes to avoid unnecessary hospital admissions<br>- Winter Deaths – to work with Stafford Health & Wellbeing Board to support warmer homes policy<br>- Increase uptake of flu vaccinations for over 65s and carers | - Reduction in A&E attendances or emergency admissions<br>- Reduction in A&E or emergency admissions. Delivery of care closer to home, easy access and improved patient satisfaction<br>- Excess winter deaths within national average<br>- Increased uptake of vaccinations and reduction in flu and pneumonia cases |
| **Coordinated Care**<br>To develop a holistic integrated care model which encompasses a preventative, anticipatory and whole person approach to ensure that patients with LTC, dementia and mental health problems feel supported to manage their condition, have improved functional ability and can access care closer to home. A seamless integration of care across all sectors | - LTC – Provision of high quality integrated care through risk stratification and case management. Care pathway reviews and patient self-management<br>- Dementia – Increased diagnosis rates and improved access to treatment, ensuring capacity for step-down and on-going treatment<br>- Mental Health – Improved access to services<br>- Increase number of diagnosed patients with hypertension<br>- Improve patients' health and wellbeing and increase numbers on disease registers<br>- Management of unwarranted variation across practices in relation to referrals across planned and unplanned care | - Reduction in A&E attendances/emergency admissions<br>- Increased number of diagnosed patients on the register, accessing services and support<br>- Increased patients accessing treatment<br>- Sustainability of patients in recovery within two years<br>- Increased number of patients diagnosed with hypertension<br>- Increased number of patients on GP disease registers<br>- Reduction in referrals and activity in secondary care |
| **Primary Care**<br>Clinically appropriate evidence based performance of care linked to local quality premium under development | | |

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing quality of life for people with long term conditions
- Domain 3: helping people to recover from episodes of ill health and following injury
- Domain 4: Ensuring people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

**Underpinned by 5 National Outcomes**

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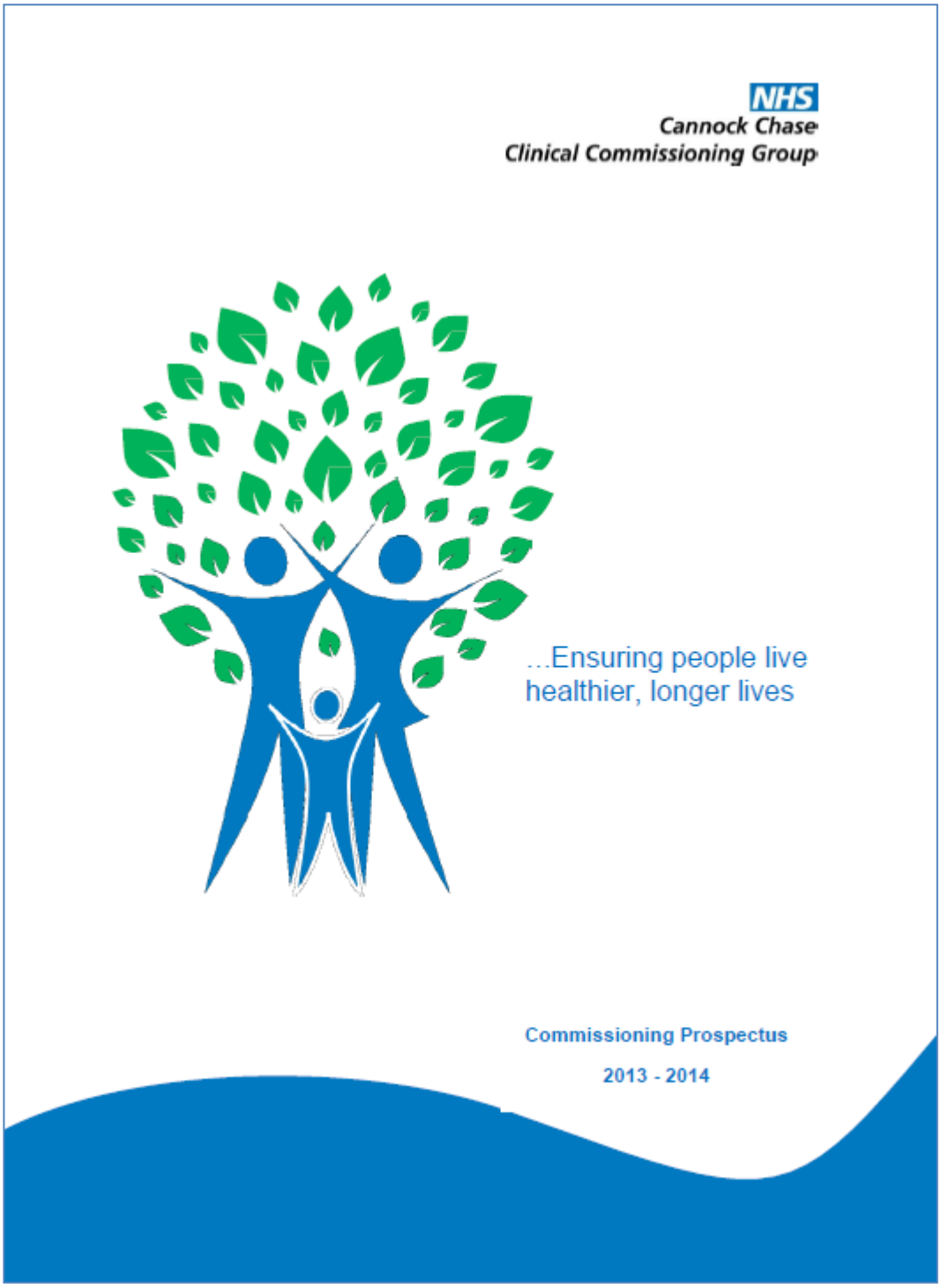

NHS
Cannock Chase
Clinical Commissioning Group
...Ensuring people live
healthier, longer lives
Commissioning Prospectus
2013 - 2014

## Foreword

Cannock Chase Clinical Commissioning (CCG) Group believes that clinical leadership will make a genuine difference to our population's health and their experiences of healthcare. It will place patients at the centre of our decision making.

Our Commissioning Prospectus describes the CCG's vision, goals and ambitions for the future, recognising the challenges we currently need to address.

By focusing on quality, the CCG will continue to ensure that it commissions high quality, safe services for all those who need health care.

An emphasis on patient education and prevention will ensure we continue to address the high levels of preventable ill health and reduce the health inequalities that are experienced in our communities.

In order to achieve the greatest health improvements for the local population, we will continue to work collaboratively with patients, public, our providers, other Clinical Commissioning Groups, the Local Authority, District Councils and the Voluntary sector to deliver the work outlined in our commissioning intentions.

We are committed to working closely with the Health & Wellbeing Board to ensure a coordinated approach to promoting the health and wellbeing of residents in Cannock Chase.

I believe the creation of Cannock Chase CCG will make a significant difference for patients and the local population. Our Commissioning Prospectus outlines how our patients will achieve a higher quality of life and longer life expectancy.

Dr Johnny McMahon
Chair,
Cannock Chase CCG

## Our Vision

Cannock Chase Clinical Commissioning Group (CCG) will commission high quality and safe services to ensure people live healthier, longer lives.

## Introduction

The CCG's Commissioning Prospectus is written for the 132,000 people who make up the localities within Cannock Chase. Each of the localities has their own health challenges in terms of poor health outcomes, high levels of health inequality and pockets of deprivation.

The CCG recognises these differences and the challenges presented for the future, particularly for those aged over 65 with long term conditions, people dying prematurely from cancer, cardio-vascular disease and obesity.

The objective of this Prospectus is to 'tell the story' of the health needs of the people of Cannock Chase. It sets out the key health priorities for our population, describes the standards that local people can expect from the services we commission on their behalf and provides information how the budget for these services will be spent.

The Prospectus explains how the views of the population have been, and will continue to be heard, and demonstrates how we will work with key partners to address health inequalities and deliver improved health outcomes for our population.

## Who are we?

Clinical Commissioning Groups (CCGs) are groups of General Practitioners (GPs) that are responsible for planning and designing local health services in England. They will do this by 'commissioning' or buying health and care services including:

- Planned hospital care
- Urgent and emergency care
- Rehabilitation and Community health services
- Mental health and learning disability services

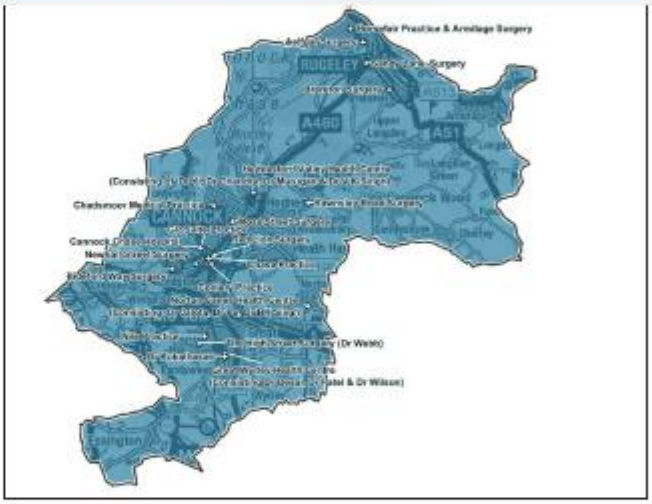
Cannock Chase CCG is a relatively new organisation that was authorised in April 2013 following a year of shadow working as a sub-committee of South Staffordshire Primary Care Trust.

The CCG is led by local GPs from the 27 GP practices in the area.

From its inception, clinicians have only been willing to participate in commissioning if they saw their involvement as a continuation of the care they provide to the patients in their own practices.

From the earliest days, it has been the opportunity to improve the quality of clinical services that has led to clinical engagement.

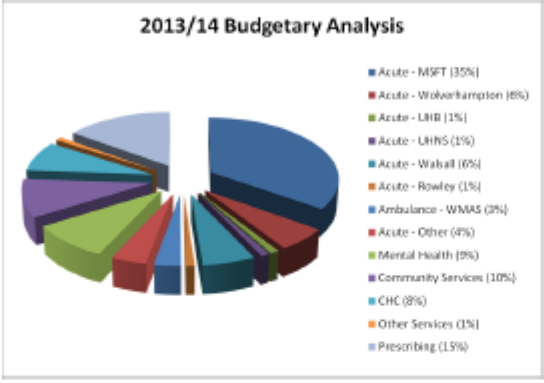
**Cannock Chase CCG Practice Locations**




CCG boards are made up of GPs from the local area, at least one registered nurse and one secondary care specialist doctor. All GP practices have to belong to a Clinical Commissioning Group.

## How we spend our money?

The CCG spends the majority of its £151m clinical budget on acute hospital care (50%), followed by prescribing (15%), mental health (9%) and community services (10%). The table below shows the budgetary analysis by service area.




## Our Values

The CCG has set a clear direction based on patients' needs, which is reflected in its values:

- Prevention: Increasing the years of quality living through targeted interventions.
- Quality: Commissioning high quality, safe treatment and care focused on individual needs.
- Education: Educating patients to improve self-care.
- Innovation: Responding to needs through engagement, innovation and change.

## Our Enduring Goals

Our Enduring Goals will enable the CCG to prioritise its work programmes and investments in a changing environment. By March 2017 CC CCG will achieve four enduring goals:

1. Reduce health inequalities across Cannock Chase through targeted interventions.
2. Identify and support patients with long term conditions to ensure care delivery is closer to home.
3. Improve and increase overall life expectancy.
4. Develop integrated services with simple, easy access.

## The Challenges

The Staffordshire Joint Strategic Needs Assessment highlights particular health and wellbeing challenges for the residents of Cannock Chase. Some of the key health priorities for the area are detailed below:

Cannock Chase CCG is set to see a significant growth in those aged 65 and over (73% compared with 65% nationally).

Over a third of the population of Cannock Chase fall within the most deprived quintile (bottom 20%) of England for education, skills and training.

23% of the people of Cannock Chase fall within the most deprived quintile for employment deprivation compared with 18% nationally and 14% for Staffordshire. One in five children is defined as living in poverty.

People are living longer, however, the gap between Cannock Chase and England is widening. Life expectancy for the area is lower than the national average, with men living 15 months and women living 10 months less.

In addition, there is a marked variation in the life expectancy across the CCG area; the gap for men is 6.5 years and for women, 2.8 years.

## The Challenges (cont)

The CCG faces a well publicised challenge relating to its main acute hospital, Mid Staffordshire NHS Foundation Trust (MSFT), which has been the subject of an independent public enquiry following significant safety concerns.

In January 2013, the Contingency Planning Team reported that MSFT was no longer clinically or financially viable and is now under the administration of the Trust Special Administrator (TSA).

Following a consultation period, the TSA will make recommendations to the Secretary of State around the future of the organisation and services it provides.

In addition, the role of Cannock Chase Hospital and the provision of locally accessible services is also under review.

The overall priority for the CCG is to ensure the delivery of consistently high quality care in the most appropriate place and the most efficient way.

## Giving Patients a Say

The CCG recognises the importance of engaging the local community in shaping the service priorities and how they will be delivered. It regularly works with Staffordshire Healthwatch, as well as community organisations such as the South Staffordshire Network for Mental Health and the Carer's Association.

The CCG has a network of patient participation groups connected to GP practices as well as Resident Champions, which act as conduits to the wider community. The Resident Champions represent their communities, including the GP practice groups within them, at a district-wide Communications and Engagement Sub-Committee, creating a two-way flow of information with the CCG.

In March 2013, the CCG launched Conversation Staffordshire in partnership with Staffordshire Healthwatch and Engaging Communities. The ongoing project aims to engage with the whole population in a more responsive and accessible way using technology and innovation where appropriate.

In addition the CCG has a Lay Member whose role is to champion patient and public engagement at Board level.

## Our Track Record

Building on the foundations of Practice based Commissioning; the CCG has a track record of delivery:

### Commissioning for Safety

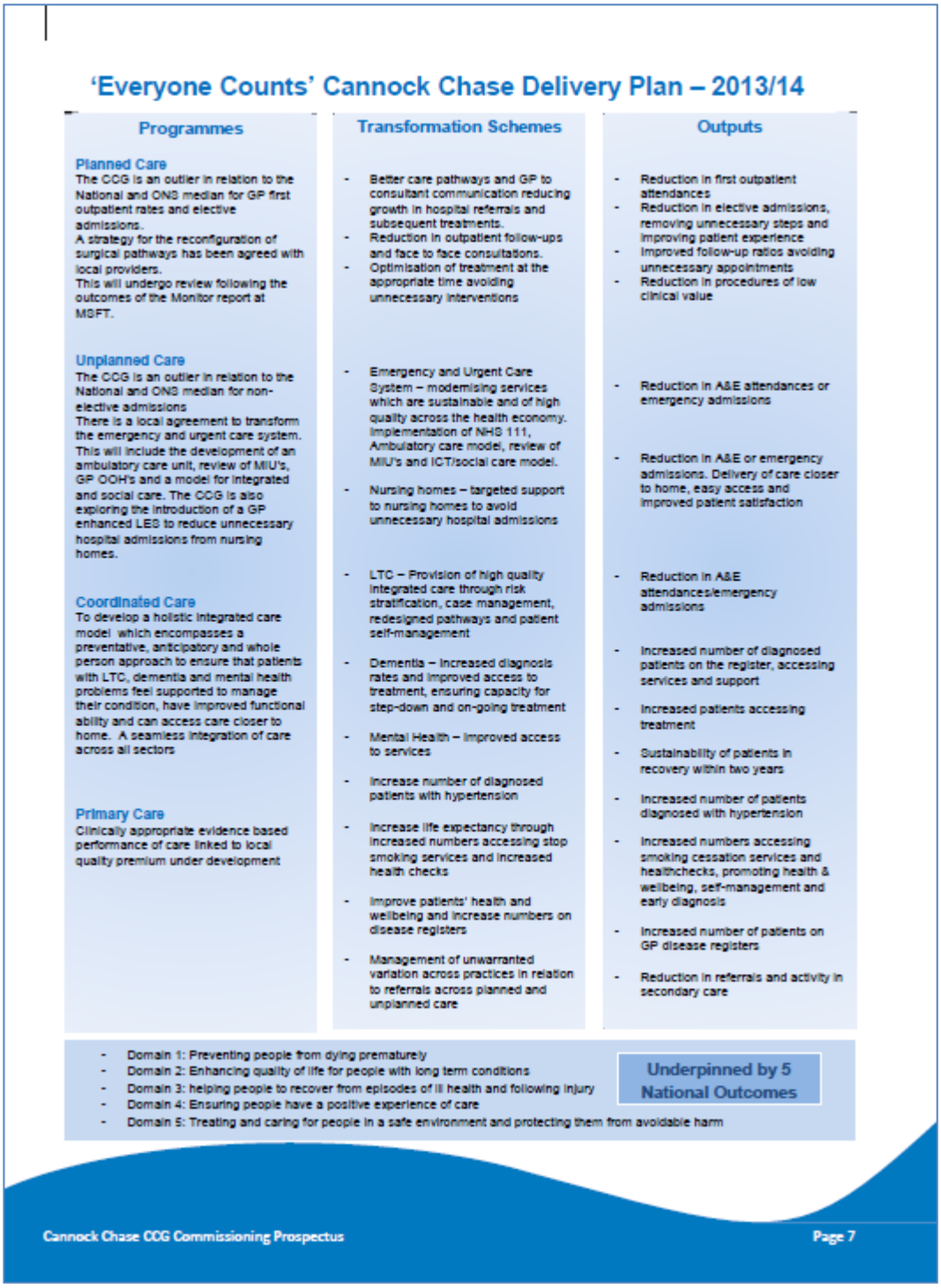
In response to issues raised by patients, it became evident that the Stroke service at MSFT was not compliant with national standards. The CCG led the process to reconfigure services to Specialist Centres and Public Health data now shows that 120 lives have been saved since the changes were introduced.

### Provision of Care Closer to Home

The CCG has redesigned a number of services including Diabetes, ENT Triage and Treatment, Dermatology, Falls, Glaucoma Triage, and Stroke ensuring that more care is delivered in the community setting, enhancing access, and improving service quality and cost efficiency.

The redesign of Respiratory & Heart Failure Services, Intermediate Care Services and the Children's Community Nursing Service has also reduced attendances and readmissions to hospital.

The CCG has introduced large scale prevention programmes, such as the integrated weight management service, which has improved access to services for over 2,500 patients every year.



## 'Everyone Counts' Cannock Chase Delivery Plan – 2013/14

| Programmes | Transformation Schemes | Outputs |
|---|---|---|
| **Planned Care**<br>The CCG is an outlier in relation to the National and ONS median for GP first outpatient rates and elective admissions.<br>A strategy for the reconfiguration of surgical pathways has been agreed with local providers.<br>This will undergo review following the outcomes of the Monitor report at MSFT. | - Better care pathways and GP to consultant communication reducing growth in hospital referrals and subsequent treatments.<br>- Reduction in outpatient follow-ups and face to face consultations.<br>- Optimisation of treatment at the appropriate time avoiding unnecessary interventions | - Reduction in first outpatient attendances<br>- Reduction in elective admissions, removing unnecessary steps and improving patient experience<br>- Improved follow-up ratios avoiding unnecessary appointments<br>- Reduction in procedures of low clinical value |
| **Unplanned Care**<br>The CCG is an outlier in relation to the National and ONS median for non-elective admissions<br>There is a local agreement to transform the emergency and urgent care system. This will include the development of an ambulatory care unit, review of MIU's, GP OOH's and a model for integrated and social care. The CCG is also exploring the introduction of a GP enhanced LES to reduce unnecessary hospital admissions from nursing homes. | - Emergency and Urgent Care System – modernising services which are sustainable and of high quality across the health economy. Implementation of NHS 111, Ambulatory care model, review of MIU's and ICT/social care model.<br>- Nursing homes – targeted support to nursing homes to avoid unnecessary hospital admissions | - Reduction in A&E attendances or emergency admissions<br>- Reduction in A&E or emergency admissions. Delivery of care closer to home, easy access and improved patient satisfaction |
| **Coordinated Care**<br>To develop a holistic integrated care model which encompasses a preventative, anticipatory and whole person approach to ensure that patients with LTC, dementia and mental health problems feel supported to manage their condition, have improved functional ability and can access care closer to home. A seamless integration of care across all sectors | - LTC – Provision of high quality integrated care through risk stratification, case management, redesigned pathways and patient self-management<br>- Dementia – Increased diagnosis rates and improved access to treatment, ensuring capacity for step-down and on-going treatment<br>- Mental Health – Improved access to services<br>- Increase number of diagnosed patients with hypertension<br>- Increase life expectancy through increased numbers accessing stop smoking services and increased health checks<br>- Improve patients' health and wellbeing and increase numbers on disease registers<br>- Management of unwarranted variation across practices in relation to referrals across planned and unplanned care | - Reduction in A&E attendances/emergency admissions<br>- Increased number of diagnosed patients on the register, accessing services and support<br>- Increased patients accessing treatment<br>- Sustainability of patients in recovery within two years<br>- Increased number of patients diagnosed with hypertension<br>- Increased numbers accessing smoking cessation services and healthchecks, promoting health & wellbeing, self-management and early diagnosis<br>- Increased number of patients on GP disease registers<br>- Reduction in referrals and activity in secondary care |
| **Primary Care**<br>Clinically appropriate evidence based performance of care linked to local quality premium under development | | |

- Domain 1: Preventing people from dying prematurely
- Domain 2: Enhancing quality of life for people with long term conditions
- Domain 3: Helping people to recover from episodes of ill health and following injury
- Domain 4: Ensuring people have a positive experience of care
- Domain 5: Treating and caring for people in a safe environment and protecting them from avoidable harm

Underpinned by 5 National Outcomes

Cannock Chase CCG Commissioning Prospectus Page 7

Office of the
Trust Special Administrator
of MSFT

# The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust

## Annex 3.2: Clinical advisors to the TSAs – terms of reference and meeting notes

December 2013

# 1. Trust Special Administrator for MSFT - National Clinical Advisory Group: Terms of reference

A medical National Clinical Advisory Group (CAG) has been established by the Trust Special Administrators (TSAs) to provide them with independent advice on the clinical safety of proposed future models for the services which are currently provided by Mid Staffordshire NHS Foundation Trust (MSFT or the Trust).

Membership of the CAG is selected by the Academy of Medical Royal Colleges from experienced clinicians nominated by individual Medical Royal Colleges or Faculties.

The remit of the CAG is to:

- Provide clinical advice to the TSAs who retain responsibility for all decisions and recommendations to the Secretary of State for Health.
- Provide its advice on the basis of available evidence, standards and current practice in the UK for ensuring the safety and quality of clinical services for the benefit of patients.
- Comment, on the basis of the information available, on the clinical safety of proposals presented to the CAG by the TSAs rather than recommend ideal services which no organisation has offered to provide.
- Comment on any aspect of the clinical safety of proposals for example:
    - Whether a proposal appears clinically safe or unsafe exactly as it is;
    - What adjustments or amendments would be required to make a proposal clinically safe;
    - The circumstances in which a proposal would or would not be clinically safe;
    - The evaluation required on an on going basis to judge whether the proposals remain clinical safe; and
    - Whether they move services closer to designated college clinical standards.
- Comment on the extent it believes specific proposals would or would not support the recruitment, retention, training and continuing professional development of appropriate medical staff.
- Acknowledge that the TSAs will make public, if required, any advice given and the rationale for the advice.

It is <u>not</u> the role of the CAG to:

- To design the initial tender for services nor stipulate which are the Location Specific Services (LSS) in the tender.
- To devise its own proposals for services currently provided by the Trust.
- To promote or support the interests of any groups of individuals or organisations.
- Make judgments or recommendations on the relative costs and benefits of proposals although it may choose to state what it believes to be the best option(s) for service provision.

It should be noted that a statement that a proposal is or could be safe should not be taken as formal endorsement by the CAG or any individual Medical Royal College or Faculty of a particular scheme or provider.

Individual Medical Royal Colleges or Faculties will be free to support or promote any specific proposals although it is expected that they will acknowledge any advice or recommendations of the CAG in respect of the clinical safety of proposals or the implications for the recruitment and retention of medical staff.

# 2. Trust Special Administrator for MSFT - National Nursing and Midwifery Advisory Group: Terms of reference

A medical Nursing and Midwifery Clinical Advisory Group (Nurse CAG or NCAG) has been established by the TSAs to provide them with independent advice on the clinical safety of proposed future models for the services which are currently provided by MSFT.

Membership of the NCAG comprise from senior nurses within the NHS.

The remit of the NCAG is to:

- Provide clinical advice to the TSAs who retain responsibility for all decisions and recommendations to the Secretary of State for Health.
- Provide its advice on the basis of available evidence, standards and current practice in the UK for ensuring the safety and quality of clinical services for the benefit of patients.
- Comment, on the basis of the information available, on the clinical safety of proposals presented to the Nurse CAG by the TSAs rather than recommend ideal services which no organisation has offered to provide.
- Comment on any aspect of the clinical safety of proposals for example:
    - Whether a proposal appears clinically safe or unsafe exactly as it is;
    - What adjustments or amendments would be required to make a proposal clinically safe;
    - The circumstances in which a proposal would or would not be clinically safe;
    - The evaluation required on an on-going basis to judge whether the proposals remain clinical safe; and
    - Whether they move services closer to designated college clinical standards.
- Comment on the extent it believes specific proposals would or would not support the recruitment, retention, training and continuing professional development of appropriate medical staff.
- Acknowledge that the TSAs will make public, if required, any advice given and the rationale for the advice.

It is <u>not</u> the role of the NCAG to:

- To design the initial tender for services nor stipulate which are the LSS in the tender.
- To devise its own proposals for services currently provided by MSFT.
- To promote or support the interests of any groups of individuals or organisations.
- Make judgments or recommendations on the relative costs and benefits of proposals although it may choose to state what it believes to be the best option(s) for service provision.

It should be noted that a statement that a proposal is or could be safe should not be taken as formal endorsement by the NCAG or the Royal College of Nursing of a particular scheme or provider.

# 3. CAG and NCAG: Meeting notes

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Meeting of the National Clinical Advisory Group**

**Date: 09/05/12**

**Time: 10:00 – 12:30**

**Location: Academy of Medical Royal Colleges**

**Attendees:**

| | |
|---|---|
| Professor Terence Stephenson | Academy of Medical Royal Colleges |
| Alastair Henderson | Academy of Medical Royal Colleges |
| Professor Robert Shaw | Royal College of Obstetricians and Gynaecologists |
| David Shortland | Royal College of Paediatrics and Child Health |
| Patrick Cadigan | Royal College of Physicians |
| Professor Peter Furness | Royal College of Pathologists |
| Dr JP Besouw | Royal College of Anesthetists |
| Dr Gary Cook | Faculty of Public Health |
| Jim Wardrope | College of Emergency Medicine |
| Professor George Youngson | Royal College of Surgeons |
| Hugo Mascie-Taylor | TSA |
| Gillian Cooksley | TSA |
| Phil Britt | TSA |
| Masha Feigelman | TSA |
| Penny Dash | TSA |

**Meeting notes:**

TS and HMT welcomed everyone to the meeting. They explained the nature and importance of this group and welcomed people's involvement. The views expressed by this group will be made public and in particular this group will be used to provide a view on the safety and recruitment and retention issues for a number of proposed clinical models.

The purpose of the meeting today was to give people the background information on MSFT and the current programme of work so everyone has the baseline knowledge needed to be able to undertake the work in an effective way.

Hugo gave the history of MSFT and talked about the clinical issues faced by the Trust both in terms of historical poor care issues and current clinical sustainability issues. Despite these issues there is still a large amount of support for the services at MSFT as demonstrated by the 50,000 people who attended the recent march.

Last August Monitor took the action of employing a Contingency planning Team (CPT) to undertake a sustainability review of MSFT and to start to work on a credible plan in the event that the Trust is put into the "failure regime"

The CPT concluded that the Trust was neither Clinically and Financially sustainable in its current form. Clinically the Trust had been unable to recruit and retain key staff which meant they were

significantly short of national guidelines in key areas. Also the small volumes of patients going through the trust meant that that it was difficult in some areas for clinicians to maintain their key skills. These situations were unlikely to change in the future.

As well as undertaking the sustainability review the CPT worked with CCGs to "protect services". These have now been renamed Location Specific Services (LSS) and describe the services which must be provided locally if a TSA is appointed. These are based on the view from commissioners that there is not alternative capacity to provide these services at other providers and/or there will be a detrimental impact to patients based on the distance of the other providers.

The CPT recommended that a TSA should be appointed to develop the plan for the delivery of sustainable services.

The TSA is working to a 145 day timetable and will need to develop a draft report with a proposed clinical model identified which is due to be consulted upon w/c 24 June 2013. There is a formal 30 day consultation period which will be followed by a final report with recommendations from the TSA on the future clinical model for MSFT. The secretary of State has 30 days at the end of the process to review the report and either agree with the plan or suggest an alternative.

The TSA is undertaking a twin track process to identify the clinical model. It is undertaking a market engagement exercise inviting any suitable qualified and willing provider to identify a proposal which will deliver clinically and financially sustainable services – a minimum these proposals will need to deliver the LSS, but could deliver more.

As well as the market engagement exercise the TSA is engaging with the local health economy (LHE) to understand the impact on them of any potential changes and how they could specifically support the development of the clinical model.

The providers in the LHE all have financial and/or performance issues which they are managing and the LHE is not particularly strong at the moment.

The TSA will be evaluating the proposals to see how they deliver: clinical, financial and operational sustainability. The CAG will be supporting the clinical evaluation, specifically around safe care and recruitment and retention. This was outlined in the terms of reference for this group.

A number of questions were asked by the group:

**Do the services proposed have to be provided fully at the Royal College standards?**
It is unlikely that any proposal will fully meet the standards. It is noted that currently MSFT are some way off the standards and proposals would have to make a suitable and safe progression to achieving the standards.
**Are the LSS binding – i.e. do they have to be provided in their entirety?**
Yes. The TSA has a legal responsibility to provide the LSS at whatever cost.
**Is there a Deanery position on this?**
The TSA has not yet talked with the Deanery but will do at relevant points through the process.
**What is the Secretary of State role at the end of the TSA process?**
The Secretary of State will do one of two things: 1) approve the recommendations, or 2) if not approved will identify an alternative plan. The legislation ensures that at the end of the process there will be a decision.
**What learning can we take from South London?**
Whilst there are similarities to South London, there are differences between the two Trusts which make this process different. The TSA will apply the learning where appropriate.

**Can providers put in proposals for single services?**
The TSA is looking for providers who can provide the full LSS as a minimum and will not look at individual service proposals initially. The TSA may look at individual service proposals at a later date if needed.
**What are the commissioner intentions?**
They are permissive intentions designed to encourage proposals that include innovation and link to the priorities of the CCGs.
**What if no providers submit a proposal?**
If this happens it re-enforces the point that the current services are un-sustainable. The TSA would look to the LHE for a solution.
**Do providers just have to provide the Core LSS or the others as well?**
They have to provide the core as a minimum but can provide other services as well.
**Is there reference to training roles in the market engagement exercise?**
The TSA will be speaking to the relevant medical schools and deanery.
**Can providers put proposals forward for non LSS?**
Yes. As a minimum it must include the LSS. In addition they can propose other clinically sustainable services.
**The LSS are quite small and low level. Is there a reason for this?**
They are what CCGs defined after going through the designation process with the CPT.
**Can we use previous examples as a reference point?**
Yes, examples of good practice are encouraged.
**To what extent is the process in the public domain?**
The TSA has announced that the CAG has been formed and will be represented by the Colleges. No individuals have been named at this stage. It is likely that a future CAG meeting will be held in Stafford.
**How do we assure there is any follow up/review of agreed models to see if they have worked as planned?**
It is important to identify any caveats in the advice given to the CAG. This can then be factored in to the implementation plan to ensure appropriate follow up.
**What if the recommended clinical model is transferring services to another organisation which is subject to review?**
The TSA will only consider proposals which are safe for the patients.
**Is it the CAGs role to just comment on proposals or to suggest alternatives?**
The CAG is to comment on proposals only.

HMT and TS thanked everyone for attending and concluded the meeting.

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Meeting of the National Clinical Advisory Group**

**Date: 23/05/2013**

**Time: 10:00 – 12:30**

**Location: Academy of Medical Royal Colleges**

**Attendees:**

| | |
|---|---|
| Professor Terence Stephenson | Academy of Medical Royal Colleges |
| Professor Robert Shaw | Royal College of Obstetricians and Gynaecologists |
| Dr Patrick Cadigan | Royal College of Physicians (London) |
| Professor Peter Furness | Royal College of Pathologists |
| Dr Peter Cavanagh | Royal College of Radiologists |
| David Shortland | Royal College of Paediatrics and Child Health |
| Dr JP Besouw | Royal College of Anaesthetists |
| Dr Gary Cooke | Faculty of Public Health |
| Dr Ian Aston | Faculty of Occupational Medicine |
| Jim Wardrope | College of Emergency Medicine |
| Professor Jacky Hayden CBE | Royal College of General Practitioners |
| George Youngson | Royal College of Surgeons |
| Hugo Mascie-Taylor | TSA |
| Gillian Cooksley | TSA |
| Martin Markus | TSA |
| Masha Feigalman | TSA |
| Ken Leong | TSA |

**Meeting notes:**

HMT started the meeting by emphasising the confidential nature of the day's discussion due to commercial sensitivities. The purpose of the meeting was stated as:

- To provide an opinion on the safety of clinical models presented
- To provide an opinion on recruitment and retention based on the clinical models.

It was added that the TSAs are not seeking views on the financial impact of the models in the meeting. Attendees of the meeting then introduced themselves.

HMT introduced the four clinical areas for discussion: A&E and urgent care, inpatient paediatrics, acute surgery and maternity (obstetrics and midwifery)

**A&E and urgent care**

HMT set the parameters for the service: the upper limit would be the current DGH model while the lower limit is a nurse or GP-led UCC model with a limited take. The group agreed that both of these models are recognised as safe.

HMT then requested the group to consider the following model:

*A consultant-led unit which does not take blue light. The consultant would be skilled to intubate and ventilate.*

Concerns were expressed on the safety of this model as with a limited take, the number of intubations carried out is likely to be insufficient to maintain a consultant's skillset. Furthermore, such a unit is likely to have the necessary support systems for patients post intubation. It was queried on why a unit that takes only walk-ins will need to be consultant led. HMT responded that such a unit can also be safely provided if nurse-led and therefore if it is consultant-led, it will only improve safety. It was noted that a consultant-led unit will typically increase expectations.

HMT proceeded to ask the group to consider another model.

*A consultant-led unit which accepts blue light. The consultant would be skilled to stabilise, intubate and ventilate acutely ill patients before transfer to a Type 1 A&E.*

The group agreed that this model carries a higher risk. However, it was also pointed out that this model is common in Australia but the significantly shorter travel distances to an A&E in the UK does not warrant the creation of an intermediate point for acutely unwell patients.

The next model considered is the following:

*A consultant-led 14/7 unit which accepts blue light. All staff would be networked with a Major Acute Teaching Hospital*

It was stated that the rotation of a large number of staff may be difficult. JH was informed that the unit's staff will include trainee doctors. She expressed that it will be risky if there are periods where trainee doctors are delivering care without senior doctor cover. It was asked if the unit will treat patients facing a septic shock. HMT answered that while the unit will not treat stroke, trauma and MI, it is possible that it will treat septic shocks. It was then stated that, once admitted, patients who faced a septic shock may need critical care support. It was then concluded that this model as unsafe and this was agreed by the group.

HMT asked the group to consider the next model:

*An emergency consultant-led unit which accepts blue light but not stroke, trauma and MI. There will be anaesthetist presence. All staff would be networked with a Major Acute Teaching Hospital. The site will also host a HDU but not critical care.*

The group's initial response to the unit is that it will be underutilised. The group expressed that an anaesthetist needs to be present 24/7 in this model even if it is accepting patients 14/7 as such a unit will likely to attract more acute patients. It was asked if the anaesthetists will undertake any other activity. HMT answered that they potentially may be involved in elective inpatient work but not emergency caesareans and epidurals. It was stated that such job plans will be unsustainable. However, it will be sustainable if it was networked such that the anaesthetist spends 4 days a week on elective surgery and 1 day a week on acute medicine. Also, the HDU need not be a separate area but instead be operated in a recovery area. It was added that a model where a patient is stabilised and then retrieved by well trained physicians for transfer has proven to work. It was agreed and pointed out that ambulance services typically carry out transfers from several hospitals, providing sufficient activity volumes to maintain skills.

It was asked if it is preferable to send a patient to a nearer hospital with acute medicine but without acute surgery and full critical care facilities or to one with a full Type 1 A&E that is further. The group replied that very few acute surgeries take place at night now. It was then asked what the specialist support that will be required for a unit with an undifferentiated take. It was noted that diagnostics including imaging, critical care and acute medicine would be needed It was asked if further details on support services e.g. blood banks were available. HMT replied that details have not been worked up yet as they will depend on the services offered.

It was asked if it is preferable to send a patient to a closer hospital and then transferred to another that is more equipped but further or to send a patient the patient to the further hospital in the first instance. A paper was cited which looked at mortality rate versus travel times. The debate then

drifted to if the solution should maximise the wellbeing of the majority (who will not be so acutely unwell such that the increase in travel time will have a material impact on mortality) or the minority who will be impacted.

The group supported the statement that Acute Surgery was not desirable in Stafford. A case was cited where outcomes improved when acute surgery was provided on fewer sites as consultant presence increased.

It was also stated that there may be a correlation between the speed of recovery and mental well being. Patients who feel that they are far from where they belong may recover slower. Therefore, there is a trade-off between travel distance and the quality of facilities. It was noted that a shuttle bus service between sites is possible. It was also added that an improvement in clinical quality will justify travelling further.

HMT then requested the group to consider the clinical models starting with Model 1. Further details were requested on the definition of ambulatory care. The model was briefly summarised to the group. HMT confirmed that that staff rotations will take place between both providers. It was asked if the other unit has the capacity to take on further non elective work. It was confirmed that there is a separate workstream analysing capacity but nevertheless informed the group that acute medicine and critical care capacity in the LHE is challenged. HMT pointed out that the admission rate for paediatrics is high given the diagnosis codes. He then asked if there are any recommendations on a minimum unit size for a sustainable paediatric inpatient unit. A paper was cited from the RCPCH, *Facing the Future,* which found that many units nationally are unsustainable due to staffing and proximity to other units. The group were informed on a Stockport unit which discharges children early but allows for easy readmissions. The unit was purported to have reduced LoS.

It was asked if the Model 1 has an observation facility staffed by advanced paediatric nurses and emergency medicine physicians. This was confirmed by HMT. It was queried if the unit will be primary care led but HMT could not confirm as the provider did not specify. HMT stated that the model of obstetrics should be presumed to be safe.

An argument was presented for a MLU. An Early Pregnancy Assessment Unit (EPAU) for incomplete miscarriages and foetal assessment will be required (Mon-Fri, 9-5). Three consultant-led clinics per week will be sufficient given the number of births. It was noted that ca. 400 births will be suitable for a MLU. The average number of births in MLUs nationally is ca. 200. An MLU will improve patient choice and also reduce the need for low risk women to present in a major acute hospital. However, women who are >23 weeks pregnant should not present at the unit as an emergency caesarean section may be required. It was asked if a MLU is required even though there is sufficient obstetrics capacity. It was noted that while it is not cost effective, it is safe and more politically acceptable. Midwives working in MLUs need to be rotated due to the low number of births. It was queried on the type of cover which will be available to support trainees when a consultant is not available. It was stated that not all newborns are seen by a paediatric consultant as midwives are trained to carry out the initial assessment and discharge them after 6 hours.

**The discussion then moved onto Model 2.**

More clarity was requested on the differences between *acute medicine* and *primary care-led acute medical unit*. Clarification will be sought from the provider. The group were informed that the model is for an unselected medical take and will cost significantly more. However, as it was developed very quickly, the model lacks detail. It was stated that Model 1 is clear on the type of patients it treats while Model 2 is not. This may create difficulties in governance. It was also added that while Model 1 will be easier to manage, it will have a larger impact on the capacity of neighbouring hospitals. The group were reminded that capacity can be expanded. It was also stated that his preference was not to have a separate critical care unit but one that is established within a recovery area. It was concluded that both models are safe but Model 2 will offer more capacity. It was asked if there will be flows from the neighbouring major acute hospital to Stafford and was informed that it is likely as Stafford

will provide elective surgery. It was also asked if the primary care-led acute medical unit will be on-site and if the step down beds are for repatriation. HMT confirmed that the unit will be on-site as it requires imaging facilities and that the step down beds are indeed for repatriation. It was stated that step down beds may increase LoS.

A debate was initiated on the relationship between safety, capacity and political acceptability. If both models are safe, using Model 2 as an interim arrangement prior to transitioning to Model 1 can be seen as a reduction in capacity and therefore a bid to safe resources. The focus should therefore not just be on safety but rather the circumstances by which the models are safe. It was added that staffing sustainability as another dimension for consideration. Furthermore, models can be equally safe but one may be more desirable than others.

The group was asked to consider the remaining models. A request was made for the definition of the emergency gynaecology service with consultant input. Clarification will be sought from the provider. The group could not support middle grade anaesthetist support for the HDU. It was pointed out that rapid access assessment unit for frail elderly patients is a good feature of the model. A query was made on the virtual HDU. It was stated that it is a facility that can be setup on a bed in the post-operative area as require. It was mentioned that it is not a HDU but a recovery area.

HMT sought the group's view recruitment and retention. The group agreed that a networked model will certainly do better in recruitment and retention than a non-networked model.

An issue was raised on the role of the CAG. Fellows of the royal colleges need to be informed that the role of the CAG is to provide a view on the proposed clinical models rather than to develop a clinical model. This needs to be reflected in the group's ToRs. Furthermore, it needs to be made clear that opinion on MSFT's sustainability was not of the Royal College's but rather a review against Royal College standards. HMT clarified that the groups remit is limited to providing an assessment on clinical safety and recruitment and retention. He then asked the group if they were prepared to define the criteria for clinical safety and be held accountable for it. A response to royal college fellows such that CAG representatives are able to provide a consistent answer to queries they receive, will be drafted.

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Meeting of the National Clinical Advisory Group**

**Date: 03/06/2013**

**Time: 11:00 – 13:00**

**Location: Academy of Medical Royal Colleges**

**Attendees:**

| | |
|---|---|
| Professor Terence Stephenson | Academy of Medical Royal Colleges |
| Dr JP Besouw | Royal College of Anaesthetists |
| Dr Gary Cooke | Faculty of Public Health |
| Jim Wardrope | College of Emergency Medicine |
| George Youngson | Royal College of Surgeons |
| Alastair Henderson | Academy of Medical Royal Colleges |
| Derek Alderson | Royal College of Surgeons |
| Hugo Mascie-Taylor | TSA |
| Gillian Cooksley | TSA |
| Penny Dash | TSA |
| Masha Feigalman | TSA |
| Ken Leong | TSA |

**Minutes:**

HMT welcomed the attendees of the meeting. He conveyed the apologies sent by Patrick Cadigan, Peter Cavanagh and Jackie Hayden. Attendees then introduced themselves.

The Group proceeded to discuss the ToRs which has been redrafted to provide more clarity of the role of the Group. The important points of the ToRs were summarised, emphasising on the remit of the group. It was noted that several members of the Group who were not present has reviewed this iteration of the ToRs and are satisfied with its content. It was suggested the addition of providing an opinion on training and CPD achievement as part of the remit of the Group and this was agreed. It was asked if the Group is autonomous and if its work will set a precedent for other reconfigurations. It was also queried if the Group is influenced by emerging work. HMT replied that the Group's work is autonomous and does not bind future reconfigurations. In addition to the CAG, there is also a local Clinical Reference Group and Nursing Clinical Advisory Group who are providing advice to the TSA in different forms. Emerging work has not been cited as they are still being developed. It was suggested adding a point on the limitations of the group to reflect the fact that it is not responsible for decision making and recommending the clinical model. It was stated that the CAG may be an opportunity for the Colleges to play a wider role and be involved in future reconfigurations. It was asked if there are any reconfigurations that did not seek advice from a body equivalent of a CAG and was provided with several examples. The Group signed-off the ToRs subject to minor amendments.

HMT then asked if the Group agrees to disclose the names of the individuals representing each College. It was suggested that the ToRs will be able to provide clarity on the limitations of the Group as well as the fact that the members do not represent a particular interest. It was added that a consistent approach to respond to College fellows. A standards response will be made available to members and the ToRs will be published alongside the Group's membership list.

The Group then discussed if Stafford visits and future meetings are required. HMT informed the Group that progress has been made in developing the model with providers. He then asked the Group if a discussion with the MDs from both the trusts will be required. The Group agreed that it will

be important to visit Stafford to engage stakeholders and that a further meeting will be required. Presence of the MDs will allow queries to be answered in real time. It was added that activity data can be made available to the Group prior to the Stafford visit if needed.

Papers on the clinical models, Royal College guidelines and discussion points from the previous meeting were handed out. The Group were to consider the following aspects of the clinical models: clinical safety, interdependencies, recruitment and retention and alignment towards Royal College guidelines. PD emphasised that the discussion should be on the clinical model when it has been fully implemented rather than the transition period. It was pointed out that the Colleges recognise that the guidelines are not met by all hospitals and it is important to understand if the model will bring the hospitals closer to the guidelines. It was asked if the Group's remit is to only consider College guidelines or if it can also consider best practice standards. The Group agreed that they are to also consider best practice standards where relevant.

HMT then initiated the review of notes from previous discussion adding the caveat that no reconfiguration model will be viable without demand management initiatives but primary care is not within the remit of the TSA. He then informed the Group that the solution at present involves UHNS and Wolverhampton. In the model, CCH is to remain largely as it is at present but taking in more elective activity. Further details on the provision of HDU and out of hours cover is still required for CCH's clinical model.

It was stated that ASA ratings will likely to determine HDU requirements. It was also added that the unit should not operate on patients who are likely to require post-operative critical care and this can be determined through post-operative assessments. HMT agreed to seek further clarity on the types of procedures that Wolverhampton plan to carry out in CCH. Key people will be sent with a list of ASAs and procedures codes so that they can provide a view on elective activity that can be suitably carried out in CCH.

The discussion then focussed on the services in Stafford. For maternity services, the Group previously suggested the provision of pre and post-natal care and early pregnancy clinics. Women who are >23 weeks pregnant and face a bleed should be treated in UHNS. The Group's view was that an MLU can be safely provided despite of low volumes. Commissioner support for such a unit will be required as it is likely to be costly. For paediatric services, no inpatient paediatric unit has been proposed. The current proposed model includes a 14/7 PAU with advanced paediatric nurse practitioner and emergency physician cover. It was stated that emergency physicians in UCLH treat children above the age of one. GC agreed to seek further clarity from UHNS on ambulance protocols, specifically on the treatment of children.

There was surprise that GP cover is not part of the model as it was proposed in December 2012. HMT replied that the model proposed by the providers is different but he will discuss with CCGs if GP cover is still desirable. HMT then asked the group to re-confirm that inpatient paediatric services cannot be safely provided. The group agreed that it cannot be safely provided due to low activity volumes, staffing difficulties and the critical care cover required,

HMT informed the Group that acute surgery has not been proposed. The 14/7 A&E will have emergency physician cover, imaging facilities and access to surgical opinion. He categorised acute inpatients into three categories – those who are very ill e.g. stroke, trauma, MI, and need to go to Stoke, those with minor injuries e.g. lacerations, and those who require slightly more complex surgery but their condition is easily diagnosed e.g. fractured NoF. Those with minor injuries can be treated in Stafford as the procedures required can be carried out by emergency physicians. However, for more complex cases, it will be difficult to ensure that a safe service can be provided all the time. It was stated that by limiting procedures that can be carried out; there is a risk of deskilling across more than one specialty due to interdependencies. HMT reassured him that all models proposed are

staffed on a networked basis. It was noted that discussion points from the previous meeting and pointed out that the Groups view on acute surgery should not be stated as “desirable”. The Group agreed and the notes to the previous meeting will be revised.

Concern was expressed on possible recruitment and retention difficulties due to low volumes. HMT replied that UHNS has had discussions with their consultants and they have indicated a willingness to work on a networked basis. It was stated that it may be difficult to maintain the model in the longer term as staff turnover may not allow for the same commitment to perpetuate. A small hospital in the West Midlands was cited as an example of one that is struggling with recruitment. It was added that payment premiums should be recognised as a possible solution to ensure OOH cover. It was stated that the rotation model proposed is different from normal networked models as all staff will need to take part in it. This non-discretional model will help ensure that all staff have equal opportunities. HMT agreed to reinforce the need for rotation with UHNS. It was pointed out that there is an A&E consultant shortfall of 5 WTEs in UHNS and this was noted by the group.

HMT then discussed the proposed 14/7 consultant-led and delivered A&E with acute medicine. The unit will have a selected take which excludes MI, stroke and major trauma patients which do not currently go to the Trust anyway. He informed the group that the model had not progressed much since the previous discussion. It was stated that the unit will be safe as long as it is staffed appropriately with the right governance in place.

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Meeting of the National Nursing and Midwifery Advisory Group**

**Date: 04/06/2013**

**Time: 15:00 – 17:00**

**Location: Ernst & Young office, London**

**Attendees:**

| | |
|---|---|
| Trish Bennett | Director of Nursing and Quality, NHS England: Greater Manchester |
| Elizabeth McManus | Chief Nurse, York Teaching Hospital |
| Helen Thomson | Director of Nursing, Calderdale and Huddersfield NHS FT |
| Ruth Holt | Director of Nursing, NHS Confederation |
| Hugo Mascie-Taylor | TSA |
| Gillian Cooksley | TSA |
| Ken Leong | TSA |

**Meeting notes:**

HMT welcomed the attendees who then introduced themselves. HMT then described the Monitor failure regime clearly describing both the CPT and TSA phases. The group were informed on the three clinical groups who provide advice to the TSA i.e. the National CAG, Local Clinical Reference Group and the Clinical Advisory Group (Nursing). The advice will pertain to clinical safety and impact on recruitment and retention. However, the groups do not have executive decision making powers and the TSA is free to adopt a proposal that is contrary to the groups' advice. The groups are free to state their position should such a situation arise. The TSA may also choose to refer to the groups' recommendations as part of the rational for the proposed solution.

A description was given of the geography of MSFT and the LHE and then explained the ToRs. When informed on the high use of locum staff, It was asked if there are alternative employers for healthcare staff in the LHE. It was noted that Walsall, Wolverhampton and UHNS are also big employers. It was emphasised that the membership of the group can be made public and the the group needs to be aware of this due to public interest and perception of the TSA. It was asked if the Royal College of Nursing is represented in any of the clinical groups and it was noted that they are represented at the local and regional level. It may be inappropriate to include them in clinical advisory groups due to conflicting interests which may prevent them from offering an objective view on the clinical models. It was suggested Howard Catton (Head of Policy and International) and Janet Davies (Director of Nursing and Service Delivery) as potential RCN representatives for the National CAG. HMT agreed to check if this is suitable. The Group then agreed the ToRs.

The TSA timeline was explained. It was asked if the local providers know of the emerging clinical models. It was noted that the six providers who responded to the market engagement exercise will know about their own clinical models. It was queried on the performance of UHNS and Wolverhampton. Both trusts have not achieved FT status but neither face quality issues. UHNS, a teaching hospital, faces some capacity issues and Wolverhampton is the more financially robust trust of the two. HMT explained that most of Stafford's tertiary work is undertaken in UHNS as the current take in Stafford is limited. It was stated that the catchment population of Stafford ranges from 190k to 300k depending on definition but the most likely estimate is 220k. It was stated that the catchment population is too small to sustain a DGH. The LHE was described in more detail.

HMT explained the current model and the proposed model. The proposal for Cannock is to increase the scope of elective work offered including a transfer of activity from Wolverhampton. The concerns still present for the proposed Cannock model is on OOH cover. It was stated that the unit should only

undertake elective procedures that do not require critical care facilities. The group expressed concern that the presence of the HDU may lead to the unit undertaking activity that is not suited for the unit. They also requested for activity data to help inform their opinion on safety. The group was informed that the unit will be staffed by Wolverhampton consultants. More information was requested on neuro-rehab and was informed that it is a stroke rehab unit. It was asked if women attending antenatal clinics in Cannock will have a choice on the location for delivery. It was noted they will continue to have choice but not Stafford. Further information on extended radiology was requested.

HMT stated that there are six areas for Stafford which need the most amount of discussion – A&E/Urgent care, Acute Medicine, Acute Surgery, Obstetrics-led Maternity, Inpatient Paediatrics and Critical Care. All staffing in the proposed model is on a networked basis. No acute surgery has been proposed and the unit will only undertake procedures which can be performed by an emergency physician or by slotting on to a Theatre list the next day. Imaging and surgical opinion will be available. It was asked if telelink is available. HMT replied that it is a possibility. Inpatient paediatrics has also not been proposed. It is recognised that the admission rate in MSFT is high. There will be consultant led OP services and diagnostics.

The proposed model for Stafford will include a 14/7 consultant-led and delivered A&E staffed on a networked basis. There could potentially be ANP cover for the other 10 hours. There will also be a 14/7 advanced paediatric nurse led PAU supported by the A&E consultant. If the unit is open for 24/7, the PAU needs to follow suit. It was stated that as the unit is currently 14/7 and since the local population understand the opening hours, it would not be an issue to keep the arrangement.

As acute medicine is provided, critical care facilities in the form of a HDU with anaesthetic cover to intubate, ventilate and stabilise are available. It was asked if GPs can directly refer to the acute medicine unit. HMT replied that it is possible and there will also be access from A&E. It was asked for more information on staffing of wards as there will be admissions from the acute medicine unit. The group required more information on the interface between the A&E, acute medicine unit and HDU.

It was asked if it is possible to close Cannock in order to consolidate a larger critical mass for Stafford and HMT replied that it was not considered at this stage. HMT then summarised the differences between the current model and the proposed model. The range of elective activity in Cannock will be expanded and Stafford will no longer have obstetric-led birthing services, acute surgery and inpatient paediatrics.

It was asked if there are MLUs in the area and it was that there is one in Lichfield and one in Walsall and the CAG has suggested that MLUs can be clinically safe. HT the group was informed that the standalone MLU is Huddersfield is delivering 900 births per annum from an area which has ca. 6,500 births. It was asked if the models have been developed based on retaining services or providing only services that are needed. It was noted that a more limited range of services may destabilise the LHE. HMT stated that the market engagement approach was to ensure that the solution proposed actually has a willing provider

A brief discussion on recruitment and retention ensued. It was stated that York & Scarborough have started to recruit as a singular organisation following integration. It was also stated that rotation of nurses across sites may be difficult but needs to be done. It was noted that the merits of rotation needs to be marketed. It was suggested that ward leaders should be able to opt out of rotation to ensure stability and the group agreed. Other nurses should however rotate.

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Meeting of the National Clinical Advisory Group**

**Date: 11/06/2013**

**Time: 15:00 – 17:00**

**Location: Academy of Medical Royal Colleges**

**Attendees:**

| | |
|---|---|
| Professor Terence Stephenson | Academy of Medical Royal Colleges |
| Professor Robert Shaw | Royal College of Obstetricians and Gynaecologists |
| Professor Peter Furness | Royal College of Pathologists |
| Dr Peter Cavanagh | Royal College of Radiologists |
| Dr JP Besouw | Royal College of Anaesthetists |
| Jim Wardrope | College of Emergency Medicine |
| Professor Jacky Hayden | Royal College of General Practitioners |
| George Youngson | Royal College of Surgeons |
| Jonathan Odum | MD, Royal Wolverhampton NHS Trust |
| Robert Courteney-Harris | MD, UHNS |
| Hugo Mascie-Taylor | TSA |
| Gillian Cooksley | TSA |
| Penny Dash | TSA |
| Masha Feigalman | TSA |
| Ken Leong | TSA |

**Meeting notes:**

HMT welcomed the attendees and briefed them on the agenda which is to:

- consider if the CAG wishes to endorse the clinical model
- discuss the models' clinical safety, impact on recruitment and retention and alignment to Royal College guidelines
- discuss the counterfactual model

He then introduced JO and RCH emphasising that the proposals are for the service model rather than the organisation providing the service. HMT expressed that he would like the group to endorse the model in writing if they agree with the model. He also informed the group that there have been invitations to appear on public engagement videos. He has also engaged with the deaneries who have responded positively to the models. The discussion then emphasised on drafting the letter of endorsement. The Group agreed that the letter of endorsement needs to reflect the role of the group as stated in the ToRs specifically emphasising that the CAG did not develop the clinical model. AH and TS will prepare a new version of the letter of endorsement by 12 June.

HMT then reinitiated the discussion on clinical models stating that the Group should provide its views on clinical safety, recruitment and retention and alignment towards College guidelines. He then presented the models noting that both Stafford and Cannock will be staffed on a networked basis. The PAU in the model is currently proposed to be 14/7 with consultant cover from A&E but it could possibly be expanded to 24/7 with advanced paediatric nurse cover for the hours where a consultant is not present. It was stated that that a 24/7 PAU is not required if the A&E is 14/7. It was added that children who present late at night tend to be very ill and require a full A&E. Therefore a 14/7 PAU will be safer.

Additionally, staffing a 24/7 PAU will be more difficult as nursing staff may be less willing to rotate across sites. It was noted that the A&E in Stafford Hospital is already being by-passed for very acutely ill children. It was asked if the 14/7 unit will allow for children who require a short stay following a daycase procedure to be admitted. It was noted that the model needs to be worked up in more detail to ensure that children do not get transferred for a short stay after a daycase procedure.

Given that the consultant pool at the moment is 24 WTEs, the resultant rota will be ca 1 in 6 rather than the more conventional 1 in 8. It was stated that the positioning of recruiting into a joint Stoke-Stafford will influence recruitment and retention. With staff networked across both sites, there will be more taxing work in Stoke followed by less taxing work in Stafford and this may attract more staff.

No acute surgery has been proposed for the Stafford site and the only emergency procedures which will be carried out are those that can be carried out in the A&E by an emergency physician or a simple procedure added to a Theatre list the next day. There will be access to surgical opinion either from surgeons performing daycases on site or from Stoke. Endoscopy will operate on a selected take basis which will exclude GI bleeds. Patients with a GI bleed will be transferred to Stoke and protocols will be developed. It was added that WMAS is familiar with operating on such protocols. However, it was agreed that there will be a small number who will not have a conclusive diagnosis which may mean that they end up in Stafford. It was stated that Stafford will need to operate with strict protocols to ensure that it treats only patients who are appropriate. The group were informed that there will be a blood bank in Stafford and clarified that there will be no interventional radiology. The Group agreed to ensure that the endorsement letter reflects the principle that the units need to operate on a selected take basis with appropriate clinical protocols.

The proposed HDU will provide monitoring with a 1:2 nurse to patient ratio. There will be 24/7 anaesthetist cover who will be able to stabilise, intubate and ventilate. Very ill patients will however still need to be transferred. The facilities available for each level of critical care were briefly summarised – Level 3 CC is when two or more organs require support or when ventilation is required. HMT stated that the model can provide short term level 3 care but it will be with the intention to transfer the patient. It was mentioned that the model appears to allow those requiring level 1 or 2 care to remain for longer. It was added that the HDU should act as an intermediate point but understands that there are sensitivities around retaining fewer patients. Concern was raised on junior staff being left without oversight when more senior doctors are transferring a patient. The impact on each group of trainee doctors needs to be looked at in detail at a later stage. The group agreed that there is a need for an ambulance service based retrieval system.

The group agreed that a networked system will work in favour of recruitment and retention. However it was stated that some staff may find the prospect of needing to work in a quieter unit occasionally to be a disadvantage. HMT then explained the model's paediatric services. There will be paediatric outpatients but no inpatients and a 14/7 PAU. The group agreed that it was a sensible arrangement. It was added that consultant paediatricians in OP clinics or daycase theatres will be able to provide input into the PAU. For maternity services, there will be consultant-led pre and postnatal screening, scanning and EPAU. No obstetric led delivery or MLU services are being proposed. A MLU has not been proposed as it is not financially sustainable. This may be an unpopular proposal but given that there are other MLUs in the LHE, women wanting to give birth in a midwife-led environment will still have the choice. It was expressed that the recruitment of midwives for MLUs may pose a challenge as they are typically less mobile. The group asked for a rationale for not proposing a MLU especially since critical care facilities, which are not financially viable, are part of the model. It was noted that there will be a significant knock on effect on patient flows in other services should critical care facilities not be available. The group agreed that the model is safe subject to the caveats discussed. Recruitment and retention will be likely to improve although for some staff, the prospect of occasional work in a quieter unit will be a disadvantage. Staff rotation will be required to keep the model safe and staffing

sustainable.

The discussion then focussed on the models alignment towards College guidelines. It was stated that the model broadly fits with College guidelines to increase the catchment area of each hospital and concentrating services. It was agreed that this is the case for maternity, acute surgery and inpatient paediatrics but not necessarily A&E. It was stated that the ECM do not have any recommendations on catchment areas and recognise the need to retain access for patients. Furthermore, the model does not lead to two 24/7 A&Es. It was stated that the nursing standards need to be maintained as well. It was confirmed that there will be a single nursing governance structure across both sites. Senior staff groups will need to rotate but a balance for other staff groups needs to be achieved. It was added that there will be a single governance structure across Wolverhampton and Cannock in the proposed model. The group agreed that while the endorsement letter needs to make clear that while the proposed model is safe, it does not preclude that there are no other safe models.

The model for Cannock was presented. It was described to be similar as current services other than the expansion of scope of elective activity for both daycases and inpatients. There will be level 1/ 2 critical care, which is more extensive than the current provision, to support the expansion. It was confirmed that Cannock currently carries out orthopaedic surgery for those up to ASA 3 and the plan is to carry out ASA 3 procedures for other specialties. Consultant anaesthetists will be present during the day with out of hours cover provided by middle grade anaesthetists. Any patient requiring critical care beyond that can be safely provided at the unit out of hours will be transferred to New Cross Hospital. It was stated that trainees should not provide out of hours cover as the unit will be insufficiently busy to meet their development needs. A correction is to be made to the models of care diagram as there will be no rehabilitation services for fractured neck of femurs in Cannock. Further detail was provided on the diagnostics services stating that CT scans, MRIs and plain film radiography will be available but there are no plans for interventional radiology. Daycase theatre sessions will be delivered by a consultants and non-consultants. It was noted that that the lack of acute work may affect training opportunities. The group concluded that the model is safe as long as the selection and staffing is appropriate. There is a small positive impact on recruitment and retention. On the whole, it does not change Cannock's position with respect to College guidelines.

A discussion on the counterfactual model was started. In the model, the services in Cannock will be as the proposed model. For Stafford, there is no acute surgery, inpatient paediatrics, obstetrics-led delivery and critical care. Instead of an A&E, Stafford will host a 14/7 primary-care led UCC with access to consultant input. It was explained that the counterfactual model is similar to the CPT model. It was stated that the role of the CAG is to provide an opinion on models that have been proposed and as the counterfactual model has not been proposed, it is not within the group's remit. It was notedby the group that the counterfactual model is very similar to one of UHNS' proposal. The model will have a knock on effect on capacity in the LHE and can only be safe if capacity is guaranteed. Furthermore, for patients with respiratory difficulties requiring emergency care will face a higher mortality rate given the need to transfer further. However, the greater concentration of services does align it closer to ECM guidelines. The group agreed that the model has not been developed sufficiently and there was not enough time to consider it. The Group agreed to visit Stafford during the consultation and a further meeting toward the end of the consultation.

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Meeting of the National Nursing and Midwifery Advisory Group**

**Date: 13/06/2013**

**Time: 15:00 – 17:00**

**Location: Ernst & Young office, London**

**Attendees:**

| | |
|---|---|
| Trish Bennett | Director of Nursing and Quality, NHS England: Greater Manchester |
| Elizabeth McManus | Chief Nurse, York Teaching Hospital |
| Helen Thomson | Director of Nursing, Calderdale and Huddersfield NHS FT |
| Ruth Holt | Director of Nursing, NHS Confederation |
| Janet Davies | Director of Nursing and Service Delivery, Royal College of Nursing |
| Howard Catton | Director of International Policy, Royal College of Nursing |
| Christina McKenzie | Board Member, Royal College of Midwives |
| Hugo Mascie-Taylor | TSA |
| Gillian Cooksley | TSA |
| Ken Leong | TSA |

**Meeting notes:**
HMT updated the group on the TSA process stating that the solution will most likely involve Stoke and Stafford working in a networked model. Services in Cannock will be limited and therefore, a solution is easier to identify although the TSA have been working with Wolverhampton the final solution may not involve them.

HMT emphasised that the role of the group is to provide an opinion on clinical safety and recruitment and retention but not finances. The views of the group as well as its membership will be made available in the public domain.

It was asked if the UHNS is in the FT pipeline. It was noted that all Trusts in England are in the FT pipeline but due to the current issues faced, UHNS is unlikely to achieve FT status in the short term. HMT stated that the current proposed model has been extensively tested and is recognised as safe. However, there is a need to compare the financial implications with that of other clinical models including the LSS and CPT models.

It was asked if the group can apply conditionality on its recommendations and HMT confirmed that it is possible. A query was raised on implementation and business as usual. HMT replied that previous MSFT execs provide leadership and guidance for BAU. At present, it is unclear who will deliver the implementation phase and the level of support available for implementation is therefore unknown. It was stated that strong governance is required to deliver a networked model and that there are risks associated with combining two poorly performing trusts. The group emphasised that the way the model is implemented is critical to clinical safety.

It was stated that community services will be crucial in delivering the models. It was asked if any assumptions have been made on the redistribution of funding from the acute sector to the community and HMT replied that such assumptions are not known at present.

The discussion then focussed on the clinical models. There are three clinical models that need to be considered – the CPT, LSS and TSA model and status quo. The impact of the model on the LHE has not been modelled for all but the TSA model. The CPT and LSS models will need to be tested further as

they cannot be assumed to be safe.

HMT proceeded to describe the TSA model. The model is staffed on a networked basis and Stafford is expected to retain ca. 90% of its current activity. It will host a 14/7 A&E, PAU and an AMU. A question was asked on the practical implications of senior staff. HMT replied that mobility is typically dependent on seniority and that senior staff are more likely to mobile. He then asked if a networked model will improve recruitment and retention. It was stated that ward nurses should not rotate and that rotation is more achievable if nurses are trained by the same organisation. It was added that rotation would be particularly attractive to band 5 nurses. It was then suggested that a development programme associated with the rotation, coordination between universities and a common audit practice across hospitals will improve with staff rotation.

HMT then informed the group that while Stafford will retain an acute medicine unit, very ill patients will either need to present directly in Stoke or be transferred there. Critical care facilities will be available in Stafford. There will be 24/7 onsite, senior anaesthetist cover whole will be able to intubate, ventilate and stabilise. Acutely ill patients will be transferred as appropriate. Discussions on the possibility of a retrieval service have taken place with WMAS. It was asked if there is a mechanism to manage deteriorating patients. HMT replied that the critical care facilities will be able to stabilise and transfer them. For those requiring surgery, Stafford will have access to imaging and surgical opinion. However, the only emergency surgeries that will take place in Stafford are those that can be carried out by an emergency physician or added to a Theatre list the next day if appropriate for the patient to be sent home and brought back. More complicated procedures will take place in Stoke.

The group recognised the importance of clinical protocols and safety although they have not been worked up in detail at present. The guiding principle is to transfer all acutely ill patients to Stafford. However, there is some reassurance as the ambulance protocols in the area are widely thought to be good.

HMT informed the group that there are ca. 1,800 births per annum in MSFT and given the low volume, no obstetrics-led birthing services have been proposed. There will however be pre- and post-natal care, scanning and EPAU. While it is recognised that an MLU can be provided safely through the rotation of midwives, it has not been proposed as it will not be financially viable. It was stated that midwives may not need to be rotated. It was further added that the volume of births can possibly be increased should access to the MLU be opened to other providers. There are two possible models for MLUS – one with midwives onsite and the other with midwives on-call from another hospital who can be present at the MLU as necessary. The critical mass for clinical safety depends on the model and a unit delivering 180 births per annum can be safe. Additionally, there is no hard evidence on the number of births a midwife needs to deliver in order to maintain skills but it is assumed that those working in an acute setting will need to deliver more births to maintain skills compared to one working in a stand-alone MLU.

It was asked if the physician led ambulatory care unit will be safe given that the low volume of forecast activity. HMT emphasised that the model will be on a networked basis and therefore, physicians will on the whole have sufficient activity volumes to maintain their skill-set. The group concluded that the model of Stafford is safe if it is staffed on a networked basis and the impact on recruitment and retention will be dependent on the opportunities offered. The creation of training/development programmes, health education, coordination with local universities and opportunities to retrain existing staff were seen as possible factors which may improve recruitment and retention. Concerns were raised on the recruitment in the low risk units. The group also raised concerns on the potential difficulty in recruiting paediatric nurses in the PAU given that there is no inpatient paediatric services. Furthermore, paediatric nurses have historically been difficult to recruit. It was noted that the paediatric nurses can offer support in the A&E.

The discussion then moved onto the Cannock site. Utilisation of the Cannock site is low and it is recognised that the proposed model for Cannock can be delivered by Wolverhampton or other organisations such as Walsall. Most responses received during the market engagement exercise proposed expanding the range of inpatient services in Cannock. HMT explained the model. There is still a need to ascertain if the level of cover provided for elective surgery is safe. It was stated that the elective site should have middle grade surgical cover out of hours and that the presence of the HDU may result in the site increasing its patient take such that it operates on patients with risk levels that are too high for the unit. It was explained that advanced medical practitioners will be able to provide additional cover alongside the proposed middle grade anaesthetist cover. It was stated that each service in Cannock appears to be quite distinct and that the linkages between them do not appear to have been worked up. The group agreed that the model needs to be developed further. More information was requested on the range of inpatient procedures offered given that most low risk procedures are now daycases. It was stated that palliative and EoL care may be a potential service for Cannock.

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Meeting of the National Clinical Advisory Group**

**Date: 25/06/2013**

**Time: 10:00 – 12:25**

**Location: Academy of Medical Royal Colleges**

**Attendees:**

| | |
|---|---|
| Professor Terence Stephenson | Academy of Medical Royal Colleges |
| Professor Robert Shaw | Royal College of Obstetricians and Gynaecologists |
| Derek Alderson | Royal College of Surgeons |
| Patrick Cadigan | Royal College of Physicians |
| Professor Peter Furness | Royal College of Pathologists |
| Dr Peter Cavanagh | Royal College of Radiologists |
| Dr David Shortland | Royal College of Paediatrics and Child Health |
| Dr JP Besouw | Royal College of Anaesthetists |
| Jim Wardrope | College of Emergency Medicine |
| Professor Jacky Hayden | RCGP |
| Jonathan Odum | MD, Wolverhampton NHS Trust |
| Robert Courteney-Harris | MD, UHNS |
| Amir Khan | MD, Walsall Healthcare |
| Nick Turner | Associate MD, Walsall Healthcare |
| Dr David Bennett | Chief Executive, Monitor |
| Hugo Mascie-Taylor | TSA |
| Phil Britt | TSA |
| Ken Leong | TSA |

**Meeting notes:**

HMT welcomed the attendees who then introduced themselves. He then explained the rational for the meeting and the postponement of the public consultation. The purpose of the meeting is to discuss the clinical safety of two other models. It will be the TSA's responsibility to assess the financial impact of the two models.

HMT explained that the LSS model was developed from a list of services which the CCGs have decided that must be provided locally or at least until an alternative provision can be found. These services must be delivered in the Stafford and Cannock localities but not necessarily from Stafford Hospital and Cannock Chase Hospital. The CPT model on the other hand was developed by the CPT team and consists of a list of services that can be delivered over and above the LSS. This model was developed in light of MSFT being the provider but as the TSA process has now been initiated, the TSA can work with local providers on the model. The TSA model was on the other hand, developed through the market engagement process and has been note by the CAG previously.

A question was asked if the TSA model was developed as an end point of reconfiguration. HMT replied that developed with the intention of it being the end point but given that the process of implementation can be long, the model may evolve over time. A query was raised on the deficit associated with the TSA model. HMT responded that the deficit of MSFT is ca. £20-22m per annum and the TSA model will bring it down to ca. £8m. Assumptions on efficiency savings is however conservative. It suggested that it was important for the group to provide an opinion on the relative

desirability of the models and the group agreed.

HMT described the revised timeline and asked the group if they were willing to hold a joint meeting with the Nurse CAG and the group agreed. The group also agreed that a visit to Stafford and Cannock is still desirable. It was stated that the visit will provide the group an opportunity to assess the condition of the estates on both sites. A filming session ahead of consultation will also need to take place. The group agreed that the letter of endorsement needs to be revisited once the discussion on the LSS and CPT model has concluded.

The discussion then shifted to the LSS model for Stafford. It was stated that the model was not developed by UHNS and that the stand-alone consultant geriatrician led step-down service is not sustainable in the absence of acute services and sufficient out of hours cover. HMT explained that the model was proposed by the CCGs and that the volume of step down activity is will lead to ca. 2 to 3 wards. It was asked if the TSAs can propose the LSS or CPT model without taking into account the impact on the LHE. HMT answered that it is theoretically possible but the TSAs will not propose a solution that destabilises the LHE. It was stated that pathology and microbiology will be required as part of the diagnostic services offered. It was also stated that there are hospitals operating repatriation beds with care delivered by consultant geriatricians staffed on a networked basis with an acute hospital. It was also added that patient selection is a key determining factor of the safety of intermediate care beds. The presence of repatriation beds may add pressure to acute hospitals to discharge patients and this can lead to inappropriate discharges should there be no clear guidelines on repatriation. A study was cited on travel distances and mortality (Jon Nicholl et al. 2007). The paper will be circulated to the group and provide a more detailed analysis of its results vis a vis MSFT's case-mix.

HMT asked if the LSS model is safe if the step-down beds were staffed on a networked basis. It was noted that the lack of back-up acute services and suitable out of hours cover may make it unsafe. It was noted that Wolverhampton's proposal is to provide middle grade cover for intermediate care beds with suitable transfer arrangements. The model could therefore be safe. It was stated that the quality of training will deteriorate as the unit especially if trainee middle grades are used to provide OOH cover. HMT replied that the model will not be staffed by trainees. It was suggested the step-down beds be named rehabilitation beds to promote more conservative patient selection. The LSS model for Stafford was concluded as safe as long the patient selection and out of hours cover is appropriate. Additionally, the TSAs will also need to consider the impact on the LHE.

HMT described the CPT model. The UCC will not take ambulance attendances and is nurse led with GP input during the day. It is assumed that the staffing for paediatric urgent care attendances will be the same. It was suggested for the nurses be trained in identifying head fractures. It was also added that capacity for admissions from daycases needs to be identified. Additionally, support needs to be offered to patients who have been discharged home following a daycase procedure. The patients will require access, including OOH, to a contact who is informed in the procedure they have undergone. It was also noted that on the 5 day ward model stating that the range of procedures which can be carried out will be greatly reduced on Fridays. Given the limited support services on site, it was suggested that the range of daycases should be limited.

Suitable OOH cover needs to be established for elective surgery patients and this includes anaesthetists, middle grade physicians and access to consultants from all specialties. It was stated that the requirement to have on-call consultants will lead to double running of rotas. It was added that patient selection will present difficulties while establishing the required OOH cover will be somewhat impossible. A MLU has not been proposed as it is viewed to be financially unviable. It was stated that while hospitals operating with a model similar to the CPT model exist, the TSA should not seek to replicate them as the model is not robust. It was explained that the step up feature of the CPT model which aims to provide consultant delivered care for frail elderly patients facing an acute

exacerbation. The group agreed that it will be unsafe to accept such patients without the backing of acute services.

The group then briefly discussed the LSS model for Cannock noting that the outpatient services in Cannock would not treat children. This was followed by a discussion on the CPT model for Cannock. It was stated that capacity to admit daycase patients who require further care needs to be identified. It was stated that the Wolverhampton model will have middle grade anaesthetists, junior doctors in surgery and generic middle grade doctors across all specialties. It was noted that the Walsall model will have consultant cover from daycase theatres during the day while those requiring admission transferred to Manor Hospital. For those who remain in Cannock, OOH cover will be provided by resident physicians, middle grade doctors, anaesthetists with access to surgical opinion. It was suggested that the level of OOH cover they proposed will allow for ASA3 patients to be treated. The group agreed that the unit should not treat ASA 3 patients as they will have co-morbidities. More information on pre-operative risk, proposed procedure types and OOH cover is required by the group for decision making.

The group discussed the relative safety of the models, noting capacity issues. It was stated that concentrating activity will always improve quality and vice versa. The group agreed that the TSA model is safer than the LSS and CPT models. The recruitment and retention of non-training middle grades and consultant surgeons for the LSS and CPT models will be very difficult.

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Meeting of the National Nursing and Midwifery Advisory Group**

**Date: 28/06/2013**

**Time: 14:00 – 16:00**

**Location: Ernst & Young office, London**

**Attendees:**

| | |
|---|---|
| Trish Bennett | Director of Nursing and Quality, NHS England: Greater Manchester |
| Elizabeth McManus | Chief Nurse, York Teaching Hospital |
| Helen Thomson | Director of Nursing, Calderdale and Huddersfield NHS FT |
| Janet Davies | Director of Nursing and Service Delivery |
| Howard Catton | Director of International Policy, Royal College of Nursing |
| Hugo Mascie-Taylor | TSA |
| Phil Britt | TSA |

**Meeting notes:**

HMT updated the group on the TSA process stating that the solution will most likely involve Stoke and Stafford working in a networked model. Services in Cannock will be limited and therefore, a solution is easier to identify although the TSA have been working with Wolverhampton the final solution may not involve them.

HMT emphasised that the role of the group is to provide an opinion on clinical safety and recruitment and retention but not finances. The views of the group as well as its membership will be made available in the public domain.

It was asked if the UHNS is in the FT pipeline. It was noted that all Trusts in England are in the FT pipeline but due to the current issues faced, UHNS is unlikely to achieve FT status in the short term. HMT stated that the current proposed model has been extensively tested and is recognised as safe. However, there is a need to compare the financial implications with that of other clinical models including the LSS and CPT models.

It was asked if the group can apply conditionality on its recommendations and HMT confirmed that it is possible. A query was raised on implementation and business as usual. HMT replied that previous MSFT execs provide leadership and guidance for BAU. At present, it is unclear who will deliver the implementation phase and the level of support available for implementation is therefore unknown. It was stated that strong governance is required to deliver a networked model and that there are risks associated with combining two poorly performing trusts. The group emphasised that the way the model is implemented is critical to clinical safety.

It was stated that community services will be crucial in delivering the models. It was asked if any assumptions have been made on the redistribution of funding from the acute sector to the community and HMT replied that such assumptions are not known at present.

The discussion then focussed on the clinical models. There are three clinical models that need to be considered – the CPT, LSS and TSA model and status quo. The impact of the model on the LHE has not been modelled for all but the TSA model. The CPT and LSS models will need to be tested further as they cannot be assumed to be safe.

HMT proceeded to describe the TSA model. The model is staffed on a networked basis and Stafford is expected to retain ca. 90% of its current activity. It will host a 14/7 A&E, PAU and an AMU. A question

was asked on the practical implications of senior staff. HMT replied that mobility is typically dependent on seniority and that senior staff are more likely to mobile. He then asked if a networked model will improve recruitment and retention. It was stated that ward nurses should not rotate and that rotation is more achievable if nurses are trained by the same organisation. It was added that rotation would be particularly attractive to band 5 nurses. It was then suggested that a development programme associated with the rotation, coordination between universities and a common audit practice across hospitals will improve with staff rotation.

HMT then informed the group that while Stafford will retain an acute medicine unit, very ill patients will either need to present directly in Stoke or be transferred there. Critical care facilities will be available in Stafford. There will be 24/7 onsite, senior anaesthetist cover whole will be able to intubate, ventilate and stabilise. Acutely ill patients will be transferred as appropriate. Discussions on the possibility of a retrieval service have taken place with WMAS. It was asked if there is a mechanism to manage deteriorating patients. HMT replied that the critical care facilities will be able to stabilise and transfer them. For those requiring surgery, Stafford will have access to imaging and surgical opinion. However, the only emergency surgeries that will take place in Stafford are those that can be carried out by an emergency physician or added to a Theatre list the next day if appropriate for the patient to be sent home and brought back. More complicated procedures will take place in Stoke.

The group recognised the importance of clinical protocols and safety although they have not been worked up in detail at present. The guiding principle is to transfer all acutely ill patients to Stafford. However, there is some reassurance as the ambulance protocols in the area are widely thought to be good.

HMT informed the group that there are ca. 1,800 births per annum in MSFT and given the low volume, no obstetrics-led birthing services have been proposed. There will however be pre- and post-natal care, scanning and EPAU. While it is recognised that an MLU can be provided safely through the rotation of midwives, it has not been proposed as it will not be financially viable. It was stated that midwives may not need to be rotated. It was further added that the volume of births can possibly be increased should access to the MLU be opened to other providers. There are two possible models for MLUS – one with midwives onsite and the other with midwives on-call from another hospital who can be present at the MLU as necessary. The critical mass for clinical safety depends on the model and a unit delivering 180 births per annum can be safe. Additionally, there is no hard evidence on the number of births a midwife needs to deliver in order to maintain skills but it is assumed that those working in an acute setting will need to deliver more births to maintain skills compared to one working in a stand-alone MLU.

It was asked if the physician led ambulatory care unit will be safe given that the low volume of forecast activity. HMT emphasised that the model will be on a networked basis and therefore, physicians will on the whole have sufficient activity volumes to maintain their skill-set. The group concluded that the model of Stafford is safe if it is staffed on a networked basis and the impact on recruitment and retention will be dependent on the opportunities offered. The creation of training/development programmes, health education, coordination with local universities and opportunities to retrain existing staff were seen as possible factors which may improve recruitment and retention. Concerns were raised on the recruitment in the low risk units. The group also raised concerns on the potential difficulty in recruiting paediatric nurses in the PAU given that there is no inpatient paediatric services. Furthermore, paediatric nurses have historically been difficult to recruit. It was noted that the paediatric nurses can offer support in the A&E.

The discussion then moved onto the Cannock site. Utilisation of the Cannock site is low and it is recognised that the proposed model for Cannock can be delivered by Wolverhampton or other organisations such as Walsall. Most responses received during the market engagement exercise proposed expanding the range of inpatient services in Cannock. HMT explained the model. There is

still a need to ascertain if the level of cover provided for elective surgery is safe. It was stated that the elective site should have middle grade surgical cover out of hours and that the presence of the HDU may result in the site increasing its patient take such that it operates on patients with risk levels that are too high for the unit. It was explained that advanced medical practitioners will be able to provide additional cover alongside the proposed middle grade anaesthetist cover. It was stated that each service in Cannock appears to be quite distinct and that the linkages between them do not appear to have been worked up. The group agreed that the model needs to be developed further. More information was requested on the range of inpatient procedures offered given that most low risk procedures are now daycases. It was stated that palliative and EoL care may be a potential service for Cannock.

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Joint meeting of the CAG and NCAG**

**Date: 16/07/2013**

**Time: 15:30 – 17:30**

**Location: Academy of Medical Royal Colleges**

**Attendees:**

| | |
|---|---|
| Professor Terence Stephenson | Academy of Medical Royal Colleges |
| Alastair Henderson | Academy of Medical Royal Colleges |
| Professor Robert Shaw | Royal College of Obstetricians and Gynaecologists |
| Derek Alderson | Royal College of Surgeons |
| Patrick Cadigan | Royal College of Physicians |
| Professor Peter Furness | Royal College of Pathologists |
| Dr JP Besouw | Royal College of Anesthetists |
| Dr Gary Cook | Faculty of Public Health |
| Jim Wardrope | College of Emergency Medicine |
| Professor Jacky Hayden | Royal College of General Practitioners |
| Professor George Youngson | Royal College of Surgeons |
| Elizabeth McManus | Chief Nurse, York Teaching Hospital |
| Helen Thomson | Director of Nursing, Calderdale and Huddersfield NHS FT |
| Howard Catton | Director of International Policy, Royal College of Nursing |
| Robert Courteney-Harris | MD, UHNS |
| Amir Khan | MD, Walsall Healthcare |
| Sue Hartley | Director of Nursing, Walsall Healthcare |
| Hugo Mascie-Taylor | TSA |
| Gillian Cooksley | TSA |
| Phil Britt | TSA |
| Ken Leong | TSA |

**Meeting notes:**

HMT welcomed the attendees who then introduced themselves. He then explained that the TSAs' have taken a view on the model to pursue. Of the three models, the TSA model was viewed by the CAG to be the safest and has the most positive impact on recruitment and retention. The LSS model is deemed to be safe. The step-up care element of the CPT model was seen as risky as it will treat patients without a definite diagnosis and no clear mechanisms have been proposed to expedite the diagnosis. Therefore, the TSA model is the safest followed by the LSS and CPT models. HMT also informed the group that financial modelling has now been completed for all models. The TSA model is the most financially attractive due to the capital costs required in the other models. It was stated by the members that the CAG has been independent in forming its views on the models rather than being influenced by the TSAs.

It was asked if the cost of transfers have been taken into account in the financial modelling. HMT replied that the costing for ambulance transfers is still being completed. However, given that there are fewer transfers in the TSA model, the financial argument will be strengthened.

The group discussed the elective surgery service at Cannock. The group queried on the interface between the intermediate care beds which are currently provided by the Community Trust and the services proposed by Wolverhampton. It was stated that the provision of services by the other organisations is not within the TSAs' remit. However, once the details of the models have been worked through, the CCGs will be informed such that plans can be put in place to ensure that services

are linked up.

The group requested further details on pre and post operative care – the proposal currently states that it will be provided by a SHO equivalent. It was stated that retaining staff at the SHO level will be difficult should they only provide out of hours care.

It was asked if out of hours reoperations will be conducted on-site or transferred. HMT replied that it will be dependent on the condition of the patient. It was then queried on medical cover onsite should medical staff be required to accompany a transfer. It was stated that a retrieval team needs to be set up. Finally it was asked if the unit will operate as a 5 or 7 day ward. Further information is required from Wolverhampton on this aspect of the model.

It was stated that the categories of procedures proposed appear to be acceptable but details at the procedure level will be required. The level of out of hours cover is not sufficiently robust especially in the lack of staff that will be able to recognise a patient who is in a critical state and therefore need to be transferred. The model is not worse than current arrangements but at the same time, is only marginally better. It was agreed that arrangements for appropriate cover, escalation processes and retrieval for transfer need to be developed further.

It was expressed that on site out of hours medical cover will be important as a high proportion of post operative issues are medical. It was stated that it will be difficult to recruit and retain middle grades due to a national shortage especially if their duties were limited to the provision of out of hours cover.

The group concluded that overnight patients will increase the risk of the unit due to the increased need for out of hours cover. Details on procedure type and volume will also be required. It was added that governance and the rotation mechanism need to be worked on further as well.

The group reviewed a summary of discussion points pertaining to the services which would no longer be provided in Stafford Hospital in the TSA model.

Emergency surgery, other than those that can be carried out in A&E or are of little urgency, will no longer be carried out in Stafford Hospital. The CAG proposed adding the following points to the narrative

- **Anaesthetic cover will be required in order to provide emergency surgery**
- **Volume of activity is unlikely to be sufficient for training and the service will therefore need to be staffed by trained staff**
- **The service will need to have access to staff who are sufficiently experienced to decide if an emergency operation is required**
- **Emergency surgery will require a full range of auxiliary services**
- **Recruitment and retention of nurses will likely to be difficult**

Level 3 critical care will no longer be provided in Stafford Hospital. The CAG proposed adding the following points to the narrative:

- **The service will require a full range of auxiliary services**
- **The service will see a low volume of activity which is likely to lead to mortality statistics being skewed negatively**

A level 2 critical care unit will still be required as Stafford Hospital will still take medical admissions

and elective admissions. It can provide non-invasive ventilation and anaesthetic cover.

Inpatient paediatrics will no longer be provided in Stafford Hospital. The CAG proposed adding the following points to the narrative:

- **The current admission rates in Stafford Hospital is significantly higher than the national average**
- **The recent publication by the RCPCH on small paediatric inpatient units needs to be cited**

Additionally, the importance of community paediatrics services needs to be emphasised.

Obstetrics led delivery services will no longer be provided in Stafford Hospital. The TSAs recognised the CAG's opinion that a MLU is safe. It is however not proposed as it is not financially sustainable and the projected low volume of births will make the retention of staff and skills difficult. Given that there are several hospitals in the area which will provide obstetrics led delivery service, women will retain a choice in the location for birth.

It was suggested that an overarching narrative to describe the interdependencies between services is required. It was stated that the availability of capacity in other hospitals needs to be considered. A view was expressed that it is likely for Stafford to be compared to other hospitals located in a town of a similar size. It was noted that a factor for changes in Stafford is due to it being financially unsustainable

It was suggested that the NHS may discuss the future of small, financially unsustainable, hospitals located in isolated areas.

The group then confirmed the date for the site visit. They will inform the TSAs on areas which they would like to focus on. Several attendees also volunteered to be filmed in the consultation video.

The group reviewed the letter of endorsement previously written. It was suggested an additional caveat that the opinion of the National CAG was based on a review of high level information. The Nurse CAG agreed to draft a similar letter.

The meeting then concluded.

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Meeting with the NCAG and RWT**

**Date: 20/08/2013**

**Time: 13:00 - 13:45**

**Location: Conference Call**

**Attendees:**

| | |
|---|---|
| Professor Terence Stephenson | Academy of Medical Royal Colleges |
| Alastair Henderson | Academy of Medical Royal Colleges |
| Dr JP Besouw | Royal College of Anesthetists |
| Professor George Youngson | Royal College of Surgeons |
| Jonothan Odum | Royal Wolverhampton NHS Trust |
| Ian Badger | Royal Wolverhampton NHS Trust |
| Hugo Mascie-Taylor | TSA |
| Gillian Cooksley | TSA |
| Phil Britt | TSA |
| Animesh Mathur | TSA |

**Meeting notes:**
HMT confirmed the agenda for the meeting which was to have a discussion about how services will be provided by Royal Wolverhampton Hospitals NHS Trust (RWT) at Cannock hospital. This included:

- What is the nature of Cannock Hospital?
- What is the staffing model at Cannock?
- What is the day Surgery provision?
- What are the overnight services to be provided at Cannock?
- What is the overnight cover for the services?
- What is the impact on recruitment and retention?

**What is the nature of Cannock Hospital?**
The profile/proposal for Cannock was described as:

- Cannock is a small hospital about 9 miles from RWT
- RWT already provide some services out of Cannock: Heamo-dialysis and Ophthalmology day surgery
- RWT as a trust would operate across both New Cross Hospital and Cannock Hospital and provide services at Cannock

**What is the Staffing model at Cannock**
The staffing at Cannock were described as follows: The staff will be employed by RWT and would rotate across both the sites. This will help the staff maintain the right level of skills
Concern was raised regarding the provision of training grade doctors on site with a lack of clinical supervision. It was noted that training grade doctors will only provide services during the day when the appropriate consultant teams are on site in Cannock

**What is the day surgery provision?**
It was confirmed that the provision of day surgery would be for the following specialties: Orthopaedics, General Surgery, and Ophthalmology. The surgery would be performed by the appropriate Consultant teams on site in Cannock.

A question was raised regarding the provision of Childrens day case surgery in Cannock. It was confirmed that no daycase procedures would be performed on Children in Cannock under the

current clinical model – RWT will develop their own local protocol for who fits this criteria.

A question was raised about whether the appropriate kit was included in the costs for the delivery of services i.e. the technical equipment for breast surgery. It was confirmed that the specialist kit had been accounted for in the costings. There would also be the relevant diagnostic services on site to support this service.

**What are the overnight services to be provided at Cannock?**
It was confirmed that the following services would be provided as overnight services:

- Medical step-down care of the elderly/rehab (patients who are admitted to New Cross as an emergency but are then stepped down to Cannock)
- Elective Orthopedic inpatients
- Elective General Surgery inpatients

A question was regarding the provision of percutaneous Urology and whether this would be provided at Cannock. It was confirmed that it would not be provided in Cannock

**What is the overnight cover for the services?**
The over-night cover at Cannock will be provided by:

- Resident middle grade doctor for Orthopaedics
- Resident middle grade doctor for General Surgery
- Resident middle grade Anaesthetist
- Resident RMO (non training grade) for General Surgery and Orthopaedics

A question was raised regarding who the middle grades were and what position they would hold in the Trust? It was confirmed that these were non training middle grade doctors i.e. staff grades or Trust Fellows who would be employed by the Trust

A question was raised about the Anaesthetic role and whether this was absolutely needed? It was noted that the Aneasthetist would be there to stabilise and manage patients on site if they could be. Any patient which could not be managed on site would be transferred to New Cross. It was confirmed that no returns to surgery would be undertaken at Cannock Hospital overnight – any patient who needs this will be transferred to New Cross.

Concern was raised regarding the middle grade cover overnight and how that would be managed. It was noted that the intention is to run a traditional “hospital at night” model. It was also noted that the middle grades would not solely work at Cannock as they would rotate through New Cross as well.

**What is the impact on recruitment and retention?**
It was noted that currently RWT employ 3 middle grades in Orthopaedics and 3 middle grades General Surgery. In order to provide the services sustainably there will need to be 8 middle grades on each rota. It is assumed that there will be a transfer of some middle grades from Stafford when the activity is transferred which will support the rota.

It is likely that RWT will need to recruit more middle grade doctors. RWT noted that they have a good track record of recruiting middle grade doctors and are confident that they will be able to recruit the extra middle grades for the rota. If for some reason they are unable to recruit them, they will provide a flexible /restricted service at Cannock (e.g. surgery provided on 4 or 5 days only).

Consultant Orthopaedic and general Surgeons from RWT will provide cover for Cannock. This will be on separate rotas from the New Cross rota. The Consultant Anaesthetists are willing to be resident

on site on occasions to cover gaps in the Anaesthetic middle grade rota.

A question was raised about what would happen to patients who could not be discharged home if an adequate in-patient service could not provided for part of the week or for weekends. It was confirmed that the service would be scheduled to minimise this risk; but if this situation were to arise, any patient who could not be discharged safely would be transferred to the appropriate specialty ward at New Cross Hospital.

HMT asked for final comments:

The members present confirmed that the concerns raised previously on the proposal had been addressed with the following notes:

- There needs to be appropriate selection and scheduling of patients to minimise any risks.
- Cocnerns regarding joint revisions taking place in Cannock
- Contingency plans need to be developed for the scenario of not being able to recruit the middle grades

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Joint meeting of the NCAG and NMAG**

**Date: 08/10/2013**

**Time: 13:00 - 16:30**

**Location: The Royal college of Obstetricians and Gynaecologists, London**

**Attendees:**

| | |
|---|---|
| Terence Stephenson | Academy of Medical Royal Colleges |
| Alastair Henderson | Academy of Medical Royal Colleges |
| Robert Shaw | Royal College of Obstetricians and Gynaecologists |
| Patrick Cadigan | Royal College of Physicians |
| JP Van Besouw | Royal College of Anesthetists |
| Jim Wardrope | College of Emergency Medicine |
| Jacky Hayden | Royal College of General Practitioners |
| Trish Bennett | Director of Nursing and Quality, NHSE: Greater Manchester |
| Elizabeth McManus | Director of Nursing, Chelsea and Westminster NHS FT |
| Helen Thomson | Director of Nursing, Calderdale and Huddersfield NHS FT |
| Robert Courteney-Harris | MD, UHNS |
| Gill Walton | Director of Midwifery, Portsmouth Hospitals NHS Trust |
| Hugo Mascie-Taylor | TSA |
| Gill Cooksley | TSA |
| Phil Britt | TSA |

**Meeting notes:**

HMT and TS welcomed the attendees who then introduced themselves. HMT explained the purpose of this meeting was for the CAG to: provide a view on the safety and recruitment and retention issues of proposals submitted by MSFT and provide views on the TSAs final recommendations to Monitor. It was confirmed that the response was to be based on Clinical sustainability only and not comment on any financial implications. Further, the TSA would not comment on any of the department's presentations and this meeting was for the CAG to discuss with the departments.

It was noted that from UHNS's point of view they had been presented with the models and proposals from the departments. As there was not sufficient time to fully consider the proposals and evaluate their impact fully they had not been considered by the Board yet at UHNS and therefore does not have sign up from them.

An update was provided on the current TSA position. At present the three models: TSA, CPT and LSS do not achieve financial balance. This was a major cause of concern for the CCGs who are not prepared to pick up the financial gap if there is one at the end of the process. It was noted that the TSA was working with the relevant bodies like NHS England, Monitor and the TDA to arrive at a consensus.

The presentations from the departments (critical care, obstetrics and paediatrics) were introduced. It was noted that there has been a difference in opinion over the numbers presented by the TSA in some of these areas.
It was noted that the activity numbers used by the departments are slightly different to those used by the TSA because either they have been counted differently or a different assumption is applied. The difference is mainly in the Paediatrics and obstetrics numbers. The differences and reasons are as follows:

Pediatrics

- Medical IP – Agree with the activity numbers at c 2,300
- PAU – The department have counted all activity that passes through PAU c 6,500. This figure is recognized by the TSA. The TSA use: 4,500 PAU attendances only plus most of the 2,300 inpatients will have a PAU episode as well
- GP referral – There is an error in the TSA numbers, the number used in the report was c300. Following a review this number is actually c750
- Pediatric Surgery – TSA stated that MSFT do not do any specialist Pediatric surgery which has been misinterpreted to mean MSFT do not do any childrens surgery. Numbers have been included in the analysis for daycase, elective and non-elective surgery numbers

Obstetrics

- The TSA stated that there will be c.1800 births in the Staffordshire area (2011/12 HES data)
- The number has been challenged on the fact that Stafford has an increasing military presence and there will be development of 10,000 new houses to accommodate population growth
- The TSA spoke to the commander of the contingent at Stafford who informed that there are about 15 births for every unit in a year and there are two more units to arrive in Stafford. So there will be a maximum of 45 births.
- Public health projections suggest that the number of births in Stafford will go up for the next two years by c 150 and then start to drop over the next 10 years to c1,800

The MSFT Critical Care department was invited in to present their response to the TSAs recommendations and to present alternate proposals/models for the Critical Care department at Stafford. The clinical departments were supported by the MSFT Medical Director, Paul Woodmansey and two Clinical Directors: Charles Spencer and Ashok Sinha

Critical Care Department

| | |
|---|---|
| John Hawkins (JH) | Consultant in Critical Care |
| Moses Chikungwa (MC) | Consultant in Critical Care |
| Jake Botfield (JB) | Nurse Consultant Critical Care |

JH summarised the Critical Care Departments proposal which had been submitted to the TSA and passed on to the CAG members. The proposal was to retain a level 3 unit with an Intensivist rota
The CAG were invited to ask questions:

**What consultant cover do you currently have?**

There are currently six anaesthetists who provide cover over five days and are then on-call during the evenings and weekends. There are 15 consultant PAs per week allocated to the critical care unit.

**Has there been any recruitment and retention issues in previous years in Consultant appointments?**

No significant problems in recruitment and retention were highlighted

**Have you ever had problems recruiting and retaining nurses?**

There has not been an issue recruiting nurses. Some nurses have moved on to take up higher positions elsewhere, but they have always managed to fill those positions quickly with staff. There is a good mix of staff who have been there a while with newer staff replacing those who have left.

Obstetrics and Paediatrics Department

| | |
|---|---|
| Karen Powell (KP) | Consultant in Obstetrics and Gynaecology |
| Anne Mellor (AM) | Head of Midwifery |
| Kim Woolliscroft (KW) | Head of Childrens Services |
| Colin Melville (CM) | Consultant Paediatrician |

The obstetrics and paediatrics departments wanted to present their proposals together as they were linked with each other. The team presented the proposals which were: the retention of obstetric led births in Stafford which would network with a larger centre and a paediatric consusltant led 23 hour PAU

The CAG were invited to ask questions:

**What happens at 23 hours for the PAU?**
If the child still needs specialist input or monitoring at this point they would be transferred to UHNS

**How many hours consultant cover would there be for Obstetrics?**
This has not been worked through in detail yet

**If obstetrics is retained will major emergency gynaecology surgery be provided as well?**
Some procedures could do in the short term this has not been considered in great detail at the moment

**How many women are currently booked on a midwife birth pathway?**
Approximately 25% of planned births at Stafford are booked as a midwife delivery?

**How many are delivered by midwifes?**
Approximately 10% are delivered by midwives – less than 200 in total

**What is the current home birth rate?**
The home birth rate is currently 1.5% – 2%

**What %age of women get 1:1 cover?**
About 90% of women get 1:1 cover

**What would happen to a child at 8pm in Stafford if they are ill and need urgent services?**
They should be taken to Stafford A&E and they will be assessed by the paediatricians

**What is the current anaesthetic cover for obstetrics and paediatrics?**
On site cover is provided 9-5 daily but not always by a consultant. Out of hours cover is provided by the off-site critical care consultant and the on-site middle grade anaesthetist

**Is the Anaesthetist covering the whole hospital overnight?**
The anaesthetist would be covering critical care, obstetrics, SCBU and the inpatient wards. If more than one patient needed an anaesthetist then the on-call consultant would come in.

**What is the utilisation rate for the SCBU?**
10% of Stafford births currently go through the SCBU. Some other babies are repatriated from larger units

**Have there been any issues with recruitment and retention issues in the services?**
There haven't been historical problems however now with the TSA in place it has made recruitment more difficult.

The Trust staff posed some questions to the CAG

**Is the TSA model for the A&E department currently a recognised one particularly in relation to the future emergency care needs?**
Yes the model is a recognised one and will provide safe and sustainable care

**Are there any examples of the PAU model elsewhere?**
Yes, there is on in Huddersfield. MSFT staff are welcome to come and visit.

The Trust staff left the meeting.

The CAG members were invited to provide their view on the department's presentations from a clinical sustainability standpoint and specifically comment on safety and recruitment and retention aspects.

CAG response to Critical Care department presentation:

The CAG praised the department for their enthusiasm and commitment. There was concern that the activity levels at Stafford for Critical Care are very low and will result in a very few level 3 admissions per year. This, in the long-term, might lead to staff not being able to keep their skills updated. It was pleasing to see a commitment to rotation of staff between sites this could help maintain skills.

Further, it was not clear why the department wanted to differentiate the roles of anaesthetists and intensivists as the intensivists have similar job plans to anaesthetists. Simple pneumonia's for example could be managed locally in Stafford but more complex level 3 patients should be stabilised and transferred based on clinical need.

If the entire ward based NIV, for example, was centralised into the critical care unit it would de-skill the nursing staff on the wards.

Concerns were raised over staffing of the unit. It was not clear from the department's presentation as to how they would staff the unit. Staffing the unit overnight with junior doctors, as suggested, is not sustainable and there are not enough consultants to provide 24/7 cover with only 15 PAs allocated to the unit.

As with most services they could be delivered clinically sustainably and having a Consultant led service is clinically safe. It is unlikely that this model is sustainable in the long term with the volumes likely to be seen.

CAG response to Obstetrics and Paediatrics department presentation:

The CAG praised the departments for their enthusiasm and commitment. It was noted that a co-located MLU is desirable for the model as it will increase in patient choice. A concern was raised that, as per the birth projections, the number of births will be very low which will have a negative impact on staff skills and training of junior staff if they are.

Concerns were raised over the Obstetrics departments numbers –they should be aiming for 75% of women scheduled for midwife led care and 50% of women still under the care of a midwife at birth.

6,000 births is not an issue if there is appropriate selection between an Obstetric unit and a co-located MLU.

As for the paediatric proposals it was noted that the consultant led PAU would be clinically safe.

The CAG noted that whilst their remit is not to make comments on financially sustainability issues it was difficult to make the separation between the two as in some situations clinical sustainability is not financially sustainable. It would be the responsibility of the TSA to make the final assessment of all areas of sustainability.

There was an update from the TSA on the proposed changes to the draft recommendations relating to the clinical model.

It was noted that for critical care, the TSA would update the recommendations to say that if there is competence and capability to manage a level 3 patient in Stafford then the patient should be managed locally, if not the patient is transferred out. Staff skills will be maintained by rotating staff, having joint protocols and networking with the provider and finally, there will be an anaesthetist to cover the CCU. The CAG did not raise any issues with regards to this change and supported an evolutionary process which is supported by clinical protocols.

The TSAs will now recommend the commissioning of an MLU at Stafford hospital and will continue to recommend the decommissioning of the obstetrics unit due to the low activity. This MLU change was based on the evidence that more women would use the unit than initially expected and therefor it would be financially sustainable. The CAG did not raise any issues with regards to this change.

With respect to Paediatrics the TSA will recommend a PAU to be co-located with A&E, staffed by a nurse and consultant with paediatric training. There would be hot clinics with GP referrals – 5 clinics/week and finally, community nursing team would be put in place for children with acute nurses who will follow-up with children after discharge from the PAU or inpatient bed. The CAG did not raise any issues with regards to this change.

HMT and TS thanked everyone for attending and concluded the meeting.

# 4. Trust Special Administrator for MSFT – Local Clinical Reference Group (CRG)

In addition to the two national clinical advisory groups, the TSAs formed a Local Clinical Reference Group comprising clinical leaders from across the local health economy. The CRG met once and the meeting notes are as follows.

**The Trust Special Administration of Mid Staffordshire NHS Foundation Trust**

**Meeting Title: Local Clinical reference group**

**Date: 28/05/2013**

**Time: 17:00 – 18:30**

**Location: Postgraduate Management Centre, Stafford Hospital**

**Attendees:**

| | |
|---|---|
| Caron Morton | Shropshire CCG |
| Craig Stenhouse | Burton Hospitals NHS FT |
| David Hughes | North Staffordshire CCG |
| Liz Gunn | East Staffordshire CCG |
| Jonathan Odum | Royal Wolverhampton NHS Trist |
| Andrew Bartlam | Stoke CCG |
| Matt Ward | West Midlands Ambulance Service |
| Anne-Marie Houlder | Stafford and Surrounds CCG |
| Najam Rashid | Walsall Healthcare NHS Trust |
| R Mohan | Walsall CCG |
| John James | South East Staffs and Seisdon Peninsula CCG |
| Doug Wulff | SSoTP |
| Robert Courteney-Harris | University Hospitals of North Staffordshire NHS Trust |
| Hugo Mascie-Taylor | TSA |
| Gillian Cooksley | TSA |
| Masha Feigelman | TSA |
| Yair Erez | TSA |
| Ken Leong | TSA |

**Meeting notes:**

HMT updated the group on the timelines of the TSA process and the progress made since the CPT. HMT stated that the solution developed by the TSA will affect the LHE although the remit of the TSA is largely limited to MSFT. The solution identified must be clinically, operationally and financially viable. The role of the local Clinical Reference Group (CRG) is to provide an opinion on clinical safety and impact on recruitment and retention of the emerging clinical models. There is also a national Clinical Advisory Group (CAG) and Nurse Advisory Group (NCAG) in addition to the CRG. HMT informed the group that the models for discussion during the meeting will be those that have met the initial hurdle criteria of providing the LSS at the minimum.

For the purpose of the day's discussion, the clinical models were split based on six areas which are most likely to be contentious i.e. A&E and urgent care, critical care, acute medicine, maternity, inpatient paediatrics and acute surgery. As a point of reference, HMT described the configuration of the current A&E to the group. The current A&E in Stafford Hospital takes blue light attendances

excluding trauma, stroke and MI patients. This service is consultant-led and is backed by acute medicine, acute surgery and critical care (inc. Ventilation) services. However, the RCP's view, via the national CAG, is that access to acute surgery need not mean on-site provision. Therefore, an A&E does not need on-site access to acute surgery. It will however need access to surgical opinion. A question was raised on the acceptable time-frame for access to emergency surgery and this was recognised as an important detail to be raised at the next national CAG meeting. Some reservations were expressed on not having on-site access to acute surgery even if the A&E does not take major trauma patients. The view was that patients with an acute abdomen will usually require immediate surgery. He was however informed that the president of the ECM's view is that access with co-location is sufficient. The group was asked if they knew the typical percentage of self presenting patients who require acute surgery. The group could not provide an answer. A question was raised regarding a possible issue on recruitment and retention arising from an A&E unit without acute surgery. It was added that the volume of critical care activity attributed to non-acute surgery activity in Stafford Hospital only takes up 4 beds and that such a unit is unlikely to be sustainable. They were however reassured that the all models will be staffed on a networked basis.

HMT informed the group that the national CAG's view is that acute medicine will be required to run an A&E especially for the frail elderly. The group agreed. For critical care, the national CAG's recommendation was for monitoring to be the level as expected of a HDU with 24/7 anaesthetist presence (not necessarily a consultant). The A&E unit will need to be backed by an ambulance retrieval service. It was stated that the existing retrieval service is only for major trauma patients. It was also stated that the need to intubate patients prior to transfer may result in patients moving from level 2 to level 3 critical care. It was asked if there is a mechanism to ensure that there is sufficient capacity at sites accepting transfers. HMT replied that it is less of a problem is the one organisation is responsible for both the site a patient is being transferred from and the site accepting the transfer.

The meeting continued with a discussion on maternity. Considering that there are only ca. 1,800 births in MSFT, an obstetrics-led unit is unlikely to be sustainable. All models proposed include ante- and post-natal care as well as early assessment clinics. An issue was raised relating to recruitment and retention faced by MLUs. Even if the units were staffed on a networked basis, midwives choosing to rotate to a MLU are likely to deliver fewer babies. Additionally, the historical transfer rate from a MLU to an obstetrics-led unit is high (ca. 20%) and this may necessitate a retrieval service.

HMT informed the group that no provider proposed acute surgery services in their clinical models. The attendees were asked to gauge the volume of acute surgery activity based on a list of diagnosis codes. A query was raised on the conversion rate of diagnosis to procedures. HMT stated that the status of inpatient paediatrics is similar to acute surgery. It was noted that the public may lack confidence in an A&E without paediatrician presence it was confirmed that the PAUs are ANP-led. HMT added that there will be access to paediatrician opinion.

HMT explained that all clinical models propose a networked staffing arrangement and that the CAG is in the opinion that this will improve recruitment and retention when compared to a non-networked model. The ability of each provider to recruit and retain staff also depends on the status of the provider but this was not discussed further in the meeting as commercially sensitive information will be revealed.

The discussion was then on the clinical models. It was stated that the models presented focus only on the elements most pertinent to the decision making process. A question was asked if the A&E in Model 1 will take minor trauma patients e.g. fractured NoF. It was stated that an ambulance will not take a patient with a fracture NoF to such a hospital. A question was then asked if the unit will take on other surgeries e.g. ENT and urology. HMT explained that no acute surgery will be carried out in any of the models. A further question was if hospital to hospital transfers are common and it was noted that they are not as protocols are well established. Concerns were expressed on the provision of anaesthetist cover but it was noted that there will be anaesthetists available as the site will carry

out elective surgery. Model 1 was concluded as safe.

HMT then presented Model 2 emphasising that the unit is doctor-led and will take only self-presenting patients. It was added that the observation facilities are not intended for admissions and all patients requiring admission will be transferred. A query was raised on the provision of diagnostics and pathology. HMT explained that there will be on-site hot clinics for diagnostics but pathology is likely to be centralised. The details behind support services have however not been developed. A concern was raised on payments for patients requiring transfer – it was noted that this will be discussed and managed appropriately. An estimate of A&E activity retention was given for Models 1, 2 and 3 (80-85%, 70%, 70%). The group concluded that the model is safe if it is with the right transfer protocols and staff.

The discussion progressed to model 3 which is nurse-led. Assuming that the nurse is an ANP, the model is estimated to retain 70% of existing A&E activity. It was suggested that such a unit may have a higher transfer rate than one that is doctor led.

Model 4 was described as one that is consultant-led but not necessarily consultant delivered. HMT suggested that the unit may be able to take non-blue light ambulance attendances as it is better staffed and hosts limited critical care facilities.

The group concluded that amongst models 2, 3 and 4, model 4 is the safest. It was asked if there will be sufficient capacity for transfers and it was noted that all necessary capacity will be made available. A question was asked on the LoS by which a short stay observation is considered to be an admission. This was noted as the group.

Models 5 and 6 were considered to be walk-in centres. It was stated that Model 5 may have a larger negative impact as it is GP-led which reduces the need for networks.

The group were asked if they could comment on the alignment of the clinical models to royal college guidelines. HMT stated that the national CAG will have that discussion. It was stated that the changes will have an impact on the LHE as a whole. HMT replied that the providers will need to reassure the TSA and commissioners that capacity in the LHE will not be adversely impacted. Therefore, prospective providers will need to ensure that the right conversations have taken place.

The discussion then focussed on MLUs. Experiences of MLUs were shared by the group. The group were informed that the units face difficulties in recruitment and retention as well as low volumes of activity. It was noted that a transfer during birth from an MLU to an obstetrics-led unit can be distressful. It was also added that there is evidence that many women choose not to give birth in a MLU even if their pregnancy is considered to be low risk. The discussion on MLUs concluded with a query on the volume of home births. The total number in the LHE is not known.

There was no further discussion on inpatient paediatric services and acute surgery as no providers have proposed them.

HMT thanked the attendees and the meeting was concluded.

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# The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust

## Annex 3.3: TSA governance

December 2013

# 1. Overview

Following the appointment of Trust Special Administrators (TSAs) to Mid Staffordshire NHS Foundation Trust (the Trust or MSFT), the responsibilities previously held by the Council of Governors and the Trust Board were transferred to the TSAs, as set out in the National Health Service Act 2006 as amended by the Health Act 2009 and the Health and Social Care Act 2012.

The TSAs wanted to ensure that a structure was put in place as quickly as possible after their appointment through which assurance on all aspects of performance, including operational, quality, workforce and financial matters, could be received. A structured process also needed to be in place to ensure an audit trail exists regarding any matters requiring approval by the TSAs.

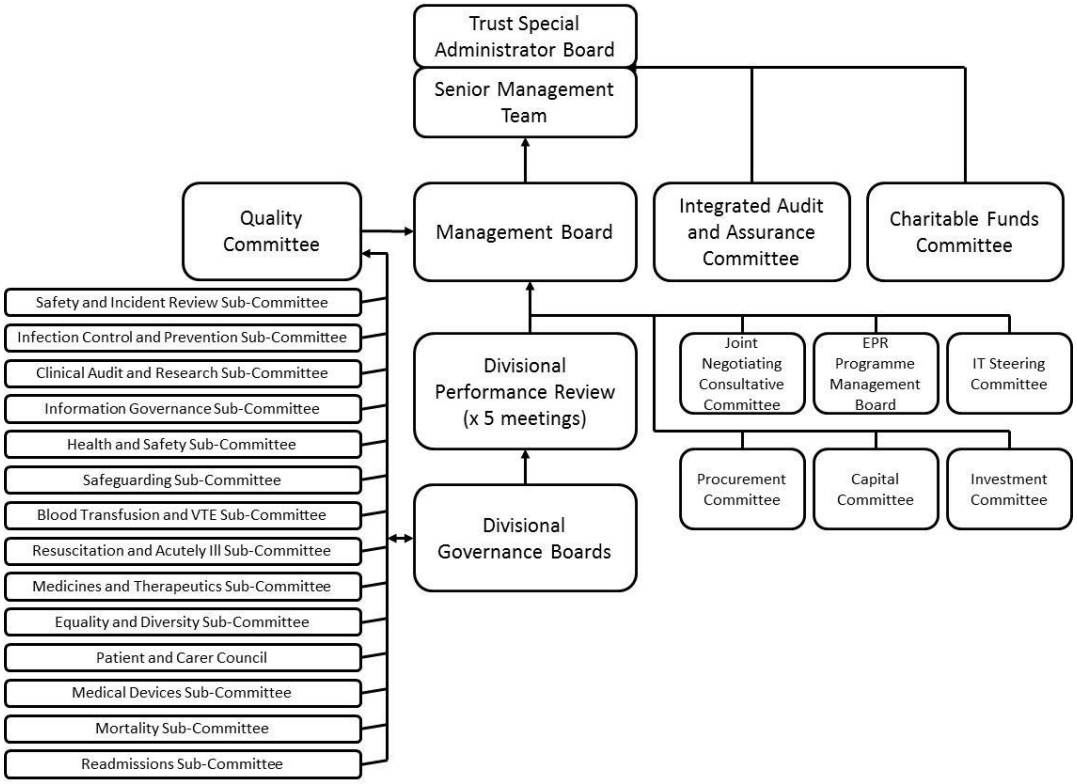
A review of the existing Corporate and Clinical Governance arrangements was therefore necessary to understand whether it was fit for purpose and to recommend changes in order to provide assurance to the TSAs that the most appropriate structure and associated terms of reference were in place throughout the TSAs' tenure. The review, initiated by the TSAs' team upon appointment, was led by Diane Whittingham, formerly an NHS Chief Executive Officer (CEO). The legacy governance structure was complex but had served its purpose over the last two years in driving the Trust to deliver progress regarding clinical and operational performance. The review recommended some simplification and refinement in order to provide clear accountability and assurance to the TSAs through the Senior Management Team.

The review considered the Council of Governors, the Trust Board and all Committees, Sub-Committees and groups. Consideration was given to any role that the Chairman and Non Executive Directors may be able to provide as Independent Members to the TSAs and the Governors as Public Representatives, particularly as their formal roles had been suspended as a part of the TSA process.

The proposed structure was reviewed by the TSAs and subsequently reported to the Management Board (Executive Committee) and the Senior Management Team on 30 May 2013, before being formally implemented from 1 June 2013.

**Governance Structure**

The new structure now in place at the Trust is summarised in the diagram below:




**The Chair as an Independent Member**

Given the Chair's formal role had been suspended, he agreed to provide support to the TSAs as an Independent Member. In this role, he chairs the TSA Board and the Senior Management Team meeting, providing independent challenge and acting as the key point of contact via the Lead Governor with the Governors, whose formal roles have also been suspended.

**The Non Executive Directors as Independent Members**

The Non Executive Directors (NEDs) formal roles have also been suspended, however, they too have agreed to provide support to the TSAs as Independent Members to generate challenge and scrutiny for the Quality Committee, Integrated Audit and Assurance Committee and Charitable Funds Committee.

Two of the NEDs resigned prior to the appointment of the TSAs and their notice period ended on 31 May 2013 and as such they are not incorporated in the revised structure.

**The Governors as Public Representatives**

The TSAs agreed the role of the Governors in an informal capacity during the TSA process. The Governors continue as public representatives and provide feedback to the Trust through a number of announced and unannounced visits.

# 2. TSA Governance Structure

**TSA Board**

The overall function of the TSA Board is for the TSAs to discharge their accounting officer role and fulfil all functions previously assigned to the Trust Board. This excludes those functions now undertaken by the Senior Management Team (see below).

This board considers issues that previously would have been dealt with in the private session of the former Trust Board. Work includes consideration and approval of business cases, approving submissions to Monitor and approving policies and other documents that require the TSAs' sign off.

The Board meets monthly in private following the Senior Management Team meeting.

**Senior Management Team**

The overall function of this meeting is for the TSAs to further discharge its accounting officer role and receive assurance from the Directors regarding the performance of the Trust in relation to quality, safety, operational targets, workforce, risk and finance. The Senior Management Team receives the Integrated Performance Reports, Assurance Framework, assurance on the Trust's statutory and regulatory compliance and the effective governance of the Trust. The Senior Management Team considers all matters escalated by the Management Board.

The Senior Management Team meets monthly in public immediately prior to TSA Board and members of the public have the opportunity to ask questions relating to agenda items.

**Management Board**

The core functions of this Board are to take on the role of the previous Executive Committee but with a broader remit to ensure that it is the conduit for the CEO, supported by the Directors, to report to the Senior Management Team and the TSAs.

The Management Board is the key operational decision making forum for all matters that do not require the approval of the TSAs but do require approval of the CEO and Directors, in addition to determining significant matters requiring escalation to and decisions requiring approval of the TSA Board.

This Board has been strengthened compared to the previous committee it has replaced and has a greater focus on performance management of the 5 divisions (4 Clinical Divisions plus the Corporate Division).

The board is advised and assured by the Quality Committee on all issues relating to service safety and quality.

TSA representatives are in attendance.

**Integrated Audit and Assurance Committee**

The terms of reference for the previous committee (called Audit, Risk and Assurance Committee) have been adopted but enhanced to include the expanding role in providing the TSAs with overall independent assurance on systems of control, operational effectiveness, risk and performance including quality. The committee receives regular reports from external advisors and auditors.

**Quality Committee**

The terms of reference for the previous committee (the Healthcare Quality Assurance Committee) have been adopted but amended to reflect that this Committee provides an opportunity for constructive challenge and scrutiny regarding clinical quality and to advise and assure the Management Board.

The committee considers all matters of quality governance including patient care, patient experience and patient safety.

The committee receives assurance from 14 sub-committees in relation to matters of a quality governance nature. These are shown on the diagram above.

**Charitable Funds Committee**

This committee replaces the previous Donated Funds Committee of the Board and includes the same functions in terms of assurance, however any matters for decision are presented to TSA Board for approval.

**Divisional and other meetings**

**1. Divisional Performance Review (5 Meetings)**

Building on the existing Divisional Performance Review meetings, these meetings support an improved performance management process to ensure appropriate clinical ownership, engagement and leadership. The core purpose of the meetings is to provide assurance on all matters of performance including quality, safety and risk for the respective division to the representative Directors.

Clinical Directors accompanied by the senior members of each respective Divisional Management Team meet with the Executive Directors. Where there are risks to service delivery then clear action plans will be agreed for which Clinical Directors and their Senior Management Team's will be held to account. Where an issue arises that prevents the achievement of the levels of performance previously agreed without additional funding then this will be escalated to Management Board for decision.

**2. Divisional Governance Boards**

These meetings combine the Divisions' previous "business meeting" and "governance meeting" and all members of the Divisional Management Team attend in addition to managers from departments within each respective Division. At these meetings all matters of performance, safety and governance are

considered in order for Clinical Directors to receive assurance that all performance targets and quality requirements are being met and risks managed.

**Other committees reporting to the Management Board**

On the diagram above there are 6 committees that will also report to Management Board. They are JNCC, EPR Programme Board, IT Steering Committee, Procurement Committee, Capital Committee and Investment Committee. Their Terms of Reference and membership have all been reviewed and agreed.

**Quality Governance meetings**

A review was undertaken by the Director of Nursing and Midwifery regarding each of the sub-committees reporting through to the Quality Committee and, as a result, 14 of these continue to meet, as shown above.

Each of these sub-committees include representatives from each divisions' Management Team and therefore will work in conjunction with the Divisional Governance Board meetings. The outcome of these meetings from a Trust-wide perspective will feed through to the Quality Committee.

**Summary of Board, Committee and Sub-Committee attendees and frequency**

| Board / Committee Name | Members | Frequency | Administered by |
|---|---|---|---|
| Trust Special Administrator Board | • A Trust Special Administrator<br>• Representatives of the TSAs (2)<br>• Independent Member (Professor John Caldwell) – who will chair the meeting<br>• Chief Executive<br>• Director of Finance and Performance<br>• Medical Director | Monthly (in private) | • Company Secretary<br>• Corporate Governance Department |
| Senior Management Team | • A Trust Special Administrator<br>• Representatives of the TSAs (2)<br>• Independent Member (Professor John Caldwell) – who will chair the meeting<br>• Chief Executive<br>• Director of Finance and Performance<br>• Medical Director<br>• Director of Nursing and Midwifery<br>• Chief Operating Officer<br>• Director of Quality and Patient Experience<br>• Director of Human Resources | Monthly (in public, same day as TSA Board) | • Company Secretary<br>• Corporate Governance Department |
| Management Board | • Chief Executive – who will chair the Board<br>• All Directors (6)<br>• Clinical Directors (4)<br>• Associate Directors / Deputies (approx 12) – when invited<br>• General Managers (4) – when invited<br>• TSA in attendance | Monthly | • Secretariat of the Executive Offices |
| Integrated Audit and Assurance Committee | • Independent Members (2) – one of whom will chair the Committee<br>• Chief Executive<br>• Directors<br>• External Auditors<br>• Internal Auditors<br>• Representative of the TSAs<br>• Company Secretary<br>• Deputy Director of Finance | Bi-monthly | • Secretariat of the Executive Offices |

| Board / Committee Name | Members | Frequency | Administered by |
|---|---|---|---|
| Quality Committee | • Independent Members (2) – one of whom will chair the Committee<br>• Chief Executive<br>• Director of Nursing and Midwifery<br>• Medical Director<br>• Chief Operating Officer<br>• Director of Quality and Patient Experience<br>• Clinical Commissioning Group representatives (2)<br>• Representative of the TSAs<br>• Company Secretary<br>• Head of Governance | Monthly | • Secretariat of the Executive Offices |
| Charitable Funds Committee | • Independent Members (2) – one of whom will chair the Committee<br>• Director of Finance and Performance<br>• Director of Nursing and Midwifery<br>• Representative of the TSAs<br>• Company Secretary<br>• Deputy Director of Finance | Three times per annum | • Secretariat of the Executive Offices |
| Divisional Performance Review | • Chief Operating Officer – who will chair the meetings<br>• Director of Finance and Performance<br>• Medical Director<br>• Director of Nursing and Midwifery<br>• Director of Quality and Patient Experience<br>• Associate Director of Human Resources<br>• Chief Executive Officer (quarterly)<br>• TSA representative (in attendance). | Monthly | • Secretariat of the Executive Offices |
| Divisional Governance Boards | • Divisional Management Team<br>• Managers from departments within each respective Division | Monthly | • Secretariat of each respective Division |

**Committees discontinued**

The following Committees of Board have been disbanded as their duties are now fulfilled by the structure outlined above.

- Finance, Investment and Operational Performance Committee
- Workforce Strategy Committee
- Shaping the Future Programme Committee
- Nominations and Remunerations Committee
- Quality and Safety Sub-Committee

**Human resources department**

A review of the Human Resources Department and functions was commissioned by the TSAs alongside the governance structure review and as a result, a new interim HR Director has been appointed.

This role will provide further guidance and support to the Human Resources Department and functions and work closely with the TSA team.

# 3. Oversight of Clinical Services

Immediately following appointment, the Trust Special Administrators commissioned a clinical review in order to identify all clinical governance risks and issues within the Trust. The clinical review took account of all reviews and assessments undertaken by external agencies and other organisations who had inspected services or sought to accredit the Trusts services. These organisations ranged from those with statutory enforcement powers to those without specific remits to healthcare and included all organisations identified in Monitor's compliance framework.

A comprehensive report was produced and all outstanding actions were identified along with mitigating actions.

The review confirmed that the number of clinical governance issues in the Trust had fallen during the last few years, substantial progress had been made and that measures were in place to respond in agreed timescales with any action plans to rectify concerns and where risks remain, that mitigation was in place in order to ensure clinical risk to patients was minimised.

The TSAs were also assured that the ongoing management of these issues and the identification of any new and emerging clinical risks would benefit from the changes made to the Trusts corporate governance structure. The changes would ensure that appropriate focus and management energy was maintained on key risk issues.

**Addressing stability – the Sustaining Services Board**

In order to ensure continuing robust internal governance and to further build partnership working across provider organisations, the TSAs proposed the establishment of a Sustaining Services Board (the SSB). This board includes Chief Executive and senior Director membership from the Trust and all adjacent provider organisations including University Hospital of North Staffordshire NHS Trust (UHNS), Walsall Healthcare NHS Trust, The Royal Wolverhampton NHS Trust and Staffordshire and Stoke-on-Trent Partnership NHS Trust.

The primary aim of the SSB is to promote system accountability and oversee the identification and management of system‐wide risks associated with the delivery of patient care during the transitional phase.

The SSB receives regular reports on progress, risks and mitigating actions from clinical and managerial groups established under the direction of the SSB, meeting on a monthly basis.

The main initial outputs of the SSB are to ensure that any risks associated with the continued safe and sustained delivery of high quality healthcare services by member organisations are identified and managed through transparent and open dialogue between relevant clinical and managerial staff of member organisations. A key task includes the development, agreement and oversight of a system-wide Workforce Framework to provide a model for managing and handling workforce risks during the transition period.

Following the approval by the Secretary of State of any recommendations of the TSAs, the SSB may have a role to oversee the development of implementation plans and the implementation of the

approved recommendations.

**Joint working arrangements with other provider organisations**

In recent years it has been necessary to develop several joint services with neighbouring providers to ensure that the safety of the services at the Trust, and local access, is maintained. It is recognised that during the transition period it may be necessary to introduce further joint service arrangements and the Sustaining Services Board will have a role in overseeing any joint arrangements and ensuring that they do not negatively impact on the final solution.

An example of joint working;

A joint arrangement between UHNS and the Trust to sustain an Emergency Department (ED) at the Trust for 14 hours a day, 7 days a week has been put in place. This has been necessary as recruitment and retention to the clinical posts at the Trust has been a challenge and the Trust could not, on its own, maintain the provision of the service going forward. The Trust ED is also within a close enough proximity to directly impact on UHNS services. The closure of the department from 22:00 hours until 08:00 had demonstrated that a further shift in emergency activity would be inevitable if the operating hours of the department further reduced. It was therefore in the interests of both services to work together and develop a joint plan that ensured the sustainability and viability of services on both sites.

Executive teams from the Trust and UHNS met in August 2013 to discuss the requirement for assistance from UHNS in the form of providing senior medical staff to undertake clinical shifts and to also provide clinical leadership. A memorandum of understanding between the two organisations, originally agreed in June 2012 and recently updated, sets out the approach by which joint services will be developed and delivered across the two sites. The SSB will have a role in overseeing the joint arrangements.

The proposed arrangements between UHNS and the Trust would see a range of mutually beneficial initiatives around medical staffing in both departments.

This proposal will not prejudice Trust Special Administration process, however, these joint service arrangements will remain in place until further notice and will be formally reviewed 3 months from commencement.

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## Annex 3.4: TSAs' stakeholder engagement summary

December 2013

# 1. Stakeholder interaction summary

The following table gives an overview of key meetings, discussions and events that took place between the Trust Special Administrators and a wide range of stakeholders. These meetings helped inform the Trust Special Administrators as they undertook the work described in this report.

| Pre-consultation meetings | | |
|---|---|---|
| **Date** | **Meeting / Event** | **TSA and/or TSA senior representative** |
| 15 April 2013 | MSFT Board meeting - Introduction to the TSAs | Alan Bloom / Hugo Mascie-Taylor / Alan Hudson / Gillian Cooksley / Jo Robinson / Executive Directors |
| 15 April 2013 | Press conference | Alan Bloom / Hugo Mascie-Taylor / Monitor |
| 15 April 2013 | Media one-to-one interviews | Hugo Mascie-Taylor |
| 16 April 2013 | Call with Jeremy Lefroy - MP for Stafford | Alan Bloom |
| 16 April 2013 | Meeting with staff side union and regional union representatives | Alan Bloom |
| 16 April 2013 | Call with Assistant Chief Constables for Stafford and Cannock | Alan Hudson / Jo Robinson |
| 16 April 2013 | Executive Committee Meeting with senior management | Alan Bloom / Hugo Mascie-Taylor / Alan Hudson |
| 16 April 2013 | Call with the Health Scrutiny Committee - Staffordshire County Council | Alan Bloom / Gillian Cooksley / Hugo Mascie-Taylor |
| 16 April 2013 | Call with Staffordshire County Council | Alan Hudson / Gillian Cooksley |
| 16 April 2013 | Call with NHS Trust Development Authority | Alan Bloom / Hugo Mascie-Taylor / Gillian Cooksley |
| 16 April 2013 | Call with Support Stafford Hospital | Alan Bloom / Alan Hudson |
| 16 April 2013 | Call with Local Area Team | Alan Bloom / Hugo Mascie-Taylor / Gillian Cooksley |
| 16 April 2013 | Interview with the media | Hugo Mascie-Taylor |
| 16 April 2013 | Clinical Directors meeting | Hugo Mascie-Taylor / Gillian Cooksley |
| 16 April 2013 | Medical staffing committee meeting | Alan Bloom / Hugo Mascie-Taylor / Alan Hudson |
| 17 April 2013 | Meeting with Stafford and Surrounds CCG | Hugo Mascie-Taylor / Gillian Cooksley |

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|---|---|---|
| | & Cannock Chase CCG | |
| 17 April 2013 | Staff briefings (Stafford Hospital) - 4 X 45 minute sessions | Alan Bloom |
| 17 April 2013 | Staff briefings (Cannock Chase Hospital) - 4 X 45 minute sessions | Alan Bloom |
| 17 April 2013 | Call with Gavin Williamson - MP for South Staffordshire | Alan Hudson / Jo Robinson |
| 17 April 2013 | Staff night shift briefing (Stafford Hospital) | Alan Bloom |
| 18 April 2013 | Staff night shift briefing (Cannock Chase Hospital) | Alan Bloom |
| 18 April 2013 | Meeting with Shrewsbury and Telford Hospital NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 18 April 2013 | Burton Hospitals NHS Foundation Trust meeting | Hugo Mascie-Taylor / Gillian Cooksley |
| 18 April 2013 | Hospital Radio interview | Alan Bloom |
| 18 April 2013 | Ward and department walkarounds – Stafford Hospital | Alan Bloom |
| 18 April 2013 | Meeting with University Hospital of North Staffordshire | Hugo Mascie-Taylor / Gillian Cooksley |
| 18 April 2013 | Call with Aidan Burley - MP for Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 18 April 2013 | Call with Paul Watson - NHS England | Alan Bloom / Hugo Mascie-Taylor / Gillian Cooksley |
| 18 April 2013 | Call with Stephen Brown – Cannock Chase Council | Alan Hudson / Jo Robinson |
| 19 April 2013 | Meeting with Aidan Burley - MP for Cannock | Alan Bloom |
| 19 April 2013 | Meeting with The Royal Wolverhampton Hospitals NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 19 April 2013 | Ward and department walkarounds – Cannock Chase Hospital | Alan Bloom |
| 19 April 2013 | Meeting with Walsall Healthcare NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 19 April 2013 | Meeting with Jeremy Lefroy - MP for Stafford | Alan Bloom |
| 19 April 2013 | Call with Stafford Borough Council | Alan Hudson / Jo Robinson |

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|---|---|---|
| 19 April 2013 | Call with NHS Trust Development Authority | Alan Bloom / Hugo Mascie-Taylor / Gillian Cooksley |
| 19 April 2013 | Call with South Staffordshire Council | Alan Hudson / Jo Robinson |
| 22 April 2013 | Meeting with Cannock Chase Council | Alan Hudson |
| 22 April 2013 | Meeting with West Midlands Ambulance Service Meeting NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 22 April 2013 | Meeting with MSFT Governors | Alan Hudson |
| 22 April 2013 | Call with the CQC | Alan Hudson / Hugo Mascie-Taylor |
| 23 April 2013 | Risk Summit meeting - Shropshire and Staffordshire area team | Jo Robinson |
| 23 April 2013 | Meeting with Staffordshire and Stoke on Trent Partnership NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 24 April 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Gillian Cooksley |
| 24 April 2013 | Meeting with Staffordshire County Council | Alan Bloom / Gillian Cooksley |
| 24 April 2013 | Call with NHS Trust Development Authority | Gillian Cooksley |
| 24 April 2013 | Meeting with Local Area Team | Gillian Cooksley |
| 24 April 2013 | Ward and department walkarounds – Stafford Hospital | Alan Bloom |
| 24 April 2013 | Meeting with other local Health Economy CCGs – North Staffordshire CCG, Stoke-On-Trent CCG, Shropshire CCG, Telford and Wrekin CCG, East Staffordshire CCG, South-east Staffordshire and Seisdon CCG, Walsall CCG and Wolverhampton CCG | Gillian Cooksley |
| 25 April 2013 | Call with Bill Cash - MP for Stone | Alan Bloom / Jo Robinson |
| 26 April 2013 | Call with the Bishop of Stafford | Alan Bloom |
| 26 April 2013 | Call with Support Stafford Hospital | Alan Bloom |
| 26 April 2013 | Call with South Staffordshire & Shropshire Mental Health Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 29 April 2013 | Call with Jeremy Lefroy - MP for Stafford | Alan Bloom |
| 29 April 2013 | Briefing with local providers - Market Engagement Exercise | Hugo Mascie-Taylor / Gillian Cooksley |

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| 29 April 2013 | Meeting with Cure The NHS | Alan Bloom |
| 30 April 2013 | Public Meeting - Staffordshire County Showground | Alan Bloom / Hugo Mascie-Taylor |
| 01 May 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 01 May 2013 | Public Meeting - Staffordshire County Showground | Alan Bloom |
| 02 May 2013 | Meeting with NHS Trust Development Authority | Alan Bloom |
| 02 May 2013 | Senior Trust Management team meeting - public in attendance | Hugo Mascie-Taylor / Alan Hudson / Diane Whittingham / Jo Robinson |
| 02 May 2013 | Call with University Hospital of North Staffordshire NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 02 May 2013 | Call with Walsall Healthcare NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 02 May 2013 | Meeting with Stafford and Surrounds CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 02 May 2013 | Call with West Midlands Ambulance Service Meeting NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 02 May 2013 | Meeting with University Hospital of North Staffordshire NHS Trust | Hugo Mascie-Taylor |
| 03 May 2013 | Call with Staffordshire and Stoke on Trent Partnership Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 03 May 2013 | Call with The Royal Wolverhampton Hospitals NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 07 May 2013 | Meeting with Walsall Healthcare NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 07 May 2013 | Meeting with Jeremy Lefroy's Working Group | Alan Bloom |
| 07 May 2013 | Meeting with The Royal Wolverhampton Hospitals NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 07 May 2013 | Meeting with Engaging Communities Staffordshire / Healthwatch | Alan Bloom |
| 07 May 2013 | Stafford and Surrounds CCG members meeting | Hugo Mascie-Taylor / Gillian Cooksley |
| 07 May 2013 | Meeting with the Health Scrutiny Committee for Stafford Borough Council | Alan Bloom |

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| 07 May 2013 | Public meeting - Premier Suite, Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 07 May 2013 | Meeting with GP First | Gillian Cooksley |
| 08 May 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 08 May 2013 | Interview with Heart radio West Midlands | Alan Bloom |
| 08 May 2013 | Interview with the Express and Star | Alan Bloom |
| 08 May 2013 | 'Regional workforce planning' meeting with various local providers, NHS England and the NTDA | Alan Bloom / Hugo Mascie-Taylor / Dianne Whittingham |
| 08 May 2013 | Staff drop-in – Stafford Hospital | Alan Bloom |
| 08 May 2013 | Meeting with University Hospital of North Staffordshire | Hugo Mascie-Taylor / Gillian Cooksley |
| 09 May 2013 | Meeting with the National CAG | Hugo Mascie-Taylor / Gillian Cooksley |
| 09 May 2013 | Meeting with Care UK | Hugo Mascie-Taylor / Gillian Cooksley |
| 10 May 2013 | Call with the Circle Partnership UK | Hugo Mascie-Taylor / Gillian Cooksley |
| 13 May 2013 | Call with Staffordshire and Stoke-on-Trent Partnership NHS Trust and Community centre | Hugo Mascie-Taylor / Gillian Cooksley |
| 14 May 2013 | Call with Burton Hospitals NHS Foundation Trust | Gillian Cooksley |
| 14 May 2013 | Ward and department walkarounds – Stafford Hospital | Alan Bloom / Hugo Mascie-Taylor |
| 14 May 2013 | Meeting with Staffordshire Borough Council and Durrows Consultants | Alan Bloom |
| 14 May 2013 | Meeting with Cannock Chase Hospital members | Hugo Mascie-Taylor / Gillian Cooksley |
| 15 May 2013 | Ward and department walkarounds – Cannock Chase Hospital | Alan Bloom |
| 15 May 2013 | Staff drop-in – Cannock Chase Hospital | Alan Bloom |
| 16 May 2013 | Workshop with Stafford and Cannock CCGs | Hugo Mascie-Taylor / Gillian Cooksley |
| 20 May 2013 | Call with NHS Commissioning Board | Hugo Mascie-Taylor |
| 20 May 2013 | Meeting with Staffordshire Police | Alan Hudson |
| 20 May 2013 | MSFT Governors' meeting | Hugo Mascie-Taylor / Gillian Cooksley |

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| 21 May 2013 | Provider meeting with University of North Staffordshire NHS Trust | Hugo Mascie-Taylor / Alan Hudson / Gillian Cooksley |
| 21 May 2013 | Provider meeting with Royal Wolverhampton Hospitals NHS Trust | Hugo Mascie-Taylor / Alan Hudson / Gillian Cooksley |
| 21 May 2013 | Provider meeting with Walsall Healthcare NHS Trust | Hugo Mascie-Taylor / Alan Hudson / Gillian Cooksley |
| 22 May 2013 | Provider meeting with Staffordshire and Stoke-on-Trent Partnership NHS Trust | Hugo Mascie-Taylor / Alan Hudson / Gillian Cooksley / Martin Markus |
| 22 May 2013 | Provider meeting with Circle Partnership UK | Hugo Mascie-Taylor / Alan Hudson / Gillian Cooksley / Martin Markus |
| 22 May 2013 | Provider meeting with Care UK | Hugo Mascie-Taylor / Alan Hudson / Gillian Cooksley / Martin Markus |
| 22 May 2013 | Staff drop-in – Stafford Hospital | Alan Hudson |
| 22 May 2013 | Ward and department walkarounds – Stafford Hospital | Alan Hudson |
| 22 May 2013 | Meeting with Health and Equality Impact Assessment Steering Group | Paras Shah |
| 23 May 2013 | Meeting with the Clinical Advisory Group | Hugo Mascie-Taylor / Gillian Cooksley |
| 28 May 2013 | Provider briefing with Royal Wolverhampton Hospitals NHS Trust | Gillian Cooksley / Hugo Mascie-Taylor |
| 28 May 2013 | Provider briefing with University Hospital of North Staffordshire NHS Trust | Hugo Mascie-Taylor / Alan Bloom / Gillian Cooksley / Jo Robinson |
| 28 May 2013 | Meeting with Clinical Reference Group | Hugo Mascie-Taylor / Alan Bloom / Gillian Cooksley |
| 29 May 2013 | Provider meeting with University Hospital of North Staffordshire and The Royal Wolverhampton Hospitals NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 29 May 2013 | Staff drop-in – Cannock Chase Hospital | Alan Hudson |
| 29 May 2013 | Ward and department walkarounds – Cannock Chase Hospital | Alan Hudson |
| 29 May 2013 | Provider meeting with Staffordshire and Stoke on Trent Partnership NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 30 May 2013 | Call with Durrows Consultants | Hugo Mascie-Taylor / Gillian Cooksley |
| 31 May 2013 | Call with University Hospital of North Staffordshire NHS Trust | Hugo Mascie-Taylor / Phil Britt |

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| 03 June 2013 | Meeting with the Clinical Advisory Group | Hugo Mascie-Taylor / Gillian Cooksley |
| 04 June 2013 | Meeting with the Nursing and Midwifery Advisory Group | Hugo Mascie-Taylor / Gillian Cooksley |
| 04 June 2013 | Call with Stoke and North Staffordshire CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 04 June 2013 | Call with Communications Liaison Group | Jo Hewitt |
| 05 June 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 05 June 2013 | Call with Stoke and North Staffordshire CCG | Hugo Mascie-Taylor |
| 05 June 2013 | Call with Keele University | Hugo Mascie-Taylor |
| 05 June 2013 | Ward and department walkarounds– Stafford Hospital | Alan Hudson |
| 05 June 2013 | Staff drop-in – Stafford Hospital | Alan Hudson |
| 05 June 2013 | Call with NHS Commissioning Board | Hugo Mascie-Taylor / Gillian Cooksley |
| 06 June 2013 | Meeting with the University Hospital of North Staffordshire NHS Trust | Hugo Mascie-Taylor |
| 06 June 2013 | Call with NHS West Midlands Workforce Deanery | Gillian Cooksley |
| 07 June 2013 | Call with Nuffield Health Consultants | Hugo Mascie-Taylor |
| 07 June 2013 | Call with NHS Commissioning Board | Hugo Mascie-Taylor / Gillian Cooksley |
| 10 June 2013 | Meeting with Local Area Team | Hugo Mascie-Taylor |
| 11 June 2013 | Meeting with the Clinical Advisory Group | Hugo Mascie-Taylor / Gillian Cooksley / Diane Whittingham |
| 12 June 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 12 June 2013 | Ward and department walkarounds – Cannock Chase Hospital | Alan Bloom / Hugo Mascie-Taylor |
| 12 June 2013 | Call with Ministry of Defence Stafford | Hugo Mascie-Taylor / Gillian Cooksley |
| 12 June 2013 | Call with Walsall Manor Hospital | Hugo Mascie-Taylor / Gillian Cooksley |
| 12 June 2013 | Call with Staffordshire and Stoke on Trent NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 12 June 2013 | Meeting with Health and Equality Impact Assessment Steering Group | Paras Shah |

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| 13 June 2013 | Meeting with the Nursing and Midwifery Advisory Group | Hugo Mascie-Taylor / Gillian Cooksley |
| 13 June 2013 | Call with the University Hospital of North Staffordshire NHS Trust | Steve Kirby |
| 13 June 2013 | Call with the Royal Wolverhampton Hospitals NHS Trust | Steve Kirby |
| 13 June 2013 | Call with the Royal Wolverhampton Hospitals NHS Trust | Hugo Mascie-Taylor |
| 13 June 2013 | Call with the Local Area Team | Alan Bloom |
| 13 June 2013 | Call with Stafford and Surrounds CCGs | Alan Bloom |
| 13 June 2013 | Call with Cannock Chase CCGs | Alan Bloom |
| 13 June 2013 | Call with Jeremy Lefroy - MP for Stafford | Alan Bloom |
| 13 June 2013 | Call with Aidan Burley - MP for Cannock | Alan Bloom |
| 13 June 2013 | Call with Health and Equality Impact Assessment Steering Group Chair | Paras Shah |
| 13 June 2013 | Call with Jeremy Lefroy's working group | Alan Hudson |
| 13 June 2013 | Call with Engaging Communities Staffordshire / Healthwatch | Alan Bloom |
| 13 June 2013 | Call with Support Stafford Hospital | Alan Hudson |
| 13 June 2013 | Call with the Bishop of Stafford | Alan Bloom |
| 13 June 2013 | Call with the CQC | Alan Hudson |
| 13 June 2013 | Call with Care UK | Hugo Mascie-Taylor / Gillian Cooksley |
| 13 June 2013 | Call with Circle Partnership UK | Hugo Mascie-Taylor / Gillian Cooksley |
| 13 June 2013 | Call with Burton NHS Foundation Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 13 June 2013 | Call with Staffordshire and Stoke-On-Trent Partnership NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 14 June 2013 | Call with Shrewsbury and Telford Hospital NHS Trust | Alan Bloom / Hugo Mascie-Taylor |
| 14 June 2013 | Call with West Midlands Ambulance Service NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 14 June 2013 | Call with The Royal Wolverhampton Hospitals NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 17 June 2013 | Meeting with Walsall Healthcare NHS | Hugo Mascie-Taylor / Gillian Cooksley |

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| 18 June 2013 | Meeting with The Royal Wolverhampton Hospitals NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley / David Pilkington |
| 18 June 2013 | Meeting with University Hospital of North Staffordshire NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley / David Pilkington |
| 18 June 2013 | Meeting with University Hospital of North Staffordshire NHS Trust | Alan Hudson / Steve Kirby |
| 18 June 2013 | Meeting with The Royal Wolverhampton Hospitals NHS Trust | Alan Hudson / Steve Kirby |
| 18 June 2013 | Call with Jeremy Lefroy - MP for Stafford | Alan Hudson |
| 19 June 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 19 June 2013 | Meeting with Walsall Healthcare NHS Trust | Alan Hudson / Steve Kirby |
| 20 June 2013 | Ward and department visit - Stafford Hospital | Alan Bloom |
| 20 June 2013 | Staff drop-in – Stafford Hospital | Alan Bloom |
| 24 June 2013 | Meeting with West Midlands Ambulance Service NHS Trust | Hugo Mascie-Taylor |
| 25 June 2013 | Meeting with NHS Trust Development Authority | Alan Bloom |
| 25 June 2013 | Meeting with the Clinical Advisory Group | Hugo Mascie-Taylor |
| 26 June 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Hugo Mascie-Taylor / Steve Kirby |
| 26 June 2013 | Call with Local Area Team | Hugo Mascie-Taylor |
| 26 June 2013 | Ward and department visit – Stafford Hospital | Alan Bloom |
| 26 June 2013 | Meeting with University Hospital of North Staffordshire NHS Trust | Steve Kirby |
| 26 June 2013 | Staff drop-in – Stafford Hospital | Alan Bloom |
| 28 June 2013 | Meeting with the Nursing and Midwifery Advisory Group | Hugo Mascie-Taylor |
| 3 July 2013 | Meeting with Health and Equality Impact Assessment Steering Group | Paras Shah |

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| 04 July 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Gillian Cooksley |
| 05 July 2013 | Call with NHS Trust Development Authority | Alan Bloom / Steve Kirby |
| 09 July 2013 | Meeting with University Hospital of North Staffordshire NHS Trust | Alan Bloom / Hugo Mascie-Taylor / Steve Kirby / Gillian Cooksley |
| 09 July 2013 | Meeting with The Royal Wolverhampton Hospitals NHS Trust | Alan Bloom / Hugo Mascie-Taylor / Steve Kirby / Gillian Cooksley |
| 10 July 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 10 July 2013 | Call with Burton Hospitals NHS Foundation Trust & Shrewsbury and Telford Hospital NHS Trust | Gillian Cooksley |
| 12 July 2013 | Meeting with the Clinical Advisory Group | Gillian Cooksley / Phil Britt |
| 15 July 2013 | Call with Local Area Team | Gillian Cooksley |
| 15 July 2013 | Call with Stafford and Surrounds CCG | Gillian Cooksley |
| 15 July 2013 | Call with Stafford and Surrounds CCG | Gillian Cooksley |
| 16 July 2013 | Meeting with National, Nurse and Midwifery Clinical Advisory Groups | Hugo Mascie-Taylor / Gillian Cooksley |
| 17 July 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Alan Bloom / Hugo Mascie-Taylor / Steve Kirby / Gillian Cooksley |
| 23 July 2013 | Meeting with Stafford and Surrounds CCG & Cannock Chase CCG | Alan Bloom / Hugo Mascie-Taylor / Steve Kirby / Gillian Cooksley |
| 23 July 2013 | Call with Stoke-on-Trent & North Staffordshire CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 23 July 2013 | Call with Wolverhampton City CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 26 July 2013 | Call with Walsall CCG | Gillian Cooksley |
| 30 July 2013 | Update meeting with the Department of Health | Alan Bloom / Hugo Mascie-Taylor |
| 30 July 2013 | Update meeting with the Health Service Journal | Alan Bloom / Hugo Mascie-Taylor |
| 30 July 2013 | Update meeting with the MSFT Executive Directors | Alan Bloom / Hugo Mascie-Taylor |
| 30 July 2013 | Update meeting with MSFT Independent Members | Alan Bloom / Hugo Mascie-Taylor |

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| 31 July 2013 | Call with the Local Area Team | Alan Bloom / Hugo Mascie-Taylor |
| 31 July 2013 | Call with Cannock Chase Borough Council | Hugo Mascie-Taylor |
| 31 July 2013 | Call Stafford Borough Council | Alan Bloom |
| 31 July 2013 | CCG Weekly Meeting | Gillian Cooksley / Steve Kirby |
| 31 July 2013 | Call with Staffordshire County Council | Alan Bloom / Hugo Mascie-Taylor |
| 31 July 2013 | Call with Jeremy Lefroy - MP for Stafford | Alan Bloom / Hugo Mascie-Taylor |
| 31 July 2013 | Call with Aidan Burley - MP for Cannock | Alan Bloom |
| 31 July 2013 | Press conference | Alan Bloom / Hugo Mascie-Taylor / Alan Hudson / Gillian Cooksley |
| 31 July 2013 | Press one to one sessions | Alan Bloom / Hugo Mascie-Taylor / Alan Hudson |
| 31 July 2013 | Staff briefing | Alan Bloom / Hugo Mascie-Taylor |
| 31 July 2013 | Staff briefing | Alan Hudson / Gillian Cooksley |
| 01 August 2013 | Meeting with the MSFT Executive Directors | Alan Hudson / Diane Whittingham |

| Consultation meetings | | |
|---|---|---|
| **Date** | **Meeting / Event** | **TSA and/or TSA senior representative** |
| 06 August 2013 | Staff consultation meeting - Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 06 August 2013 | Staff consultation meeting - Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 06 August 2013 | Staff consultation meeting - Stafford | Alan Bloom / Hugo Mascie-Taylor |
| 06 August 2013 | Staff consultation meeting - Stafford | Alan Bloom / Hugo Mascie-Taylor |
| 07 August 2013 | Consultation meeting with Cannock Borough Council | Alan Bloom / Hugo Mascie-Taylor |
| 07 August 2013 | Meeting with HEIA Steering Group | Alan Bloom / Hugo Mascie-Taylor |
| 07 August 2013 | Consultation meeting with Aiden Burley - MP for Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 07 August 2013 | Consultation meeting with Jeremy Lefroy - MP for Stafford | Alan Bloom / Hugo Mascie-Taylor |
| 07 August 2013 | Public meeting - Stafford | Alan Bloom / Hugo Mascie-Taylor |
| 08 August 2013 | Public meeting - Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 08 August 2013 | Consultation meeting with Staffordshire County Council | Alan Bloom / Hugo Mascie-Taylor |
| 08 August 2013 | Consultation meeting with Staffordshire Health and Wellbeing Board (in public) | Alan Bloom / Gillian Cooksley |
| 09 August 2013 | Update call with The Shrewsbury and Telford Hospital NHS Trust | Hugo Mascie-Taylor |
| 09 August 2013 | Update call with Staffordshire and Stoke on Trent Partnership NHS Trust | Hugo Mascie-Taylor |
| 09 August 2013 | Update call with West Midlands Ambulance Service | Hugo Mascie-Taylor |
| 12 August 2013 | Update call with Burton Hospitals NHS Foundation Trust | Hugo Mascie-Taylor |
| 12 August 2013 | Interview with Stafford and Cannock hospital radio | Hugo Mascie-Taylor |
| 13 August 2013 | Consultation meeting with MSFT Governors | Alan Bloom / Hugo Mascie-Taylor |
| 13 August 2013 | Consultation meeting with Staffordshire Borough Council | Alan Bloom / Hugo Mascie-Taylor |

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| 13 August 2013 | Call with Walsall CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 13 August 2013 | Call with Wolverhampton CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 13 August 2013 | Public meeting - Stone | Alan Bloom / Hugo Mascie-Taylor |
| 14 August 2013 | Staff Consultation meeting - Stafford | Alan Bloom / Hugo Mascie-Taylor |
| 14 August 2013 | Public meeting - Stafford | Alan Bloom / Hugo Mascie-Taylor |
| 14 August 2013 | Staff Consultation meeting - Stafford | Alan Bloom / Hugo Mascie-Taylor |
| 15 August 2013 | Staff Consultation meeting - Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 15 August 2013 | Call with Walsall Healthcare NHS Trust | Alan Bloom / Gillian Cooksley |
| 15 August 2013 | Consultation meeting with the Joint Negotiating Consulting Committee | Alan Bloom / Hugo Mascie-Taylor |
| 15 August 2013 | Update meeting with the MSFT Executive Directors | Alan Bloom / Hugo Mascie-Taylor |
| 16 August 2013 | Meeting with head of MSFT Paediatrics | Hugo Mascie-Taylor / Gillian Cooksley |
| 16 August 2013 | Meeting with Health Service Journal | Alan Bloom |
| 16 August 2013 | Meeting with head of MSFT Maternity | Hugo Mascie-Taylor / Gillian Cooksley |
| 16 August 2013 | Meeting with head of MSFT Critical Care | Hugo Mascie-Taylor / Gillian Cooksley |
| 16 August 2013 | Meeting with head of MSFT Surgical Assessment Unit | Hugo Mascie-Taylor / Gillian Cooksley |
| 19 August 2013 | Consultation meeting with specific staff group - Maternity | Alan Bloom / Hugo Mascie-Taylor |
| 19 August 2013 | Consultation meeting with specific staff group - Critical Care | Alan Bloom / Hugo Mascie-Taylor |
| 19 August 2013 | Call with Support Stafford Hospital Group | Alan Bloom |
| 19 August 2013 | Consultation meeting with specific staff group – Surgical Assessment Unit | Alan Bloom / Hugo Mascie-Taylor |
| 19 August 2013 | Consultation meeting with specific staff group - Paediatrics | Alan Bloom / Hugo Mascie-Taylor |
| 19 August 2013 | Staff consultation meeting - Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 20 August 2013 | Consultation meeting with specific staff group - Back office | Alan Bloom / Hugo Mascie-Taylor |
| 20 August 2013 | Update call with Lieutenant Colonel Ronnie Westerman, Station Commander Stafford | Hugo Mascie-Taylor |

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| 20 August 2013 | Consultation meeting with specific staff group - Maternity | Alan Bloom / Hugo Mascie-Taylor |
| 20 August 2013 | Update call with NHS England | Alan Bloom / Hugo Mascie-Taylor / Gillian Cooksley |
| 20 August 2013 | Consultation meeting with MSFT Staff Consultant Committee | Alan Bloom / Gillian Cooksley |
| 28 August 2013 | Consultation meeting with the Bishop of Stafford | Alan Hudson / Gillian Cooksley |
| 28 August 2013 | Consultation meeting with National Childbirth Trust | Alan Hudson / Gillian Cooksley |
| 29 August 2013 | Consultation meeting with ASSIST | Ian Sheldrake |
| 02 September 2013 | Consultation meeting with Healthy Staffordshire Select Committee | Alan Bloom / Hugo Mascie-Taylor |
| 02 September 2013 | Staff consultation meeting - Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 02 September 2013 | Consultation meeting with Keele University | Alan Bloom / Hugo Mascie-Taylor |
| 02 September 2013 | Consultation meeting with specific staff group - Surgical Assessment Unit | Alan Bloom / Hugo Mascie-Taylor |
| 02 September 2013 | Update call with Joan Walley (MP for Stoke-on-Trent North), Robert Flello (MP for Stoke-on-Trent South), Tristam Hunt (MP for Stoke-On-Trent Central), Mark Hackett (UHNS), Steve Allen (UHNS), Sandra Chadwick (Stoke CCG), Dr Steve Fawcett (Stoke CCG) | Alan Bloom/ Hugo Mascie-Taylor |
| 03 September 2013 | Update call with Walsall Healthcare NHS Trust | Alan Bloom |
| 03 September 2013 | Update meeting with NTDA, NHS England, Department of Health and Monitor | Alan Bloom / Hugo Mascie-Taylor |
| 04 September 2013 | Consultation meeting with POhWER | Ian Sheldrake |
| 04 September 2013 | Consultation meeting with ASIST | Ian Sheldrake |
| 05 September 2013 | MSFT Annual Members Meeting | Suzanne Westney |
| 05 September 2013 | Update meeting with University Hospital of North Staffordshire NHS Trust | Alan Hudson / Hugo Mascie-Taylor |
| 06 September 2013 | Consultation call with West Midlands Ambulance Service NHS Trust | Hugo Mascie-Taylor |

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| 09 September 2013 | Update call with University Hospital of North Staffordshire NHS Trust | Hugo Mascie-Taylor |
| 09 September 2013 | Update call with the Academy of Royal Colleges | Hugo Mascie-Taylor |
| 09 September 2013 | Consultation call with West Midlands Deanery | Hugo Mascie-Taylor |
| 10 September 2013 | Public meeting - Stafford | Alan Bloom / Hugo Mascie-Taylor |
| 10 September 2013 | Consultation meeting with specific staff group - Paediatrics | Alan Bloom / Hugo Mascie-Taylor |
| 10 September 2013 | Consultation meeting with specific staff group - Critical Care | Alan Bloom / Hugo Mascie-Taylor |
| 10 September 2013 | Consultation meeting with Support Stafford Hospital Group | Alan Bloom / Hugo Mascie-Taylor |
| 10 September 2013 | Public meeting with Jeremy Lefroy | Alan Bloom / Hugo Mascie-Taylor |
| 11 September 2013 | Consultation call with Bill Cash - MP for Stone | Alan Hudson / Hugo Mascie-Taylor |
| 11 September 2013 | Consultation call with Dr Charles Pidsley, East Staffordshire CCG | Alan Hudson / Hugo Mascie-Taylor |
| 11 September 2013 | Meeting with the Adult and Neighbourhood Committee for Stoke-on-Trent | Alan Hudson / Hugo Mascie-Taylor |
| 11 September 2013 | Consultation meeting with AGE UK Stafford | Ian Sheldrake |
| 11 September 2013 | Consultation meeting with the Stroke Association South Staffordshire and Cannock | Ian Sheldrake |
| 11 September 2013 | Consultation meeting with Cannock Chase CCGs | Alan Hudson / Hugo Mascie-Taylor |
| 11 September 2013 | Consultation meeting with District Expert Patient Groups | Alan Hudson |
| 12 September 2013 | Consultation meeting with Staffordshire and Stoke-on-Trent Partnership NHS Trust | Hugo Mascie-Taylor |
| 12 September 2013 | Update meeting with University Hospital of North Staffordshire NHS Trust | Hugo Mascie-Taylor |
| 12 September 2013 | Consultation meeting with MSFT Independent members | Alan Bloom |

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| 12 September 2013 | Consultation meeting with Staffordshire Parent Action Network | Ian Sheldrake |
| 12 September 2013 | Update meeting with the MSFT Executive Directors | Alan Bloom / Hugo Mascie-Taylor |
| 12 September 2013 | Public meeting - Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 16 September 2013 | Consultation call with Gavin Williamson - MP for South Staffordshire | Alan Hudson |
| 16 September 2013 | Consultation meeting with Stafford and Surrounds CCGs | Alan Hudson / Hugo Mascie-Taylor |
| 17 September 2013 | Update meeting with MSFT Clinical Directors | Hugo Mascie-Taylor |
| 17 September 2013 | Consultation call with NTDA | Alan Bloom / Hugo Mascie-Taylor |
| 17 September 2013 | Public meeting with Healthwatch Stoke | Alan Bloom / Hugo Mascie-Taylor |
| 18 September 2013 | Consultation meeting with specific staff group - Maternity | Alan Bloom |
| 18 September 2013 | Staff consultation meeting - Stafford | Alan Bloom / Hugo Mascie-Taylor |
| 18 September 2013 | Consultation call with Shrewsbury and Telford Hospital NHS Trust | Alan Bloom / Hugo Mascie-Taylor |
| 18 September 2013 | Consultation meeting with Staffordshire University | Alan Bloom / Hugo Mascie-Taylor |
| 18 September 2013 | Public Meeting - Rugeley | Alan Bloom / Hugo Mascie-Taylor |
| 19 September 2013 | Consultation meeting with Healthwatch / Engaging Communities | Alan Bloom / Hugo Mascie-Taylor |
| 19 September 2013 | Consultation meeting with specific staff group - Back office | Alan Bloom / Hugo Mascie-Taylor |
| 19 September 2013 | Public Meeting - Cannock | Alan Bloom / Hugo Mascie-Taylor |
| 20 September 2013 | Consultation meeting with Royal College of Midwives | Gillian Cooksley / Hugo Mascie-Taylor |
| 20 September 2013 | Consultation call with South East Staffordshire CCG | Hugo Mascie-Taylor |
| 24 September 2013 | Consultation meeting with Walsall Healthcare NHS Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 24 September 2013 | Consultation call with Stoke-on-Trent CCG | Hugo Mascie-Taylor / Gillian Cooksley |
| 24 September 2013 | Consultation meeting with Stafford and | Alan Hudson / Hugo Mascie-Taylor |

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| | Surrounds CCGs | |
| 24 September 2013 | Consultation call with North Staffordshire CCG | Alan Bloom |
| 25 September 2013 | Call with South Staffordshire & Shropshire Healthcare NHS Foundation Trust | Hugo Mascie-Taylor / Gillian Cooksley |
| 25 September 2013 | Meeting with Helen Simkins | Hugo Mascie-Taylor |
| 25 September 2013 | Consultation call with Ramsay Healthcare | Hugo Mascie-Taylor / Gillian Cooksley |
| 25 September 2013 | Consultation meeting with the Trust Staff Consultant Committee | Hugo Mascie-Taylor / Gillian Cooksley |
| 26 September 2013 | Consultation meeting with Cannock Chase CCGs | Alan Hudson / Gillian Cooksley |
| 26 September 2013 | Consultation call with Burton Hospitals NHS Foundation Trusts | Hugo Mascie-Taylor |
| 30 September 2013 | Consultation meeting with MSFT Executive Directors | Hugo Mascie-Taylor |
| 01 October 2013 | Update meeting with Royal college of Midwives | Hugo Mascie-Taylor |

| Post consultation meetings | | |
|---|---|---|
| **Date** | **Meeting / Event** | **TSA and/or TSA representative** |
| 2 October 2013 | Weekly CCG meeting | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt |
| 8 October 2013 | Trust Team Briefing | Alan Bloom |
| 8 October 2013 | Trust Executive Directors team meeting | Alan Bloom |
| 8 October 2013 | Staff drop-in session | Alan Bloom |
| 8 October 2013 | Ward and department walkaround - Stafford | Alan Bloom |
| 8 October 2013 | Meeting with National CAG | Hugo Mascie-Taylor / Gillian Cooksley |
| 9 October 2013 | Weekly CCG meeting | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt |
| 9 October 2013 | Conference call with Walsall Healthcare NHS Trust | Alan Bloom |
| 14 October 2013 | Update call with CCGs | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt |
| 16 October 2013 | Call with NHS England | Alan Bloom / Hugo Mascie-Taylor / Gillian Cooksley |
| 16 October 2013 | Weekly CCG meeting | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt |
| 18 October 2013 | Update call with Trust CEO | Alan Bloom |
| 18 October 2013 | Update call with Walsall Healthcare NHS Trust | Alan Bloom |
| 22 October 2013 | Update call with Trust CEO | Alan Bloom |
| 22 October 2013 | Update call with Trust Executive Directors | Alan Bloom |
| 23 October 2013 | Weekly CCG call | Gillian Cooksley / Phil Britt |
| 25 October 2013 | Meeting with University Hospital of North Staffordshire, NHS Trust Development Authority and Monitor | Gillian Cooksley / Phil Britt / Richard Guest |
| 29 October 2013 | Meeting with University Hospital of North | Gillian Cooksley / Phil Britt / Richard |

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| | Staffordshire Executive Team | Guest |
| 30 October 2013 | Weekly CCG meeting | Gillian Cooksley / Phil Britt |
| 04 November 2013 | Meeting with University Hospital of North Staffordshire advisors | Gillian Cooksley / Michael Barber |
| 06 November 2013 | Weekly CCG meeting | Hugo Mascie-Taylor/ Gillian Cooksley |
| 06 November 2013 | Call with University Hospital of North Staffordshire | Phil Britt |
| 07 November 2013 | Call with Mike Bostock - University Hospital of North Staffordshire | Phil Britt |
| 11 November 2013 | Meeting with University Hospital of North Staffordshire | Hugo Mascie-Taylor/ Gillian Cooksley |
| 12 November 2013 | Meeting with University Hospital of North Staffordshire | Hugo Mascie-Taylor/ Gillian Cooksley |
| 13 November 2013 | Weekly CCG meeting | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt |
| 13 November 2013 | Call with NHS England, NHS Trust Development Authority and Monitor | Richard Guest / Gillian Cooksley |
| 14 November 2013 | Call with The Royal Wolverhampton Hospitals NHS Trust | Gillian Cooksley / Phil Britt / Nayan Rughani |
| 14 November 2013 | Call with University Hospital of North Staffordshire | David Pilkington / Phil Britt / Nayan Rughani |
| 18 November 2013 | Meeting with University Hospital of North Staffordshire and KPMG | David Pilkington / Nayan Rughani |
| 19 November 2013 | Meeting with University Hospital of North Staffordshire | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt |
| 19 November 2013 | Meeting with University Hospital of North Staffordshire | Gillian Cooksley / Phil Britt |
| 20 November 2013 | Weekly CCG meeting | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt |
| 20 November 2013 | Call with NHS England | Hugo Mascie-Taylor / Richard Guest / Gillian Cooksley / Phil Britt |

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| 20 November 2013 | Meeting with North Staffordshire CCGs | Alan Hudson / Gillian Cooksley / Phil Britt |
| 20 November 2013 | Meeting with University Hospital of North Staffordshire | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt |
| 21 November 2013 | Meeting with University Hospital of North Staffordshire | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt / Nayan Rughani |
| 21 November 2013 | Meeting with University Hospital of North Staffordshire | Gillian Cooksley / Phil Britt / Nayan Rughani |
| 26 November 2013 | Sustaining Services Board with the Trust Executives | Alan Hudson / Diane Whittingham |
| 26 November 2013 | Meeting with University Hospital of North Staffordshire | Gillian Cooksley / Phil Britt / Nayan Rughani |
| 26 November 2013 | Meeting with University Hospital of North Staffordshire | Gillian Cooksley |
| 27 November 2013 | Weekly CCG meeting | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt |
| 27 November 2013 | Meeting with The Royal Wolverhampton Hospitals NHS Trust | Gillian Cooksley / Phil Britt / Nayan Rughani |
| 04 December 2013 | Weekly CCG meeting | Hugo Mascie-Taylor / Gillian Cooksley / Phil Britt |
| 04 December 2013 | Risk review meeting with Graham Urwin | Hugo Mascie-Taylor / Gillian Cooksley |
| 05 December 2013 | Sustaining Services Board with the Trust Executives | Diane Whittingham |

## 2. Public correspondence

Since the TSAs were appointed on Tuesday 16 April 2013 they have received a significant amount of correspondence from the public, in excess of 1,900 letters, 700 emails and 200 telephone calls.

During the consultation period, from Tuesday 6 August 2013 to Tuesday 1 October 2013, the TSAs received in excess of 200 letters, 300 emails and 100 telephone calls from stakeholders. The Office of the TSAs has taken into account all correspondence received during the consultation period when forming this report.

# 3. TSA website

In order to provide the public with regular updates, the TSA website was set up (www.tsa-msft.org.uk), which went live from the date of appointment and allowed all stakeholders to access information on:

- The TSA process
- Information about the TSAs
- The consultation process
- Consultation documents
- Consultation events
- Press releases
- Stakeholder bulletins (See Section 4)
- Details of the Health and Equality Impact Assessment Steering Group
- Frequently Asked Questions in relation to the Health and Equality Impact Assessment Steering Group
- Videos and audio readings from all public meetings
- Frequently Asked Questions as updated on 2 October 2013 (See Section 5)
- Contact information for the office of the TSAs – includes a dedicated email address, telephone information line and on-line form for queries

# 4. Stakeholder bulletins

The TSAs have released stakeholder bulletins since their date of appointment in order to provide stakeholders with a summary updates on the TSA process. A copy of each stakeholder bulletin released up to 2 October 2013 is copied below:

## Stakeholder bulletin – Friday 3 May 2013

*This bulletin is the first of bi-weekly bulletins which will provide updates throughout the TSA process.*

Since our appointment on 16 April 2013, Hugo, Alan and I have been delighted to see the level of passion and engagement in the TSA process from the public, staff and other stakeholder groups. We would like to thank all of those who have made time to meet with us and we hope that this level of engagement continues throughout the process.

**Progress to date**

*Recommendations*
We have started developing recommendations for the Trust which will be published in our draft report at the end of June. As part of this work, we are conducting a market engagement exercise which will help us to understand the appetite of other healthcare providers to deliver services for the local community.

*Stakeholder engagement*
Since our last update, 10 working days ago, we have continued to speak with and meet a large number of stakeholders in order to provide updates on the TSA process and market engagement process.

We held our third public meeting at the Premier Suites in Cannock town centre with over 800 people attending. The video recordings and the updated Frequently Asked Questions will shortly be uploaded to the TSA website (www.tsa-msft.org.uk). A third public meeting will be held at the Premier Suite in Cannock on 7 May 2013. Please note that capacity at this third public meeting is restricted to 350 people.

Trust Staff and senior management have been engaged through briefings, ward and department visits, meetings and written correspondence. I would like to reiterate our thanks to staff for their continued resilience and as always, for putting patients first and continuing to provide high quality healthcare services.

In addition to staff and public engagement, we have also spoken to a number of other stakeholders, including:

| External stakeholders | NHS and affiliated bodies |
|---|---|
| Unions | Local Clinical Commissioning Groups |
| Local MPs | Local Provider Trusts |
| County and Borough Councils | The West Midlands Ambulance Service |
| The Police | NHS England |
| Local interest groups | NHS Trust Development Authority |
| The Bishop of Stafford | The Care Quality Commission |

*Clinical Advisory Group*

We have set up an independent clinical advisory group and asked the Academy of Medical Royal Colleges to nominate senior representatives from the UK's Medical Royal Colleges to form the group and consider any proposed arrangements to ensure they are safe for patients. The formal advice of the Clinical Advisory Group will be made publicly available and the members of the Group will be announced shortly.

*Independent Health and Equality Impact Assessment Steering Group*

We are currently creating an independent Health and Equality Impact Assessment Steering Group who will consider the equality and impact of our recommendations on the local population. The Steering Group will include five members of the public and the full list of members will be published once confirmed.

*Consultation*

We are working on the formal public consultation plan which will include a series of public meetings at different times of the day in different areas served by the Trust. During this period there will be many opportunities and ways for people to contribute their views on our draft proposals. These meetings will be well publicised in advance.

It is currently anticipated that the formal public consultation will start in the week commencing 24 June 2013.

We hope that this bulletin has provided you with more information on the work we are undertaking and we look forward to meeting as many of you as possible throughout the TSA process.

Alan Bloom
Joint Trust Special Administrator

**Contact details**

- Online at www.tsa-msft.org.uk
- On Twitter @tsamsft
- By email at TSApublic@midstaffs.nhs.uk
- By writing to the TSAs, Stafford Hospital, Weston Road, Stafford, ST16 3SA
- By calling the TSA Information Line on 01785 887506

## Stakeholder Bulletin – Friday 17 May 2013

*This bulletin is the second fortnightly bulletin providing an update on the progress of the TSAs.*

**Progress to date**

*Recommendations*
We have now received a number of responses to the market engagement exercise which detail other healthcare providers' proposals for the provision of future services for the local community. We have also held a number of meetings with other local providers in order to understand their interest in the provision of services.

The market engagement responses and the outcomes of these meetings are currently being considered and work is being undertaken to determine how they may form part of the recommendations.

*Stakeholder engagement*
Since our appointment we have received an overwhelming response from the public in the form of letters and e-mails. Due to the large volume of written correspondence, we are unable to reply with personal messages however we want to reassure you that all letters and emails are being recorded and considered when developing our recommendations. We hope that you will continue to provide us with your views and that this high level of engagement continues throughout the TSA process.

Since the last fortnightly bulletin, we have held our third public meeting at the Premier Suite in Cannock with just under 200 people attending. The video recordings of the first three public meetings and the updated Frequently Asked Questions are now available on the TSA website (www.tsa-msft.org.uk).

We are currently arranging the next series of public and staff meetings which will take place during the formal consultation period. We hope to announce details of these meetings shortly.

*Clinical Advisory Group*
Since our last stakeholder bulletin, we have confirmed the membership of the independent Clinical Advisory Group. Further details on the membership can be found under the 'Latest News' section on our website (www.tsa-msft.org.uk).

*Health and Equality Impact Assessment Steering Group (HEIA SG)*
We have recently announced that Sophia Christie, who has previous experience in managing impact assessments and dealing with strategic change, has accepted the invitation to chair the HEIA SG.

Sophia will confirm members of the steering group, which will include up to five members representing the public and patients. The HEIA SG will then develop and communicate its scope of work and will work within the TSA timetable.

*Key dates*

| Milestone | Anticipated date |
|---|---|
| Publication of our draft report | Week commencing 17 June 2013 |
| Start of the formal consultation process | Week commencing 24 June 2013 |

We hope to confirm the exact dates for the publication of our draft report and the start of the formal consultation process within the next week.

We hope that this bulletin has provided you with more information on the work we are undertaking and please continue to visit the website (www.tsa-msft.org.uk) for further information and updates.

Alan Bloom
Joint Trust Special Administrator

**Contact details**

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- By calling the TSA Information Line on 01785 887506

## Stakeholder Bulletin – Friday 31 May 2013

*This bulletin is the third fortnightly bulletin providing an update on the progress of the TSAs.*

**Progress to date**

*Recommendations*

Since the last stakeholder bulletin, we have continued to develop our recommendations and we are now in the process of concluding our discussions with respondents to the market engagement exercise and local providers. Our next step is to finalise our analysis ensuring that our recommendations are both clinically and financially sustainable.

Our draft recommendations will be published on Wednesday 19 June 2013. Following this, the formal consultation period will open on Tuesday 25 June 2013 for 30 working days, closing at midnight on Monday 5 August 2013.

The consultation documents will be published on the TSA website (www.tsa-msft.org.uk) on Wednesday 19 June 2013 with hard copies available from Tuesday 25 June 2013 in locations throughout the local area, including Stafford and Cannock Chase hospitals, GP surgeries and council buildings.

*Having your say*

We are currently developing a range of materials in a variety of formats, which will be used to generate awareness and understanding of our recommendations and the consultation process. The consultation materials and activities are being designed to appeal to the broadest range of people to make sure that people can be informed and have their say.

Local people are encouraged to have their say by attending one of the public meetings (detailed below) and by completing the consultation response form which will be available from Tuesday 25 June 2013. More details on the process will be published in due course.

The following public meetings have been organised:

- **Tuesday 25 June 2013, 7pm** *Staffordshire County Showground (Capacity: 1,100)*
- **Thursday 27 June 2013, 10am** *Stafford Gatehouse Theatre (Capacity 540)*
- **Thursday 27 June 2013, 7pm** *Chase Leisure Centre, Cannock (Capacity 1,000)*
- **Friday 28 June 2013, 10am** *Prince of Wales Theatre, Cannock (Capacity 427)*
- **Wednesday 3 July 2013, 7pm** *Lea Hall Social Club, Rugeley (Capacity 360)*
- **Tuesday 9 July 2013, 2pm** *Staffordshire County Showground (Capacity 1,100)*
- **Wednesday 10 July 2013, 7pm** *St Dominic's Priory School, Stone*

*(Capacity 230)*

- **Thursday 11 July 2013, 2pm** *Chase Leisure Centre, Cannock*
  *(Capacity 1,000)*

The meetings are open to anyone who wishes to attend and places are allocated on a first-come, first-served basis.

The public meetings will begin promptly and are scheduled to last two hours. Doors open 30 minutes prior to the start. Every effort has been made to book venues with good accessibility and capacity. However, in some locations venues have limited capacity and may fill up quickly. You are welcome to attend a larger venue even if it is not the closest to your home.

In addition to the public meetings, we are also in the process of organising a number of other meetings and briefings with the staff, directors, governors and other stakeholder groups.

We value the opinion of local people and want as many as possible to respond to the formal consultation. We will reflect on the views of the people, groups and stakeholders who respond up to the closing date of the consultation period at midnight on Monday 5 August 2013.

We hope that this bulletin has provided you with more information on the work we are undertaking and please continue to visit the website (www.tsa-msft.org.uk) for further information and updates.

Alan Bloom
Joint Trust Special Administrator

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- By calling the TSA Information Line on 01785 887506

## Stakeholder Bulletin – Friday 14 June 2013

*This bulletin is the fourth fortnightly bulletin providing an update on the progress of the TSAs.*

**Extension request**

We have asked Monitor for an extension of 30 working days to finalise our draft recommendations and 10 extra working days for the public consultation to take into account the summer holiday period. If Monitor decide to grant an extension, they will lay an order in Parliament and make an announcement about the new timetable for the draft report.

We have been working towards the initial publication date of 19 June 2013 and whilst our work has been encouraging and we have made significant progress, it has become clear that we need additional time to develop our recommendations.

The additional time will allow us to continue discussions with potential providers so we can ensure that our draft recommendations deliver a clinically and financially sustainable solution for the Trust whilst not simply shifting the burden elsewhere. It would be a disservice to the people served by Stafford and Cannock Chase hospitals and MSFT's staff to not request the additional time we believe we need to develop our proposals fully.

We have contacted a number of stakeholder groups in order to advise them of this development. These groups include the staff, local MPs, councils and local interest groups.

**Public consultation**

Due to the extension request, the public meetings which were organised between 25 June 2013 and 11 July 2013 have now been cancelled.

Since the extension request was made, we have spoken to the majority of meeting venues and external suppliers, such as the printers of the consultation document. Nearly all of those that we have spoken to have kindly agreed to waive any cancellation charges as the public consultation will be rescheduled to a later date. To date, the costs of the rescheduling total c. £9,000 which includes the printing and distribution of postcards to residential addresses within the local area.

**Progress since our last stakeholder bulletin**

*Developing our draft recommendations*

We have recently set up a Nursing and Midwifery Advisory Group which is made up of senior nurses and midwives from the NHS. The Nursing and Midwifery Advisory Group, along with the Clinical Advisory Group, will consider any proposed arrangements to ensure they are safe for patients.

*Health Equalities Impact Assessment Steering Group (HEIA SG)*

We have recently met with the HEIA SG, providing the members with an overview of our consultation plan. This allowed the HEIA SG an opportunity to ask questions and provide their views on engagement with the public during the consultation phase.

We hope that this bulletin has provided you with more information on the work we are undertaking and please continue to visit the website (www.tsa-msft.org.uk) for further information and updates.

Alan Bloom
Joint Trust Special Administrator

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- On Twitter @tsamsft
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## Stakeholder Bulletin – Friday 28 June 2013

*This bulletin is the fifth fortnightly bulletin providing an update on the progress of the TSAs.*

**Extension request**

As you will be aware from our previous update, we formally asked Monitor for an extension of 30 working days to finalise the draft recommendations and an extra 10 working days for the public consultation to take into account the summer-holiday period.

On Wednesday 19 June 2013, we announced that Monitor approved our request and the revised dates for the TSA timetable are now confirmed as follows:

- Wednesday 31 July 2013 – Publication of draft recommendations
- Tuesday 6 August 2013 – Formal consultation period starts
- Tuesday 1 October 2013 – Formal consultation period ends

The additional time will help to further develop our draft recommendations about the future of hospital services for people in Stafford and Cannock prior to the public consultation.

**Public consultation**

As a result of the extension of the TSA timetable, the original public meetings which were organised between 25 June 2013 and 11 July 2013 were cancelled.

We are currently rescheduling the public and staff meetings which will take place during the formal consultation period and we hope to announce the details of these meetings shortly.

**Media speculation**

Following the request for the extension period, there has been and will continue to be a significant amount of speculation in the media about the decisions that we will make. We have made it clear from the start of the process that we will only release information about our recommendations once the report is formally published on 31 July 2013. Any articles or comments that appear in the media before that date which go beyond our official updates are pure speculation and have not come from us.

We hope that this bulletin has provided you with more information on the work we are undertaking and please continue to visit the website (www.tsa-msft.org.uk) for further information and updates.

Alan Bloom
Joint Trust Special Administrator

**Contact details**

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- On Twitter @tsamsft
- By email at TSApublic@midstaffs.nhs.uk
- By writing to the TSAs at Mid Staffordshire Foundation Trust, Stafford Hospital, Weston Road, Stafford, ST16 3SA
- By calling the TSA Information Line on 01785 887506

## Stakeholder Bulletin – Friday 12 July 2013

*This bulletin is the sixth fortnightly bulletin providing an update on the progress of the TSAs.*

**Progress to date**

Hugo, Alan and I continue to receive letters, emails and telephone calls from the public, staff and other stakeholder groups. To date we have received a total of 1671 letters, 329 emails and 103 telephone calls. We would like to thank all of those who have taken the time to engage with us and we hope that this level of engagement continues through to the consultation period. Public opinion is key to ensuring that the finalised recommendations that go to Monitor and the Secretary of State consider the concerns of the local community.

**Public consultation**

We are currently scheduling the public and staff meetings which will take place during the formal consultation period in both August 2013 and September 2013. Details of these meetings are to be announced shortly.

**HEIA SG**

The Health and Equality Impact Assessment Steering Group tab is now active on our website.

The role of the Steering Group is to provide independent advice to the TSAs and produce an independent impact assessment of our draft recommendations, particularly how they related to specific sections of the population as defined by the legislation.

The Steering Group will publish a scoping report, setting out the areas that they will assess, at the same time as the publication of our draft report on 31 July 2013. The Steering Group will then publish its final report setting out its analysis of the impacts of our final recommendations following the formal consultation period.

Please click on (www.tsa-msft.org.uk/heia-sg) for more information and for a summary of the Steering Group's first meeting.

We hope that this bulletin has provided you with more information on the work we are undertaking. Please continue to visit the website (www.tsa-msft.org.uk) for further information and updates.

Alan Bloom
Joint Trust Special Administrator

**Contact details**

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- On Twitter @tsamsft
- By email at TSApublic@midstaffs.nhs.uk
- By writing to the TSAs at Mid Staffordshire Foundation Trust, Stafford Hospital, Weston Road, Stafford, ST16 3SA
- By calling the TSA Information Line on 01785 887506

## Stakeholder Bulletin – Monday 1 July 2013

*This bulletin is the fifth fortnightly bulletin providing an update on the progress of the TSAs.*

**Extension request**

As you will be aware from our previous update, we formally asked Monitor for an extension of 30 working days to finalise the draft recommendations and an extra 10 working days for the public consultation to take into account the summer-holiday period.

On Wednesday 19 June 2013, we announced that Monitor approved our request and the revised dates for the TSA timetable are now confirmed as follows:

- Wednesday 31 July 2013 – Publication of draft recommendations
- Tuesday 6 August 2013 – Formal consultation period starts
- Tuesday 1 October 2013 – Formal consultation period ends

The additional time will help to further develop our draft recommendations about the future of hospital services for people in Stafford and Cannock prior to the public consultation.

**Public consultation**

As a result of the extension of the TSA timetable, the original public meetings which were organised between 25 June 2013 and 11 July 2013 were cancelled.

We are currently rescheduling the public and staff meetings which will take place during the formal consultation period and we hope to announce the details of these meetings shortly.

**Media speculation**

Following the request for the extension period, there has been and will continue to be a significant amount of speculation in the media about the decisions that we will make. We have made it clear from the start of the process that we will only release information about our recommendations once the report is formally published on 31 July 2013. Any articles or comments that appear in the media before that date which go beyond our official updates are pure speculation and have not come from us.

We hope that this bulletin has provided you with more information on the work we are undertaking and please continue to visit the website (www.tsa-msft.org.uk) for further information and updates.

Alan Bloom
Joint Trust Special Administrator

## Stakeholder Bulletin – Friday 12 July 2013

*This bulletin is the sixth fortnightly bulletin providing an update on the progress of the TSAs.*

**Progress to date**

Hugo, Alan and I continue to receive letters, emails and telephone calls from the public, staff and other stakeholder groups. To date we have received a total of 1671 letters, 329 emails and 103 telephone calls. We would like to thank all of those who have taken the time to engage with us and we hope that this level of engagement continues through to the consultation period. Public opinion is key to ensuring that the finalised recommendations that go to Monitor and the Secretary of State consider the concerns of the local community.

**Public consultation**

We are currently scheduling the public and staff meetings which will take place during the formal consultation period in both August 2013 and September 2013. Details of these meetings are to be announced shortly.

**HEIA SG**

The Health and Equality Impact Assessment Steering Group tab is now active on our website.

The role of the Steering Group is to provide independent advice to the TSAs and produce an independent impact assessment of our draft recommendations, particularly how they related to specific sections of the population as defined by the legislation.

The Steering Group will publish a scoping report, setting out the areas that they will assess, at the same time as the publication of our draft report on 31 July 2013. The Steering Group will then publish its final report setting out its analysis of the impacts of our final recommendations following the formal consultation period.

Please click on (www.tsa-msft.org.uk/heia-sg) for more information and for a summary of the Steering Group's first meeting.

We hope that this bulletin has provided you with more information on the work we are undertaking. Please continue to visit the website (www.tsa-msft.org.uk) for further information and updates.

Alan Bloom
Joint Trust Special Administrator

## Stakeholder Bulletin – Monday 29 July 2013

*This bulletin is the seventh fortnightly bulletin providing an update on the progress of the TSAs.*

**Progress to date**

**Recommendations**

Since the last stakeholder bulletin, we have continued to develop our draft recommendations and we are now in the process of concluding these.

Our draft recommendations will be published on Wednesday 31 July 2013.The formal consultation period will begin on Tuesday 6 August 2013, and last for 40 working days, and will close at midnight on Tuesday 1 October 2013.

The consultation documents will be published on the TSA website (www.tsa-msft.org.uk) on the afternoon of Wednesday 31 July 2013 with printed versions available from Tuesday 6 August 2013.

We value the opinion of local people and want as many as possible to respond to the formal consultation. We will reflect on the views of the people, groups and stakeholders who respond up to the closing date.

People are encouraged to have their say by attending one of the public meetings (detailed below) and by completing the online or printed consultation response form, which will be available from Tuesday 6 August 2013. More details about the process will be published in due course.

- **Wednesday 7 August 2013, 7pm** (Capacity: 1,100) — Staffordshire County Showground
- **Thursday 8 August 2013, 10am** (Capacity 427) — Prince of Wales Theatre, Cannock
- **Tuesday 13 August 2013, 7pm** (Capacity 230) — St Dominic's Priory School, Stone
- **Wednesday 14 August 2013, 2pm** (Capacity 543) — Stafford Gatehouse Theatre
- **Tuesday 10 September 2013, 10am** (Capacity 1,100) — Stafford County Showground
- **Thursday 12 September 2013, 7pm** (Capacity 1,000) — Chase Leisure Centre, Cannock

- **Wednesday 18 September 2013, 7pm** Lea Hall Social Club, Rugeley (Capacity 360)

- **Thursday 19 September 2013, 2pm** Chase Leisure Centre, Cannock (Capacity 1,000)

The meetings are open to anyone who wishes to attend and places are allocated on a first-come, first-served basis.

We would like to thank all of those who have taken the time to engage with us and we hope that this level of engagement continues through to the consultation period. Public opinion is key to ensuring that the finalised recommendations that go to Monitor and the Secretary of State consider the concerns of the local community.

Please continue to visit the website (www.tsa-msft.org.uk) for further information and updates.

Alan Bloom
Joint Trust Special Administrator

## Stakeholder Bulletin – Monday 12 August 2013

*During the formal consultation process, the TSAs will issue weekly stakeholder bulletins which will provide an update on their progress.*

**Draft recommendations**

On Wednesday 31 July 2013 we published our draft recommendations on the future of Mid Staffordshire NHS Foundation Trust.

We have made 14 recommendations for the future of the two hospitals. Under our proposals 91% of current patient visits will continue to take place locally at Stafford and Cannock Chase hospitals.

The draft recommendations are detailed within the draft report and they are summarised within the consultation document. The consultation materials, including an easy read version of the consultation document, are available from the TSA website www.tsa-msft.org.uk/consultation/consultation-documents/.

We are now in the process of consulting on our draft recommendations and seeking the views of staff, local people and stakeholder groups.

**Consultation**

On Tuesday 6 August 2013, we launched a public consultation which will run for 40 working days, closing at midnight on Tuesday 1 October 2013.

Members of the public can provide their views on the draft recommendations by:

- completing the printed response form included with the printed consultation document and returning it using the Freepost envelope provided;
- completing the online response from which can be accessed via the TSA website www.tsa-msft.org.uk; or
- writing to Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG.

The consultation documents and an online response form are available on the TSAs website at: www.tsa-msft.org.uk/consultation/consultation-documents/. Alternatively, you can request hard copies of the consultation document and response form by emailing TSAconsultation@midstaffs.nhs.uk or calling 0800 408 6399.

We value the opinion of local people and want as many as possible to respond to the formal consultation. We will reflect on the views of the people, groups and stakeholders who respond up to the closing date.

*Public meetings*

We have held two public meetings during the first week of the consultation, one at the Staffordshire County Showground and the other at the Prince of Wales Theatre in Cannock. We are pleased to see the level of public engagement and the combined attendance from both meetings totalled over 1,400.

We have another six public meetings scheduled for the consultation period. Please visit the TSA website for further information.

*Staff meetings*

On the first day of the consultation, we attended four staff meetings across Stafford and Cannock Chase hospitals. These meetings, which were open to all staff and their union representatives, were very productive and provided staff with an opportunity to discuss the draft recommendations and to provide us with additional information about their wards and departments.

We are also arranging specific meetings for those staff members who will be particularly impacted by the draft recommendations.

*Stakeholder meetings*

In addition, we have also met with the following groups since Tuesday 6 August 2013.

- Health and Equality Impact Assessment Steering Group;
- Jeremy Lefroy, MP for Stafford;
- Aidan Burley, MP for Cannock Chase;
- Staffordshire County Council;
- Cannock Chase District Council; and
- Staffordshire Health and Wellbeing Board (in public).

We are continuing discussions with University Hospital of North Staffordshire NHS Trust, The Royal Wolverhampton Hospitals NHS Trust and Walsall Healthcare NHS Trust. These discussions will help us to inform our final recommendations which will be submitted to Monitor and the Secretary of State for Health.

Please continue to visit the website (www.tsa-msft.org.uk) for further information and updates.

Alan Bloom
Joint Trust Special Administrator

## Stakeholder Bulletin – Monday 19 August 2013

*During the formal consultation process, the TSAs will issue weekly stakeholder bulletins which will provide an update on their progress.*

**Consultation**

On Tuesday 6 August 2013, we launched a public consultation which will run for 40 working days, closing at midnight on Tuesday 1 October 2013.

*Responses received*

We are pleased to see that a large number of responses have been received already. We have commissioned Ipsos MORI, an independent research organisation, to independently receive, collate and analyse the replies during the consultation period and provide us with detailed analysis about the views being received.

Ipsos MORI will prepare a report analysing the feedback received during the consultation. This will be published alongside our final recommendations.

The consultation is not a vote on the draft recommendations but a means for us to receive views so that they can contribute to creating the final recommendations. We will listen to and consider all responses we receive, by the deadline of midnight on Tuesday 1 October 2013, in drawing up our recommendations.

*How to respond*

We have received a number of queries with regards to whether people need to complete the response form in order to provide their views on our draft recommendations. Please note that you do not have to use the response form – responses can also be provided by writing to or emailing us, as well as by attending consultation meetings.

We value the opinion of local people and want as many as possible to respond to the formal consultation. Further details about the consultation and how to respond can be found on the TSA website.

*Public meetings*

Two further public meetings have been held during the second week of the consultation; one at St Dominic's Priory School in Stone and the other at the Stafford Gatehouse Theatre. We are pleased to see a continued high level of public engagement at these meetings and the combined attendance from both meetings totalled 486.

Since the beginning of the consultation four public meetings have been held in total and more than 2,000 people have attended to hear about plans for Stafford and Cannock Chase hospitals.

We have another four public meetings scheduled for the consultation period. Please visit the TSA website for further information including dates and locations.

*Staff meetings*

Since Tuesday 13 August 2013 we have held three further staff consultation meetings. These meetings are open to all staff and their union representatives and continue to be very productive, providing staff with an opportunity to discuss the draft recommendations and providing us with additional information about their wards and departments.

We are aware that our draft recommendations particularly impact a number of specific staff groups and we have therefore arranged separate consultation meetings for these groups, being Paediatrics, Maternity, Critical Care and the Surgical Assessment Unit. These meetings will take place from week commencing 19 August 2013.

Last week we also met with the individual heads of departments for these staff groups.

*Staff consultation*

A number of queries have been received as to why staff members were not consulted to a greater extent prior to the draft recommendations being published.

We have reassured local residents that the services at Cannock Chase and Stafford hospitals are currently safe. Our remit is not to look at the services as they are today. Instead we have been asked to look at their sustainability 10 years into the future, once you add in the two to three year transition period, we are looking out 13 years from now. The services are safe today but we have to examine how safe they will be in the future.

We have done this with the help of the Royal Colleges as they are the experts on future safety requirements. It is right that our draft recommendations have been influenced by national evidence and the views of national experts before being tested with the staff.

Members of staff are now being actively engaged in the consultation and their views are being listened to - we actively want to test our recommendations with staff and hear their response.

In developing the recommendations we have also worked closely with the Clinical Commissioning Groups who are the buyers of the hospital services and dictate what services must be provided locally. Other providers of hospital services were asked to submit proposals about what services they would be able to provide at Stafford and Cannock Chase hospitals in order to maximise the range of high quality, safe services that can be provided at the hospitals within budget in the future.

Ultimately we had to come up with a proposal that would provide services which would be safe into the future, which the commissioners were willing to commission and which providers are willing to provide. The blueprint for services set out in our draft recommendations achieves this.

*Stakeholder meetings*

In addition to the public and staff meetings detailed above, we have also met with or spoken to the following groups since Tuesday 13 August 2013:

- Stafford Borough Council;
- Walsall CCG;
- Wolverhampton CCG;
- Joint Negotiating & Consultative Committee (unions); and
- The Public Representatives of the Trust (the former governors).

A list of all stakeholders we have met with or spoken to during the consultation so far can be found at Appendix A.

We have also been arranging to meet with a number of local community groups, for example groups representing particular individuals such as older people or those representing individuals with a particular health condition. A list of these groups has been compiled with the assistance of local stakeholder such as MPs and Engaging Communities Staffordshire.

We would like to thank you all for your participation in the formal consultation and hope that as many people as possible will continue to contribute to the process.

Please continue to visit the website for further information and updates.

Alan Bloom

Joint Trust Special Administrator

**Contact details**

- Online at www.tsa-msft.org.uk
- On Twitter @tsamsft
- By email at TSAconsultation@midstaffs.nhs.uk
- By calling the TSA consultation information line on 0800 408 6399

**Appendix A**

List of stakeholders met with or spoken to during the formal consultation as at 19 August 2013

- Public (four meetings);
- Staff (seven general meetings and four meetings with department heads);
- Health and Equality Impact Assessment Steering Group;
- Jeremy Lefroy, MP for Stafford;
- Aidan Burley, MP for Cannock Chase;
- Staffordshire County Council;
- Cannock Chase District Council;
- Staffordshire Health and Wellbeing Board (in public);
- Stafford Borough Council;
- Walsall CCG;
- Wolverhampton CCG;
- Joint Negotiating & Consultative Committee (unions); and
- The Public Representatives of the Trust (the former governors).

This list will be updated on a weekly basis for the duration of the consultation process.

## Stakeholder Bulletin – Tuesday 27 August 2013

*During the formal consultation process, the TSAs will issue weekly stakeholder bulletins which will provide an update on their progress.*

*This is the third stakeholder bulletin issued since the start of the consultation and the tenth since the appointment of the TSAs.*

**Consultation**

On Tuesday 6 August 2013, we launched a public consultation which will run for 40 working days, closing at midnight on Tuesday 1 October 2013.

*Public meetings*

We have another four public meetings scheduled for the consultation period. The next one is on Tuesday 10 September 2013 at 10am at Staffordshire County Showground. Please visit the TSA website for further information including dates and locations of all public meetings.

In addition to these four TSA organised public consultation meetings, we will also be attending a meeting in Penkridge on Tuesday 10 September 2013 at 7pm, hosted by Jeremy Lefroy MP. This is not a formal consultation meeting, but will be an opportunity for the local community to ask us questions around the draft recommendations. The meeting will be held at the Monckton Recreation Centre, Pinfold Lane, Penkridge, ST19 5QP.

*Attendance at meetings*

It has come to our attention that there are rumours circulating on the internet that a young couple and their baby were asked to leave a public meeting in Stafford. I would like to confirm that no one has been asked to leave any of the public meetings and we have made every effort to make the venues as accessible as possible to everyone who wants to attend.
At the Staffordshire County Showground we expected large numbers of attendees and had therefore set up an overspill room and speakers in the car park to ensure that everyone who attended could listen to the proceedings. At the Stafford Gatehouse Theatre we laid on an additional room on the ground floor of the building as an alternative to the main auditorium, for people with baby buggies should they not wish to take buggies into the main auditorium. This room had a live feed to the main auditorium and runners on hand to take questions direct to the panel on behalf of the public.

*Staff meetings*

Since Monday 19 August 2013 we have held five further staff consultation meetings.

Of these meetings, four were with specific staff groups who may be particularly impacted by the draft recommendations, including Maternity, Critical Care, Surgical Assessment Unit and back office staff.

We also held a consultation meeting with the Staff Consultant Committee.

*Stakeholder meetings*

In the past week we have been mainly focused on staff meetings, but in addition to the staff meetings detailed above, we have also spoken with the Ministry of Defence Station Commander for Stafford to discuss the draft recommendations and also to confirm the number of military families expected to move to the area in the future. This was reconfirmed as 1,000 troops and 420 families.

A list of all stakeholders we have met with or spoken to during the consultation so far can be found at Appendix A.

We would like to thank you all for your participation in the formal consultation and hope that as many people as possible will continue to contribute to the process.

**Midwifery involvement in preparing the draft recommendation**

As you may be aware, The Royal College of Midwives (RCM) recently issued a press release regarding their concerns around the level of involvement the RCM and staff at the Trust had in acting as advisory groups for our draft recommendations around Maternity.

We have to look at the sustainability of services ten years into the future. The services are safe today but we have to examine how safe they will be in the future. We have done this with the help of national clinical experts, including midwives. A senior midwife was part of the TSAs' National Nursing and Midwifery Advisory Group throughout and a member of the RCM was also in attendance during the first of these group meetings.

Our draft report contains a letter dated 26 July 2013 from the National Nursing and Midwifery Advisory Group stating, based on the information it had at the time, its support for our model.

Further, the Royal College of Obstetricians and Gynaecologists has been involved in the process as part of the National Clinical Advisory Group which has advised us. This group has also confirmed in writing to us that based on the evidence they have seen, our draft recommendations are clinically safe and sustainable.

Our proposals for maternity are described in the consultation document. Although women will no longer have their babies at Stafford Hospital, they can still choose a home birth and all their routine pre- and post-natal care will continue to be delivered locally in Stafford and Cannock.

In developing the recommendations, we have worked closely with the Clinical Commissioning Groups (CCGs) who are the buyers of the hospital services and dictate what services must be provided locally, known as Location Specific Services (LSS). The CCGs have said that routine obstetrics (services for women with normal pregnancies), must only continue to be provided at Stafford Hospital until other hospitals are in a position to take on more patients and provide these services instead of Stafford Hospital.

Stafford Hospital has one of the smallest consultant led delivery maternity units in the country. Leading national clinical advisors say that the small number of births means Stafford Hospital will not be able to provide the recommended level of consultant cover to provide safe maternity services within budget in the long term. For this reason, when we invited other health care providers to propose how they might take on the maternity services currently provided by Mid Staffordshire NHS Foundation Trust as part of our market engagement exercise, not one offered to provide a consultant led-maternity service at Stafford.

Ultimately we had to come up with a proposal that would provide services which would be safe into the future, which the commissioners are willing to commission and which providers are willing to provide. The blueprint for services, set out in our draft recommendations, achieve this.

We have considered a Midwife-Led Unit. Stafford currently delivers circa 1,800 babies each year, of these only 50% are suitable for a birth at a Midwife-Led Unit. National evidence is that of those eligible only 20% would choose a birth at a Midwife-Led Unit. Therefore there would only be 180 births (3-4 a week) at such a unit in Stafford which is not financially sustainable. As TSAs, we have a responsibility to make proposals which are financially sustainable and this is why we have not recommended a Midwife-Led Unit at Stafford.

As the RCM acknowledges, we are now consulting with local staff as part of the process to test the proposals for maternity and will take their views into account when developing the final recommendations.

**Paediatric surgery at Stafford Hospital**

We would like to take this opportunity to clarify some confusion surrounding paediatric surgery and whether or not this is performed at the hospital and our draft recommendations for this area.

Paediatric surgery is a small sub-speciality of surgery. It deals with some common but importantly also rare conditions in children which require specialised surgical treatment.

Paediatric surgeons are only found in large centres - not in smaller hospitals. They operate only on children. Stafford Hospital does not have a paediatric surgical department.
Adult surgeons in some surgical specialities see and offer surgical treatment to children with a problem within their area of surgical expertise. For example Ear, Nose and Throat (ENT) surgeons may do tonsillectomies on children as well as adults. This type of surgery takes place in Stafford. When surgical procedures like tonsillectomies are carried out they are coded to the speciality, in the case of tonsillectomies this would be to ENT. Over 1,000 such operations took place last year.

Please continue to visit the website for further information and updates.

Alan Bloom

Joint Trust Special Administrator

**Contact details**

- Online at www.tsa-msft.org.uk
- On Twitter @tsamsft
- By email at TSAconsultation@midstaffs.nhs.uk
- By calling the TSA consultation information line on 0800 408 6399

**Appendix A**

List of stakeholders met with or spoken to during the formal consultation as at 27 August 2013

- Public (four meetings);
- Staff - eight general meetings;
- Staff - four meetings with department heads;
- Staff – four meetings with specific staff groups;
- Health and Equality Impact Assessment Steering Group;
- Jeremy Lefroy, MP for Stafford;
- Aidan Burley, MP for Cannock Chase;
- Staffordshire County Council;
- Cannock Chase District Council;
- Staffordshire Health and Wellbeing Board (in public);
- Stafford Borough Council;
- Walsall CCG;
- Wolverhampton CCG;
- Joint Negotiating & Consultative Committee (unions);
- The Public Representatives of the Trust (the former governors); and
- Ministry of Defence, Station Commander for Stafford.

This list will be updated on a weekly basis for the duration of the consultation process.

## Stakeholder Bulletin – Tuesday 3 September 2013

*During the formal consultation process, the TSAs will issue weekly stakeholder bulletins which will provide an update on their progress.*

*This is the fourth stakeholder bulletin issued since the start of the consultation and the eleventh since the appointment of the TSAs.*

On Tuesday 6 August 2013, we launched a public consultation, which will run for 40 working days, closing at midnight on Tuesday 1 October 2013. Last week, the eight-week public consultation reached its halfway point.

To date, we have reached a vast number of the public as well as several other stakeholder groups, but we are urging local people to make sure their views are recorded by responding to the consultation in whatever way they can.

In the coming four weeks, we have four more public consultation meetings being held in both Stafford and Cannock (Please visit the TSA website for more information).

As well as the four TSA organised public consultation meetings, we will also be attending a meeting in Penkridge on Tuesday 10 September 2013 at 7pm. This will be hosted by Jeremy Lefroy MP. This is not a formal consultation meeting, but will be an opportunity for the local community to ask us questions around the draft recommendations. The meeting will be held at the Monckton Recreation Centre, Pinfold Lane, Penkridge, ST19 5QP.

In the past week we have begun to speak with local community groups, including the National Childbirth Trust, which we met with on Wednesday 28 August 2013.

During the coming weeks, we will continue to try and reach as many stakeholder groups as possible and will be, amongst other actions, trying to organise meetings with approximately 15 further community groups as well as speaking to several more of the local MPs and other local CCGs.

We realise that some have questioned our decision not to hold any public meetings in North Staffordshire and we would like to take this opportunity to explain that as TSAs we are only permitted to make recommendations in respect of the trust over which we have been appointed i.e. Mid Staffordshire Foundation Trust and the legal process, which we must follow confines the consultation to the stakeholders of the trust in administration only. We cannot therefore hold formal public consultation meetings outside this area.

However, it should be noted that members of the public, whether they are located in the Trust's catchment area or not, are able to respond to the consultation and can access the consultation documents via the TSA website, can complete an online response form or request a hard copy of any of the consultation documents.

People from outside the catchment are also free to attend one of the four remaining public meetings which have been scheduled.

In addition, Healthwatch Stoke are holding a public meeting at 6pm on 17 September in Stoke which we will be attending and whilst this is not a formal consultation meeting, it will give the people of Stoke the opportunity to ask us questions. (Further details are on their website **info@healthwatchstoke.co.uk**)

A list of all stakeholders we have met with or spoken to during the consultation so far can be found at Appendix A.

We would like to thank you all for your participation in the formal consultation and hope that as many people as possible will continue to contribute to the process.

Please continue to visit the website for further information and updates.

Alan Bloom

Joint Trust Special Administrator

**Contact details**

- Online at www.tsa-msft.org.uk
- On Twitter @tsamsft
- By email at TSAconsultation@midstaffs.nhs.uk
- By calling the TSA consultation information line on 0800 408 6399

**Appendix A**

List of stakeholders met with or spoken to during the formal consultation as at 2 September 2013:

- Public (four meetings);
- Staff - eight general meetings;
- Staff - four meetings with department heads;
- Staff – four meetings with specific staff groups;
- Health and Equality Impact Assessment Steering Group;
- Jeremy Lefroy, MP for Stafford;
- Aidan Burley, MP for Cannock Chase;
- Staffordshire County Council;
- Cannock Chase District Council;
- Staffordshire Health and Wellbeing Board (in public);
- Stafford Borough Council;
- Walsall CCG;
- Wolverhampton CCG;
- Joint Negotiating & Consultative Committee (unions);
- The Public Representatives of the Trust (the former governors); and
- Ministry of Defence, Station Commander for Stafford.
- Staff consultant committee
- The National Childbirth Trust
- The Bishop of Stafford

This list will be updated on a weekly basis for the duration of the consultation process.

## Stakeholder Bulletin – Monday 9 September 2013

*During the formal consultation process, the TSAs will issue weekly stakeholder bulletins which will provide an update on their progress.*

*This is the fifth stakeholder bulletin issued since the start of the consultation and the twelfth since the appointment of the TSAs.*

On Tuesday 6 August 2013, we launched a public consultation, which was due to run for 40 working days, closing at midnight on Tuesday 1 October 2013. We are now over half way through the consultation period. We continue to engage with as many stakeholders as possible and urge local people to continue to submit their responses to our draft recommendations. It is vital that local people and other stakeholder groups submit their responses before the deadline as they will be considered as part of our final recommendations submitted to the Secretary of State.

In the past week we have continued to speak with local community groups, including ASIST and POhWER, which we met with on Wednesday 4 September 2013. We also met with the Healthy Staffordshire Select Committee on Monday 2 September 2013. A live webcast of this meeting can be found at:
http://www.staffordshire.publici.tv/core/portal/webcast_interactive/112114/start_time/255000

As well as these formal consultation meetings, we have also held regular update meetings with various Staffordshire CCGs, who are key stakeholders in the TSA process.

In the final three weeks of the consultation period, we have four more public consultation meetings being held in both Stafford and Cannock. Details of the two public consultation meetings taking place this week are as follows:

- Tuesday 10 September 2013 at 10am Staffordshire County Showground
- Thursday 12 September 2013 at 7pm at Cannock Chase Leisure Centre

Please visit the TSA website for more information regarding public consultation meetings.

We would like to remind you that we will also be attending a meeting in Penkridge, Tuesday 10 September 2013 at 7pm. This will be hosted by Jeremy Lefroy MP. This is not a formal consultation meeting, but will be an opportunity for the local community to ask us questions around the draft recommendations. The meeting will be held at the Monckton Recreation Centre, Pinfold Lane, Penkridge, ST19 5QP.

Going forward and during these final three weeks of the consultation period, we intend to meet with other community groups and as many other stakeholder groups as possible.

We would like to thank you all for your participation in the formal consultation and continue to urge as many people as possible to continue to contribute to the process.

An updated list of all stakeholders we have met with or spoken to during the consultation so far can be found at Appendix A.

Please continue to visit the website for further information and updates.

Alan Bloom

Joint Trust Special Administrator

**Contact details**

Online at www.tsa-msft.org.uk

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**Appendix A**

List of stakeholders met with or spoken to during the formal consultation as at 9 September 2013:

- Public (four meetings);
- Staff - eight general meetings;
- Staff - four meetings with department heads;
- Staff – four meetings with specific staff groups;
- Health and Equality Impact Assessment Steering Group;
- Jeremy Lefroy, MP for Stafford;
- Aidan Burley, MP for Cannock Chase;
- Staffordshire County Council;
- Cannock Chase District Council;
- Staffordshire Health and Wellbeing Board (in public);
- Stafford Borough Council;
- Walsall CCG;
- Wolverhampton CCG;
- Joint Negotiating & Consultative Committee (unions);
- The Public Representatives of the Trust (the former governors);
- Ministry of Defence, Station Commander for Stafford;
- Staff consultant committee;
- The National Childbirth Trust;
- The Bishop of Stafford;
- ASSIST;
- Keele University;
- ASIST;
- Pohwer; and
- West Midlands Deanery.

This list will be updated on a weekly basis for the duration of the consultation process.

## Stakeholder Bulletin – Wednesday 18 September 2013

*During the formal consultation process, the TSAs will issue weekly stakeholder bulletins which will provide an update on their progress.*

*This is the sixth stakeholder bulletin issued since the start of the consultation and the thirteenth since the appointment of the TSAs.*

We are now into the final two weeks of the consultation period and would like to remind local people to submit their responses to our draft recommendations by the deadline of midnight on Tuesday 1 October 2013. All responses, providing that they are submitted by the deadline, will be considered as part of the drafting of our final recommendations, which will be submitted to the Secretary of State.

In the past week we have spoken to more local community groups, including Age UK, the Stroke Association and the Stafford Parent Action Network. We have also met with Bill Cash (MP for Stone), West Midlands Deanery, the Support Stafford group, East Staffordshire CCG, the Adult and Neighbourhood Committee for Stoke, the Staffordshire and Stoke-on-Trent Partnership Trust, District expert patient groups and the Independent members.

We have also continued to consult with Trust staff by holding two further meetings with those staff, who work in the departments, which are expected to be most affected by our draft recommendations.

On Friday 13 September the Trust was visited by four members of the National Clinical Advisory Group ("NCAG"). The NCAG has been regularly consulted with throughout the TSA process as they have expertise in the clinical areas relevant to the Trust. However, this particular visit, although not part of the TSAs' formal consultation, provided the NCAG with an opportunity to see some of the services in action and also to talk to staff members regarding the issues being faced with local service delivery. The NCAG visited as many clinical areas within the Trust as possible and spoke to a wide range of staff. We have also met with the Health Overview and Scrutiny Committee for Stoke-on-Trent (also known as Adult and Neighbourhood Committee for Stoke-on-Trent).

In addition to the above, we have also attended three public meetings; one public meeting in Penkridge, hosted by Jeremy Lefroy MP. This was not a formal consultation meeting, but was an opportunity for the local community to ask us questions relating to the draft recommendations. The other two public meetings that we attended were the TSA public consultation meetings, which took place in Stafford and in Cannock.

Going forward, we will be holding two final public consultation meetings, both of which will take place this week. Details are as follows:

- Wednesday 18 September 2013 at 7pm at Lea Hall Social Club in Rugeley
- Thursday 19 September 2013 at 2pm at Cannock Chase Leisure Centre

Please visit the TSA website for more information regarding public consultation meetings.

In addition to the two public meetings due to be held this week, Healthwatch Stoke, held a public meeting at 6pm on 17 September in Stoke which we attended and whilst this was not a formal consultation meeting, it gave the people of Stoke the opportunity to ask us questions. (Further details are on their website info@healthwatchstoke.co.uk).

We are not due to attend any other public meetings during the final weeks of the consultation period.

Following feedback that we have received at the recent public meetings, I would like to clarify two issues that have arisen:

*Midwifery Led Units ("MLUs")*

At recent public meetings we referred to the fact that senior nurses in the midwifery department at the Trust agreed with the concept that the direction of travel in these units was towards having more consultant cover. We wanted to clarify this statement.

*The Health and Equality Impact Assessment Steering Group ("HEIA SG")*

Recently, we have received queries relating to the independence of the HEIA SG in relation to the TSA process. As you may be aware, a group called the HEIA SG is looking at the impact of our draft recommendations. This group's role is to independently scrutinise our recommendations. They will produce their impact assessment report shortly after the closure of the consultation period so that we have sufficient time to consider its content prior to the completion of our final report.

We secured an experienced and independent chair, Sophia Christie, who has extensive experience of leading NHS organisations, with no connection to us as TSAs or the Trust. The Chair selected people to cover a range of criteria and expertise. The HEIA SG acts completely independently of the TSAs.

We have also received several queries regarding how best to contact the HEIA SG. As mentioned, the HEIA SG has been set up independently from the TSA process. Therefore, in order to maintain their independence, please do not use the TSA email or postal address to contact the HEIA SG. We have been advised that the HEIA SG will release contact details shortly.

We would like to thank you all for your participation in the formal consultation and continue to urge as many people as possible to continue to contribute to the process in these final two weeks.

An updated list of all stakeholders we have met with or spoken to during the consultation so far can be found at Appendix A.

Please continue to visit the website for further information and updates.

Alan Bloom

Joint Trust Special Administrator

**Contact details**

- Online at www.tsa-msft.org.uk
- On Twitter @tsamsft
- By email at TSAconsultation@midstaffs.nhs.uk
- By calling the TSA consultation information line on 0800 408 6399

**Appendix A**

List of stakeholders met with or spoken to during the formal consultation as at 17 September 2013:

- Public (four meetings);
- Staff - eight general meetings;
- Staff - four meetings with department heads;
- Staff – six meetings with specific staff groups;
- Health and Equality Impact Assessment Steering Group;
- Jeremy Lefroy, MP for Stafford;
- Aidan Burley, MP for Cannock Chase;
- Staffordshire County Council;
- Cannock Chase District Council;
- Staffordshire Health and Wellbeing Board (in public);
- Stafford Borough Council;
- Walsall CCG;
- Wolverhampton CCG;
- Joint Negotiating & Consultative Committee (unions);
- The Public Representatives of the Trust (the former governors);
- Ministry of Defence, Station Commander for Stafford;
- Staff consultant committee;
- The National Childbirth Trust;
- The Bishop of Stafford;
- ASSIST;
- Keele University;
- ASIST;
- Pohwer;
- West Midlands Deanery;
- The Support Stafford group;
- Bill Cash, MP for Stoke;
- East Staffordshire CCG
- AGE UK
- District expert patient groups
- Independent members
- Parent Action Network

This list will be updated on a weekly basis for the duration of the consultation process.

## Stakeholder Bulletin – Tuesday 24 September 2013

*During the formal consultation process, the TSAs will issue weekly stakeholder bulletins which will provide an update on their progress.*

*This is the seventh stakeholder bulletin issued since the start of the consultation and the fourteenth since the appointment of the TSAs.*

Now that we are into the final week of the consultation period, we would like to remind local people to submit their responses to our draft recommendations by the deadline of midnight on Tuesday 1 October 2013. All responses, providing that they are submitted by the deadline, will be considered as part of the drafting of our final recommendations, which will be submitted to the Secretary of State.

An update on last week's consultation meetings; Last week we met with the Stafford and Surrounds CCG, the Trust's Clinical Directors, Staffordshire University, Healthwatch Staffordshire and the Royal College of Midwives. We also spoke to the NHS Trust Development Authority, Gavin Williamson (MP for South Staffordshire), Shrewsbury and Telford Hospital NHS Trust, and the South East Staffordshire CCG.

We also held our final three consultation meetings with Trust staff and our final two public consultation meetings, which took place in Rugeley and in Cannock.

In addition to the two public meetings that we held last week, Healthwatch Stoke held a public meeting on 17 September which we attended and whilst this was not a formal consultation meeting, it gave the people of Stoke the opportunity to ask us questions. (Further details are on their website info@healthwatchstoke.co.uk).

During this final week, we will continue to collate responses. We are not due to attend any other public meetings during the final weeks of the consultation period.

We would like to thank you all for your participation in the formal consultation so far and continue to urge as many people as possible to contribute to the process in this final week. Please be aware that we are not able to taken into account any responses received after the deadline of midnight on 1 October 2013.

An updated list of all stakeholders we have met with or spoken to during the consultation so far can be found at Appendix A.

Please continue to visit the website for further information and updates.

Alan Bloom

Joint Trust Special Administrator

**Contact details**

- Online at www.tsa-msft.org.uk
- On Twitter @tsamsft
- By email at TSAconsultation@midstaffs.nhs.uk

- By calling the TSA consultation information line on 0800 408 6399

**Appendix A**

List of stakeholders met with or spoken to during the formal consultation as at 20 September 2013:

- Public (eight meetings);
- Staff - ten general meetings;
- Staff - four meetings with department heads;
- Staff – eleven meetings with specific staff groups;
- Health and Equality Impact Assessment Steering Group;
- Jeremy Lefroy, MP for Stafford;
- Aidan Burley, MP for Cannock Chase;
- Staffordshire County Council;
- Cannock Chase District Council;
- Staffordshire Health and Wellbeing Board (in public);
- Stafford Borough Council;
- Walsall CCG;
- Wolverhampton CCG;
- Joint Negotiating & Consultative Committee (unions);
- The Public Representatives of the Trust (the former governors);
- Ministry of Defence, Station Commander for Stafford;
- Staff consultant committee;
- The National Childbirth Trust;
- The Bishop of Stafford;
- ASSIST;
- Keele University;
- ASIST;
- Pohwer;
- West Midlands Deanery;
- The Support Stafford group;
- Bill Cash, MP for Stoke;
- East Staffordshire CCG;
- AGE UK;
- District expert patient groups;
- Independent members;
- Parent Action Network;
- Gavin Williamson, MP for South Staffordshire;
- Stafford and Surrounds CCG;
- Staff - Clinical Directors;
- Staffordshire University;
- Healthwatch Staffordshire;
- NHS Trust Development Authority;
- Shrewsbury and Telford Hospital NHS Trust; and
- South East Staffordshire CCG.

This list will be updated on a weekly basis for the duration of the consultation process.

## Stakeholder Bulletin – Wednesday 2 October 2013

*During the formal consultation process, the TSAs issued weekly stakeholder bulletins which provided an update on their progress.*

*This stakeholder bulletin is the fifteenth since the appointment of the TSAs and it marks the end of the consultation process.*

The public consultation on our draft recommendations for Mid-Staffordshire NHS Foundation Trust ("the Trust") for the future of Stafford and Cannock Chase Hospitals closed at midnight on 1 October 2013.

In the past week we have met with or spoken to; Walsall Healthcare NHS Trust, Stoke-on-Trent CCGs, North Staffordshire CCGs, South Staffordshire and Shropshire Healthcare NHS Foundation Trust, Ramsay Healthcare UK, Cannock Chase CCGs, the Trust's Staff Consultant Committee, Burton Hospitals NHS Foundation Trust and the Trust's Executive Directors.

Over the past eight weeks, we have met with many people, including members of the public, Trust staff, MPs, councillors, community groups and various other key stakeholders. We would like to thank everyone who has taken part in the consultation process.

Going forward, we now have 15 working days in which to finalise our recommendations and report, taking into account responses received during the consultation.

The final report will set out our final recommendations and is due to be delivered to Monitor, the regulator for Foundation Trusts, on 22 October 2013. Monitor will then be responsible for publishing the report and passing it to the Secretary of State for Health for a final decision on the future of Stafford and Cannock Chase Hospitals.

We have been impressed by the strength of feeling and passion local people have for Stafford and Cannock Chase Hospitals. The public have attended our public meetings, questioned our draft recommendations in detail and challenged us on our assumptions. Our job now is to consider their responses in our drafting of our final recommendations and our final report.

Please be aware that we are not able to take into account any responses received from now onwards.

An updated list of all stakeholders we have met with or spoken to during the consultation so far can be found at Appendix A.

Please continue to visit the website for further information and updates.

Alan Bloom

Joint Trust Special Administrator

**Contact details**

- Online at www.tsa-msft.org.uk
- On Twitter @tsamsft

- By email at TSApublic@midstaffs.nhs.uk
- By calling the TSA information line on 01785 887 506

**Appendix A**

List of stakeholders met with or spoken to during the formal consultation as at 2 October 2013:

- Public (eight meetings);
- Staff - ten general meetings;
- Staff - four meetings with department heads;
- Staff – eleven meetings with specific staff groups;
- Health and Equality Impact Assessment Steering Group;
- Jeremy Lefroy, MP for Stafford;
- Aidan Burley, MP for Cannock Chase;
- Staffordshire County Council;
- Cannock Chase District Council;
- Staffordshire Health and Wellbeing Board (in public);
- Stafford Borough Council;
- Walsall CCG;
- Wolverhampton CCG;
- Joint Negotiating & Consultative Committee (unions);
- The Public Representatives of the Trust (the former governors);
- Ministry of Defence, Station Commander for Stafford;
- Staff consultant committee;
- The National Childbirth Trust;
- The Bishop of Stafford;
- ASSIST;
- Keele University;
- ASIST;
- Pohwer;
- West Midlands Deanery;
- The Support Stafford group;
- Bill Cash, MP for Stoke;
- East Staffordshire CCG;
- AGE UK;
- District expert patient groups;
- Independent members;
- Parent Action Network;
- Gavin Williamson, MP for South Staffordshire;
- Stafford and Surrounds CCG;
- Staff - Clinical Directors;
- Staffordshire University;
- Healthwatch Staffordshire;
- NHS Trust Development Authority;
- Shrewsbury and Telford Hospital NHS Trust;
- South East Staffordshire CCG;
- Walsall Healthcare NHS Trust;
- Stoke-on-Trent CCGs;
- North Staffordshire CCGs;
- South Staffordshire and Shropshire Healthcare NHS Foundation Trust;

- Ramsay Healthcare UK, Cannock Chase CCGs;
- MSFT Staff Consultant Committee;
- Burton Hospitals NHS Foundation Trust; and
- Trust Executive Directors.

# 5. Frequently Asked Questions

**Pre-Consultation frequently asked questions**

A copy of the Frequently Asked Questions ("FAQs") which have been published on the TSA website have been updated to Thursday 4 July 2013. These are included below.

The FAQs originally published on the Trust Special Administrators' (TSAs) website on 16 April 2013 have been updated following progress through the TSA process and incorporates the themes of queries raised in the public meetings held on 30 April 2013, 1 May 2013 and 7 May 2013.

The FAQs have been further updated on Thursday 4 July 2013. Section 2 now reflects the revised timetable for the TSA process following Monitor's approval on Wednesday 19 June 2013 of the TSAs' request for extra time. More details can be found on the TSAs' website www.tsa-msft.org.uk/request-approved-by-monitor.

## Overview of key messages from the FAQs

- The Trust is operating as usual and patient services continue to be provided in the normal manner.
- Patients should continue to use the Trust's services as they usually do.
- Patient appointments and GPs' referrals continue as usual.
- Joint Trust Special Administrators were appointed by Monitor to oversee the running of Mid Staffordshire NHS Foundation Trust (MSFT or the Trust), under its powers to intervene in Foundation Trusts that it considers are unsustainable. The TSAs are responsible for developing and consulting locally on a draft report about what should happen to the organisation and the services it provides in the future so that high quality, sustainable health services are delivered to the local communities.
- The MSFT senior management team continue to work at the Trust and run the Trust on a day-to-day, business-as-usual basis, however, they now report into the TSAs with whom they will work closely.
- The employment of the Trust's staff is unaffected by the appointment of the TSAs.
- There will be a full public consultation on the TSAs' draft proposals for the future and no proposals can be implemented before the Secretary of State for Health has made a decision about them.
- The public consultation process will start on Tuesday 6 August 2013 and will run for a 40 working-day period, ending on Tuesday 1 October 2013.
- Details of the consultation process will be widely publicised.

## Questions and Answers

The following questions and answers have been published at various stages during the first 75 working days of the TSAs.

| | Question | Answer |
|---|---|---|
| **1.** | **About the Trust Special Administration** | |
| **1.1** | **What is a TSA?** | A TSA is a Trust Special Administrator. More than one may be appointed and between them they will have expert skills in clinical and organisational restructuring.<br>They take over the role of overseeing the running of the Trust from the Chairman, non-Executives, Executives and Governors.<br>The role was created by the National Health Service Act 2006 (as amended in 2012) to give Monitor the power to intervene in Trusts that are considered unsustainable. |
| **1.2** | **Who appointed the TSAs?** | Monitor under its powers from the National Health Service Act 2006 (as amended in 2012) to intervene in Foundation Trusts that it considers are unsustainable.<br>Details about Monitor and their role can be found on their website: www.monitor-nhsft.gov.uk. |
| **1.3** | **Why have the TSAs been appointed?** | The TSAs were appointed by Monitor under its powers from the National Health Service Act 2006 (as amended in 2012) to intervene in Foundation Trusts that it considers are unsustainable.<br>This step was taken because despite MSFT's success in improving clinical performance, its small scale means it is both clinically and financially unsustainable in its current form. |
| **1.4** | **Who are the TSAs?** | There are three Joint TSAs: Professor Hugo Mascie-Taylor, and Alan Bloom and Alan Hudson of Ernst & Young LLP.<br>The TSAs have a range of skills and experience that Monitor considers will be essential to creating effective recommendations for the sustainable future of high quality health services and ensuring the hospitals continue on a business-as-usual basis.<br>Professor Hugo Mascie-Taylor is a former hospital Medical Director and Chief Executive. He has had a long career as a senior hospital consultant.<br>Alan Bloom and Alan Hudson have substantial experience of leading complex organisations in unsustainable situations and developing and implementing solutions for them.<br>The TSAs' team also comprises health planners and former clinicians, NHS managers and NHS Commissioners. |
| **1.5** | **What has happened before the TSAs were appointed?** | Last September it became apparent to Monitor, the Trust's regulator, that the Trust could not become financially self-sufficient and Monitor decided to bring in experts (the Contingency Planning Team (CPT)) to examine how services could be made sustainable both clinically and financially, for patients in the area. The CPT concluded that in its current form the Trust is both clinically and financially unsustainable.<br>Having considered all the evidence Monitor concluded that the appointment of TSAs was the best way of securing the future of health services for local people. |

| | | |
|---|---|---|
| | | More details of the CPT's findings and Monitor's decision to appoint the TSAs can be found on Monitor's website: www.monitor-nhsft.gov.uk. |
| **1.6** | **Who do the TSAs answer to?** | The TSAs are accountable to Monitor and will be reporting back to it with recommendations, after public consultation, within 135 working days. Monitor continues to regulate MSFT as usual. |
| **1.7** | **Are the TSAs independent?** | The TSAs are independent of Monitor and the Secretary of State for Health who cannot influence their report. The TSAs have confirmed to Monitor that they are free of any conflicts of interest in taking this appointment. The TSAs are legally required to review all options neutrally, only considering how to ensure patients receive the high quality health services and care they need in the long term, as well as achieving financial sustainability. |
| **1.8** | **How will the Contingency Planning Team's report be used?** | The CPT report and stakeholders' responses to it will be considered by the TSAs in addition to the considerable work being undertaken during the first 75-day phase of the TSA process. Further detail on how the TSAs will develop their proposals is contained in Section 5 of the FAQs.<br>All these factors will contribute to the recommendations the TSAs will make in their final report which may differ to conclusions raised in the CPT report. |
| **1.9** | **Who is paying for the TSA?** | The TSAs' costs are being paid for by the Department of Health through Monitor. The costs are not coming out of local NHS funds.<br>The Department of Health is currently subsidising the Trust by c.£20m per year. |
| **1.11** | **How much is the TSA process going to cost?** | As referred to in the explanatory memorandum to the appointment of the TSAs, which was laid before Parliament, the TSA process is expected to cost in the region of £6 million. Following the extension to the timetable, Monitor have announced that the cost for the additional 40 working days is anticipated to be £750,000.<br>In making the decision to appoint TSAs, the cost of the TSA process was considered against the current subsidy by the Department of Health to the Trust of c.£20m per year. |
| **1.12** | **How many people from the CPT are involved in the TSA?** | The TSA team consists of over 20 people (excluding subcontractors) of which nine (including Professor Hugo Mascie-Taylor) were part of the CPT. |
| **2.** | **About the TSA timetable and the TSAs' request for an extension to this timetable** | |
| **2.1** | **Is there a timetable for the TSA?** | Yes, the TSAs must develop and publish a draft report and consultation plan within a timetable based on statutory guidelines.<br>On 13 June 2013, the TSAs formally asked Monitor for an extension of 30 working days to finalise the draft recommendations and an extra 10 working days for the public consultation to take into account the summer-holiday period.<br>Following the public consultation, the TSAs have 15 working days to submit their recommendations to Monitor who then, with the Secretary of State for Health, have 50 working days to respond to it.<br>The full details are available on the TSA website at www.tsa-msft.org.uk/about-the-tsa. |
| **2.2** | **The guidelines state that there is an opportunity to** | In exceptional circumstances, there is an opportunity for the TSAs to request from Monitor an extension of this time period.<br>The TSAs requested an extension to the timetable on Thursday 13 |

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| | **extend the statutory timetable – how can this be done?** | June 2013. |
| **2.3** | **Why have the TSAs requested an extension to the process?** | Whilst the TSAs have made a lot of progress in developing solutions for the best set of services available for patients locally, the TSAs felt they required more time to continue discussions with other providers and commissioners and to finalise the draft recommendations.<br>Furthermore, the TSAs believe that it would be a disservice to the people served by Stafford and Cannock Chase hospitals and MSFT's staff to have not request the additional time believed to be needed to develop their proposals fully |
| **2.4** | **Has the TSAs' request for an extension to the timetable been granted?** | On Wednesday 19 June 2013, Monitor approved the TSAs' request and the revised dates for the TSA timetable are confirmed as follows:<br>Wednesday 31 July 2013 – Publication of draft recommendations<br>Tuesday 6 August 2013 – Formal consultation period starts<br>Tuesday 1 October 2013 – Formal consultation period ends |
| **2.5** | **What happens next?** | The proposed public consultation meetings already announced, due to take place in June and July 2013, have been cancelled.<br>The TSAs will announce the dates and venues for the revised public meetings once they have been confirmed.<br>Should you require further clarification, please contact the TSA information line on 01785 887506. |
| **3.** | **About the Trust** | |
| **3.1** | **What does the appointment of TSAs mean for the hospitals?** | It is business-as-usual for the Trust, its hospitals, management and staff. The TSAs will now be responsible for overseeing the running of the Trust and developing proposals to ensure local people have access to high quality health services. This 'business-as-usual' approach has been communicated to all relevant stakeholders.<br>The TSAs will make recommendations to the Secretary of State about what should happen to the organisation and the services it provides so that high quality, sustainable health services are delivered to local communities. The Trust will continue to provide its patient services on a business-as-usual basis until the Secretary of State has made his decision on the TSAs' recommendations. |
| **3.2** | **Are services safe at the Trust?** | Yes. The Care Quality Commission says the current quality of services at MSFT is meeting national standards. |
| **3.3** | **Is the Trust bankrupt? Is it closing?** | The Trust is not closing and it is not bankrupt, however, it is dependent on funding from the Department of Health, which is unsustainable in the long-term.<br>Currently the Trust cannot break even without a c.£20m annual subsidy from the Department of Health. Without this financial support the Trust would be technically insolvent. |
| **3.4** | **Who is running the hospitals?** | The TSAs are now responsible for the Trust but the MSFT senior management team continue to work at the Trust and run the Trust on a business-as-usual, day-to-day basis, however, they will now report into the TSAs who they will work with closely. The employment of the Trust's staff is unaffected by the appointment of the TSAs. |
| **3.5** | **Are the TSAs** | No. Patient care decisions will continue to be made in the same way |

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| | **making decisions about patient care?** | as before, by the patient's clinical team. |
| **3.6** | **Who represents the Foundation Trust Members now?** | The TSAs have agreed the role of the Governors in an informal capacity during the TSA process as their formal roles are currently suspended due to the appointment of the TSAs. The Governors shall continue as public representatives and feedback on announced and unannounced visits to the Trust. The Chair of Governors has also agreed to support the TSAs in providing them with independent challenge.<br>Members continue as members of the Foundation Trust and will receive periodic updates on the TSA process through their usual communication channels with the Trust.<br>As with all stakeholders, the TSAs hope that the Members will participate in the formal consultation process so that the widest range of knowledge, experience and views contribute to the recommendations in the report that goes to Monitor and the Secretary of State. |
| **3.7** | **Have staff been informed?** | Yes. Staff have been informed by email and notices have been circulated. The TSAs held several open staff meetings at both Stafford and Cannock Chase hospitals, and hold regular staff drop-in sessions and undertake ward and department visits to keep staff informed. The TSAs also met with Union representatives.<br>The employment of the Trust's staff is unaffected by the appointment of the TSAs. The Trust is recruiting staff as required on a 'business-as-usual' basis and remains subject to normal recruitment issues. |
| **3.8** | **Who do staff report to now?** | The TSAs are now responsible for overseeing the running of the Trust, but the MSFT senior management continue to work at the Trust and run the Trust on a business-as-usual, day-to-day basis, however, they will now report to the TSAs who they will work with closely. All other line management and reporting arrangements stay the same. There is no change to Trust staff who remain NHS employees on the same terms and conditions. |
| **3.9** | **Will suppliers and contractors still be paid?** | Yes. It is business as usual and there are no changes to contractual arrangements caused by the appointment of the TSAs.<br>Suppliers will be paid and should continue to take instructions and orders from Trust staff in the usual way. |
| **4.** | **Information for patients** | |
| **4.1** | **Should I still keep my appointment?** | Yes. You do not need to change anything about how you use the hospitals; they will carry on as usual. |
| **4.2** | **Will appointments and clinics be moved around or stop?** | No. It is business as usual, carry on going to the hospitals as normal. |
| **4.3** | **Is the Trust safe for patients?** | Yes. The Care Quality Commission says the current quality of services at MSFT is meeting national standards. |
| **4.4** | **Will my GP still be able to refer me to the Trust?** | Yes. Patient appointments and GPs' referrals continue as usual. |

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| **4.5** | **Will I still see the same staff? Are they still in the NHS?** | Yes. You will see the same clinical team as usual. There is no change to any staff terms and conditions or employment terms. |
| **5.** | **Information about how proposals for the future will be developed** | |
| **5.1** | **How will the TSAs develop their proposals?** | The TSAs will work with the local commissioners to secure the provision of health services that commissioners require for the care of local people by the Trust.<br>The TSAs will use evidence and plans from commissioners and other stakeholders, other parts of the NHS, the knowledge of the Trust's staff and management, information from the Care Quality Commission and data gathered from the CPT process to produce a draft report for public consultation.<br>The TSAs have set up an independent clinical advisory group (CAG) and asked the Academy of Medical Royal Colleges to nominate senior representatives from the UK's Medical Royal Colleges to form the group and consider any proposed arrangements to ensure they are safe and sustainable for patients. Confirmation of the members of the CAG can be found on the TSAs' website: www.tsa-msft.org.uk/confirmation-of-members-of-the-clinical-advisory-group.<br>In addition, a Nursing and Midwifery Advisory Group which is made up of senior nurses and midwives from the NHS has been set up who will, along with the CAG, consider any proposed arrangements to ensure they are safe for patients. The draft report that will be published on 31 July 2013 shall contain further details about the members of these groups.<br>The TSAs cannot comment as to the likely recommendations, save to say that the solution has to be both clinically and financially sustainable.<br>Clinical sustainability is where the Trust is likely to be able to deliver acceptable levels of care in the medium and longer term, i.e. up to 10 years. Factors that influence clinical sustainability are whether the Trust can recruit and retain sufficient numbers of appropriately skilled staff to deliver the right levels of care, and whether there will be enough patients in the coming years to make sure that staff's skills are sufficiently up to date to meet national safety standards set by independent bodies.<br>Financial sustainability is whether the Trust is able to deliver the appropriate level of care to the required number of patients without it costing more than the money that the Trust receives to deliver that care.<br>Clinical and financial sustainability are linked because there comes a point where reducing costs adversely impacts the quality of care that can be delivered. |
| **5.2** | **How will the TSAs engage with surrounding providers in developing a solution for the Trust?** | A core part of developing the TSAs' proposals is a market engagement exercise whereby the TSAs will invite any suitably qualified and willing provider to submit their proposals on how they could deliver a clinical solution for providing future health services to Stafford and Cannock.<br>This market engagement exercise was widely published nationally in the Health Service Journal, the UK's leading healthcare journal, and in other areas. The TSAs are in discussions with a number of providers who have responded to the market engagement exercise. |

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| | | During the additional time granted to the TSAs to develop their draft recommendations, they will continue to engage with other providers and commissioners to develop the draft proposals fully. |
| **5.3** | **How will financial issues be addressed?** | The report shall consider the financial impact on other trusts so that the Trust's current financial issue is not simply transferred to another. The additional time granted by Monitor allows the TSAs to consider the financial impact of the solution further in order to develop the draft proposals fully.<br>As part of the proposals for the solution being recommended for the Trust, details of any capital required will also be considered. |
| **5.4** | **How will travel issues be addressed?** | This point has been raised by a significant number of parties who the TSAs have spoken to. The TSAs understand its importance and the issue is being taken on board and will be reviewed as part of the TSAs' proposals.<br>The TSAs will consider evidence from a number of sources. The West Midlands Ambulance Service are very experienced in this area and can provide a lot of information about both emergency and non-emergency travel times. They will also have a lot of expertise on quality and safety issues to do with the treatment and movement of emergency patients.<br>There are also a number of companies who use a combination of satellite information and postcodes or local area codes to calculate the driving distances between various points - similar to the modern satnav or various internet route planners. The TSAs will also be taking into account that times can vary due to time of travel, method of travel including the availability of public transport, or routes taken, etc.<br>There are also developed methodologies for assessing the travel times of patients that have been used nationally by commissioners and those reviewing services to help inform analysis of these areas.<br>The TSAs are looking at how to reasonably provide the most accurate picture of the impact on patients and staff using these types of tools where appropriate. |
| **5.5** | **Are you taking into account of the number of families moving into the area due to new houses being built and the Ministry of Defence redeployment which will result in extra people needing to use the Trust's services?** | Population data is being taken into account as part of the TSAs' proposals.<br>The TSAs are fully aware of the arrival of military staff and families into the catchment area of the Trust. The Ministry of Defence's redeployment will be taken into account by the TSAs. The TSAs' recommendations will be assessed independently by the Health and Equality Impact Assessment Steering Group (HEIA SG). More information on the HEIA SG can be found in section 5.6. |
| **5.6** | **How will the TSAs ensure that they consider equality issues?** | Throughout their work, the TSAs will be required to observe equality legislation and principles and demonstrate that due regard has been paid to the equality duty of the Equality Act 2010.<br>To do this, an independent Health and Equality Impact Assessment Steering Group has been formed. The group comprises of 13 members including the chairman, Sophia Christie and five members |

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| | | representing patients and the public.<br><br>Materials produced by the steering group will be published on the TSA website. |
| **5.7** | **How are the TSAs different from other reviews that have happened before?** | The TSAs are required by legislation to make recommendations that are sustainable for at least 10 years so that local people and stakeholders can have confidence that the future of their local health services are safe and secure.<br>The Secretary of State will make a decision on the TSAs' recommendations, which will lead directly to implementation of the recommendations he accepts. |
| **5.8** | **How are Clinical Commissioning Groups (CCGs) involved in the process?** | The TSAs are working closely with the local commissioners to secure the provision of health services that commissioners require for the care of local people. The TSAs cannot submit their draft proposals without having first obtained a statement from the CCGs that the recommendations in the report would achieve the objectives of the TSA.<br>Members of the public can contribute their views to the CCGs through public meetings set up by CCGs.<br>In the event that the CCGs disagree with the draft recommendations, agreement may be sought from NHS England, the ultimate commissioning body. |
| **6.** | **Information on how to get involved** | |
| **6.1** | **How can patients, public and organisations get involved?** | The TSAs are keen to ensure there is wide understanding of their role and the process and that everyone has an opportunity to contribute their views about their draft proposals during the formal consultation phase.<br>The TSAs will be contacting local stakeholder organisations, unions and statutory bodies to advise them of the TSAs' appointment and how the TSA process will work and to hear their views.<br>There have been three public meetings within two to three weeks of the appointment of the TSAs where the TSAs explained their role and the process.<br>Formal consultation will happen when the draft report is completed and a consultation document summarising the proposal is published on Wednesday 31 July 2013. There will be more public and specific stakeholder meetings and information will be publicised about the public meetings arranged for the consultation period which will start on Tuesday 6 August 2013. Further information on the public consultation can be found in Section 7 of these FAQs.<br>The TSAs hope that local people and all stakeholders will fully participate in the process so that the widest range of knowledge, experience and views contribute to the recommendations in the report that goes to Monitor and the Secretary of State for Health.<br>Throughout the process, all stakeholders including members of the public are encouraged to share their views with the TSAs either by way of letter to the TSAs (The TSAs, Mid Staffordshire NHS Foundation Trust, Weston Road, Stafford, ST16 3SA), e-mail (TSApublic@midstaffs.nhs.uk) or by telephone (01785 887506). |
| **6.2** | **How can I be sure that patients and the public will be listened to?** | The TSAs have a duty to ensure that they have effectively collected and considered the views of local people, staff and stakeholders. The TSAs will establish a range of ways for people to contribute their views, online, through meetings, surveys and receiving responses from anyone who wants to have their say. More details on how people can contribute their views will be provided closer to the |

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| | | consultation period and will be widely publicised. |
| **6.3** | **Where can I find more information?** | The TSAs have created a website (www.tsa-msft.org.uk) which is a key way in which the TSAs will provide updates on their work.<br>The TSAs have also set up an information line on 01785 887506 which you can call for updates. |
| **7.** | **Information about public consultation** | |
| **7.1** | **Will there be a public consultation?** | Yes. Following Monitor's approval of the TSAs' request for an extension to the timetable, the TSAs confirm their draft recommendations for the Trust will be published on Wednesday 31 July 2013. Following this, the formal consultation period will open on Tuesday 6 August 2013 for 40 working days*, closing at midnight on Tuesday 1 October 2013.<br>The consultation document summarising the draft recommendations will be published on the TSA website (www.tsa-msft.org.uk) on Wednesday 31 July 2013 with printed copies and a response form, as well as an online response form, available from Tuesday 6 August 2013.<br>*The TSAs noted that the consultation period falls within the summer-holiday period and therefore requested an extra 10 working days, on top of the 30 working days based on statutory guidelines, for the public consultation. This was also granted by Monitor. |
| **7.2** | **How will public consultation take place?** | The TSAs will be publishing consultation materials which summarise the draft recommendations. Public consultation will include public meetings, direct meetings with stakeholders, local organisations and statutory bodies.<br>As a result of the extension to the timetable, the proposed public meetings already announced, due to take place in June and July 2013, have been cancelled. The TSAs will announce the dates and venues for the revised public meetings once they have been confirmed. |
| **7.3** | **How can I see the TSAs' draft report?** | The consultation document which summarises the draft recommendations will be made available in different formats, including online on the TSAs' website. Every reasonable effort will be made to ensure that, on request, consultation materials can be accessed in different formats and languages.<br>Copies of the consultation materials will be widely distributed in NHS premises, libraries, community facilities, on request and people will be able to give their views in response to the draft report in writing or by email, or with assistance by telephone.<br>A copy of the consultation document will be made available to anyone who has written to or emailed the TSAs.<br>From Tuesday 6 August 2013, it will subject to public consultation for 40 working days.<br>The TSAs will engage Ipsos MORI, an independent research company, to assist in collating responses and views from the draft recommendations. |
| **7.4** | **What happens at the end of public consultation?** | Following the end of the formal consultation process on Tuesday 1 October 2013, the TSAs will finalise their recommendations and submit their final report to Monitor.<br>Monitor and the Secretary of State will consider the report before making a decision about the recommendations and the mechanism for implementing any recommendations. |

| 8. | Information about what happens after public consultation | |
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| **8.1** | **What happens after the TSAs submit their report to Monitor?** | Monitor and the Secretary of State will consider the report and make a decision about the recommendations and the mechanism for implementing any such recommendations.<br>The TSAs cannot comment at this stage on what form the Trust will be and how it will be administered in the future. |
| **8.2** | **What is the role of Monitor and the Secretary of State in the process?** | Following public consultation, the TSAs have to present final recommendations to Monitor within 15 working days. Monitor then has 20 working days to consider whether the TSAs have completed their duties satisfactorily and whether the TSAs recommendations in the final report would achieve the objectives of the Trust Special Administration.<br>If Monitor is satisfied with the TSAs' final report it must provide it to the Secretary of State for Health who then has 30 working days to accept or reject the TSAs' recommendations. |
| **8.3** | **What happens once a decision has been made?** | The Secretary of State for Health will ask Monitor and the TSAs to implement the recommendations he accepts, if appropriate.<br>It is impossible to say at this stage what that will be or what timescale will be needed.<br>There are recognised processes for the review of a challenged decision which include involvement of the courts. |

**Consultation frequently asked questions**

A copy of the Frequently Asked Questions ("FAQs") which have been published on the TSA website have been updated to Wednesday 2 October 2013. These are included below:

## TSAs' draft recommendations - Frequently Asked Questions and Answers

### UPDATED: 2 October 2013

The FAQs originally published on the Trust Special Administrators' (TSAs) website have been updated following the publication of the TSAs' draft recommendations on 31 July 2013.

**ADDENDUM TO CONSULTATION DOCUMENT**

It has come to our attention that there is a factual inaccuracy in the Consultation Document, which we set out below.

**Page 31 - Draft recommendation 7 – Paediatric Assessment Unit**

There is a factual inaccuracy on page 31 of the Consultation Document, relating to the opening hours of the Paediatric Assessment Unit.

The draft recommendation in the consultation document states that the PAU will continue during its present opening hours of 8am to 10pm. This is incorrect. The PAU is currently open 24/7. The draft recommendation is that the PAU should be led by specially trained nurses who will consult with paediatricians and emergency physicians as necessary and that the PAU should only open between the hours of 8am to 10pm everyday, to operate the same hours as A&E.

We apologise for any confusion caused.

Alan Bloom

Trust Special Administrator

| | Question | Answer |
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| **CONSULTATION** | | |
| **1.** | **What will the TSAs be doing during the consultation?** | The TSAs will be meeting people and discussing their draft recommendations at public, staff and stakeholder meetings. They will also be considering the responses they receive to the consultation and continuing to collect information and evidence to consider in making their final recommendations. |
| **2.** | **When is the consultation starting?** | The consultation started on Tuesday 06 August 2013. All the documents and forms are available on line.<br><br>The Draft Report and Consultation Document were published on 31 July 2013 so that as many people as possible have the opportunity to read and think about it before the consultation started.<br><br>This timetable is following the TSA timeline which is set down in legislation.<br><br>The Consultation will run for 40 working days until midnight on Tuesday 1 October 2013.<br><br>The early publication of the report means people will have additional time to consider it before responding. |
| **3.** | **Why has the consultation been delayed?** | The TSAs requested additional time to develop their draft recommendations about the future of hospital services for people in Stafford and Cannock prior to the public consultation.<br><br>We had made a lot of progress, in a short space of time, in developing solutions for the best set of services available for patients locally. However, the solutions must be clinically and financially sustainable and the TSAs believed they needed more time to continue their discussions with other providers and commissioners and to finalise their draft recommendations.<br><br>This is why we formally asked Monitor for both an extension of 30 working days to finalise the draft recommendations and 10 extra working days for the public consultation to take into account the summer-holiday period.<br><br>The legislation clearly allows for extra time to be granted in this way by Monitor, the health care regulator, where there are good reasons to do so. |
| **4.** | **How will the consultation work?**<br><br>**When are the public meetings?** | All this information is in the Consultation Plan, which was been published on 31 July 2013.<br><br>This is available on the TSA website.<br><br>The public meetings which have been organised are as follows:<br><br>• Wednesday 7 August 7pm Staffordshire County Showground |

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| | | • Thursday 8 August 10am Prince of Wales Theatre, Cannock<br>• Tuesday 13 August 7pm St Dominic's Priory School, Stone<br>• Wednesday 14 August 2pm Stafford Gatehouse Theatre<br>• Thursday 10 September 10am Staffordshire County Showground<br>• Thursday 12 September 7pm Chase Leisure Centre, Cannock<br>• Wednesday, 18 September 7pm Lea Hall Social Club, Rugeley<br>• Thursday 19 September 2pm, Chase Leisure Centre, Cannock |
| **5.** | **How did you choose the venues?**<br><br>**Why wasn't the first venue large enough for all the people to fit in?** | We carried out an extensive search to identify suitable venues for the public meetings.<br><br>The first public meeting was held at the Staffordshire County Showground because it was the largest venue in Stafford that had availability during the consultation period and was the most accessible for all members of the public.<br><br>At this meeting we used both the main meeting room and a subsidiary room and we placed loud speakers in the car park so that everyone who turned up could hear what was going on. No one was turned away.<br><br>To ensure that people are able to attend a public consultation meeting, we have scheduled 8 meetings throughout the consultation period, at varying times and at a number of different locations in the area. |
| **6.** | **Who is being consulted?** | The consultation area has been determined by the TSAs to be the populations served by Stafford and Surrounds and Cannock Chase CCGs. This is postcodes starting with WS6, WS11, WS12, WS15, ST15, ST16, ST17, ST18, ST19, ST20, ST21<br><br>This area was selected because 95% of referrals to MSFT come from this area. Responses from other areas will be considered. |
| **7.** | **Have staff been consulted?** | The TSAs' met with many members of staff whilst they were developing their draft recommendations through ward and department visits and staff drop-in sessions. The TSAs' draft recommendations are now being heavily consulted on with staff.<br><br>It is important to understand that the TSAs' remit is not to look at the services as they are today. Instead they have been asked to look at their sustainability 10 years into the future, once you add in the two to three year transition period, they are looking out 13 years from now. The services are safe today but the TSAs' job is to examine how safe they will be in the future.<br><br>The TSAs have undertaken this task with the help of the Royal Colleges as they are the experts on future safety requirements. It is right that the TSAs' draft recommendations have been influenced by national evidence and the views of national experts before being tested with the staff.<br><br>Members of staff are now being actively engaged in the consultation and their views are being listened to. |

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| | | The TSAs have scheduled 20 staff meetings. These include general staff meetings and a series of staff meetings for the services that are most affected by the draft recommendations. |
| **8.** | **Why are you not formally consulting with people in the catchment area of the neighbouring hospitals which will be providing services to the people of Stafford and Cannock?** | The TSAs are only permitted by law to actively consult with individuals from the catchment area of the Trust in respect of which we have been appointed, i.e. the catchment area of MSFT which is Stafford and Cannock. Therefore they cannot hold public meetings outside this area.<br><br>However, it should be noted that members of the public, whether they are located in the Trust's catchment area or not, are able to access the consultation documents via the TSA website, can complete an online response form or request a hard copy of any of the consultation documents.<br><br>People from outside the catchment are also free to attend one of the public meetings which have been scheduled in Stafford, Cannock, Stone or Rugeley. |
| **9.** | **Have the staff been banned from talking to the media?** | No, absolutely not. Staff are free to talk to the media.<br><br>The Trust management have requested that if staff do talk to the media that they make it clear that they are speaking in a personal capacity, and not speaking on behalf of the Trust. |
| **10.** | **How will you consider the responses?**<br><br>**Will you read them all?** | We have commissioned Ipsos MORI, an independent research organisation, to independently receive, collate and analyse the replies during the consultation period and provide us with detailed analysis about the views being received.<br><br>We will also be directly meeting with staff and stakeholders and directly hearing from the public at Public Meetings. All these meetings will be carefully noted so we capture and consider the views of the people and organisations who attend the meetings.<br><br>Ipsos MORI will prepare a report analysing the feedback received during the consultation. This will be published alongside the TSAs' final recommendations. |
| **11.** | **Will you publish all questions that are being submitted to the TSAs?** | Audio recordings of the public meetings will be made available online, via the TSA website, which will include all the questions raised at the public meetings<br><br>We will also update the FAQs on a weekly basis, to reflect the general themes of questions that are being submitted to the TSAs. |
| **12.** | **Will you listen to the people? If most responses disagree with your recommendations** | We will absolutely listen to and consider all responses we receive in drawing up our recommendations.<br><br>The consultation is not a vote on the draft recommendations but a means for the TSAs to receive views so that they can contribute to creating the final |

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| | **will you change them?** | recommendations. |
| **13.** | **Will we be able to see the responses to the consultation?** | Ipsos MORI are an independent research organisation and they are collecting and analysing all the responses to the consultation, whether these are responses on the official response forms, separate communications or indeed formal responses from stakeholder groups. This report will be included alongside the TSAs' final report which must be submitted to Monitor by 22 October 2013. |
| **14.** | **If I have some feedback for the TSAs that is outside the 14 recommendations included in the consultation document, will these be taken into account?** | The independent research organisation, Ipsos MORI, will collect and analyse all the responses to this consultation, even those that do not directly relate to the 14 consultation questions.<br><br>Q28 in the response form allows for other comments to be made, or if you prefer you can send them in separately.<br><br>A report on the consultation responses will be included alongside the TSAs' final report which must be sent to Monitor by 22 October 2013. |
| **15.** | **As these are recommendations , what can we do to change them?** | By telling us what you think about them and giving us alternatives. We will consider every response we receive in formulating our final report. Ultimately we will be responsible for putting our final recommendations to Monitor and the Secretary of State for Health for a decision. |
| **16.** | **Over 50,000 people have signed the Save Stafford Hospital petition which has been presented to parliament.**<br><br>**The petition calls for acute services to be retained at Stafford and Cannock Chase hospitals. Are you going to listen to the views of 50,000 people or ignore them?** | We have been impressed by the strength of public support for the hospital.<br><br>We will listen to everyone who responds to the consultation and we would urge everyone who signed the petition to read our recommendations and to comment on them.<br><br>Our proposals recommend that Stafford and Cannock Chase hospitals will still be acute hospitals and many acute services will be delivered from them. |
| **17.** | **The Government keeps saying that local people know best, so will you** | The views of the local people are important, which is why we are consulting with them.<br><br>Our statutory duty is to ensure we capture and consider the views of |

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| | **recommend what local people tell you is best for Stafford and Cannock?** | everybody who wants to make their views known. We must also consider the evidence we have and is submitted and abide by the commissioning intentions of local CCGs.<br><br>Above all, our recommendations must in our opinion, provide for safe, sustainable and affordable NHS services for the patients who use Stafford and Cannock Chase hospitals for the future. |
| **18.** | **If the recommendations change, will local people be consulted on the new recommendations ?** | No. There will only be one set of recommendations submitted to Monitor and the Secretary of State for Health, which will take into account the responses already received during the consultation phase.<br><br>As a result of the feedback from the consultation, the final recommendations may be different.<br><br>There is no provision in the legislation for further consultation on the TSAs' final recommendations. |
| **19.** | **You say you have more work to do. Does this mean you are consulting on unfinished work?**<br><br>**Why aren't we being consulted on the final recommendations ?** | These are draft recommendations and you are being consulted on them so that we are able to consider your views in drawing up the final recommendations.<br><br>In our final report we will show what we have heard and learned from the consultation and how the recommendations reflect our consideration of local views.<br><br>We are following the process laid down by law, which requires that we consult at this stage, whilst recommendations can be informed, by evidence and views, rather than once they have been completed. |
| **20.** | **Will you publish the final report and recommendations ?** | We are reporting to Monitor, so it will be for Monitor to publish the final reports and recommendations. The final report is expected to be published late October / early November 2013. |
| **21.** | **Why is there no mention of the improvements that have been made with the staff and hospital in recent times?** | The TSAs have publically, and on many occasions, praised the hospital staffs' hard work and commitment during what must be very uncertain times for them. The TSAs have also continued to confirm that they believe that the hospitals are safe today.<br><br>In fact, the very first line of the first paragraph of the consultation document states just this: "Care at MSFT has improved over the last couple of years according to inspectors and thousands of local people now safely use Stafford and Cannock Chase hospitals' services".<br><br>The TSAs have been tasked with coming up with a proposal which ensure |

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| | | services continue to be the safe into the future – as far forward as 10 years from now.<br><br>This consultation is about the future of MSFT, not its current performance. The TSAs' draft recommendations are no reflection at all on the hospital staff's performance today. |
| **22.** | **You have provided a tick box response form – can the public submit free text responses if they wish?** | Yes. We will accept and consider all responses received before the end of the consultation period being midnight on 1 October 2013. |
| **23.** | **Will an impact assessment report be prepared and when will I be able to see it?** | A group called the Health & Equality Impact Assessment Steering Group ("HEIA SG") is looking at the impact of the TSAs' draft recommendations. The work of this independent group is described on page 18 of the consultation document, under the heading "Independent scrutiny of the recommendations". They will produce their impact assessment report shortly after the closure of the consultation period so that the TSAs have sufficient time to consider its content prior to the completion of the TSAs' final report. The HEIA SG's report will be published alongside the TSAs' final report, which must be sent to Monitor by 22 October 2013. |
| **24.** | **Does the recent Lewisham judicial review impact this process?** | The Lewisham ruling relates to specific circumstances of that case and does not impact the Trust Special Administration of the Trust. The TSAs continue to comply with the statutory process under which we have been appointed by Monitor and are working within their powers. |
| **25.** | **How much has the consultation document cost to produce, it looks expensive?** | It is important to have a clear and easy to understand consultation document that allows the public to easily understand the draft recommendations that are being made by the TSAs. The cost of printing the consultation documents is approximately 42 pence per copy. |
| **ADVISORS** | | |
| **26.** | **How did you choose the national Clinical Advisory Groups (CAG)?** | Two CAGs were established: the National Clinical Advisory Group (NCAG) and the National Nursing and Midwifery Advisory Group (NMAG).<br><br>The NCAG is jointly chaired by the Academy of Medical Royal Colleges, and we asked the Academy to nominate independent clinical experts from the Medical Royal Colleges. Our only requirement was that they have expertise in the clinical areas relevant to MSFT.<br><br>The NCAG's membership is made up of the Royal Colleges for all the relevant medical specialities including physicians, obstetricians, gynaecologists, surgeons, paediatricians, pathologists, radiologists, |

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| | | anaesthetists, public health physicians, GPs and emergency doctors.<br><br>The NMAG members were nominated by the Chief Nurse. |
| **27.** | **Was there a specialist for each speciality you have looked at and made recommendations on?** | Yes. The requirement in setting up the CAG was that they had expertise in the clinical areas relevant to MSFT.<br><br>The group's membership is made up of the Royal Colleges for all the relevant medical specialities including physicians, obstetricians, gynaecologists, surgeons, paediatricians, pathologists, radiologists, anaesthetists, public health physicians, GPs and emergency doctors. |
| **28.** | **How did you choose who sat on the Health Equality Impact Assessment Steering Group (HEIA SG)?** | We secured an experienced and independent chair, Sophia Christie, who has extensive experience of leading NHS organisations, with no connection to the TSAs or the Trust.<br><br>The Chair selected people to cover a range of criteria and expertise:<br><br>• Representative of local people and patients<br>• Having knowledge, skills and experience in transport, public health, local issues<br>• Unconnected to and independent of the TSAs<br>• Able to work as a group and not on behalf of a specific organisation's view. |
| **29.** | **Will we be consulted on what the HEIA SG decide?** | Their role is to provide independent, external views on what impact the draft recommendations may have on the accessibility of services to local people or any disadvantage they may create based on the nine protected characteristics of the Equality Act 2010.<br><br>The HEIA SG's scoping report was published on Wednesday 31 July 2013, and is available on the TSA website www.tsa-msft.org.uk. This scoping report sets out the main areas that the Steering Group will focus on to understand the impacts of the TSAs' draft recommendations.<br><br>These main areas will include the protected characteristics covered by the public sector equality duty of age, disability, sex(gender), pregnancy and maternity, race and religion or belief. The Steering Group will also be reaching out to the community to understand the impact on the protected characteristics sexual orientation and gender reassignment (transsexual people). The Steering Group has also decided in its scoping report to include socioeconomic deprivation and rural isolation as additional characteristics, and to look at the impact of recommendations on people with combinations of characteristics, for example older poor people.<br><br>The HEIA SG's report will contain proposals to the TSAs to mitigate the impacts of the draft recommendations. These proposals will be signed off by the HEIA SG prior to completion of the report so that the TSAs have sufficient |

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| | | time to consider them prior to the completion of the TSAs' final report.<br><br>The HEIA SG's report will be published alongside the TSAs' final report, which will be completed by 22 October 2013. |
| **30.** | **Why are the names and job titles of the public members of the HEIA SG not published?** | There is a clear distinction between members of HEIA SG who are acting in their professional capacity and those that are involved as members of the public, acting as patient, carer and public representatives. The names and details of four of the five patient, carer and public representatives have been omitted because, as a group, these four members have requested for their names not to be published since they are on the HEIA SG in their personal capacity (rather than as professionals providing subject matter expertise).<br><br>The name of one of the patient, carer and public representative has been published (Jan Sensier) due to this particular member acting in her professional capacity as Chief Executive of Engaging Communities Staffordshire on the HEIA SG. |
| **TSA PROCESS** | | |
| **31.** | **How have you done this in only 65 days?**<br><br>**How thorough has your work been?** | We have worked thoroughly and quickly. Many people and organisations have helpfully cooperated to ensure we have all the information needed to make the draft recommendations.<br><br>We think it is important that questions about the future of services for MSFT patients and employees are resolved as soon as possible to put an end to the uncertainty and anxiety about them and put in place clinically and financially sustainable services for the benefit of local people who rely on MSFT's services.<br><br>We have been able to deploy the resources necessary to work effectively to the timetable set down by Parliament and had access to the information and expertise we needed to draft these recommendations.<br><br>We would like to thank the CCGs, other local Trusts and the staff of MSFT who have assisted us whilst we developed our recommendations.<br><br>We have also been able to use the work which was completed as part of the CPT process and this has reduced the amount of time we have needed to spend finding a solution. |
| **32.** | **How did you decide what services were to be kept and which would change?** | Our starting point was the list of Location Specific Services which are the minimum services which must be provided locally. It is drawn up by the CCGs covering each hospital, which are: Stafford and Surrounds CCG for Stafford Hospital and Cannock Chase CCG for Cannock Chase Hospital.<br><br>These are lists of services which the CCGs have determined need to be provided from hospitals in Stafford and Cannock to avoid seriously impacting |

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| | | on the health and access to services of local people.<br><br>The CCGs are led by and represent the views of local GPs.<br><br>We applied our 4 guiding principles, to develop our recommendations, namely:<br>○ high quality, safe services<br>○ provided as near to patients' homes as possible<br>○ without incurring the significant financial losses that have been a problem to date<br>○ determined that they won't simply shift the problem elsewhere.<br>We have then taken on board the CCG's commissioning intentions, which are their plans for future care. They want to see more services provided in or close to people's homes and outside hospital settings because it is the best way for patients to stay well and out of hospital. |
| **33.** | **How much has this all cost?** | This is a very complex and serious problem and it needs to be properly fixed to make sure that services can be provided in the future for people in Mid Staffordshire.<br><br>The Department of Health is currently subsidising the Trust by over £20m per year and it is important that the Trust is able to function on its own.<br><br>If no changes are made, MSFT would require funding support indefinitely in order to pay its staff and suppliers.<br><br>Therefore a solution must be found to resolve the problem. The money spent on the TSA process is necessary to enable this to happen.<br><br>The TSA process is expected to cost in the region of £7.5m, which is paid for by the Department of Health. The costs are not coming out of the local NHS funds. |
| **34.** | **What happens after the consultation?** | The consultation closes at **midnight on Tuesday 01 October 2013.**<br><br>The TSAs will then have 15 working days to review the feedback received and to develop their final recommendations.<br><br>These final recommendations will be set out in the TSAs' final report which will be submitted to Monitor, the health care regulator, by **Tuesday 22 October 2013.**<br><br>The final report is then put forward to the Secretary of State for Health who will make a decision by **Tuesday 31 December 2013** on the TSAs' recommendations about the future of services for local people who use Stafford and Cannock Chase hospitals.<br><br>Ipsos MORI, an independent research organisation, will also prepare a report |

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| | | analysing the feedback received during the consultation. This will be published alongside the TSAs' final recommendations.<br><br>The final report will belong to Monitor and it will be up to Monitor to publish it. The final report is expected to be published late October / early November 2013. |
| **35.** | **Have you approached the government and asked them why they do not use our taxes and NI income to support the hospitals instead of sending money overseas?** | Whilst everyone will have a view on how the Government spends our taxes, this is not a matter for the TSAs and it is not within their remit. |
| **36.** | **Have the TSAs commissioned a report on impact analysis of the draft recommendations on local people and ask for this to be back dated? (Reference 'The Skwawkbox Blog' on 13 August 2013)** | The work commissioned referred to in the posting on 'The Skwawkbox Blog' on 13 August 2013 has been commissioned by the Health and Equality Impact Assessment Steering Group ("HEIA SG"). The HEIA SG was established to comply with the TSAs' public sector equality duty and the guidelines set out by Monitor (the regulator for Mid-Staffordshire NHS Foundation Trust, "MSFT"). The role of the HEIA SG is to provide independent advice to the TSAs through an impact assessment of the TSAs' proposals for MSFT.<br><br>The HEIA SG's report will be published alongside the TSAs' final report, which will be completed by 22 October 2013.<br><br>The HEIA SG's report will contain proposals to the TSAs to mitigate the impacts of the draft recommendations. These proposals will be signed off by the HEIA SG prior to completion of the report so that the TSAs have sufficient time to consider them prior to the completion of the TSAs' final report. |
| **37.** | **Given that the TSAs will be involved for another 2-3 years during the transition period, what is this going to cost? This is meant to be a cost reduction exercise.** | It is not yet possible to determine the costs for implementing the TSAs recommendations because at this stage they are only draft recommendations which are subject to public consultation.<br><br>The final decision on whether or not to implement all or some of the recommendations rests with the Secretary of State, and therefore the costs will be calculated when this decision is made. |

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| **38.** | **The final report will be sent to Monitor within 15 working days of the closing date for the consultation. Is this enough time to fully consider all the feedback received?** | The TSAs will be reviewing and considering the feedback as it is received throughout the consultation period and therefore we believe that we will have sufficient time to consider all the feedback received and then develop our final recommendations during the 15 working day period.<br><br>The timeframe that the TSAs are working to are set out by legislation and are therefore fixed. |
| **39.** | **Have the TSAs' draft recommendations already been decided?** | No - The TSAs urge the public to respond to the consultation. All responses, provided that they are received by the deadline of midnight on 1 October 2013, will be considered as part of the TSAs' drafting of their final recommendations.<br><br>Ipsos MORI an independent research organisation is collating all responses to the TSAs' draft recommendations. These responses will be summarised and published as part of the TSAs' final recommendations. |
| **40.** | **What role do the Clinical Commissioning Groups ("CCGs") play and who do they represent?** | The CCGs are groups of GP practices that are responsible for commissioning and purchasing a wide range of healthcare services for the patients registered with the GP practices.<br><br>CCGs do not provide hospital based services and therefore are not responsible for the running of the Trust<br><br>The TSAs have worked closely with the CCGs and have met with them on a regular basis to ensure that the recomendations are ones which the CCGs would support.<br><br>The CCGs have also provided written confirmation that the TSAs' draft recommendations fulfilled the objective to secure the provision of Location Specific Services. The TSAs will need further confirmation from the CCGs should any amendments be made to the TSAs' draft recommendations before they submit the final report to Monitor. |
| **41.** | **How can I access the TSAs' final report?** | Once the TSAs' final report has been published by Monitor, it will be available to view and download from the TSAs' website (www.tsa-msft.org.uk). |
| **EVIDENCE** | | |
| **42.** | **People stopped going to Stafford Hospital because they were worried about the quality** | Unfortunately no. Even if the referral numbers returned to their previous levels, which we believe is unlikely as there has been no sign of this happening, MSFT is still one of the smallest trusts in the country and is clinical and financially unsustainable. |

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| | **of care.**<br><br>**If local people choose to go there – ie, we vote with our feet - can we keep the services it currently provides.** | |
| **43.** | **Why can't you attract enough doctors and nurses to the hospitals?** | Unfortunately it is not as simple as just attracting more doctors and nurses to the Trust.<br><br>Smaller hospitals find it harder to attract and retain the most experienced and sought-after staff, which means that posts are filled temporarily. The Trust's difficult history also deters staff from joining permanently.<br><br>It is also about making sure that the doctors and nurses see enough patients to keep their skills up-to-date. It is also about having enough doctors to be able to run safe services around the clock.<br><br>In large hospitals with more consultants in each speciality, individuals can be expected to be on call (on top of their daytime commitment) about one night in five. In a small hospital like Cannock Chase or Stafford they could be on call as often as every second day, but these numbers will vary depending upon the speciality.<br><br>The historical reputation of MSFT has also made it difficult to recruit permanent members of staff for the hospitals. |
| **44.** | **Has a risk assessment of potential dangers to mothers or babies by removing maternity services been carried out?**<br><br>**If so, does a publically available document exist?** | The TSAs have engaged with three clinical advisory groups. This includes the Local Reference Group, National Clinical Advisory Group ("NCAG") and the National Nursing and Midwifery Advisory Group ("NMAG").<br><br>The NCAG's membership is made up of the Royal Colleges for all the relevant medical specialities including physicians, obstetricians, gynaecologists, surgeons, paediatricians, pathologists, radiologists, anaesthetists, public health physicians, GPs and emergency doctors.<br><br>In drafting their recommendations, the TSAs have chosen to consult with these groups of experts in order to gain advice relating to clinically and financially sustainable maternity services, rather than completing a risk assessment.<br><br>The NCAG confirmed to them, during consultation, that they would not support a full obstetrics unit as the number of births, taking into account expected changes in local population is expected to be too low to retain a |

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| | | sufficient level of skill.<br><br>Furthermore, the HEIA SG has been set up to independently and impartially access and report on the health of local people. |
| **TRAVEL** | | |
| **45.** | **How will I be able to visit friends or family in hospital when it is so far away?** | Many patients living in the Mid Staffordshire area already travel to other hospitals either for NHS services currently not provided at Stafford or Cannock Chase hospitals or because they choose to. Whilst we appreciate it may be less convenient for patients and their visitors, we have not seen any information to suggest that these arrangements do not work or are unsafe.<br><br>We believe there is a balance to be found between the benefits of safe and sustainable services and how accessible they are. We believe the improvement in the sustainability of services and their potential to adopt and offer new treatments created by our recommended changes, outweigh the additional travel times that some people might experience.<br><br>Our proposals recognise that patients should be nearer home where possible. This is why we are making it easier for older and very young patients to be closer to home where possible. Beds will be made available locally for recuperating patients.<br><br>Older people will be moved back to Stafford as soon as they are well enough to recuperate fully following a period of specialist treatment at a larger hospital. We believe that this is better for patients than the present arrangements. |
| **46.** | **How did you work out travel times?** | We have based our travel times on evidence from a number of sources, such as the West Midlands Ambulance Service, who are very experienced in this area and plus a number independent companies (such as Tom, Tom) that use satellite information to calculate driving distances and times between various points.<br><br>We revalidated the original data used by the CPT and carried out additional work using the Tom Tom data, which reflects actual travel times over a 4 year period. |
| **47.** | **Did you calculate what the additional costs would be for people to travel further?**<br><br>**Who pays for that, it's just a tax on the sick and their** | We believe that there is a balance to be found between the benefits of safe and sustainable services and how accessible they are.<br><br>We believe that the improvements in the sustainability of certain services outweigh the additional time and cost that some people might experience. |

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| | **families?** | |
| **SUSTAINABILITY** | | |
| **48.** | **Why is the trust financially unsustainable?**<br><br>**Why is it more expensive to run than other hospitals?** | Providers of NHS services are paid a tariff by commissioners for the patients they treat. These tariffs are set nationally and are based on the average cost to deliver each specific treatment.<br><br>Although local commissioners, the CCGs, are allowed to pay over tariff, they could only do this by taking funds from the budgets of other parts of the NHS they pay, such as primary care, mental health and community services.<br><br>There are a number of causes of the Trust's financial problems:<br><br>1) The Trust does not treat enough patients to generate the income it needs to balance its books.<br>2) MSFT's staff costs are high because it is experiencing recruitment and retention problems and has too many temporary and agency staff which are expensive.<br>3) The Trust spends a high proportion of its income on managing its unoccupied buildings, as it has two hospitals to operate, despite being a small Trust. |
| **49.** | **Why is MSFT clinically unsustainable? It seems to be doing fine.** | Care at MSFT has improved over the last couple of years and the Care Quality Commission has indicated that the Trust is safe. However, the CQC have not looked at the long term financial and staffing issues that the Trust faces, which are both warning signs that the Trust will not be able to provide safe care, within budget in the medium to long term.<br><br>In the near future if financial balance is to be achieved, it is likely that standards of care will slip compared to the wider NHS in England leaving local people worse off.<br><br>Independent medical studies have found that both 24/7 consultant cover and the scale of larger specialist hospitals is critically important to the treatment of patients.<br><br>Smaller hospitals like Stafford and Cannock Chase aren't able to take on enough specialist doctors to have constant cover.<br><br>Stafford and Cannock Chase hospitals have significantly less specialist doctors than recommended by the latest national guidelines to give constant cover safely for some specialist services.<br><br>Smaller hospitals can't give their specialist doctors enough breadth of experience of patients for their essential skills to be kept up to date. |
| **50.** | **The TSAs claim that maternity is clinically unsafe, yet the consultant** | The TSAs have never suggested that the maternity unit at Stafford hospital is unsafe. Indeed, the TSAs can confirm that the maternity unit at the Trust is currently safe. |

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| | **numbers specified by the Royal Colleges are met by fewer than 27% of existing maternity units. Are they therefore also deems 'unsafe'?** | The issue is around long-term clinical and financial sustainability and retention of suitable specialists. It is not within the TSAs' remit to consider the clinical safety of other Trusts' services. |
| **RECOMMENDATIONS** | | |
| **51.** | **What is a clinical network?** | A clinical network in this case means clinical and other staff working to an agreed set of standards and protocols across a number of hospitals usually, under single leadership and management.<br><br>Clinical networks for different specialties means that Stafford and Cannock Chase hospitals' services will in some specialties be part of larger teams and services from other parts of the NHS.<br><br>This allows some services, which would have been too small to continue in hospitals the size of Stafford and Cannock Chase to carry on by being part of a wider service across several sites. For patients this also means they will have access to consultant-led teams and equipment that a small trust like MSFT could not offer.<br><br>For staff this means they can be part of a larger service that ensures they see a wider range of patients, which is essential for maintaining clinical skills and providing training. It will be easier for the service to recruit staff. |
| **52.** | **Do your proposed Clinical Network with UHNS and RWT mean these are the two trusts whose proposals you have accepted?** | No. We asked over 100 healthcare providers across the UK how they thought they could be involved. The best proposals, which means those offering the most services locally, were from these two trusts.<br><br>Nothing has been agreed yet. We are using their proposals to work up a blueprint that demonstrate it is possible to offer these services in a clinically and financially sustainable way. The final report will give more details on which providers should run services.<br><br>No changes will be implemented until after the public consultation when we submit our final report to Monitor and then ultimately on to the Secretary of State for Health. |
| **53.** | **All the other Trusts have much worse mortality rates than MSFT. Why should we be forced to go to** | Hospital Standard Mortality Ratios (HSMR) and Summary Hospital-level Mortality Indicators (SHMI) are complex measures of a range of conditions and treatments. MSFT's performance has improved, but it is now treating fewer and less complex cases since it was first investigated by the Healthcare Commission in 2008. Very ill patients whose lives are in the balance mostly now go to UHNS and Royal Wolverhampton Hospitals Trust. |

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| | **them?** | The mortality ratios for Stafford hospital are:<br><br>HSMR 83.6 and SHMI 93.3, both of which are below the national average of 100.<br><br>The trusts in Staffordshire are making progress to improve outcomes and the patient experience and most have shown improvements on these metrics.<br><br>We are clear that there needs to be change and improvements for MSFT but this will also require change at surrounding Trusts as well.<br><br>Our recommendations are based on what we believe will provide the safest and most sustainable options for MSFT patients in the future.<br><br>There is no alternative but to make significant change. If things continue as they are, this change will happen in an unplanned, unmanaged and potentially unsafe way.<br><br>This will not only adversely impact patients at Stafford and Cannock Chase hospitals but will put even more pressure on other local hospitals. |
| **54.** | **Stafford hospital has some of the best survival rates for patients than other local hospitals – why downsize Stafford over Stoke/Wolverhampton?** | We accept that the quality of its services at Stafford and Cannock Chase hospitals are good and that they are currently safe.<br><br>Unfortunately MSFT is not clinically or financially viable in its present form. This means that the hospitals will not be able to provide safe, high quality services within budget in the future unless things change. That is why we have been asked to make recommendations about its future.<br><br>This consultation is not about Stoke or Wolverhampton which are separate trusts.<br><br>The CCGs will only commission services from Stoke and Wolverhampton when they are able to demonstrate their own quality standards. |
| **55.** | **Why can't A&E reopen 24/7?** | We believe the current arrangements for A&E are safe and can be supported by staff and resources. The reasons that caused the A&E to restrict its hours in the first place are still there and will continue. ie the difficulty of recruitment and retention of consultants to provide cover 24/7.<br><br>A&E would need 10 consultants to cover it safely 24/7, but the Trust is currently struggling to fill 6 posts.<br><br>The Trust had previously been supported by the MOD, who provided some medical and nurse cover, this cover was due to stop in January 2012. Without his cover, the Trust could not sustainably provide middle grade consultants to cover A&E.<br><br>The current arrangements for A&E have been successfully implemented and are working well and we believe should stay the way they were. |

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| **56.** | **Why are you moving maternity services?** | The TSAs are recommending that babies will no longer be delivered at Stafford Hospital. Ante and post natal care will continue at Stafford and Cannock for women with routine pregnancies.<br><br>Stafford Hospital has one of the smallest consultant – led delivery units in the country. Leading national clinical advisors say that the small number of births means Stafford hospital will not be able to provide the recommended level of consultant cover to provide safe delivery services for women within budget in the long term. |
| **57.** | **When will maternity services close?** | We recommend that babies will no longer be delivered at Stafford Hospital once alternative services are in place at neighbouring hospitals.<br><br>But ante and post natal care will continue at Stafford for women with routine pregnancies. They will continue to have their scans and antenatal appointments as usual and would only travel to another hospital of their choice for the birth itself.<br><br>Women with complications identified later on in their pregnancies or with high-risk complications will need to attend a larger specialist hospital.<br><br>Any woman who wants a home birth will continue to be able to have one, providing her pregnancy is low-risk. |
| **58.** | **Babies have always been safely born in Stafford. I was born here. What has changed?** | Stafford Hospital delivers approximately 1800 babies a year in a consultant-led obstetric service. This number is much smaller than minimum standards recommended by the Medical Royal Colleges for a consultant-led, 24/7 obstetric service.<br><br>We believe the service should move as soon as arrangements have been made at other hospitals to ensure a safe maternity service is provided to mothers from Stafford. |
| **59.** | **Why can't there be a midwife-led delivery unit (MLU)?** | The numbers of deliveries would be too small. About 50% of current deliveries might be suitable for a midwife led service, but experience from across the country shows that many mothers who could use one don't and opt instead for a consultant-led delivery. This means that a Stafford MLU would see on average less than one birth per day. This would not be financially sustainable. The TSAs have a responsibility to make proposals which are financially sustainable and this is why the TSAs have not recommended a Midwife-Led Unit at Stafford.<br><br>In developing the recommendations, the TSAs have worked closely with the Clinical Commissioning Groups (CCGs) who are the buyers of the hospital services and dictate what services must be provided locally. The CCGs have said that births must only continue to be provided at Stafford Hospital until other hospitals are in a position to take on more patients and provide these services instead of Stafford Hospital. |

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| **60.** | **How many births do there need to be to keep the current consultant maternity service at Stafford?** | To run a consultant-led maternity service there needs to be a minimum of 2,500 births per year in order to be able to provide the recommended level of consultant cover to provide safe services. Approximately 1,800 babies are born at Stafford Hospital each year making it one of the smallest consultant led delivery units in the country.<br><br>Additional births due to the relocation of military families, new housing developments in the area and general increases in population are not expected to increase the number of births above 2,000 per year. |
| **61.** | **Why is it considered acceptable to allow pregnant women in labour to be transported all the way to Stoke with the risk of problems occurring en route, whilst there is a maternity unit at Stafford?** | The consultant led maternity unit at Stafford is clinically unsustainable because not enough babies are born there every year. To ensure the highest safety levels we have recommended that women should deliver their babies elsewhere.<br><br>It is estimated that under the TSAs' draft recommendations, approximately 50% of women would deliver their babies at Stoke. The rest would be delivered elsewhere.<br><br>Women would continue to have all their routine ante and post-natal care in Stafford or Cannock. |
| **62.** | **You state that the Paediatric Assessment Unit is open 8am to 10pm, this is incorrect.** | There was a factual inaccuracy in the consultation document, the PAU is in fact open 24/7 not 14/7 which was stated on p31 of the consultation document.<br><br>The draft recommendation is that the PAU will only open 8am to 10pm, in line with the opening times for A&E.<br><br>We have issued an addendum to correct this. |
| **63.** | **Where does patient choice come in? Are you reducing patient choice?** | Whilst it is true that for the delivery of babies, some emergency and specialist operations and A&E between 10pm and 8am you will not be able to choose Stafford Hospital, a range of choices do still exist for you to make.<br><br>It is not possible for services to continue as they are, because the underlying problems would still be there, which could lead to services changing or closing at short notice. This would be a far worse outcome. |
| **64.** | **Who will decide which organisations will deliver the services at the hospitals in the future?**<br><br>**Will they definitely** | MSFT is not being privatised. All services to patients will be funded by the NHS as they are at the moment.<br><br>The TSAs expect to be able to include more information in their final report on when MSFT will be dissolved and who could provide the services at Stafford and Cannock Chase hospitals. |

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| | **be other NHS organisations or could a private company run them or is MSFT being privatised?** | |
| **65.** | **What's to stop the organisations who would run the hospitals taking over the services and then deciding to keep elective at their existing sites and running down the services at Stafford and Cannock Chase hospitals?** | Two things will make this impossible. Firstly, the commissioners decide where they want the services to be delivered from. They will not pay for or agree to the services being delivered anywhere else.<br><br>Secondly, the arrangements proposed by the organisations are only affordable if based at the Stafford and Cannock sites and being delivered through clinical networks. |
| **66.** | **How can you guarantee this will be the end of the TSAs' recommendations and that there will be no further changes?**<br><br>**Will other services be cut in future?** | We can never be sure what will happen in the future but we believe our draft recommendations are clinically and financially sustainable and that there will be no need for further changes.<br><br>The TSAs' draft recommendations have been developed in conjunction with other local providers and they have been signed off by the CCGs who commission services at the hospitals. |
| **67.** | **Have you taken into account the increase in population caused by the return of military personnel or the significant increase in new housing being planned?** | Yes, we have taken both of these issues into account when assessing the future population of Stafford and Cannock.<br><br>We also confirm that we have spoken to the Ministry of Defence to confirm the numbers which we have used in our analysis.<br><br>The increase has been taken into consideration. It has no material effect on the plans for maternity and paediatrics or any recommendations under the TSAS' draft proposals. |
| **68.** | **Why do your recommendations** | Our draft recommendations provide an opportunity to significantly reduce the overspend at the Stafford and Cannock Chase sites and provides the |

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| | **not reduce the deficit to zero?**<br><br>**Does this mean that your recommendations are not financially sustainable?** | opportunity for further possible savings / improvements to reduce this overspend to zero.<br><br>We will continue to refine our recommendations, in particular we will continue our discussions with other local hospitals and CCGs in order to reduce the deficit further. Our final report with include detail of this further work. |
| **69.** | **What vested interests do members of the CCG have?** | Members of the Clinical Commissioning Groups have no personal vested interests but as the commissioners of health services in Staffordshire they have a vested interest in ensuring that the widest range of clinically and financially sustainable services are commissioned as locally as possible. |
| **70.** | **Many of the proposals seem based upon staffing numbers regarding Doctors, Nurses and Consultants – how can the proposals be successful with a staff shortage within the profession?** | In specialties where there are national staff shortages individuals can pick and choose where they want to work. Large, busy units are more attractive because they offer more variety and scope for personal development.<br><br>The national experts advising the TSAs have confirmed that they believe the draft recommendations would improve the retention and recruitment issues faced at MSFT. |
| **71.** | **Parking is currently impossible at other local hospital, what arrangements have been made for the extra patients and visitors?** | We acknowledge there are problems with transport and accessibility and this is something that the commissioners, other hospitals and the local authorities will be considering. |
| **72.** | **How will the ambulances cope with the extra journeys, especially navigating around the M6 which is usually gridlocked?** | West Midlands Ambulance Service has been part of the process so far and is a key partner in it. |

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| **73.** | **Why is it always about the "cost" of everything and the "value" of nothing?** | It is about clinical and financial sustainability and the importance of ensuring local residents have access to high quality, safe health services in the future. |
| **74.** | **Why are the local people being punished for mistakes made in the past by NHS Senior Managers?** | There is no desire to 'punish' local people. We cannot re-write history but we can try to ensure that local people have access to high quality, safe and sustainable services in the future.<br><br>The TSAs have not dwelled on the Trust's troubled history and have instead focused their efforts on finding a long term solution for the Trust's present problems. However, it must be recognised that the reputational issues faced by the Trust due to events from the past is one of the key drivers of the problems faced by the Trust today such as recruitment and retention issues and the fall in patient referrals as some GPs and patients choose to use other hospitals. |
| **75.** | **What assessment has been undertaken on the ability of Wolverhampton and Stoke and Cannock to deal with the transfer of services?** | This has been part of the process and we have worked closely on this in conjunction with both Wolverhampton and Stoke.<br><br>We are very clear that no services would transfer until the receiving organisations are ready and have the capacity to accept them. This transition is likely to take 2-3 years. |
| **76.** | **How confident are you that the recommendations are based on accurate statistics and factual information?**<br><br>**At the public meetings some staff questioned the accuracy of the data being used by the TSAs.** | We are confident that the information we have been given is robust and accurate. Some potential discrepancies have been raised but on investigation these have been minor and have had no impact on the recommendations. |
| **77.** | **How are you going to retain staff during the 2-3 year period?** | Staff are understandably unsettled by uncertainty which is why we believe it is important that a decision is made on our final recommendations as soon as possible.<br><br>It is also important to recognise that 91% of patient visits will still take place at |

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| | | local hospitals therefore most staff will have a secure future in them. |
| **78.** | **How much involvement have the local GPs had in this process?** | GPs have been involved through their Clinical Commissioning Groups.<br><br>The TSAs have also written to all GP practices in the catchment area providing a copy of the consultation document and asking for a response to ensure that feedback is received from the local GPs on their recommendations. |
| **79.** | **What do you mean by 91% of patient visits will continue to be at Stafford or Cannock?** | The TSAs have stated that under their draft recommendations 91% of patient visits will be unaffected.<br><br>This means that 91% of patient visits that currently take place at Stafford or Cannock will continue to take place at either Stafford or Cannock. |
| **80.** | **Where are the extra beds going to come from if they haven't got enough at Stoke and Wolverhampton already?** | We have stated that other providers may need to create additional space at their hospitals, through additional building work, in order to accommodate some of the additional services.<br><br>We are very clear that no services would transfer until the receiving organisations are ready and have the capacity to accept them. This transition is likely to take 2-3 years. |
| **81.** | **Why is there no mention of the improvements that have been made with the staff and hospital in recent times?** | The staff have worked very hard over the last few years to make improvements to the hospital both in terms of financially and clinical standards. We have always highlighted the good work that the staff are doing at the Trust. Indeed it is the very first sentence of chapter 1of our consultation document.<br><br>However, despite this hard work the issues facing the Trust are significant, and the Trust is not clinically or financially viable in its current form. |
| **82.** | **How does transferring services from MSFT to another provider with financial difficulties solve the problem?** | We have been clear that this process is not about shifting the financial issues onto neighbouring Trusts. We have worked very closely with other providers to ensure that the recommendations are financially sustainable for all parties. However, this process is not about dealing with any financial difficulties of any other trust, those are for their own boards to deal with.<br><br>No services would transfer until the receiving organisations are ready. |
| **83.** | **Can you clarify whether the proposal is for a takeover, merger, run by or a new Trust?** | At this stage, the TSAs have made no proposals about what happens to the organisational form other than MSFT is dissolved.<br><br>Contrary to many reports, the TSAs have not, at this stage, made any recommendations about which organisations should provide services in Stafford or Cannock. The TSAs expect to make recommendations on these |

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| | | points in their final report.<br><br>If our recommendation for MSFT to be dissolved is retained in the final report and is accepted by the Secretary of State for Health, then a merger is unlikely as MSFT as an entity will no longer exist. |
| **84.** | **What is the estimated timescale for dissolving the Trust? If you are unable to confirm a date now, when will you be able to do so?** | The formal consultation process on the TSAs' draft recommendations commenced on 6 August 2013 and will run until 1 October 2013. Following the consultation period, the TSAs will be reviewing the draft recommendations and finalising their report and recommendations in light of the responses to the consultation. The final report will be sent to Monitor within 15 working days following the end of the formal consultation process. Following review by Monitor the final report will then be submitted to the Secretary of State, who will decide on what action is to be taken.<br><br>The TSAs are not in a position to talk about or answer detailed implementation questions at this stage in the process. However, as part of the TSAs' final report they will provide a draft implementation plan, which will be submitted to the Secretary of State along with the final report. At this stage, further, more detailed information relating to the dissolution of the Trust will be available. Once the Secretary of State has made his decision the detail of the final implementation plan and time scales will be worked through with the department heads and senior management. |
| **85.** | **What will be the likely impact on the continuity of antenatal care?**<br><br>**The proposal for Stafford women is for antenatal clinics at Stafford to be staffed by consultants from other hospitals. What guarantee is there that pregnant woman will see the same consultant at each appointment?**<br><br>**Will this consultant also definitely be the consultant at the mother's chosen** | Although the TSAs have worked with a number of providers to develop their draft recommendations, it has yet to be confirmed which provider will be implementing the recommended services.<br><br>The recommendations currently state that pregnant women who wish to have their antenatal care in Stafford will be able to do so and delivery would be at another hospital of their choice other than Stafford.<br><br>The TSAs' draft recommendations are based on a network of consultants who would be used throughout the whole Stafford area.<br><br>It is intended that, where possible, pregnant women would see the same consultant team from the same organisation during their antenatal care and for the birth using this network of consultants. However, it may not be possible to guarantee that the same consultant would be present at the birth if it were unplanned. This is exactly the same scenario as is currently the case at Stafford. |

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| | **delivery hospital?** | |
| **86.** | **Will low risk women continue to be cared for at midwife-led clinics run at local GP surgeries?**<br><br>**Where will the community midwives for Stafford be based?** | It is currently expected that low risk women will continue to be cared for at midwife-led clinics run at local GP surgeries, where it is currently the case.<br><br>It will be the new providers' responsibility to decide how all recommendations will be implemented, including those recommendations relating to community and community midwife services. The TSAs will make suggestions regarding implementation. We are not able to confirm where community midwives for Stafford will be based. |
| **87.** | **What is the likely impact of the proposals on women with a history of rapid labour who are likely to only just be able to make it to Stafford Hospital in time and who may not wish to have a homebirth?** | The greater distance will have to be incorporated into the normal planning process for pregnancy.<br><br>It is intended that a risk assessment will be carried out allowing midwives to ensure that these women are aware of what to do.<br><br>The TSAs are also working with the ambulance service and recognise that there are costs associated with increased ambulance transfers for women in labour, which are included in the TSAs' financial forecast. |
| **88.** | **If the Stafford maternity unit closes, what will the impact be for women in Stafford who wish to have a homebirth?** | Where the option of homebirth is available now, it will remain available under the TSAs' proposals. It is intended that there will be a midwife risk assessment carried out for each patient, in order to determine whether a homebirth would be appropriate. It would therefore be each woman's decision, supported by the midwife's risk assessment. |
| **89.** | **What measures will be put in place to ensure that the financial expectations of the TSAs' proposals are met without detriment to services?** | The financial assumptions in the TSAs' proposals have been and continue to be scrutinised by providers and other NHS bodies such as the Clinical Commissioning Groups ("CCGs"), the NHS Trust Development Authority, NHS England and the Department of Health. The purpose of this scrutiny is to provide assurance that the financial assumptions made are realistic and achievable. Once these assumptions have been confirmed it will be the responsibility of the implementation team to ensure that they are further tested and delivered.<br><br>Unfortunately, the TSAs are not in a position to comment further on detailed implementation at this stage in the process. As part of our final report, however, a draft implementation plan will be provided, which will be submitted |

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| | | to the Secretary of State along with the final report. |
| **90.** | **Where will staff be based following the implementation of the TSAs' recommendations ?** | The main principle of the TSAs' draft recommendations is to maintain as many services in Stafford and Cannock. These services would be delivered by deploying staff in a clinical network with a larger more specialised hospital.<br><br>It is the TSAs' expectation that the senior clinical staff, who are primarily consultants, will work a shift pattern that means they will work across multiple sites in the network. |
| **91.** | **What will be the effects on the communities of Stoke on Trent, North Staffordshire and Wolverhampton?** | The objective of the TSAs' draft recommendations of 'step down' beds in Stafford and Cannock, is to provide local rehabilitation beds for the local population of Stafford and Cannock. It is not the expectation or intention of the TSAs' recommendations that these beds are used by patients from outside of the catchment area. It may be that the providers running services at Stafford and Cannock in the future may use some of the capacity at Stafford and Cannock to treat patients from outside of the catchment area (for example, by consolidating some elements of elective surgery onto the Stafford or Cannock sites), but it would be highly unlikely that these facilities will be used as rehabilitation or recovery centres for patients out of the catchment area.<br><br>The vast majority of CCGs across the country are looking to ensure as much care is delivered close to home as possible. Therefore, using capacity at Stafford and Cannock to treat patients from outside of the catchment, would very much run counter to this intention. |
| **92.** | **Does the Maternity department at the Trust support TSAs' proposals?** | The senior nurse in the Midwifery department at the Trust agrees with the advice we have been given regarding the direction of travel for obstetric led units, specifically, to have more consultant presence in these units and preferably larger units with 24 hours a day, 7 days a week cover.<br><br>The view of the National Clinical Advisory Groups is that units with low numbers of births will be unable to meet this in the future. |
| **93.** | **How far in depth have the TSAs considered services that are split site services where they are provided at both sites?** | The draft recommendations, made by the TSAs, describe a high level clinical model for the provision of services at both Cannock and Stafford. Whilst the TSAs have been working with local providers to understand how local services could be delivered, no decision has been made on who the provider would be. Should the TSAs' recommendations be accepted by the SOS, clinical commissioning groups will then decide how best to provide services and whether this is undertaken by single or multiple providers. |
| **94.** | **Have the TSAs looked at each of the services budgets** | Whilst the TSAs have had this information it has not undertaken a detailed review of every budget. In order for the TSAs to understand the cost of delivering the range of services that are currently provided at the Trust, they obtained the individual budgets of each of these services. |

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| | **individually?** | |
| **95.** | **Is it sensible to maintain an A&E department without the facility to carry out emergency surgery?** | National guidance states that an emergency surgery service should have at least one dedicated emergency theatre. Currently, with the low number of emergency surgical cases and a lack of general surgeons on the surgical rotas, the Trust does not and cannot manage a dedicated emergency theatre. Furthermore, the Royal College of Surgeons (in 2009) and subsequent internal reviews have raised genuine concerns about the viability of the emergency surgery service in Stafford. We concur with these views and do not believe that the emergency surgery service is clinically sustainable, in the short, medium or long term.<br><br>Currently, no major trauma patients are currently treated at MSFT. These patients are taken to larger, more specialised hospitals, for example University Hospital North Staffordshire ("UHNS") or Royal Wolverhampton Hospitals NHS Trust ("RWT") (a "Trauma Centre"). There are currently protocols in place which mean that the ambulance service takes these patients directly to the larger more specialised hospital.<br><br>Furthermore, in the case of an A&E walk-in case at Stafford hospital, the patient would be triaged and then stabilised whilst a transfer to the Trauma Centre was arranged. These are the patients that typically need emergency surgery. As such, at the moment an average of 3-4 patients per day have unplanned or emergency surgery in Stafford. On average there are 120 attendances per day at the A&E in Stafford and over 95% of attendees to A&E do not require surgery. These patients are typically moderate or minor trauma cases, for example, an operation to set a fracture under general anaesthetic.<br><br>However, removing emergency surgery from Stafford is not expected to have a significant impact on the service as it is currently not provided by the Trust. |
| **96.** | **If a patient is currently receiving long term care, will they continue to see the same consultant?** | The service received from the existing consultant will continue as normal during the transition period, which could be up to three years. If the patient's particular treatment is long-term and continues after the transition period, the patient would then have the option to continue with their existing consultant, who may be based at a different hospital, or transfer to a new consultant who is more locally based. |

Office of the
Trust Special Administrator
of MSFT

# The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust

## Annex 3.5: TSAs' financial evaluation

December 2013

# 1. Financial evaluation overview

This paper sets out the context behind the financial evaluation of the three clinical models described in the main report, namely the Location Specific Services (LSS), Contingency Planning Team (CPT) and Trust Special Administrators' (TSAs) clinical models. It describes the size of the financial challenge that Mid Staffordshire NHS Foundation Trust (MSFT or the Trust) faces over the next three years and how, through each of the clinical models, productivity and synergy savings have been analysed and taken into account to consider how the overall finances of the Trust might improve.

The financial evaluation focuses on four aspects for each of the three clinical models:

- The financial benefit/consequence for the delivery of the services proposed;
- The capital expenditure required;
- The transitional costs; and
- The cost/funding required through a net present value calculation.

The financial evaluation concludes that the clinical models present:

- An improved financial position on the TSAs forecast deficit for 2016/17 of £42.5m to a deficit of between £18.4m (for the LSS model) and £14.87m (for the TSA model – please note that for the purposes of this annex it is rounded to £14.9m). It is envisaged that some of this improvement can be achieved in the first 12-24 months of implementation.
- The majority of cost reductions will come from productivity improvements including length of stay reductions, removal or reduction of estates costs, workforce redesign, changes to management structures and central functions and the reduction of the Board and executive team costs resulting from the dissolution of MSFT as a stand-alone organisation.
- There are a number of further opportunities available to bridge the remaining financial gap which are outside the scope of the TSAs' work. These are referred to later in this Annex.

Due to historic under investment in the estates, a considerable level of capital investment is required to remodel and refurbish Stafford and Cannock Chase sites to an acceptable standard with the exact amount determined by the clinical model. Additional capital is also required to provide capacity at the other provider sites, although some of this may be mitigated through demand management initiatives and productivity improvements.

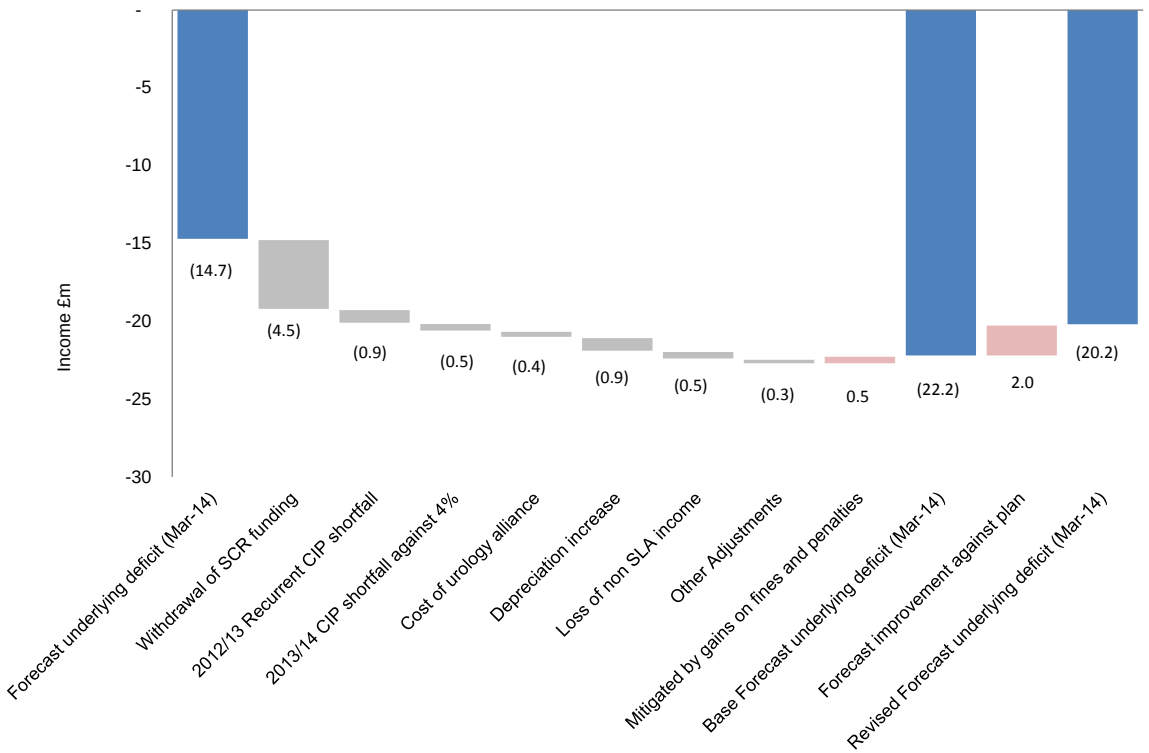
Total funding for transition costs, capital and any time-limited ongoing deficit from 17/18 onwards will be provided by a combination of financing from the Department of Health (DH) and income from NHS England, paid via the CCGs.

# 2. The forecast financial position of MSFT for March 2014

In 2012/13, MSFT reported a deficit position of £14.7m. This included non-recurrent funding of £4.5m resulting in a normalised deficit of £19.2m.

The financial plan for MSFT for 2013/14 initially showed a forecast deficit position of £22.2m. This deterioration from 2012/13 was mainly due to a combination of CIP shortfalls in both 2012/13 and 2013/14 as well as a number of Service Level Agreement (SLA) adjustments.

However, the TSAs' forecast normalised position for the 2013/14 is a deficit of £20.2m, which is based on the anticipated improved performance against the activity plan resulting in an increase in income seen in Q1 of 2013/14. The TSAs have therefore based the financial evaluation on this 2013/14 forecast position. The detailed movements from the 12/13 outturn to the 13/14 forecast outturn are shown below.




*Note: SCR = strategic change reserve*

# 3. Additional cost pressures during FY15 – FY17

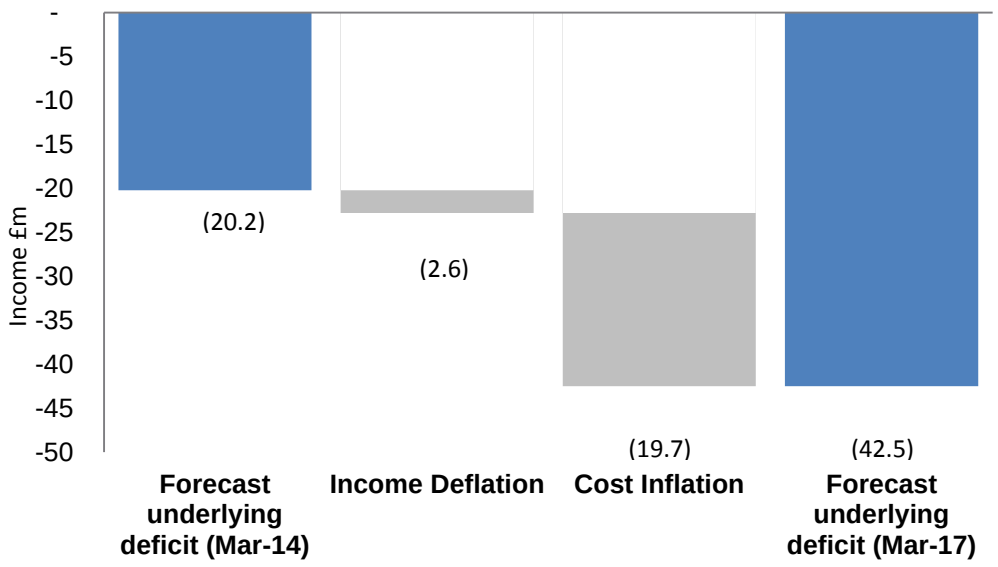
In the report, the TSAs describe a transition and implementation period of between two to three years and, therefore, the financial evaluation has considered the financial pressures that are likely to arise throughout this period. Common with all NHS trusts and other NHS organisations, MSFT will continue to be faced with an annual efficiency requirement which is driven by both an annual tariff deflation and cost inflation. There is an expectation that all organisations will need to deliver efficiencies of 4-5% per annum under the current planning assumptions.

Monitor publishes financial planning assumptions which all foundation trusts, and aspirant foundation trusts, must build into their financial forecasting. These are outlined in the table below.

| *Assumption** | 13/14 | 14/15 | 15/16 | 16/17 |
|---|---|---|---|---|
| Tariff inflator/ deflator | -1.30% | -1.30% | -0.20% | -0.20% |
| Cost inflation | 3.70% | 3.70% | 4.00% | 4.00% |

** Based on Monitor's 2012/13 planning assumptions*

Applying these planning assumptions to forecast the MSFT outturn in 2016/17, based on the £20.2m 2013/14 forecast outturn detailed in the previous section, results in a deficit of £42.5m as shown in the figure below assuming that the current level of costs and income (before inflation) remains the same. This means that if nothing were to change at MSFT (e.g. The Trust does not implement any CIP plans) and the above assumptions are applied, the Trust would have an underlying annual deficit of £42.5m in 2016/17.



# 4. Changes as a result of the consultation

During the consultation period, the TSAs have received feedback from a number of sources relating to both the clinical model and the costing assumptions. As has been described in the main report, the TSAs are amending their recommendations for the clinical model, which impacts the detailed costing of the model and as a result the TSAs have made some changes to the forecast outturn position for each model. In addition, the TSAs have also worked with a number of providers to further refine the costing of services.

The key changes that have been included in the latest forecast are detailed below.

**Midwife Led Unit (MLU)** - Following feedback from the consultation, the TSAs have updated their recommendations to include a MLU at Stafford under the TSA model. This has led to a marginal improvement in the position as the impact of the new tariff (relating to birth without complications) is recognised.

**Medical Assessment Unit (MAU)** - Following work with other providers, the TSAs recommended that two Medical Assessment Units should be provided at Stafford under the TSA model with the costs allocated to other providers under the LSS and CPT model. This adds a premium cost above the cost of a standard 24 bed ward, which was included in the original forecast.

**Capital assumptions** – Capital assumptions have been further reviewed to determine the annual revenue impact. This has included updating the revenue impact of existing MSFT assets based on the current 13/14 capital plan as well as the future capital outlay required.

**Productivity** - Feedback received on the proposed bed reduction and the availability of new data led to the TSAs reviewing the potential bed reduction. This has reduced the overall opportunity.

**Excess bed days (XBD) adjustment** - XBD income is the payment received when a patient's length of stay in a hospital bed is longer than expected. As the model has recognised improvements to the length of stay, the excess bed day income is expected to decrease. The TSAs have completed a detailed review of the impact and adjusted in the model accordingly.

**Other income adjustment –** Other Income has been updated to remove non recurrent income and those income streams that are expected to cease. The allocation of this income has also been reviewed to determine which site it is most likely to relate to in the future model.

**Paediatric premium –** A review of guidance has resulted in the TSAs providing a greater level of nursing cover for Paediatric inpatient services at other provider sites than was previously included in the model.

**Clinical Nurse Specialists (CNS) –** Through work with the providers, the TSAs have now incorporated a greater level of CNS presence on the Stafford and Cannock sites

Finally, the impact of each of these movements on the overall inflation position has been accounted for within the forecasts for the models.

# 5. Distribution of activity and income

MSFT's actual income and activity for the financial year 2012/13 was used as the baseline for the modelling of each option, with non-recurrent items removed on the basis that they were 'one off' items. Other income adjustments such as fines have been retained within the overall quantum although excess bed day income has been adjusted in line with expected productivity improvements as described earlier.

The income allocations within the three models are outlined in the summary below.

| *Currency: £m* | Stafford | Cannock | UHNS | RWT | WHT | BHFT | SaTH | Good Hope | Total |
|---|---|---|---|---|---|---|---|---|---|
| LSS | 37.4 | 30.9 | 33.0 | 29.9 | 10.0 | 5.5 | 1.5 | 5.5 | 153.6 |
| CPT | 49.8 | 43.6 | 23.2 | 16.5 | 9.2 | 5.0 | 1.4 | 5.0 | 153.6 |
| TSA | 66.6 | 48.1 | 14.3 | 13.7 | 4.9 | 2.7 | 0.7 | 2.7 | 153.7* |

** The additional £0.1m of income relates to the tariff adjustment included as part of the MLU inclusion at Stafford under the TSA model*

**Activity split for each model**

Activity and income were allocated to specific sites in each of the three models; assumptions used for these allocations were driven primarily by the service configuration for each model and then adjusted where appropriate for factors such as travel times and locality, as described below. This exercise was completed at a specialty and 'point of delivery' (POD) level.

The table on the following page summarises the method which has been used to allocate activity

Three main methods of allocating activity have been used within each of the models:

- CCG allocation – this is the allocation based on CCG locality; for example, Stafford and Surrounds CCG activity would be allocated to the Stafford site. That is to say this method assumes that patients living within the catchment for Stafford and Surrounds CCG would in future expect to be treated in most instances at Stafford Hospital.
- Travel Time – Analysis has been undertaken around non-elective patients currently using Stafford and Cannock Chase sites. This analysis identifies the next nearest hospital that patients would be likely to use if they were no longer going to Stafford Hospital.
- Provider assumptions – following detailed discussions with providers, some services have been adjusted to take into account the most appropriate configuration and location of some specialties to make sure that patients are treated in the right locations by the right sub-specialty medical teams.

| Point of Delivery | LSS | CPT | TSA |
|---|---|---|---|
| Elective | CCG allocation | CCG allocation | CCG / Provider assumptions |
| Day Case | CCG allocation | CCG allocation | CCG / Provider assumptions |
| Non-Elective | Travel Time | Travel Time | Travel Time / Provider assumptions |
| Outpatients | CCG allocation | CCG allocation | CCG allocation |
| Critical Care | Travel Time | Travel Time | Travel Time / Provider assumptions |
| A&E | Travel Time | Travel Time + UCC at Stafford | Travel Time + A&E at Stafford |

**Elective activity**

Allocation of Elective activity is the same in the LSS and CPT models and has been allocated to other hospitals (i.e. not Stafford and Cannock) based on the CCG with responsibility for the patients; e.g. all Cannock Chase CCG patients would be expected to be admitted to a provider in the south of the region.

Under the TSA model, specific specialties are assumed to be provided within specific hospitals and the activity has been allocated on this basis. If the specialty is provided in more than one provider, the activity is split based on the responsible CCG as per the LSS and CPT models.

**Day case activity**

Under the LSS model, all day case activity has been allocated to other hospitals (i.e. not Stafford and Cannock) based on the CCG with responsibility for the patients; e.g. all Cannock Chase CCG patients would be expected to be admitted to a provider in the south of the region.

Under the CPT model, day case activity remains at Stafford and Cannock and is allocated based on the CCG with responsibility for the patients; e.g. all Cannock Chase CCG patients would be expected to be admitted to Cannock.

Under the TSA model, specific specialties are assumed to be provided within specific hospitals and the activity has been allocated on this basis. If the specialty is provided in more than one provider, the activity is split based on the responsible CCG as per the LSS and CPT models.

**Non Elective activity**

Non elective activity is allocated to other hospitals (i.e. not Stafford and Cannock) based on travel time analysis for the LSS and CPT models (i.e. the next nearest hospital based on time taken to drive there). The

exceptions to this are Breast Surgery, Cardiology, Clinical Haematology, Clinical Oncology and Urology where, given the specialist nature of these services, the activity was allocated to specialist providers within the region.

Under the TSA model, it is assumed that, post-implementation, 70% of the activity from General Medicine, Geriatric Medicine and Respiratory Medicine remains on the Stafford site. This was derived through discussions with other providers and was based on the assumption that this lower acuity activity could continue to be delivered safely on the Stafford site given the configuration of medical specialties and clinical support retained under the TSA model.

Post consultation, the TSAs have revised their recommendations to include the provision of a MLU in Stafford. The evidence from the consultation and that presented by the RCM demonstrated to the TSAs that there would be sufficient demand to make this service financially viable. As a result 357 births have been assumed to take place in Stafford to be delivered in an MLU; note the TSAs have estimated that it requires 357 births for the unit to breakeven. The remainder of the Obstetrics activity is allocated to other hospitals based on travel time.

**Outpatient activity**

The allocation of outpatient activity is the same in all three models and has been allocated based on the CCG with responsibility for the patients; e.g. all Cannock Chase CCG patients would be expected to be seen for outpatient appointments in Cannock except where a particular sub-specialty is based elsewhere. All outpatient activity remains on the existing Stafford and Cannock sites; however, there may be some movement between these hospital sites.

Patients from Stafford and Surrounds CCG are allocated to Stafford Hospital with those from Cannock Chase CCG allocated to Cannock Chase Hospital. Patients from other CCGs are allocated across Stafford and Cannock sites in the same proportions as those from Stafford and Surrounds CCG and Cannock Chase CCG.

**Critical Care activity**

Critical care activity is allocated to other hospitals (i.e. not Stafford and Cannock) based on travel time analysis for the LSS and CPT models (i.e. the next nearest hospital based on time taken to drive there).

For the TSA model, there is an assumption that 4 beds will remain at Stafford with 6 beds provided at other sites. Income and activity have been split based on these proportions.

**Accident and Emergency (A&E) attendances**

A&E activity allocations differ under each of the three models based on the type of A&E/Urgent Care Centre (UCC) proposed.

Under the LSS model, no A&E services are provided on the Stafford or Cannock site with activity allocated to other providers based on travel time.

Under the CPT model, an UCC is maintained on the Stafford site and an assumption has been made that 50% of the activity will remain at Stafford with the remainder being allocated to the nearest alternate provider based on travel time.

Under the TSA model, a full 14/7 A&E service is maintained on the Stafford site and an assumption has been made that 70% of the activity will remain at Stafford Hospital, 20% will go to the Provider responsible for service provision at Cannock Chase Hospital with the remainder being allocated to the nearest alternate provider based on travel time. The assumption on which activity remains at Stafford is based on the remaining services on the Stafford site.

**Other income and CQUIN (Commissioning for Quality and Innovation)**

Common to other trusts, MSFT attracts a range of income which is not necessarily covered by the usual tariff system and which will continue to be a source of income under all three models; as such it needs to be reallocated dependent on model assumptions. 'Other income' and 'pass-through income' has been linked to specific clinical services and are allocated in the same way. For example, high cost drugs have been linked with the allocation of Chemotherapy services.

An assumption has been made that CQUIN achievement will remain at the current rate regardless of where the services are being delivered under each model. Therefore, CQUIN has been split as an overhead to activity based income.

# 6. Estimated investment required to deliver the models

**Estimated capital investment to deliver the clinical models**

The MSFT Estate summary details the assumptions and analysis behind the estimated capital investment required to deliver the clinical models.

The capital investment required is detailed in the table below:

**Capital investment required – TSA baseline**

| Investment as per TSA baseline | LSS model | CPT model | TSA model |
|---|---|---|---|
| Stafford | £18.2m | £21.4m | £35.8m |
| Cannock | £2.0m | £6.0m | £7.0m |
| Other providers | £137.6m | £125.9m | £83.6m |
| IT | £7.1m | £7.1m | £3.8m |
| **Total** | **£164.9m** | **£160.4m** | **£130.2m** |

Note that this capital investment excludes any costs relating to replenishing/replacing the existing assets as it is assumed that any funding required for this purpose is covered by the depreciation charge included in the forecast deficit.

Any capital expenditure will attract an annual charge in the form of:

- Depreciation costs associated with any investment; and
- Public Dividend Capital (PDC) dividend which is effectively the finance charge to the organisation associated with the capital expenditure.

The tables below set out the additional annual cost of depreciation and PDC dividend for each of the models, based on the estimated capital investment above. Note that the depreciation and PDC for the existing asset replenishment is already included within the current depreciation and PDC.

**Depreciation and PDC**

| TSA Baseline | LSS model | CPT model | TSA model |
|---|---|---|---|
| Depreciation | £4.6m | £4.5m | £4.0m |
| PDC dividend | £3.7m | £3.6m | £2.9m |
| Total annual cost | £8.3m | £8.1m | £6.9m |

Note that, given the complexities in relation to the potential value of the sites following any capital investment, we have assumed that depreciation and PDC are both calculated following a 40% impairment of the assets. This is in line with impairments typically seen on capital investments of this scale within the NHS. However, this would need to be reviewed in more detail as capital plans are developed. In addition, we have not made any adjustment to the existing life of the buildings which may increase following an investment of this scale. The impairment is assumed to take place in the year of investment with depreciation on an asset beginning the year after the initial capital outlay.

**Estimated financial investment / impact on the local Ambulance Trust**

Indicative costs were provided by the West Midlands Ambulance Service (WMAS) which cover the additional journey times and transfers for each model. This cost is £1.2m per annum in relation to the TSA model and £2.7m in relation to the LSS and CPT models.

The costs are based on WMAS assumptions on the likely increase in travel times and transfers based on the volumes of activity in each of the clinical model options. The activity analysis was provided by the TSAs.

# 7. Standard costing of services

Activity and income has been allocated to specific provider sites based on agreed principles which vary under the three models, as described earlier in this Annex.

A bottom up standard costing has been used to calculate the direct cost of delivering these services and the associated overheads required.

**Cost of admitted patient care**

Admitted patient care activity (Elective, Non Elective and Day case) was taken for each provider/site as an output from the activity allocation. In order to calculate the beds required for each model at each site, a national average length of stay was applied to the activity at a specialty and POD level to calculate the number of bed days required.

Bed occupancy rates are an important factor in determining the number of beds a hospital requires to deliver a specific range of services at defined volumes/activity levels. There is clinical evidence to suggest that an occupancy rate of 85% should be used to maintain patient safety, capacity management and quality of care; however it is not unusual to see occupancy rates significantly in excess of 85%. Occupancy rates are derived from the number of bed days occupied over the number of bed days available. An 85% occupancy rate has been applied to non-elective and elective care to determine the number of bed days required, which is then translated into the number of beds required by dividing by 365.

The day case beds requirement was calculated using 100% occupancy for the period that day case procedures would be expected to be conducted. Since it has been assumed that the day case ward will run for 5 days a week for 44 weeks a year, the number of beds were calculated by dividing by 220 rather than 365. 44 weeks is used to allow for annual leave and study leave for consultants and nursing staff. 44 weeks were used rather than 42 (as per the outpatient costings) as it has been assumed that day case staffing will be able to provide a greater degree of cover.

The beds requirement by POD for each site was translated into a ward requirement. This was done by splitting the overall bed requirements into ward sizes (as per the table below) in order to minimise the number of excess beds. However, as a ward is a stepped cost, a whole ward would need to be assumed regardless of whether only half the beds were needed or the full quota of beds.

There are various ward types for each POD. For each ward type, there was a standard pay cost calculated to staff the ward. This is detailed in the table below:

| POD | Ward type | Qualified to Unqualified ratio* | WTE | Nurse to bed ratio** | Pay cost |
|---|---|---|---|---|---|
| Non Elective | 16 beds | 67% : 33% | 19.64 | 1.09 : 1 | £638,400 |
| Non Elective | 19 beds | 72% : 28% | 23.06 | 1.10 : 1 | £758,691 |
| Non Elective | 24 beds | 65% : 35% | 28.86 | 1.11 : 1 | £920,638 |
| Non Elective | 28 beds | 61% : 39% | 36.38 | 1.07 : 1 | £1,134,220 |
| Elective | 16 beds | 67% : 33% | 18.42 | 1.09 : 1 | £624,608 |
| Elective | 28 beds | 62% : 38% | 31.74 | 1.10 : 1 | £1,027,863 |
| Day case | 16 beds | 71% : 29% | 19.22 | 1.14 : 1 | £604,003 |
| Day case | 28 beds | 69% : 31% | 34.83 | 1.21 : 1 | 1,054, 338 |

*Based on minimum 60:40 qualified to unqualified ratio and on experience from other providers. An additional Band 7 is included above this ratio to provide management cover on the ward.

**Nurse to bed ratio of approximately 1.1 nurses to each bed. This is based on an assumption that most patients will fall between a level 0 and level 1a on the AUKUH acuity tool. The guidance suggests 0.79 nurses per bed for level 0 and 1.70 for level 1a.

Pay costs in the table above do not include medical consultant costs. The cost of a consultant is typically calculated based on the number of PAs (Programmed Activities) that they are contracted to perform. An assumption has been made that 10 PAs would be required for each 30 beds. The cost of each PA was estimated to be £13k. This cost is based on the current cost at MSFT.

Non pay costs are based on the current cost per bed day at MSFT and are applied to the number of bed days required at each site. This cost has been calculated at £16.45 per bed day based on the 12/13 outturn position of MSFT

The costing of Maternity inpatient services is costed as per above. The TSAs recognised that a delivery suite will have a richer skill mix than a standard ward and to recognise this, a £1.2m premium cost was included.

Under the TSA model, 357 births are forecast to take place in Stafford; the number at which the TSAs have calculated an MLU at Stafford would breakeven. This is deemed to be a reasonable assumption based on benchmarking with similar units and feedback provided by the RCM. The new maternity tariff was used to determine the income related to this service. The additional income relating to the tariff change has been included at Stafford to demonstrate the financial viability of this option.

**Cost of a Medical Assessment Unit**

MAUs provide assessment for patients admitted through A&E. The patients are typically either discharged home following diagnosis and treatment or admitted into an inpatient bed. Through the consultation process and work undertaken with the providers, it was determined that two Medical Assessment Units should be included in the TSA model at Stafford to ensure compliance with the Department of Health's same-sex accommodation guidance and to allow for a range of functions such as Frail Elderly Assessment Unit and Clinical Decision Unit

In terms of the model, these two wards replaced existing 24 bedded wards; ie they were not additional beds added into the model.

Due to the relatively high volume of patients managed in a typical MAU in comparison to a normal ward, and to minimise the length of stay on this unit, the staffing and non-pay costs on this unit are higher than a standard 24 bed unit. A premium cost has been included to account for this as detailed in the table below.

| Grade | WTE | Total cost | Already included within 24 bed unit | Increase (Premium cost) |
|---|---|---|---|---|
| 8a | 1 | £53,901 | - | £53,901 |
| 7 | 3.00 | £151,381 | £50,460 | £100,921 |
| 6 | 6.00 | £280,287 | £93,429 | £186,858 |
| 5 | 18.25 | £642,783 | £543,057 | £99,726 |
| 2 | 15.03 | £342,069 | £209,906 | £132,163 |
| Consultant | 3 | £390,000 | £104,000 | £286,000 |
| Ward Clerk (Band 2) | 3 | £58,490 | £23,786 | £34,704 |
| Non Pay | | £240,000 | £148,105 | £91,895 |
| **TOTAL** | **49.28** | **£2,158,910** | **£1,172,743** | **£986,167** |

**Cost of Paediatric inpatient services**

As the cost of Paediatric inpatient activity has been included within the inpatient costing, a premium was included to allow for the enhanced skill mix required (based on RCN guidance). The guidance recommends a 1:3 qualified nursing level for children under the age of two and 1:4 (with 1:5 at night) for children over the age of two. Based on a review of historic activity, it has been assumed that 33% of the Paediatric admissions will be under the age of two.

Based on the levels of activity, the qualified nursing level has been calculated and compared to the staffing already included within the inpatient costings. The difference has been included as a premium cost. Unqualified nursing has also been included to maintain a 60:40 qualified to unqualified ratio.

This adjustment has only been included for those providers where the TSAs have assumed the new activity cannot be completely absorbed within existing services.

**Cost of outpatient services**

Outpatient activity (first, follow up and procedure appointments) was taken for each provider as an output from the activity allocation. Non face to face outpatient appointments and direct access services have been costed as outpatient appointments and are included in the calculation below.

The average minutes per appointment has been calculated at a specialty level based on MSFT's current performance and applied to the activity to calculate the number of minutes required by specialty for each site. No adjustment has been made to the appointment length in terms of productivity as the productivity at MSFT is in line with other providers.

This is shown in the table overleaf.

**Minutes per outpatient attendance**

| Specialty | Cons First | Cons Follow-Up | Cons Procedure | Nurse First | Nurse Follow-Up |
|---|---|---|---|---|---|
| Accident & Emergency | 30 | 30 | | | |
| Anaesthetics | 30 | 30 | | 30 | |
| Breast Surgery | 30 | 30 | 30 | | |
| Cardiology | 30 | 15 | 120 | | |
| Cardiothoracic Surgery | 30 | 30 | 30 | | |
| Chemical Pathology | 15 | 15 | | | |
| Clinical Haematology | 30 | 30 | 30 | | |
| Clinical Oncology | 30 | 30 | 30 | | |
| Colorectal Surgery | 15 | 15 | 45 | | |
| Community Obstetrics | | | | 45 | 45 |
| Dermatology | 30 | 15 | 45 | | |
| Diagnostic Imaging | 15 | 15 | 30 | | |
| Dietetics | 30 | 30 | | | |
| Endocrinology | 30 | 30 | | | |
| ENT | 15 | 15 | 30 | | |
| Gastroenterology | 30 | 15 | 60 | | |
| General Medicine | 30 | 10 | 60 | | |
| General Surgery | 15 | 10 | 20 | | |
| Geriatric Medicine | 30 | 15 | 60 | | |
| Genitourinary Medicine | 25 | 20 | | | |
| Gynaecology | 15 | 15 | 30 | | |
| Interventional Radiology | 30 | 30 | | | |
| Neonatology | 30 | 30 | | | |
| Nephrology | 20 | 20 | 20 | | |
| Neurology | 30 | 30 | 45 | | |
| Neurosurgery | 60 | 15 | | | |
| Nursing Advice | 30 | 30 | | 50 | 30 |
| Obstetrics | 15 | 10 | 15 | | |
| Occupational Therapy | | | | | |
| Ophthalmology | 10 | 10 | 30 | | |
| Oral Surgery | 15 | 15 | 30 | | |
| Orthodontics | 20 | 15 | 60 | | |
| Paediatric Assessment Unit | 30 | 30 | | | |
| Paediatric Dermatology | 20 | 20 | | | |
| Paediatric Diabetic Medicine | 20 | 20 | | | |
| Paediatric Endocrinology | 30 | 15 | | | |
| Paediatric Gastroenterology | 30 | 15 | | | |

| Specialty | Cons First | Cons Follow-Up | Cons Procedure | Nurse First | Nurse Follow-Up |
|---|---|---|---|---|---|
| Paediatric Ophthalmology | 20 | 20 | | | |
| Paediatric Respiratory Medicine | 30 | 30 | | | |
| Paediatric Surgery | 15 | 10 | | | |
| Paediatric Urology | 30 | 15 | | | |
| Paediatrics | 30 | 15 | | | |
| Pain Management | 30 | 30 | | | |
| Physiotherapy | | | | | |
| Plastic Surgery | 20 | 20 | 20 | | |
| Pre-Assessment | | | | 30 | 30 |
| Rehabilitation | 30 | 30 | 30 | | |
| Respiratory Medicine | 30 | 15 | 60 | | |
| Rheumatology | 30 | 15 | 30 | | |
| Speech And Language Therapy | | | | | |
| Trauma & Orthopaedics | 10 | 15 | 30 | | |
| Upper Gastrointestinal Surgery | 15 | 10 | 52 | | |
| Urology | 15 | 15 | 30 | | |
| Vascular Surgery | 15 | 15 | 60 | | |
| Ward | | | | | |
| Well Babies | 30 | 30 | | | |

An assumption has been made that each clinic will run for 240 minutes and based on the number of minutes per appointment and the activity volumes, the number of clinics has been calculated by specialty for each site.

The total number of clinics has then been converted into the number of clinics required per week assuming a 42 week year; 42 weeks is used to allow for annual leave and study leave for consultants and nursing staff.

A standard cost is applied to each clinic with a different cost for Nurse led, Consultant led, Occupational Therapy and Physiotherapy.

The standard cost is detailed in the table below.

| Clinic type | Currency | Pay (£) | Non pay (£) |
|---|---|---|---|
| Outpatient | Nurse based cost | £11,434 | £6,390 |
| Outpatient | Consultant based cost | £30,500 | £6,390 |
| Physiotherapy | Cost per visit | £5,525 | |
| Occupational Therapy | Cost per visit | £5,525 | |

**Cost of theatres and procedure rooms**

Admitted patient care activity (elective, non-elective and day case) was taken from the output of the activity allocation for each provider. Analysis was undertaken on MSFT's 2012/13 activity to calculate the proportion of patients that were admitted that required theatre time (conversion ratio) and the average number of patients seen in each theatre session. This is shown in the table below.

| Specialty | Elective Conversion Ratio | Elective theatre patients seen per Session | Day case Conversion Ratio | Day case theatre patients seen per Session | Non-elective theatre patients seen per Session |
|---|---|---|---|---|---|
| Breast Surgery** | 140% | 2.28 | 140% | 2.28 | 1.09 |
| ENT | 97% | 3.23 | 97% | 3.23 | 1.09 |
| General Surgery | 40% | 3.41 | 40% | 3.41 | 1.09 |
| Gynaecology | 44% | 3.14 | 44% | 3.14 | 1.09 |
| Ophthalmology | 69% | 4.04 | 69% | 4.04 | 1.09 |
| Oral Surgery | 39% | 4.06 | 39% | 4.06 | 1.09 |
| Paediatric Surgery | 73% | 1.90 | 73% | 1.90 | 1.09 |
| Trauma & Orthopaedics | 80% | 2.87 | 80% | 2.87 | 1.09 |
| Upper Gastrointestinal Surgery | 78% | 2.23 | 78% | 2.23 | 1.09 |
| Urology | 54% | 4.46 | 54% | 4.46 | 1.09 |
| Vascular Surgery | 40% | 3.41 | 40% | 3.41 | 1.09 |
| Cardiology* | 70% | 5.00 | 70% | 5.00 | |
| Dermatology* | 70% | 5.00 | 70% | 5.00 | |
| Gastroenterology* | 75% | 5.00 | 75% | 5.00 | |

** Cardiology, Dermatology and Gastroenterology are assumed to take place in procedure rooms rather than theatres.*

*** The conversion ratio for Breast Surgery is due to the number of theatre sessions required being greater than the number of patients admitted. This is due to patients often being seen in Theatres on more than one occasion during their stay.*

Using conversion ratios and patients per a session, the number of annual theatre sessions was calculated based on the activity at each site. This was then converted into the number of sessions required per week based on a 42 week year; 42 weeks is used to allow for annual leave and study leave for consultants and nursing staff.

A standard cost was applied to each session required. There are 8 theatre types to recognise the variations in cost for each specialty and there are 2 standard costs for procedure rooms.

The standard cost applied for each is show in the table below.

| Theatre category | Description | Specialties | Pay costs per session | Non-pay costs per session |
|---|---|---|---|---|
| Type 1 | Inpatient general anaesthetic list | Breast, colorectal, upper GI, plastic surgery | £65,260 | £25,000 |
| Type 2 | Inpatient general anaesthetic list | ENT, Gynaecology | £65,260 | £35,000 |
| Type 3 | Inpatient general anaesthetic list | General surgery | £65,260 | £40,000 |
| Type 4 | Inpatient general anaesthetic list | Oral surgery | £65,260 | £45,000 |
| Type 5 | Inpatient general anaesthetic list | Orthopaedics | £65,260 | £85,000 |
| Type 6 | Inpatient general anaesthetic list | Urology | £65,260 | £50,000 |
| Type 7 | Day surgery general anaesthetic list | Ophthalmology | £64,266 | £45,000 |
| Type 8 | Inpatient general anaesthetic list | Paediatric surgery, CEPOD lists | £65,260 | £20,000 |
| Procedure room – cardio | Angio general anaesthetic list | Cardiology | £64,266 | £60,000 |
| Procedure room – regular | Outpatient procedures local anaesthetic list | Dermatology, gastroenterology | £31,471 | £30,000 |

**Cost of critical care**

The cost of critical care wards remains at the current cost of delivery under the LSS and CPT models with the allocation of this cost following the allocation of activity; note that there is no remaining activity or cost at Stafford or Cannock sites for these two models.

Under the LSS and CPT models, activity is allocated based on travel times with no activity allocated to Stafford or Cannock sites.

The current cost of the critical care provision at MSFT is apportioned in the same way as the activity allocation.

For the TSA model, there is an assumption that 4 beds will remain at Stafford with 6 beds provided at other sites. Income and activity have been split based on these proportions. The current cost of the critical care provision at MSFT is apportioned in the same way as the activity allocation

The provision of services under the TSA model will require an anaesthetic rota to be included at Stafford to support the 4 beds to ensure compliance with Royal College guidance and to maintain safety. The annual cost of this rota is estimated to be £260k, and is made up of 40 hours per week of consultant anaesthetic cover and out of hours cover for transfers (8 PAs per week).

**Cost of SCBU**

SCBU remains at cost under all the models with the allocation of cost following the allocation of activity; note that there is no remaining activity or cost at Stafford or Cannock sites for any of the models.

Activity is allocated based on non-elective travel times for Obstetrics as the service will be co-located with this service. Cost is allocated in the same proportion as activity allocation.

**Cost of A&E and PAU**

The full cost of delivering a co-located A&E and PAU service for the full patient cohort has been calculated based on covering a 14/7 (0800 to 2200) rota. The rota includes Medical, Nursing and admin cover and includes allowances and on costs.

Under the TSA model, it is assumed that the PAU patient cohort that is currently not admitted can continue to be seen at Stafford. This is around 65% of the attendances. The remaining activity is split across other providers based on travel time as per the LSS and CPT models.

This cost is then apportioned over the provider sites as per activity allocation. The allocation to sites, other than Stafford, is a reimbursement towards additional activity being seen in existing A&E/PAU departments. The cost allocated to Stafford is sufficient for running a 14/7 service for the activity levels that remain in Stafford.

This method is replicated in the CPT model, however once the costs have been allocated across each provider site, the cost of the A&E activity remaining at Stafford has been replaced with the cost of an UCC. This has been derived from benchmarked costs with other UCC departments across other providers.

**Cost of Diagnostics**

Diagnostics have been included at current cost with specific exclusions:

- Outpatient diagnostic imaging services are excluded as the activity is already included within outpatient costing, therefore removing any duplication of cost.
- Mammography is excluded as it is already included as a pass-through cost.
- The remaining cost of diagnostics is then apportioned across the split of all activity based income.

**Cost of other support functions**

Other support functions include other clinical services required to maintain hospital services such as Stoma care, Dietetics, Continence and Metabolic unit. These services have been maintained at current cost under all three models with specific costs removed where they are services which will no longer be required in the new configuration.

Some savings have been identified relating to non-recurrent spend items and other areas that could be removed or rationalised through synergies. Amongst others, these included Clinical Audit, Practice Development, Capacity Team and Occupational Health.

Remaining costs have then been allocated based on the overall income allocation to each provider site.

**Cost of Clinical Nurse Specialists**

Originally the TSAs allocated the cost of CNS on an activity based approach. Following a review of the CNS provision at Stafford and Cannock under the consultation proposals, the TSAs have recommended that the number provided in the model at Stafford and Cannock be increased. The TSAs have undertaken analysis to determine the CNS requirement at Stafford and Cannock and have included the costs at these sites based on both the current cost of the CNS provision and the anticipated operational model.

**Cost of Junior Doctors**

Junior doctors have been maintained at current cost, with a cost reduction to represent identified synergies, and allocated based on the overall activity based income allocation to each provider site.

**Cost of back office, management and executive team pay**

Under all three models, the cost for the executive team is reduced as it is assumed that a different structure will be provided under the recommendation to dissolve the Trust.

Back office and Management pay costs have been benchmarked for each site against monthly NHS Hospital and Community Health Service (HCHS) Workforce statistics. Consideration was taken of the size of the provider assumed to be receiving the additional activity/income in determining the benchmarks to be used. Peer groups were selected through differentiation between large acute and small acute trusts using the ERIC (Estates Return Information Collection) returns.

HCHS Workforce statistics provide monthly figures for headcount, full time equivalent, role count and turnover of NHS HCHS staff groups working in England.

The ERIC returns are mandatory returns provided to the NHS Information Centre. The outputs contain details on estates and facilities services and provide a categorisation between large acute trusts and small acute trusts.

The additional income at each site has been used to estimate the cost of management and back office functions required to deliver the extra activity.

Where the additional income allocated to a site is below £2.5m, the TSAs assume that the additional back office and management requirements can largely be absorbed into the existing provision. An adjustment has therefore been made to reduce the back office and management cost allocation to those sites.

**Cost of Back office non pay**

Back office non pay costs have been allocated at current cost less identified savings to provider sites based on the overall activity based income.

Further review of the current costs has identified additional savings opportunities of £1.3m through rationalisation and through removal of non-recurrent back office expenditure.

**Cost of CNST, rents and rates, and energy**

CNST costs have been allocated to provider sites based on clinical pay costs (excluding diagnostics).

The current cost of CNST is used with a £325k reduction applied. The assumption used is that over 3 years, there should be an improvement in the CNST level allowing for a 10% discount to be applied.

Existing rents and rates costs relate specifically to the Stafford and Cannock sites and have been allocated to the sites based on current allocation within the ledger.

Energy costs have been apportioned at current costs based on the allocation of admitted patient care activity. This is to recognise the additional costs that will be incurred on other sites to maintain additional ward capacity.

# 8. Savings included within the model

**Corporate / Back Office and other support function synergies**

The back office and corporate expenditure has been costed using the approach detailed above. This approach resulted in a net reduction in cost when compared against MSFT's forecast outturn for 2013/14. Other support functions includes the cost of Clinical Nurse Specialists and Back office non pay includes CNST, PDC, rents and rates, depreciation and energy.

This saving is outlined in the table below.

| | LSS (£m) | CPT (£m) | TSA (£m) |
|---|---|---|---|
| 2013/14 MSFT corporate/back office | 52.0 | 52.0 | 52.0 |
| TSAs' costing for corporate/back office expenditure | 42.3 | 42.0 | 41.5 |
| corporate/back office synergies/savings | 9.7 | 10.0 | 10.5 |

**Clinical synergies**

It is likely that clinical synergies will be delivered once Stafford and Cannock sites are run as part of another health organisation, such as a larger neighbouring acute trust. As part of this work, the TSAs have identified a number of clinical synergies that it is confident can be realised and has attributed a cost saving to each of these. These would include medical rotas and provision of support services. The TSAs have estimated that £2.5m of savings could be released although further analysis will be required during implementation.

**Productivity - Beds**

The TSAs looked at a number of areas for delivering savings through productivity initiatives; length of stay (LoS) was an area identified with the largest opportunity for productivity improvements based on the current performance at MSFT.

The HES (Hospital Episode Statistics) data for 2012/13 was used to derive national average spell length of stay by HRG and POD. The length of stay was capped at 49 days to remove any outliers and those spells with a length of stay of zero were removed from the benchmark.

HES is a data warehouse containing details of all admissions, outpatient appointments and A&E

attendances at NHS hospitals in England. The HES data covers all NHS trusts in England. The admitted patient care data contains episode level length of stay for each admission and this has been aggregated to determine a spell level average length of stay.

National average length of stay benchmarks (derived from the HES data) were applied to HRG and POD and specialty combinations. Where the Trust was currently outperforming the average length of stay for a HRG within a specific specialty, the benchmark was not applied and the existing length of stay was retained. This was done to retain the performance in areas where the Trust is currently exceeding national average.

Spells with a length of stay of zero are those patients that have been admitted but have been discharged the same day. In order to recognise the beds required to serve these patients, a length of stay 0.66 bed days was applied for each admission. This same approach was applied to day case activity.

The tables below show the average length of stay at a specialty level for the national average and MSFT's current performance for both elective and non-elective activity.

## Elective length of stay

| | Current spells | | | Current bed days | | | HRG National method bed days | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| **Specialty** | LOS=0 | LOS>0 | Total | LOS=0 | LOS>0 | Total | ALOS (for LOS>0) | LOS=0 | LOS>0 | Total | Reduction |
| Urology | 159 | 462 | 621 | 105 | 1,107 | 1,212 | 2.1 | 105 | 968 | 1,072 | 139 |
| ENT | 54 | 173 | 227 | 36 | 225 | 261 | 1.3 | 36 | 217 | 252 | 8 |
| Accident & Emergency | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 |
| Breast Surgery | 18 | 170 | 188 | 12 | 377 | 389 | 2.2 | 12 | 371 | 383 | 6 |
| Cardiology | 5 | 49 | 54 | 3 | 216 | 219 | 4.3 | 3 | 210 | 213 | 6 |
| Cardiothoracic Surgery | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 |
| Clinical Haematology | 9 | 69 | 78 | 6 | 461 | 467 | 6.4 | 6 | 441 | 447 | 20 |
| Clinical Oncology | 10 | 10 | 20 | 7 | 22 | 29 | 2.2 | 7 | 22 | 29 | 0 |
| Colorectal Surgery | 37 | 289 | 326 | 24 | 2,105 | 2,129 | 5.8 | 24 | 1,677 | 1,701 | 428 |
| Dermatology | 26 | 0 | 26 | 17 | 0 | 17 | 0.0 | 17 | 0 | 17 | 0 |
| Endocrinology | 29 | 0 | 29 | 19 | 0 | 19 | 0.0 | 19 | 0 | 19 | 0 |
| Gastroenterology | 50 | 200 | 250 | 33 | 843 | 876 | 3.9 | 33 | 783 | 816 | 60 |
| General Medicine | 23 | 5 | 28 | 15 | 37 | 52 | 7.4 | 15 | 37 | 52 | 0 |
| General Surgery | 21 | 158 | 179 | 14 | 767 | 781 | 4.5 | 14 | 709 | 723 | 58 |
| Geriatric Medicine | 4 | 15 | 19 | 3 | 315 | 318 | 20.1 | 3 | 301 | 303 | 14 |
| Gynaecology | 105 | 350 | 455 | 69 | 851 | 920 | 2.4 | 69 | 836 | 906 | 15 |
| Neurology | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 |
| Obstetrics | 0 | 2 | 2 | 0 | 5 | 5 | 2.5 | 0 | 5 | 5 | 0 |
| Ophthalmology | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 |
| Oral Surgery | 3 | 0 | 3 | 2 | 0 | 2 | 0.0 | 2 | 0 | 2 | 0 |
| Paediatric Surgery | 2 | 0 | 2 | 1 | 0 | 1 | 0.0 | 1 | 0 | 1 | 0 |
| Paediatrics | 3 | 12 | 15 | 2 | 31 | 33 | 2.6 | 2 | 31 | 33 | 0 |
| Pain Management | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 |
| Plastic Surgery | 2 | 1 | 3 | 1 | 3 | 4 | 3.0 | 1 | 3 | 4 | 0 |
| Respiratory Medicine | 13 | 16 | 29 | 9 | 178 | 187 | 9.6 | 9 | 154 | 162 | 24 |
| Rheumatology | 21 | 35 | 56 | 14 | 321 | 335 | 7.7 | 14 | 270 | 284 | 51 |
| Trauma & Orthopaedics | 178 | 1,121 | 1,299 | 117 | 4,373 | 4,490 | 3.7 | 117 | 4,183 | 4,300 | 190 |
| Upper Gastrointestinal Surgery | 17 | 123 | 140 | 11 | 250 | 261 | 2.0 | 11 | 248 | 260 | 2 |
| Vascular Surgery | 0 | 6 | 6 | 0 | 32 | 32 | 5.3 | 0 | 32 | 32 | 0 |
| **TOTAL** | 789 | 3,266 | 4,055 | 521 | 12,519 | 13,040 | | 521 | 11,498 | 12,019 | 1,021 |

## Non-elective length of stay

| | Current spells | | | Current bed days | | | HRG method bed days | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Specialty | LOS=0 | LOS>0 | Total | LOS=0 | LOS>0 | Total | ALOS (for LOS>0) | LOS=0 | LOS>0 | Total | Reduction |
| Urology | 8 | 50 | 58 | 5 | 638 | 643 | 8.6 | 5 | 430 | 436 | 208 |
| ENT | 16 | 32 | 48 | 11 | 73 | 84 | 2.2 | 11 | 70 | 80 | 3 |
| Accident & Emergency | 39 | 31 | 70 | 26 | 177 | 203 | 3.1 | 26 | 97 | 123 | 80 |
| Breast Surgery | 7 | 8 | 15 | 5 | 29 | 34 | 3.2 | 5 | 26 | 30 | 3 |
| Cardiology | 53 | 763 | 816 | 35 | 4,347 | 4,382 | 5.0 | 35 | 3,826 | 3,861 | 521 |
| Clinical Haematology | 2 | 60 | 62 | 1 | 708 | 709 | 7.5 | 1 | 450 | 452 | 258 |
| Clinical Oncology | 0 | 1 | 1 | 0 | 1 | 1 | 1.0 | 0 | 1 | 1 | 0 |
| Colorectal Surgery | 142 | 531 | 673 | 94 | 2,733 | 2,827 | 4.4 | 94 | 2,331 | 2,425 | 402 |
| Dermatology | 1 | 2 | 3 | 1 | 6 | 7 | 3.0 | 1 | 6 | 7 | 0 |
| Gastroenterology | 14 | 258 | 272 | 9 | 3,758 | 3,767 | 8.3 | 9 | 2,154 | 2,163 | 1,604 |
| General Medicine | 939 | 5,624 | 6,563 | 620 | 36,885 | 37,505 | 5.9 | 620 | 33,105 | 33,725 | 3,780 |
| General Surgery | 673 | 2,275 | 2,948 | 444 | 10,795 | 11,239 | 4.1 | 444 | 9,235 | 9,680 | 1,560 |
| Geriatric Medicine | 15 | 437 | 452 | 10 | 9,039 | 9,049 | 10.1 | 10 | 4,400 | 4,410 | 4,639 |
| Gynaecology | 214 | 370 | 584 | 141 | 993 | 1,134 | 2.3 | 141 | 869 | 1,011 | 124 |
| Neonatology | 17 | 270 | 287 | 11 | 642 | 653 | 2.3 | 11 | 633 | 644 | 9 |
| Neurology | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 |
| Obstetrics | 2,364 | 2,184 | 4,548 | 1,560 | 5,092 | 6,652 | 2.2 | 1,560 | 4,853 | 6,414 | 239 |
| Ophthalmology | 0 | 0 | 0 | 0 | 0 | 0 | 0.0 | 0 | 0 | 0 | 0 |
| Paediatric Assessment Unit | 4,575 | 0 | 4,575 | 3,020 | 0 | 3,020 | 0.0 | 3,020 | 0 | 3,020 | 0 |
| Paediatric Surgery | 0 | 1 | 1 | 0 | 3 | 3 | 2.6 | 0 | 3 | 3 | 0 |
| Paediatrics | 370 | 1,955 | 2,325 | 244 | 4,192 | 4,436 | 1.9 | 244 | 3,750 | 3,994 | 442 |
| Pain Management | 1 | 1 | 2 | 1 | 22 | 23 | 4.0 | 1 | 4 | 5 | 18 |
| Respiratory Medicine | 34 | 417 | 451 | 22 | 4,510 | 4,532 | 6.8 | 22 | 2,839 | 2,862 | 1,671 |
| Rheumatology | 5 | 11 | 16 | 3 | 167 | 170 | 7.3 | 3 | 80 | 83 | 87 |
| Trauma & Orthopaedics | 267 | 1,182 | 1,449 | 176 | 11,672 | 11,848 | 8.0 | 176 | 9,497 | 9,673 | 2,175 |
| Upper Gastrointestinal Surgery | 8 | 72 | 80 | 5 | 789 | 794 | 5.8 | 5 | 418 | 423 | 371 |
| Vascular Surgery | 0 | 1 | 1 | 0 | 2 | 2 | 2.0 | 0 | 2 | 2 | 0 |
| **TOTAL** | 9,764 | 16,536 | 26,300 | 6,444 | 97,273 | 103,717 | | 6,444 | 79,079 | 85,523 | 18,194 |

In order to calculate the savings generated through bed reduction under each model, MSFT's current productivity was applied before comparing to the outputs using the national average. The savings that were realised in each model are shown in the table below.

| Model | Bed productivity realised (£m) |
|---|---|
| LSS | 0.87 |
| CPT | 0.87 |
| TSA | 2.93 |

The reason for the variation in potential savings through bed productivity relates to the stepped costs of providing wards. For example, an 8 bed requirement on a site will require a 16 bedded ward, the minimum size of a typical ward. If this were to increase to a 16 bed requirement, there would be no additional pay cost change.

Each HRG has a maximum expected length of stay. Where spells exceed this 'Trim point', the Trust are reimbursed on a per day basis. MSFT are currently receiving £2.2m of excess bed day income. As productivity reduces the average length of stay, it is the TSAs' expectation that the level of excess bed day funding required will decrease. The TSAs' estimate this reduction to be c£1m under each of the three models.

| Model | | Stafford | Cannock | UHNS | RWT | WHT | BHFT | SaTH | Good Hope | Total |
|---|---|---|---|---|---|---|---|---|---|---|
| TSA | Total beds required | 156 | 51 | 69 | 56 | 42 | 16 | 4 | 16 | 408 |
| | Beds provided | 172 | 60 | 72 | 65 | 42 | 16 | 0 | 16 | 443* |
| CPT | Total beds required | 55 | 41 | 118 | 64 | 65 | 29 | 8 | 29 | 408 |
| | Beds provided | 56 | 44 | 124 | 74 | 74 | 28 | 16 | 28 | 444 |
| LSS | Total beds required | 26 | 1** | 146 | 84 | 85 | 29 | 8 | 29 | 408 |
| | Beds provided | 28 | 0 | 152 | 96 | 96 | 28 | 16 | 28 | 444 |

** The beds requirement is calculated based on the bed days required and then rounded to the nearest whole number. The distribution of activity under the TSA model has led to a rounding difference of one bed across the model.*

*** Under the LSS model, a small amount of ward based activity has been allocated to Cannock.*

**Workforce synergies/savings**

As part of the standard costing approach a standardised workforce mix has been applied (based on benchmarks and/or other organisations), which has resulted in a net reduction in the overall pay costs when compared to MSFTs current forecast outturn position. This is shown for all three models in the table below. The reduction is calculated prior to the inclusion of length of stay productivity and does not overlap with the savings generated through productivity.

The standard pay expenditure used was consistent across all three models. It is worth remembering that the Contingency Planning Team (CPT) found that the skill mix in MSFT was richer than benchmarks and the cost of staffing relatively higher.

| | LSS (£m) | CPT (£m) | TSA (£m) |
|---|---|---|---|
| 2013/14 MSFT pay expenditure | 89.2 | 89.2 | 89.2 |
| TSAs' costing for pay expenditure | 84.3 | 83.9 | 86.7 |
| Workforce synergies/savings | 4.9 | 5.3 | 2.5 |

**Non-pay synergies/savings**

As part of the standard costing approach a standardised non pay cost has been applied for each of the services being delivered, which has resulted in a net reduction in the overall non pay costs when compared to MSFTs current forecast outturn position. This is shown for all three models in the table below. The standard non pay expenditure used was consistent across all three models. The reduction is calculated prior to the inclusion of length of stay productivity and does not overlap with the savings generated through productivity.

| | LSS (£m) | CPT (£m) | TSA (£m) |
|---|---|---|---|
| 2013/14 MSFT non pay expenditure | 35.0 | 35.0 | 35.0 |
| TSAs' costing for non pay expenditure | 33.4 | 33.7 | 33.4 |
| Non pay synergies | 1.6 | 1.3 | 1.6 |

**Estate rationalisation**

Estate running costs were also reviewed for further rationalisation; MSFT currently spends 6% of turnover on the running costs of the estate this is against a national benchmark of 1%.

The total non-pay costs were identified and it was assumed that running costs could be reduced to 3.5% of turnover during the three year transition process. This reduced the overall estates running cost by £4m per annum. Pay costs were not included within this calculation as they had already been reviewed as part of the back office benchmark.

**2% tactical CIP**

Further cost reductions of 2% per annum have been assumed over and above the productivity already included. This is to meet the annual efficiency requirements driven through annual inflation of costs and deflation of tariff (currently assumed to be 4%-5%).

Although the overall combined cost reductions through synergy and productivity in the TSAs' models are greater than the annual efficiency requirement (4%-5%), it is the belief of the TSAs that a further c.2% can be delivered per annum. This is due to a high proportion of the savings being as a result of synergies and moving productivity to current average rather than keeping pace with ongoing efficiency requirement in the delivery of services. The total additional CIP included is £10.4m in real terms over the three years.

**Inflation**

Inflation of costs and deflation of tariff drives the annual efficiency requirement. To provide a true reflection of the forecast position at the end of 2016/17, inflation of costs and deflation of income has been applied. The assumptions used are those published by Monitor.

# 9. The forecast position at the end of FY17

As described earlier in this Annex, there have been some changes made to the clinical model and therefore also to the financial forecast following the consultation. The bridges below show the movement from the 2013/14 forecast outturn position through to the TSAs' forecast for 2016/17 for each of the three model options – namely, TSA, CPT and LSS. This section also outlines the key movements that have occurred since the previous forecasts presented in the consultation document and the Draft TSA Report.

The key movements are:

**Midwife Led Unit (MLU)** - Following feedback from the consultation, the TSAs have updated their recommendations to include a Midwife Led Unit (MLU) at Stafford under the TSA model. This has led to a marginal improvement in the position as the impact of the new tariff (relating to birth without complications) is recognised.

**Medical Assessment Unit (MAU)** - Following work with other providers, the TSAs recommended that two Medical Assessment Units should be provided at Stafford under the TSA model with the costs allocated to other providers under the LSS and CPT model. This adds a premium cost above the cost of a standard 24 bed ward, which was included in the original forecast.

**Capital assumptions** – Capital assumptions have been further reviewed to determine the annual revenue impact. This has included updating the revenue impact of existing MSFT assets based on the current 13/14 capital plan as well as the future capital outlay required.

**Productivity** - Feedback received on the proposed bed reduction and the availability of new data led to the TSAs reviewing the potential bed reduction. This has reduced the overall opportunity.

**Excess bed days (XBD) adjustment** - Excess Bed Day (XBD) income is the payment received when a patient's length of stay in a hospital bed is longer than expected. As the model has recognised improvements to the length of stay, the excess bed day income is expected to decrease. The TSAs have completed a detailed review of the impact and adjusted in the model accordingly.

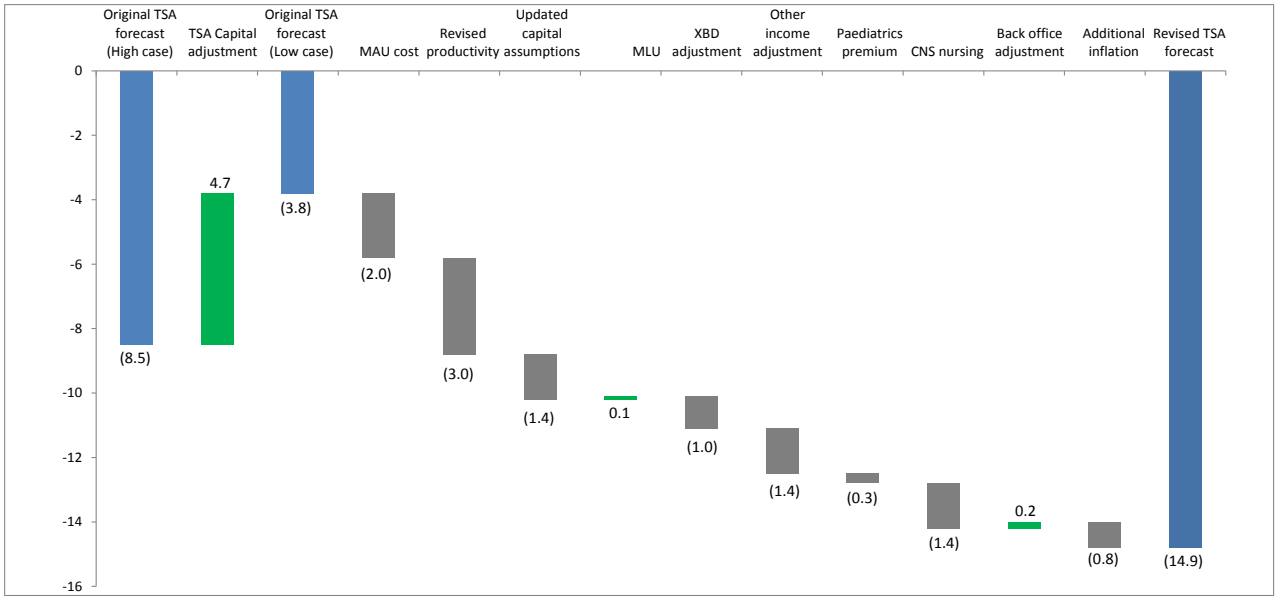
**Other income adjustment –** Other Income has been updated to remove non recurrent income and those income streams that are expected to cease. The allocation of this income has also been reviewed to determine which site it is most likely to relate to in the future model.

**Paediatric premium –** A review of guidance has resulted in the TSAs providing a greater level of nursing cover for Paediatric inpatient services at other provider sites than was previously included in the model.

**Clinical Nurse Specialists (CNS) –** Through work with the providers, the TSAs have now incorporated a greater level of CNS presence on the Stafford and Cannock sites

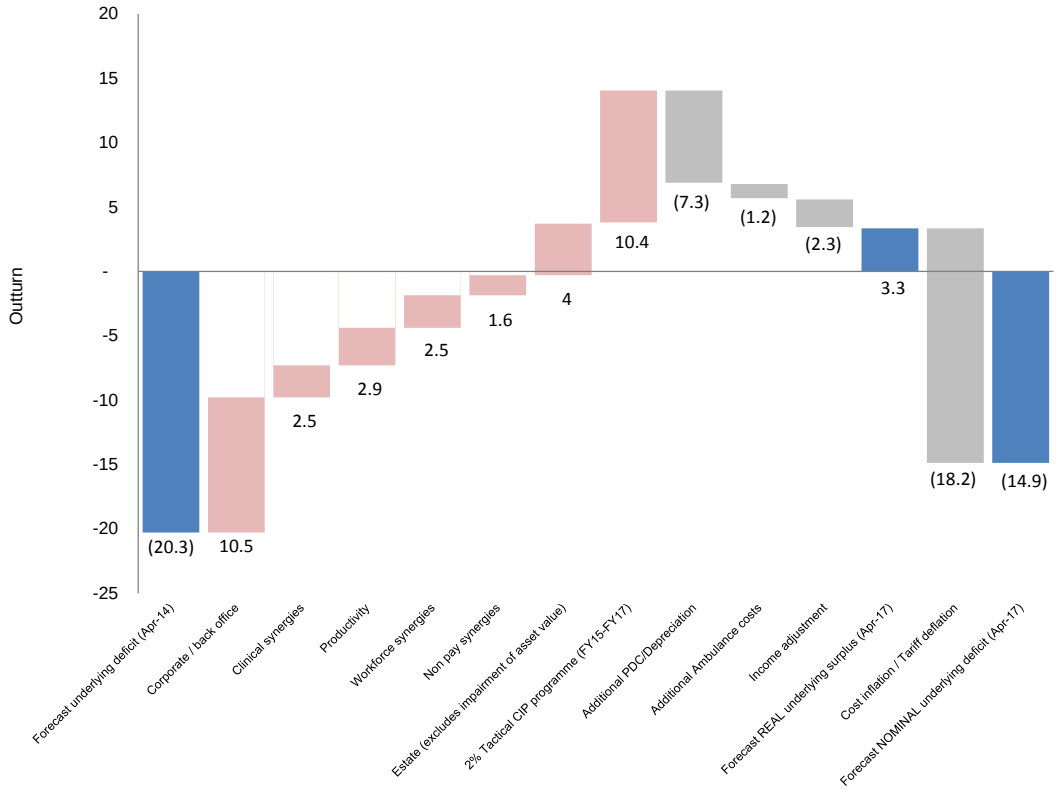
## TSA Model

### Movement from forecast presented in consultation document




*Note: small rounding difference in bridge.*

### TSA model - bridge from 2013/14 to 2016/17 forecast outturn

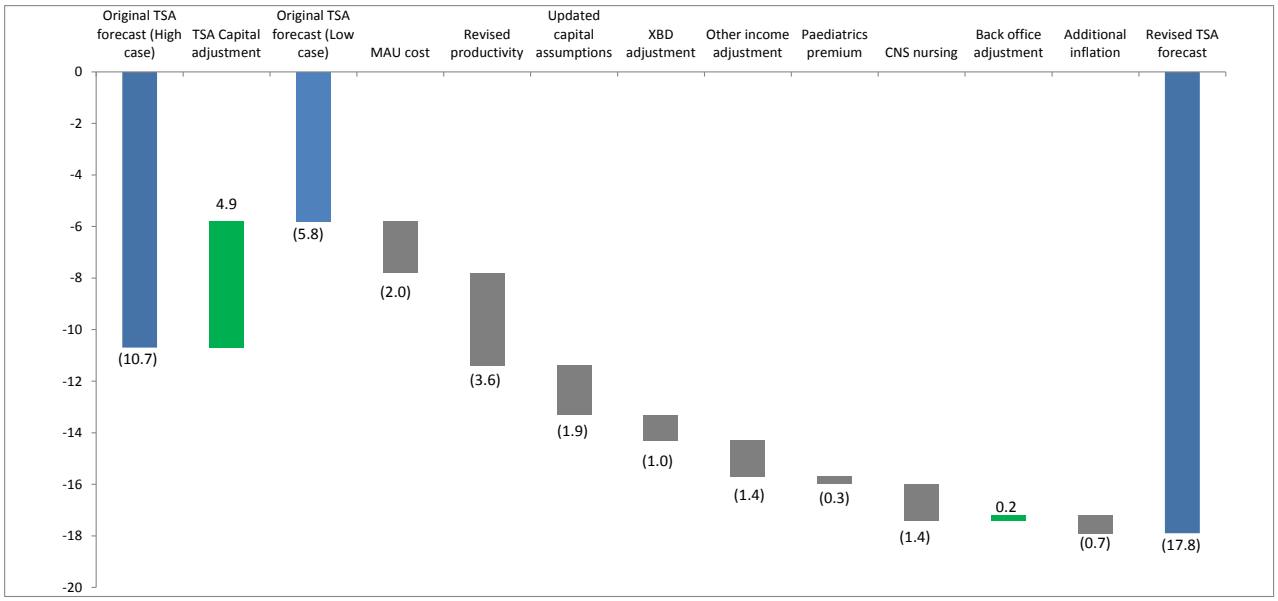


**TSA**

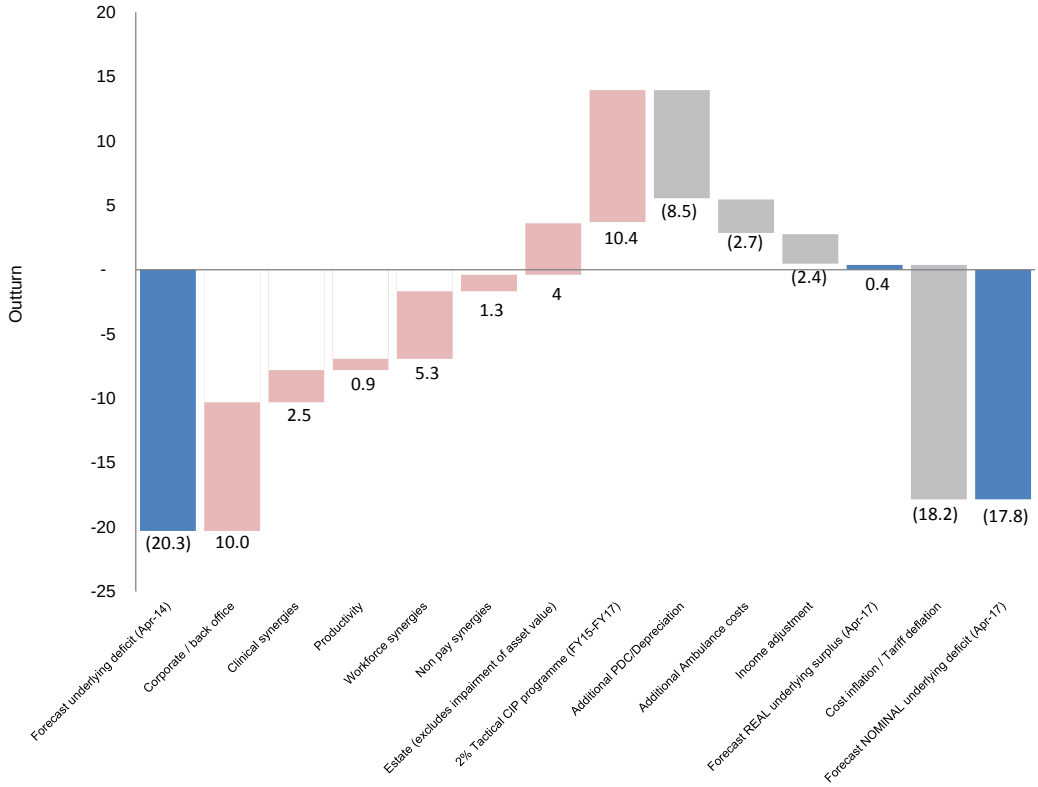
| Element | Movement | Subtotal | Description |
|---|---|---|---|
| Forecast underlying deficit (Mar-14) | | (20.3) | Forecast outturn for 2013/14 |
| Corporate / back office | 10.5 | | Movement in the cost of Corporate/back office functions between the benchmarked total and the original cost |
| Clinical synergies | 2.5 | | Synergy improvements relating to Aseptic lab, Pathology labs and Junior Doctor rota for Paediatrics |
| Productivity | 2.9 | | Cost improvements as a result of length of stay improvements |
| Workforce synergies | 2.5 | | Movement in the cost of workforce between the current model and the standard cost model |
| Non pay synergies | 1.6 | | Movement in the cost of non-pay between the current model and the standard cost model |
| Estate (excludes impairment of asset value) | 4.0 | | Estates non pay improvements based on comparison with other providers |
| 2% Tactical CIP programme (FY15-FY17) | 10.4 | | Additional CIP programme to offset the impact of inflation |
| Additional PDC/Depreciation | (7.3) | | Increase in PDC and depreciation as a result of capital expenditure. Increase in PDC dividend as a result of capital expenditure in 13/14 (£0.4m) and to deliver the clinical model (£6.9m) |
| Additional Ambulance costs | (1.2) | | Additional costs to the ambulance trust as a result of the future configuration |
| Income adjustment | (2.3) | | Loss of Excess Bed Day income as a result of length of stay reductions (£1m) and removal of non-recurrent other income streams (£1.4m). The TSA includes a small increase in income related to the MLU (£0.1m) |
| Forecast REAL underlying surplus (Mar-17) | | 3.3 | Forecast outturn for 2016/17 (In real terms i.e. before applying inflation) |
| Inflation impact | (18.2) | | Impact of applying Monitor's inflation assumptions between 2013/14 and 2016/17 |
| Forecast NOMINAL underlying deficit (Mar-17) | | (14.9) | Forecast outturn for 2016/17 (In nominal terms i.e. after applying inflation) |

## CPT Model

### Movement from forecast presented in consultation document




### CPT model - bridge from 2013/14 to 2016/17 forecast outturn

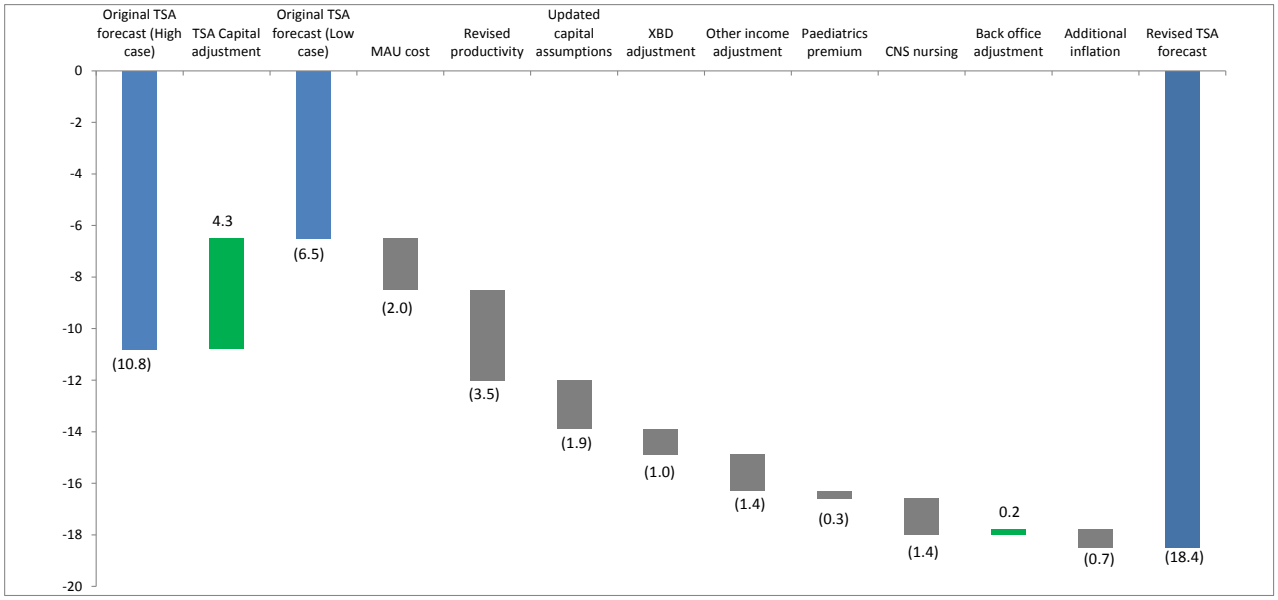


**CPT**

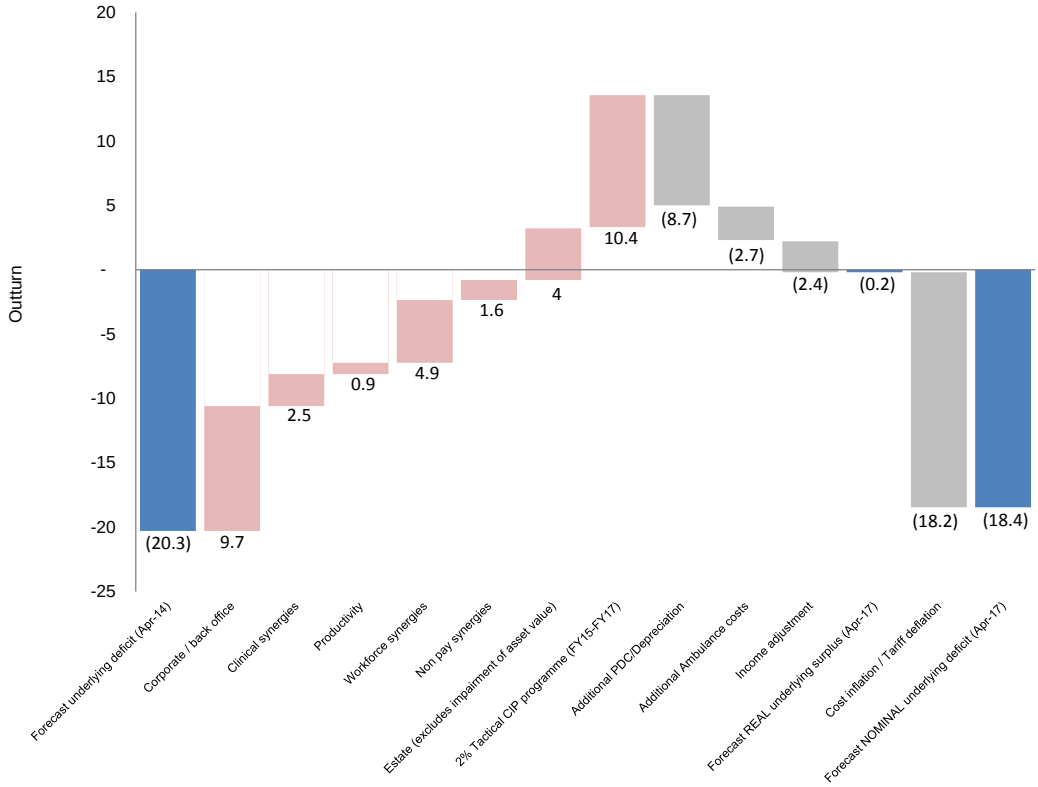
| Element | Movement | Subtotal | Description |
|---|---|---|---|
| Forecast underlying deficit (Mar-14) | | (20.3) | Forecast outturn for 2013/14 |
| Corporate / back office | 10.0 | | Movement in the cost of Corporate/back office functions between the benchmarked total and the original cost |
| Clinical synergies | 2.5 | | Synergy improvements relating to Aseptic lab, Pathology labs and Junior Doctor rota for Paediatrics |
| Productivity | 0.9 | | Cost improvements as a result of length of stay improvements |
| Workforce synergies | 5.3 | | Movement in the cost of workforce between the current model and the standard cost model |
| Non pay synergies | 1.3 | | Movement in the cost of non-pay between the current model and the standard cost model |
| Estate (excludes impairment of asset value) | 4.0 | | Estates non pay improvements based on comparison with other providers |
| 2% Tactical CIP programme (FY15-FY17) | 10.4 | | Additional CIP programme to offset the impact of inflation |
| Additional PDC/Depreciation | (8.5) | | Increase in PDC and depreciation as a result of capital expenditure. Increase in PDC dividend as a result of capital expenditure in 13/14 (£0.4m) and to deliver the clinical model (£8.1m) |
| Additional Ambulance costs | (2.7) | | Additional costs to the ambulance trust as a result of the future configuration |
| Income adjustment | (2.4) | | Loss of Excess Bed Day income as a result of length of stay reductions (£1m) and removal of non-recurrent other income streams (£1.4m) |
| Forecast REAL underlying surplus (Mar-17) | | 0.4 | Forecast outturn for 2016/17 (In real terms i.e. before applying inflation) |
| Inflation impact | (18.2) | | Impact of applying Monitor's inflation assumptions between 2013/14 and 2016/17 |
| Forecast NOMINAL underlying deficit (Mar-17) | | (17.8) | Forecast outturn for 2016/17 (In nominal terms i.e. after applying inflation) |

## LSS model

### Movement from forecast presented in consultation document




### LSS model - bridge from 2013/14 to 2016/17 forecast outturn



**LSS**

| Element | Movement | Subtotal | Description |
|---|---|---|---|
| Forecast underlying deficit (Mar-14) | | (20.3) | Forecast outturn for 2013/14 |
| Corporate / back office | 9.7 | | Movement in the cost of Corporate/back office functions between the benchmarked total and the original cost |
| Clinical synergies | 2.5 | | Synergy improvements relating to Aseptic lab, Pathology labs and Junior Doctor rota for Paediatrics |
| Productivity | 0.9 | | Cost improvements as a result of length of stay improvements |
| Workforce synergies | 4.9 | | Movement in the cost of workforce between the current model and the standard cost model |
| Non pay synergies | 1.6 | | Movement in the cost of non-pay between the current model and the standard cost model |
| Estate (excludes impairment of asset value) | 4.0 | | Estates non pay improvements based on comparison with other providers |
| 2% Tactical CIP programme (FY15-FY17) | 10.4 | | Additional CIP programme to offset the impact of inflation |
| Additional PDC/Depreciation | (8.7) | | Increase in PDC and depreciation as a result of capital expenditure. Increase in PDC dividend as a result of capital expenditure in 13/14 (£0.4m) and to deliver the clinical model (£8.3m) |
| Additional Ambulance costs | (2.7) | | Additional costs to the ambulance trust as a result of the future configuration |
| Income adjustment | (2.4) | | Loss of Excess Bed Day income as a result of length of stay reductions (£1m) and removal of non-recurrent other income streams (£1.4m) |
| Forecast REAL underlying surplus (Mar-17) | | (0.2) | Forecast outturn for 2016/17 (In real terms i.e. before applying inflation) |
| Inflation impact | (18.2) | | Impact of applying Monitor's inflation assumptions between 2013/14 and 2016/17 |
| Forecast NOMINAL underlying deficit (Mar-17) | | (18.4) | Forecast outturn for 2016/17 (In nominal terms i.e. after applying inflation) |

# 10. Reducing the gap further

In the course of our work with various parties prior to, during and after the consultation, the TSAs have identified a number of opportunities to further reduce the gap. These are outside the scope of the TSAs work and as such have not been included in the forecasts:

**Incentives within commissioning**

Incentives included within commissioning agreements can be used to drive improvements in efficiencies.

**Tariff adjustment**

Adjustments to local agreements can be made to recognise areas of underfunding or where the Trust's do not have the critical mass to generate economies of scale. Additional payments in these areas will reduce the deficit

**Whole health economy initiatives**

The TSAs had a specific scope around the activity currently provided by MSFT. Coordinated initiatives across the local health economy could allow commissioners to explore alternative clinical models and identify savings from other areas within the health economy (that sit outside the TSAs' scope).

NHS England, in their letter confirming that the final report meets the objectives of the Trust Special Administration, have suggested a number of mitigating actions. These include:

- Integrated use of community beds
- Refurbishment/regeneration of existing excess capacity
- Revision of the ambulance contract to minimise the impact on patients and costs
- Review of capital plans and alignment to commissioning plans
- Updating the forecast based on future commissioning intentions
- Incentivising providers to deliver maximum value for money

**National allocation**

The allocation of resources to CCGs is determined by an allocation formula. A review of the allocation formula may increase the commissioning budget for the CCGs allowing implementation of the above schemes as well as continuing to fund existing services.

**Capital accounting treatment**

The capital investment in all options has been impaired by 40%. The accounting treatment of this may allow for further changes to the treatment of capital and the resulting PDC and deprecation. NHS England, in their letter confirming that the final report meets the objectives of the Trust Special Administration, have proposed that NHS England, Monitor and the NHS TDA will review the accounting treatment of capital expenditure, particularly once capital plans are further developed.

# 11. Transition costs and funding requirements

The total costs can be broken down between revenue and capital.

| | LSS model | CPT model | TSA model |
|---|---|---|---|
| **Revenue costs** | **£69.4m** | **£68.5m** | **£63.6m** |
| **Capital costs** | **£192.1m** | **£187.5m** | **£156.6m** |
| **Total costs** | **£261.5m** | **£256.0m** | **£220.2m** |

**Revenue costs**

It is assumed that the implementation of the TSAs' recommendations will start in April 2014 and will take no longer than three years. The table below outlines the estimated costs during this transition period under the LSS, CPT and TSA models. For the TSA model, the cost of transition is the lowest at £63.6m for the TSA model and the highest at £69.4m for the LSS model.

The transition costs are estimated based on the level of investment required at other organisations that have recently undergone large reconfigurations.

| | LSS model | CPT model | TSA model |
|---|---|---|---|
| Forecast deficit for three years | £65.3m | £64.3m | £58.7m |
| Less: Depreciation | (£27.2m) | (£27.1m) | (£26.4m) |
| **Forecast deficit for three years (Excluding depreciation)** | **£38.1m** | **£37.2m** | **£32.3m** |
| Transaction costs | £18m | £18m | £18m |
| Redundancy costs | £5.3m | £5.3m | £5.3m |
| Implementation costs (double running costs) | £8m | £8m | £8m |
| **Total transition costs** | **£69.4m** | **£68.5m** | **£63.6m** |

The forecast outturn position for 2014/15 to 2016/17, for each model, is calculated using the assumptions detailed below.

The outturn is reflective of the model forecasts detailed above with cost reduction phased over a three year period. The anticipated cumulative savings are 20% in year one, 40% in year two and 40% in year

three. This is based on total identified recurrent savings of £33.5m for LSS, £33.9m for CPT and £40.0m for the TSA model.

Transaction costs are estimated to be £18m across the transition period, based on an average of £500k per month for the 36 months.

Double running costs of £8m are profiled at £3m in year two and £5m in year three, with zero double running costs anticipated in year one.

Transaction and double running costs are assumed to be the same across all models.

Redundancy costs are estimated at £5.3m assuming that where activity moves to different sites, employees transfer across and, therefore, redundancy costs are consistent under all models.

**Capital costs**

The table below shows the total capital costs across the three models.

**Capital cost requirement**

| TSA Baseline CAPEX | LSS model | CPT model | TSA model |
|---|---|---|---|
| CAPEX (TSA baseline) | £164.9m | £160.4m | £130.2m |
| Maintenance (3 Years) | £27.2m | £27.1m | £26.4m |
| **TOTAL** | **£192.1m** | **£187.5m** | **£156.6m** |

The Capex charge relates to reconfiguration of the estate to deliver each of the clinical models. The maintenance capital expenditure is to maintain the existing assets and is assumed to be equal to depreciation.

**Total funding requirement**

Total funding for the transition will be provided by a combination of financing from the Department of Health and income from NHS England.

**TSA**

The TSA model cost of £220.2m is split across the three transition years as shown in the tables below. The table shows the total revenue and capital costs forecast across the three years.

**TSA model**

| TSA Baseline CAPEX | TSA | | | |
|---|---|---|---|---|
| **Year** | Y1 | Y2 | Y3 | **Total** |
| **Transition costs** | | | | |
| Forecast Deficit (Excluding depreciation) | £17.4m | £11.4m | £3.5m | **£32.3m** |
| Implementation costs | £6.0m | £6.0m | £6.0m | **£18.0m** |
| Redundancy costs | £1.3m | £1.3m | £2.7m | **£5.3m** |
| Double running costs | - | £3.0m | £5.0m | **£8.0m** |
| **Total transition costs** | **£24.7m** | **£21.7m** | **£17.2m** | **£63.6m** |
| CAPEX (TSA baseline) | £45.6m | £65.1m | £19.5m | **£130.2m** |
| Maintenance | £7.2m | £8.6m | £10.6m | **£26.4m** |
| **TOTAL** | **£77.5m** | **£95.4m** | **£47.3m** | **£220.2m** |

CAPEX costs have been split based on 35% spent in year one, 50% in year two and 15% in year three. Note that this split is for illustrative purposes only. Further work in relation to this will need to be completed during the implementation phase.

**CPT**

The CPT model cost, shown below, of £256.0m is split across the three transition years based on the same assumptions. The table shows the total revenue and capital costs forecast across the three years.

**CPT model**

| TSA Baseline CAPEX | CPT | | | |
|---|---|---|---|---|
| **Year** | Y1 | Y2 | Y3 | **Total** |
| **Transition costs** | | | | |
| Forecast Deficit (Excluding depreciation) | £17.8m | £13.5m | £5.9m | **£37.2m** |
| Implementation costs | £6.0m | £6.0m | £6.0m | **£18.0m** |
| Redundancy costs | £1.3m | £1.3m | £2.7m | **£5.3m** |
| Double running costs | - | £3.0m | £5.0m | **£8.0m** |
| **Total transition costs** | **£25.1m** | **£23.8m** | **£19.6m** | **£68.5m** |
| CAPEX (TSA baseline) | £56.1m | £80.2m | £24.1m | **£160.4m** |
| Maintenance | £7.2m | £8.8m | £11.1m | **£27.1m** |
| **TOTAL** | **£88.40** | **£112.8m** | **£54.8m** | **£256.0m** |

CAPEX costs have been split based on 35% spent in year one, 50% in year two and 15% in year three. Note that this split is for illustrative purposes only.

**LSS**

The LSS model cost, shown below, of £261.5m is split across the three transition years as per in the tables below. The table shows the total revenue and capital costs forecast across the three years.

**LSS model**

| TSA Baseline CAPEX | LSS | | | |
|---|---|---|---|---|
| **Year** | Y1 | Y2 | Y3 | **Total** |
| **Transition costs** | | | | |
| Forecast Deficit (Excluding depreciation) | £17.8m | £13.8m | £6.5m | **£38.1m** |
| Implementation costs | £6.0m | £6.0m | £6.0m | **£18.0m** |
| Redundancy costs | £1.3m | £1.3m | £2.7m | **£5.3m** |
| Double running costs | - | £3.0m | £5.0m | **£8.0m** |
| **Total transition costs** | £25.1m | £24.1m | £20.2m | **£69.4m** |
| CAPEX (TSA baseline) | £57.7m | £82.4m | £24.8m | **£164.9m** |
| Maintenance | £7.2m | £8.8m | £11.2m | **£27.2m** |
| **TOTAL** | £90.0m | £115.3m | £56.1m | **£261.5m** |

CAPEX costs have been split based on 35% spent in year one, 50% in year two and 15% in year three. Note that this split is for illustrative purposes only.

**Net Present Value (NPV)**

The table below includes the NPV calculation for each of the models assuming that the Trust meets the annual efficiency requirement each year and therefore maintains the same deficit position throughout. The NPV is calculated based on the forecast outturn of the Trust each year over a 20 year period.

The outturn for the first three years is reflective of the model forecasts detailed above with cost reduction phased over a three year period. The anticipated cumulative savings are 20% in year one, 40% in year two and 40% in year three. This is based on total identified recurrent savings of £33.5m for LSS, £33.9m for CPT and £40.0m for the TSA model.

Year 4 represents the full year effect of the steady state position. It is assumed that from year 4 to year 20, the annual efficiency requirement (offsetting the impact of inflation) is met and the annual capital expenditure is equal to the annual depreciation charge.

Depreciation is excluded as it is not a relevant cash flow and would represent a double count with the capital expenditure. The annual capital investment is included within the calculation.

A discount rate of 3.5% is applied to calculate the Net Present Value of each of the options and all cash flows are assumed to take place at the end of each year.

**TSA NPV**

| TSA Baseline Capex | | | | | |
|---|---|---|---|---|---|
| Year | Outturn less Depn | Capital | Cash flow | Discount Rate | NPV |
| 0 | -13.1 | 0.0 | -13.1 | 1.000 | -13.1 |
| 1 | -17.4 | -52.8 | -70.2 | 0.966 | -67.8 |
| 2 | -11.4 | -73.7 | -85.1 | 0.934 | -79.4 |
| 3 | -3.5 | -30.1 | -33.6 | 0.902 | -30.3 |
| 4 | -3.7 | -11.2 | -14.9 | 0.871 | -13.0 |
| 5 | -3.7 | -11.2 | -14.9 | 0.842 | -12.5 |
| 6 | -3.7 | -11.2 | -14.9 | 0.814 | -12.1 |
| 7 | -3.7 | -11.2 | -14.9 | 0.786 | -11.7 |
| 8 | -3.7 | -11.2 | -14.9 | 0.759 | -11.3 |
| 9 | -3.7 | -11.2 | -14.9 | 0.734 | -10.9 |
| 10 | -3.7 | -11.2 | -14.9 | 0.709 | -10.5 |
| 11 | -3.7 | -11.2 | -14.9 | 0.685 | -10.2 |
| 12 | -3.7 | -11.2 | -14.9 | 0.662 | -9.8 |
| 13 | -3.7 | -11.2 | -14.9 | 0.639 | -9.5 |
| 14 | -3.7 | -11.2 | -14.9 | 0.618 | -9.2 |
| 15 | -3.7 | -11.2 | -14.9 | 0.597 | -8.9 |
| 16 | -3.7 | -11.2 | -14.9 | 0.577 | -8.6 |
| 17 | -3.7 | -11.2 | -14.9 | 0.557 | -8.3 |
| 18 | -3.7 | -11.2 | -14.9 | 0.538 | -8.0 |
| 19 | -3.7 | -11.2 | -14.9 | 0.520 | -7.7 |
| 20 | -3.7 | -11.2 | -14.9 | 0.503 | -7.5 |
| TOTAL | -108.1 | -346.6 | -454.7 | | -360.2 |

**CPT NPV**

| TSA Baseline Capex | | | | | |
|---|---|---|---|---|---|
| Year | Outturn less Depn | Capital | Cash flow | Discount Rate | NPV |
| 0 | -13.1 | 0.0 | -13.1 | 1.000 | -13.1 |
| 1 | -17.8 | -63.4 | -81.2 | 0.966 | -78.4 |
| 2 | -13.5 | -89.0 | -102.5 | 0.934 | -95.7 |
| 3 | -5.9 | -35.1 | -41.0 | 0.902 | -37.0 |
| 4 | -6.1 | -11.8 | -17.8 | 0.871 | -15.5 |
| 5 | -6.1 | -11.8 | -17.8 | 0.842 | -15.0 |
| 6 | -6.1 | -11.8 | -17.8 | 0.814 | -14.5 |
| 7 | -6.1 | -11.8 | -17.8 | 0.786 | -14.0 |
| 8 | -6.1 | -11.8 | -17.8 | 0.759 | -13.5 |
| 9 | -6.1 | -11.8 | -17.8 | 0.734 | -13.1 |
| 10 | -6.1 | -11.8 | -17.8 | 0.709 | -12.6 |
| 11 | -6.1 | -11.8 | -17.8 | 0.685 | -12.2 |
| 12 | -6.1 | -11.8 | -17.8 | 0.662 | -11.8 |
| 13 | -6.1 | -11.8 | -17.8 | 0.639 | -11.4 |
| 14 | -6.1 | -11.8 | -17.8 | 0.618 | -11.0 |
| 15 | -6.1 | -11.8 | -17.8 | 0.597 | -10.6 |
| 16 | -6.1 | -11.8 | -17.8 | 0.577 | -10.3 |
| 17 | -6.1 | -11.8 | -17.8 | 0.557 | -9.9 |
| 18 | -6.1 | -11.8 | -17.8 | 0.538 | -9.6 |
| 19 | -6.1 | -11.8 | -17.8 | 0.520 | -9.3 |
| 20 | -6.1 | -11.8 | -17.8 | 0.503 | -9.0 |
| TOTAL | -153.6 | -387.4 | -541.0 | | -427.7 |

**LSS NPV**

| TSA Baseline Capex | | | | | |
|---|---|---|---|---|---|
| Year | Outturn less Depn | Capital | Cash flow | Discount Rate | NPV |
| 0 | -13.1 | 0.0 | -13.1 | 1.000 | -13.1 |
| 1 | -17.9 | -64.9 | -82.8 | 0.966 | -80.0 |
| 2 | -13.8 | -91.3 | -105.1 | 0.934 | -98.1 |
| 3 | -6.4 | -35.9 | -42.3 | 0.902 | -38.1 |
| 4 | -6.6 | -11.8 | -18.4 | 0.871 | -16.1 |
| 5 | -6.6 | -11.8 | -18.4 | 0.842 | -15.5 |
| 6 | -6.6 | -11.8 | -18.4 | 0.814 | -15.0 |
| 7 | -6.6 | -11.8 | -18.4 | 0.786 | -14.5 |
| 8 | -6.6 | -11.8 | -18.4 | 0.759 | -14.0 |
| 9 | -6.6 | -11.8 | -18.4 | 0.734 | -13.5 |
| 10 | -6.6 | -11.8 | -18.4 | 0.709 | -13.1 |
| 11 | -6.6 | -11.8 | -18.4 | 0.685 | -12.6 |
| 12 | -6.6 | -11.8 | -18.4 | 0.662 | -12.2 |
| 13 | -6.6 | -11.8 | -18.4 | 0.639 | -11.8 |
| 14 | -6.6 | -11.8 | -18.4 | 0.618 | -11.4 |
| 15 | -6.6 | -11.8 | -18.4 | 0.597 | -11.0 |
| 16 | -6.6 | -11.8 | -18.4 | 0.577 | -10.6 |
| 17 | -6.6 | -11.8 | -18.4 | 0.557 | -10.3 |
| 18 | -6.6 | -11.8 | -18.4 | 0.538 | -9.9 |
| 19 | -6.6 | -11.8 | -18.4 | 0.520 | -9.6 |
| 20 | -6.6 | -11.8 | -18.4 | 0.503 | -9.3 |
| TOTAL | -163.9 | -392.8 | -556.7 | | -439.7 |

The NPV of the three models is summarised on the table below

| Scenario | TSA | CPT | LSS |
|---|---|---|---|
| NPV | (£360.2m) | (£427.7m) | (£439.7m) |

# 12. Sensitivities

The financial information presented above is based on the assumption that income in real terms will remain constant in each year and the only movement in nominal terms will be tariff deflation in line with Monitor's 2012/13 planning assumptions. Delivery of all identified cost reductions (through synergies and productivity) has also been assumed within the three year transition period. The TSAs have undertaken analysis to determine the impact of any variation to these assumptions. The impact of each of these on the year three outturn position is presented below. It should be noted that these do not account for changes to the capital programme that may have a further impact on the revenue position.

**Revenue impact on year 3 outturn**

| Sensitivity | TSA Model impact | CPT Model impact | LSS Model impact |
|---|---|---|---|
| Only 75% of the CIPs and Synergies achieved in each year | (£9.5m) | (£9.5m) | (£9.4m) |
| 4% decrease in activity in each of the three years – assumed that only 70% of the marginal cost can be removed | (£6.8m) | (£6.8m) | (£6.8m) |
| 4% increase in activity in each of the three years which the commissioners cannot afford to pay for | (£16.8m) | (£16.8m) | (£16.8m) |
| Additional efficiency requirement (0.5% in each year) | (£2.1m) | (£2.1m) | (£2.1m) |

The table below shows the cash impact by year 3 of the sensitivities outlined above. It has been assumed that the impact of each of these is even throughout the three year period.

| Sensitivity | TSA Model impact | CPT Model impact | LSS Model impact |
|---|---|---|---|
| Only 75% of the CIPs and Synergies achieved in each year | (£16.8m) | (£16.7m) | (£16.5m) |
| 4% decrease in activity in each of the three years – assumed that only 70% of the marginal cost can be removed | (£14.4m) | (£14.5m) | (£14.5m) |
| 4% increase in activity in each of the three years which the commissioners cannot afford to pay for | (£32.4m) | (£32.3m) | (£32.3m) |
| Additional efficiency requirement (0.5% in each year) | (£4.3m) | (£4.3m) | (£4.4m) |

The cash requirement is greater than the revenue requirement under each of these sensitivities as the impact on cash of a year on year deficit is cumulative.

Office of the
Trust Special Administrator
of MSFT

# The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust

## Annex 3.6: TSAs' estates assessment

December 2013

# 1. Introduction and summary

The purpose of this Annex is to provide an overview of the Trust's estate, summarise the different options for delivering the TSA model and provide an outline of the anticipated changes required as a result of the TSAs' final recommendations.

Following analysis of the options and discussions with various stakeholders, the TSAs estimate of capital expenditure for delivering the TSA model is £130.2m, which includes the capital cost of delivering a Midwife Led Unit (MLU) (ca. £1.06m).

Of this, ca. £42.8m is investment in Stafford and Cannock Chase Hospitals, with £23.6m dealing with any backlog maintenance on the areas which are not being reconfigured and the remaining spend being used to improve patient care by enhancing the current reconfiguration and standards.

The level of funding required has been shared and discussed with key stakeholders, with any capital funding being provided as financing from the Department of Health.

As per the letter from NHS England dated 11 December 2013, any requirement for new capital expenditure will need a signed business case that takes full account of commissioning capacity plans, therefore ensuring all new capital spend is genuinely unavoidable.

In addition, NHS England, in this letter, has identified other opportunities which could potentially reduce the requirement for new capital spend, including; the integrated use of North Staffordshire community beds to increase overall system productivity, the refurbishment of spare capacity at Bradwell Hospital and developing Cannock Chase Hospital with the local authority to fully explore the possibility of regenerating the current site. These opportunities will need to be reviewed further during the implementation phase.

It should be noted that other providers are already experiencing increased demand and have alternative views with regards to capital expenditure which have not been included in this report. However, as above, any capital expenditure will be subject to further discussions and approved business cases.

# 2. Overview of the Trust's estate

The Trust's estate consists of two sites, one in Stafford and one in Cannock Chase, with a total land area of 17.99 hectares. The table below summarises the key metrics of the estate.

| Estate | Stafford | Cannock Chase | Total |
|---|---|---|---|
| Gross internal area ($m^2$) | 42,852 | 19,758 | 62,610 |
| Percentage of building to land | 29% | 59% | 35% |
| Site area (ha) | 14.64 | 3.35 | 17.99 |
| Net internal area ($m^2$) | 31,788 | 18,190 | 49,978 |
| Car park spaces | 907 | 337 | 1,244 |
| Net Book Value (£m / Value of the asset as at 31 March 2013 | 61.656 | 31.506 | 93.162 |

The Trust does not have any Private Finance Initiative (PFI) commitments and owns the land and buildings apart from the exceptions noted below.

Stafford Hospital opened in 1983; 72% of the current buildings were built between 1977 and 1984 and 22% between 1985 and 1994. Some parts of the estate are not owned by the Trust including:

- Main reception – leasehold expires 2017
- Medical records area – leasehold expires 2024
- Post Graduate Medical Centre – leasehold expires 2092

Cannock Chase Hospital (on the current site) opened in 1991, however, the majority (96%) of the building is dated between 1985 and 1994. Parts of the estate are leased out to other parties on tenancy at will or short term tenancy agreements. 43% of the space is occupied by MSFT, 37% by third party providers and 20% is not utilised. With regards to the areas leased out, the majority end in September 2014, with the exception of:

- MRI – lease expires 24 March 2022 with Alliance Medical
- BPAS – lease expires 2015

The current amount of estate allocated to clinical administration/hospital administration/facilities management (FM) services/plant is ca. 23% for Stafford and ca. 14% for Cannock Chase.

# 3. Current site configuration

## 4.1 Stafford Hospital

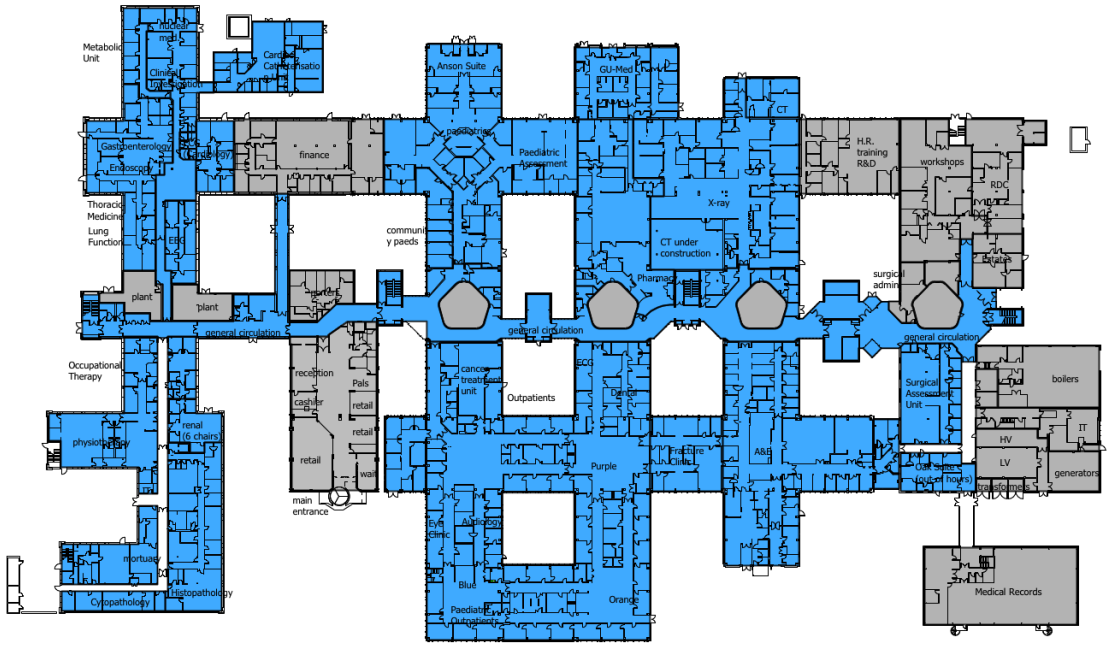
Below are the site plans for Stafford showing the current configuration.

Key

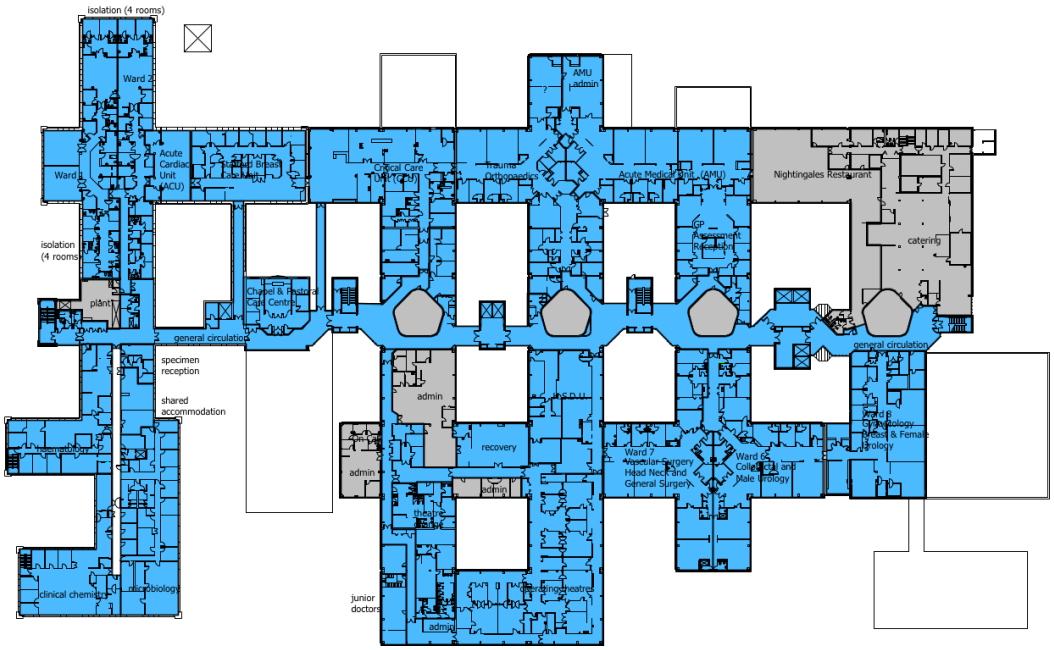
Clinical Accommodation

Non-clinical or vacant accommodation incl. facilities & admin

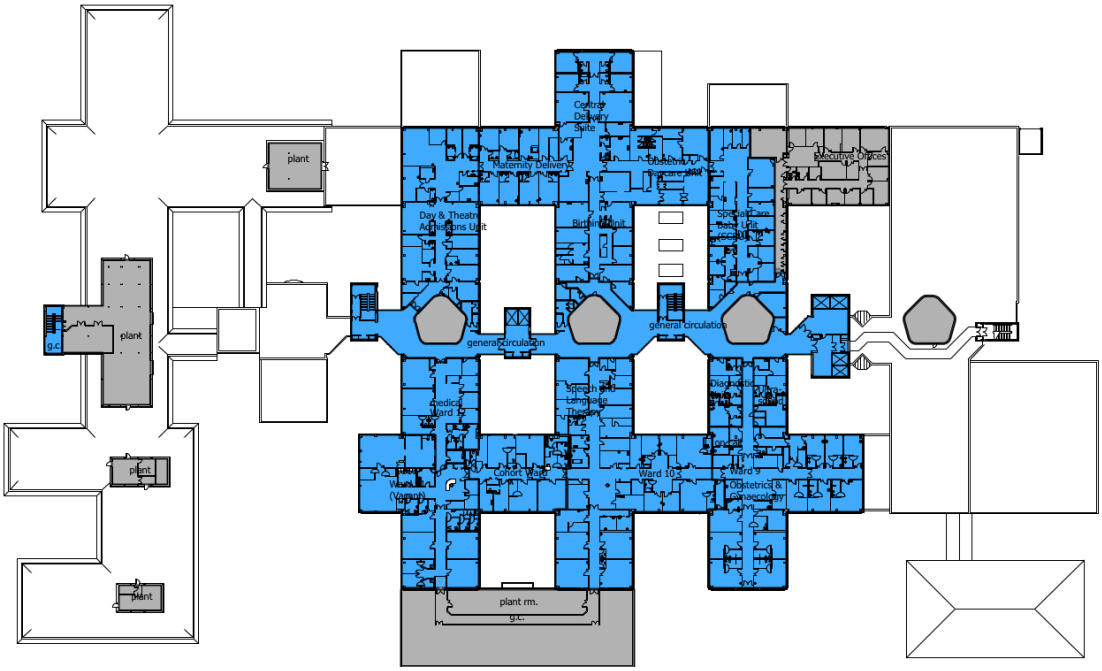
**Level one (ground floor)**



**Level two**




**Level three**




At Stafford there are fifteen ward-based areas, including paediatrics and maternity. One of these wards remains empty and is currently being used as spare clinical space to facilitate general improvements to the others. There are seven theatres in use at Stafford.

### 4.2 Cannock Chase Hospital

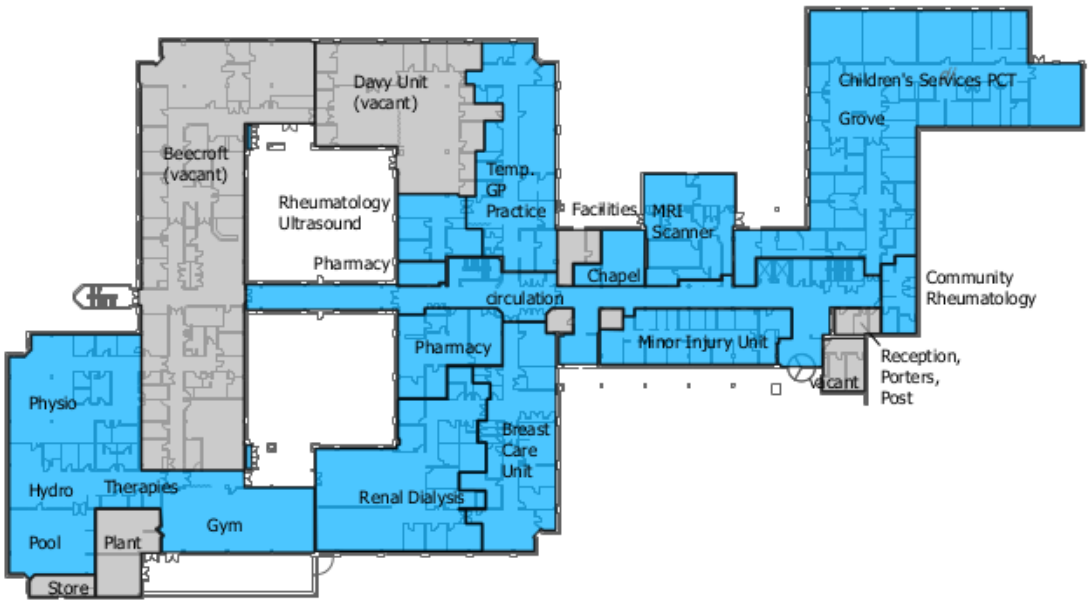
Below are the site plans for Cannock Chase showing the current configuration.

Key

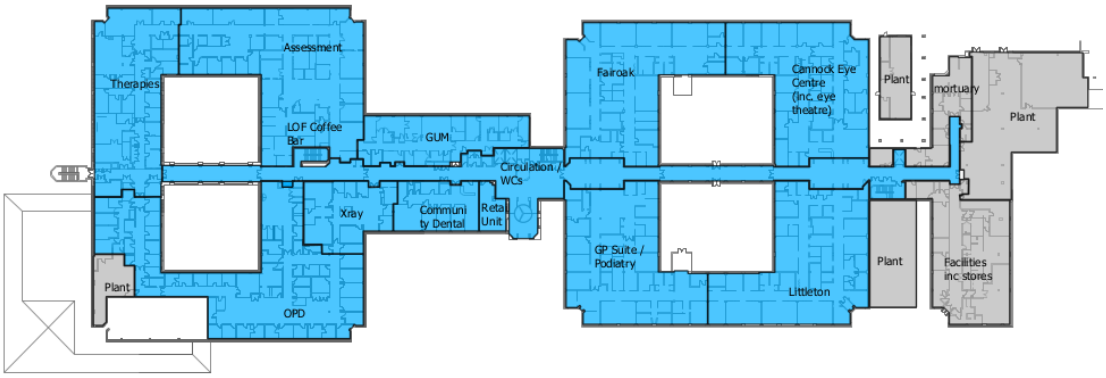
Clinical Accommodation

Non-clinical or vacant accommodation incl. facilities & admin

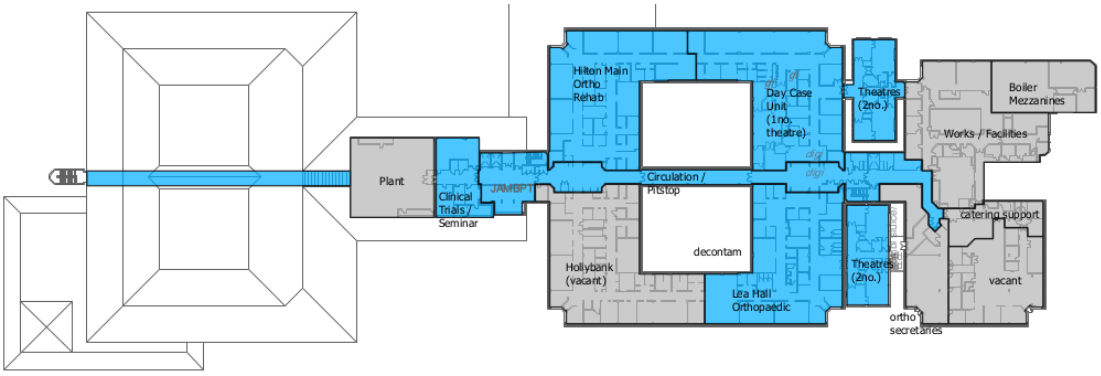
**Level one**




**Level two**



**Level three**




Cannock Chase has nine available wards, of which only three are used: two wards run by the Trust and a ward run in collaboration with the local Community Trust (Staffordshire and Stoke-on-Trent Partnership NHS Trust). There are five theatres in use at Cannock Chase.

# 4. Current condition of the estate

The Trust has maintained and upgraded the estate where necessary, however, there has been relatively low investment which the Trust has tried to rectify in recent years.

The table below illustrates the Trust's capital expenditure over the last 4 years and that planned for the current year.

| | 2009/10 £'000 | 2010/11 £'000 | 2011/12 £'000 | 2012/13 £'000 | 2013/14 £'000 |
|---|---|---|---|---|---|
| Projects | 847 | 917 | 666 | 4,681 | 2,991 |
| Medical and surgical equipment | 1,296 | 879 | 1,522 | 3,744 | 3,987 |
| Plant replacement | 545 | 790 | 595 | 1,266 | 1,510 |
| Environmental | 395 | 248 | 179 | | |
| I M & T | 292 | 887 | 1,398 | 1,010 | 1,088 |
| DDA and fire | 51 | 63 | 94 | | |
| EPR | - | 147 | 361 | | 4,501 |
| Contingency | | | | | 289 |
| Carry forward | | | | 1,206 | 1,664 |
| Total | 3,425 | 3,932 | 4,815 | 11,907 | 16,029 |

Given the relatively low investment in the past, a comprehensive condition appraisal (six facet survey) of the estate was completed by NIFES Consulting Group dated February 2012. The appraisal was undertaken in accordance with NHS 'Estatecode' and associated guidance and identified an estimate of the costs of bringing the estate up to condition B, meaning the estate is sound, operationally safe and exhibits only minor deterioration and complies with the relevant guidance and statutory requirements.

Five out of the six facets are attributed to costs to remedy any identified failings/shortfalls.

The NIFES report generated a total works backlog cost for the five facets of

- £36.0m for Stafford
- £8.3m for Cannock Chase

In November/December 2012 the Trust also commissioned an estates review conducted by an external party – Strategic Healthcare Planning (SHP). SHP has been working with the TSAs to review the estate requirements as a part of any recommendation.

As a part of this estates review, The Trust identified the need for investment in both sites to improve patient pathways, clinical efficiencies and estate utilisation. It identified the need to invest potentially:

- £18.0m – £34.0m at Stafford
- £9.0m – £19.0m at Cannock Chase

These figures included some areas covered by the facet survey but not all.

As a part of the work undertaken by SHP over the past couple of months, they revisited the NIFES report to ascertain the backlog maintenance cost to bring it up to date by:

- Excluding any backlog costs that have been covered by work undertaken by MSFT to date;
- Taking into account inflation since 2011 to the projected year of expenditure;
- Including contractors'/project costs/fees; and
- Including VAT where applicable.

This increased the five facet costs to;

- £56.3m at Stafford
- £13.5m at Cannock Chase

# 5. Position at the time of issuing the draft report

In July 2013, at the time of issuing the draft report, three different scenarios had been considered:

- Location Specific Services (LSS) model
- Contingency Planning Team (CPT) model
- Draft TSA model.

The table below summarises the proposed configuration, including repatriation estimates received from the providers in July 2013, for the Stafford and Cannock Chase sites under each of these options.

| | Stafford | Cannock Chase |
|---|---|---|
| LSS model | • To be determined – lease?<br>• If no significant reconfiguration, ca. 40% occupied | • New build<br>• ca. 40% occupied if remain in Cannock Chase building |
| CPT model | • To be determined – lease?<br>• If no significant reconfiguration, ca. 43% occupied | • New build<br>• ca. 44% occupied if remain in Cannock Chase building |
| Draft TSA model | • Retain building<br>• If no significant reconfiguration, ca. 60% occupied<br>• Repatriate patients to Stafford and reconfigure site up to 100% occupancy | • Retain building<br>• ca. 50% occupied if no significant reconfiguration<br>• Repatriate patients to Cannock Chase to ensure at least 85% occupied |

Under the CPT and LSS options, there was less incentive for providers to take on the entire sites at Stafford and Cannock Chase given the amount of space being utilised to provide the services. The Draft TSA model utilised more of the existing sites.

The providers had calculated the capital costs required to deliver each of the three draft models and, under all scenarios, given the backlog of maintenance identified in the NIFES report, the providers' proposals have identified significant capital expenditure at Stafford, Cannock Chase and at their own sites to take on the additional activity which will flow to them.

The range of costs from providers at the time of issuing the draft report is outlined in the table below.

| | LSS model | CPT model | Draft TSA model |
|---|---|---|---|
| Stafford | £48.9m | £64.7m | £69.0m |
| Cannock Chase | £3.5m to £19.2m | £6.0m to £22.2m | £28.6m |
| Other providers | £165.4m to £172.0m | £148.2m to £157.4m | £99.8m |
| Total | £217.8m to £240.1m | £218.9m to £244.3m | £197.4m |

As a part of the work undertaken by SHP, on behalf of the TSAs, SHP reviewed the activity remaining at Stafford and Cannock Chase Hospitals under each of the models and evaluated a minimum cost requirement should limited reconfiguration be required. This cost is outlined in the table below.

| | LSS model | CPT model | Draft TSA model |
|---|---|---|---|
| Stafford | £18.2m | £21.4m | £24.1m |
| Cannock Chase | £2.0m | £6.0m | £8.0m |
| Total | £20.2m | £27.4m | £32.1m |

The figures included in the draft report were the TSA baseline numbers and the provider responses, as detailed below.

**TSA baseline**

| | LSS model | CPT model | Draft TSA model |
|---|---|---|---|
| Stafford | £18.2m | £21.4m | £24.1m |
| Cannock Chase | £2.0m | £6.0m | £8.0m |
| Other providers | £137.6m | £125.9m | £79.9m |
| Total | £157.8m | £153.3m | £112.0m |

**Provider responses**

| | LSS model | CPT model | Draft TSA model |
|---|---|---|---|
| Stafford | £48.9m | £64.7m | £69.0m |
| Cannock Chase | £19.2m | £22.2m | £28.6m |
| Other providers | £172.0m | £157.4m | £99.8m |
| Total | £240.1m | £244.3m | £197.4m |
| Additional cost | £82.3m | £91.0m | £85.4m |

# 6. Updated position

Following on from the TSAs' draft report, the TSAs requested SHP undertake some further analysis of the draft TSA model to identify and categorise the potential costs to enable further clarity on the differences and to help agree the level of capital spend required. This included updating the TSA capital expenditure estimates following ongoing discussions with providers and breaking these down into the following categories.

A. Updated assessment of the backlog maintenance costs (five facet) allowing for life cycle costs for years 1-5 from the original study and excluding any functional/quality costs due to the different requirements for remodelling/utilisation and costs associated with areas occupied by tenants.

B. Refurbishment/reconfiguration costs associated with providing the TSA model, using the current ward/bed structure where possible (TSA proposed approach).

C. Additional costs required to deliver the TSA model if bed facilities were refurbished to provide enhanced quality standards associated with patient privacy and dignity.

D. Additional costs required by the providers associated with delivering additional services that the provider Trusts may look to move to Stafford/Cannock Chase.

The table below provides a summary of the potential total capital expenditure under each of the above categories (including the MLU).

| | Five facet* | A | B | C | D |
|---|---|---|---|---|---|
| Stafford | £56.3m | £21.7m | £35.8m | £48.9m | £55.2m |
| Cannock Chase | £13.5m | £4.8m | £7.0m | £11.4m | £30.5m |
| Other provider sites | | | £83.6m | £83.6m | £74.6m |
| IT costs | | | £3.8m | £3.8m | £3.8m |
| Total | £69.8m | | £130.2m | £147.7m | £164.1m |

* The five facet survey figures relates to the entire site – these have been reduced when looking at the different categories due to vacant space, areas being reconfigured, functional/quality costs and any costs relating to year 6 onwards.

Following review of the proposed capital spend and discussions with key stakeholders, it was determined that the TSAs proposed approach would incorporate an element of reconfiguration to optimise Stafford and Cannock Chase but use the current ward structure where possible (category B above) - a total capital estimate of £130.2m.

As the five facet survey estimate (£69.8m) would need to be spent on the Stafford and Cannock Chase sites in any event, the incremental cost of delivering the TSA model is £60.4m which is a significant further investment in the local community to improve patient care.

Further information on category A, C and D is included in the appendix to this annex.

**Midwife Led Unit (MLU)**

The public consultation in relation to the proposed plans for Stafford Hospital has highlighted significant concern about the loss of maternity services. Therefore the TSAs asked SHP to consider how an MLU could be accommodated within the retained hospital at Stafford to support approximately 400 births per annum.

To support 400 births, SHP have advised that 3-4 delivery rooms would be required on the premise that on average one women would arrive in labour per day and potentially remain up to three days. This unit could be located within the current Maternity unit on level two which would require re-modelling, as the service model could not be supported within the existing accommodation.

The additional cost of delivering this unit is ca. £1.06m.

**Other mitigations**

As per the letter from NHS England dated 11 December 2013, any requirement for new capital expenditure will need signed business case that takes full account of commissioning capacity plans, therefore ensuring all new capital spend is genuinely unavoidable. This process will be undertaken during the implementation phase.

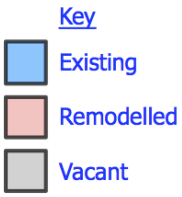
In addition, NHS England, in this letter, have identified other opportunities which could potentially reduce the requirement for new capital spend, including; the integrated use of North Staffordshire community beds to increase overall system productivity, the refurbishment of spare capacity at Bradwell Hospital and developing Cannock Chase Hospital with the local authority to fully explore the possibility of regenerating the current site. These opportunities will need to be reviewed further during the implementation phase, recognising that these actions will need extensive further engagement.

**Category B – TSA model – further information**

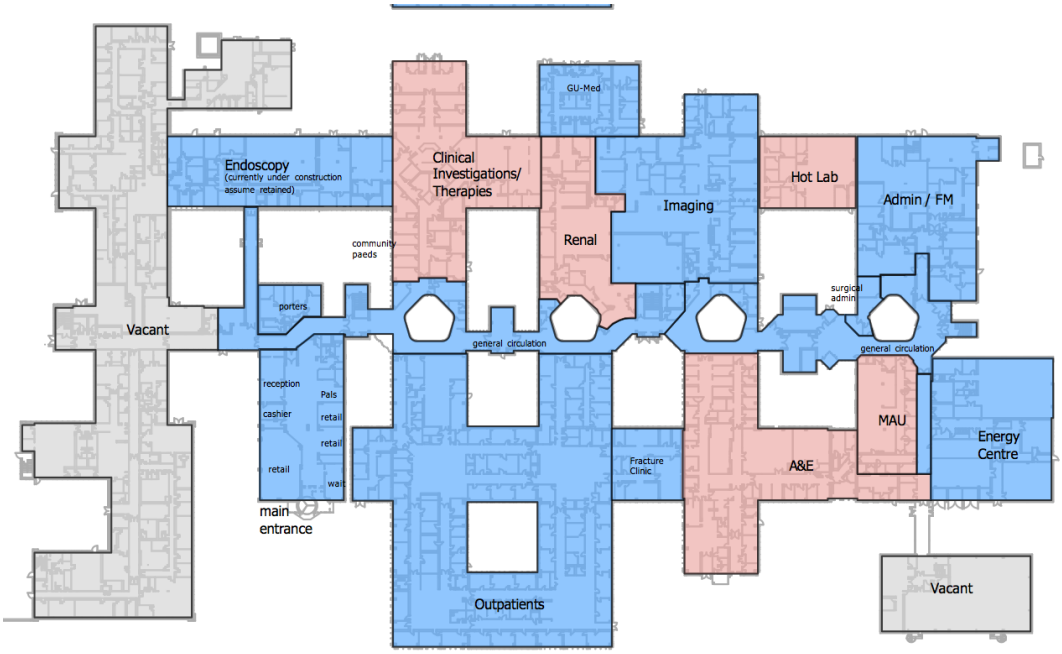
The approach taken in calculating the estimated capital expenditure cost is that, where possible, the existing facilities will be retained in their current configuration, with no modification to improve standards (with the exception of any backlog maintenance), unless relocation of the department is required to achieve site rationalisation.

Under this model, ca. 37.5% of Stafford and ca. 28% of Cannock Chase would remain unoccupied. The diagrams below outline the proposed configuration.

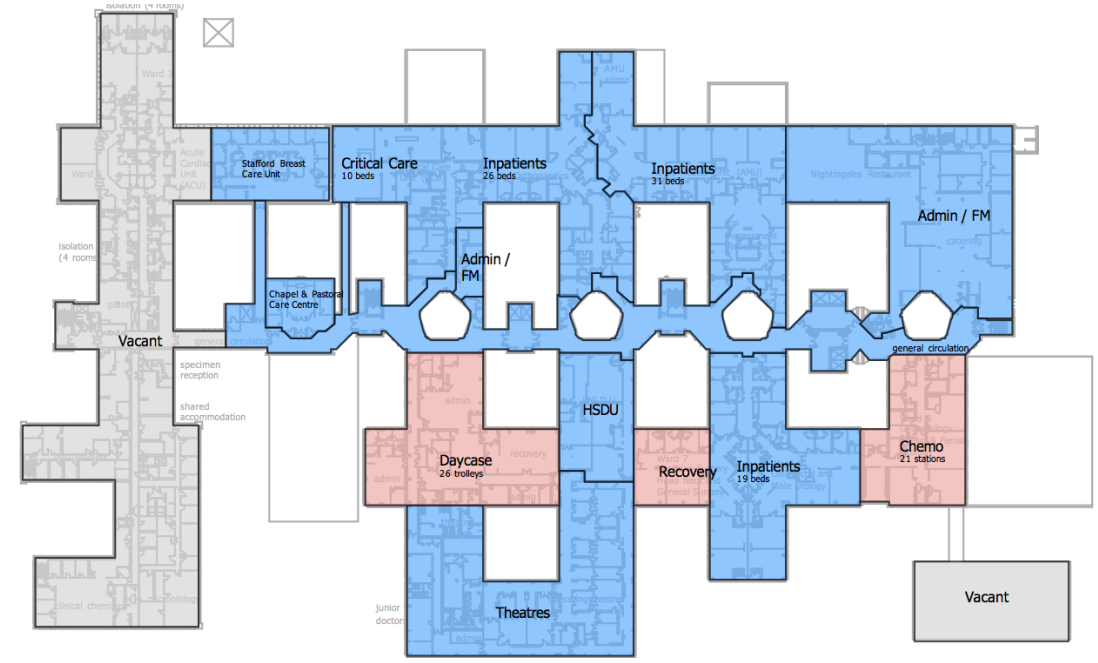
**Stafford Hospital**



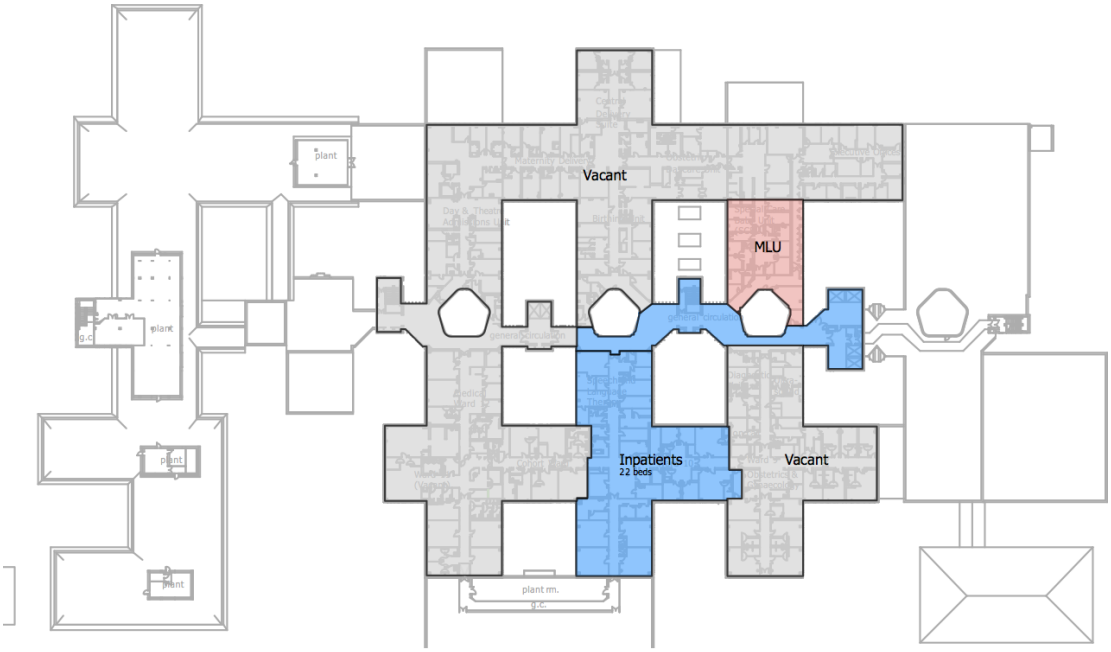

**Level one**



**Level two**

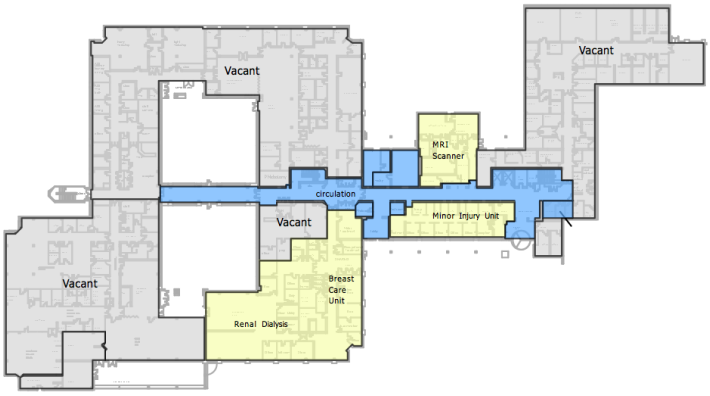



**Level three**



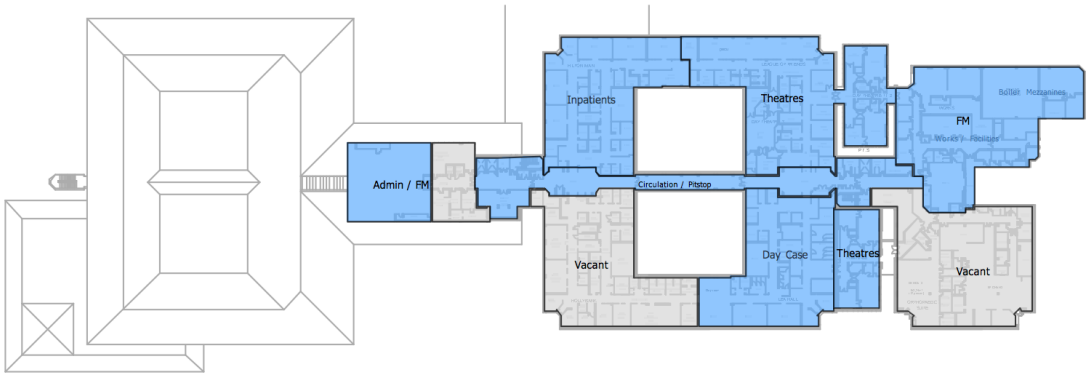
**Cannock Chase Hospital**


**Level one**




**Level two**

**Level three**


Inpatients
Theatres
FM
Admin / FM
Circulation / Pitstop
Vacant
Day Case
Theatres
Vacant

# 7. Appendix

**Category A - Backlog maintenance**

The backlog maintenance costs are lower than the updated estimated five facet costs as they exclude any costs from April 2017 onwards; costs associated with accommodation at Cannock Chase not occupied by MSFT; and functional suitability/quality costs for areas on both sites that will be left vacant or are used by other tenants.

**Category C – Draft TSA model with enhanced standards**

The estimated capital expenditure for this category has been assessed to determine how improved standards for wards, in line with current space and facility guidelines, could be achieved for the TSA model required beds.

Specifically, it has been assumed:

- A minimum of 50% single rooms;
- Multi bedrooms with no more than 4 beds;
- Ensuite sanitary accommodation; and
- HBN space standards.

This means that the vacant areas are reduced to ca. 32.7% for Stafford and remain at ca. 28% for Cannock Chase.

**Stafford Hospital**

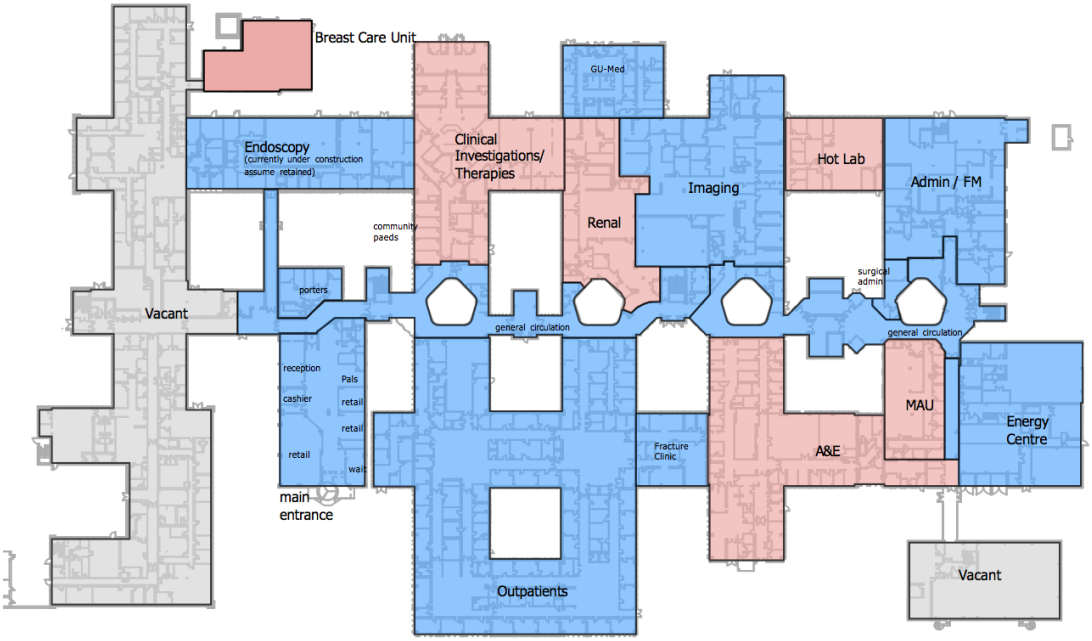
Key

Existing

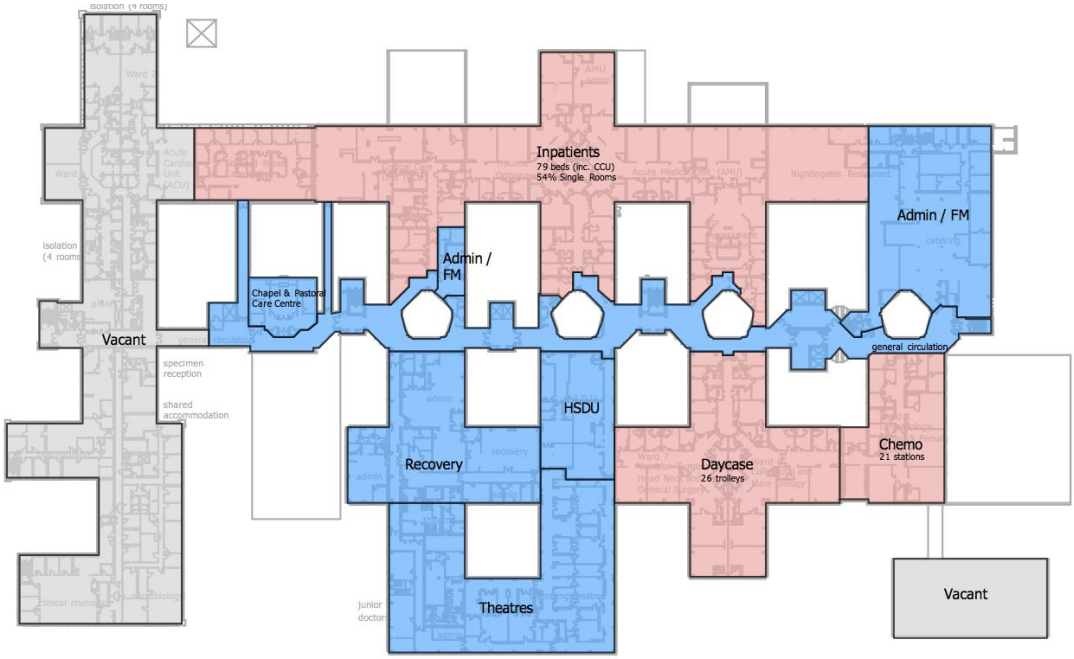
Remodelled

Vacant

**Level one**



**Level two**

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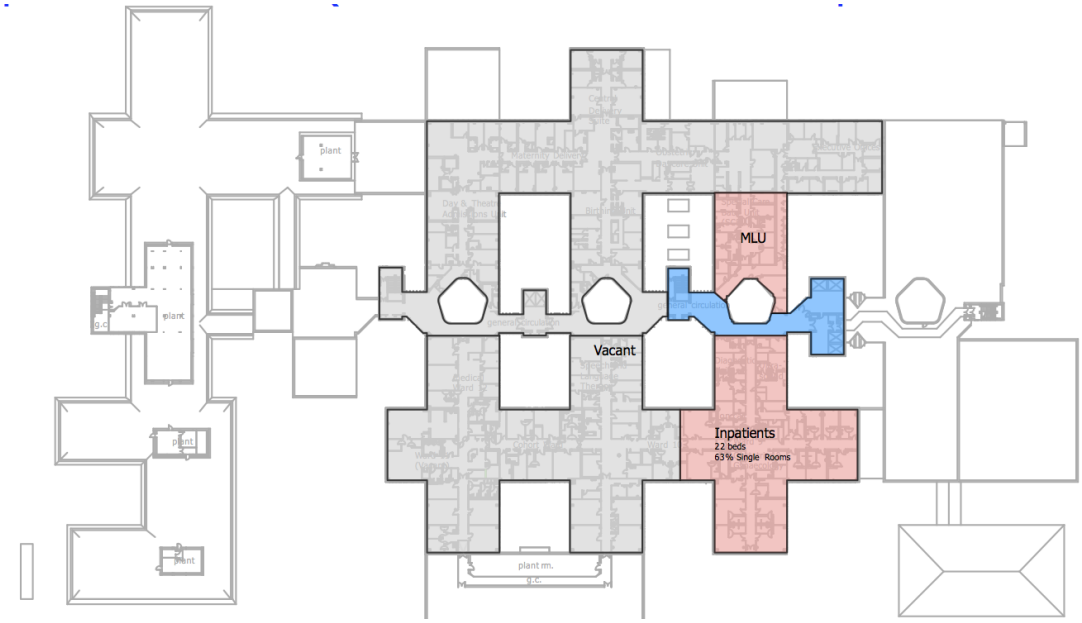
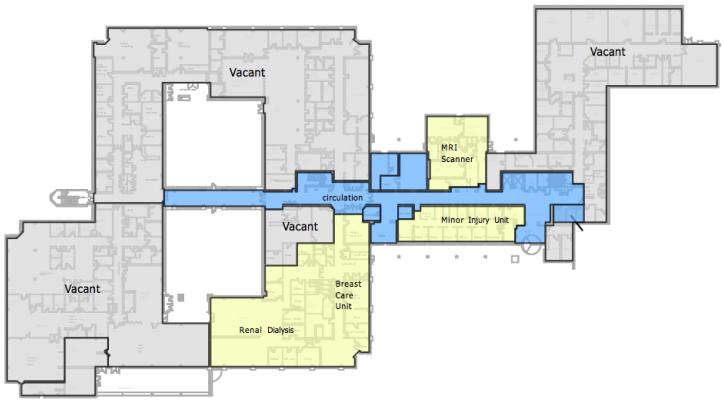


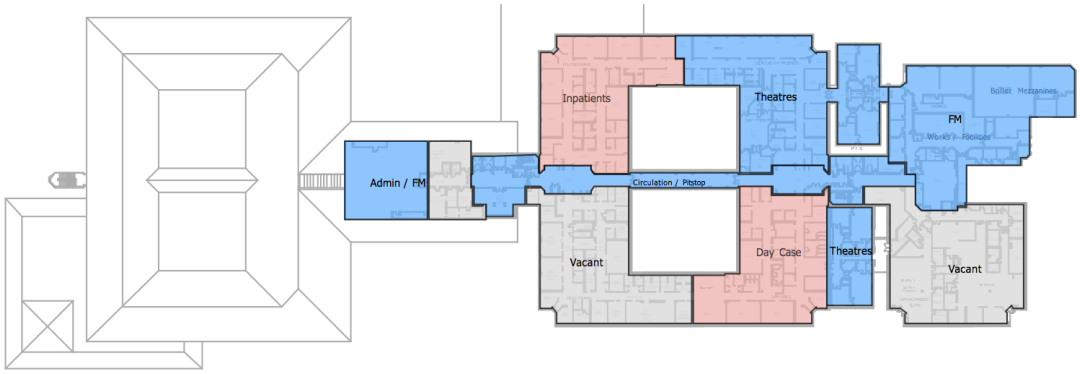
**Cannock Chase Hospital**


**Level one**




**Level two**

**Level three**


Inpatients
Theatres
FM
Admin / FM
Circulation / Pitstop
Vacant
Day Case
Theatres
Vacant

**Category D – Provider enhanced service plans**

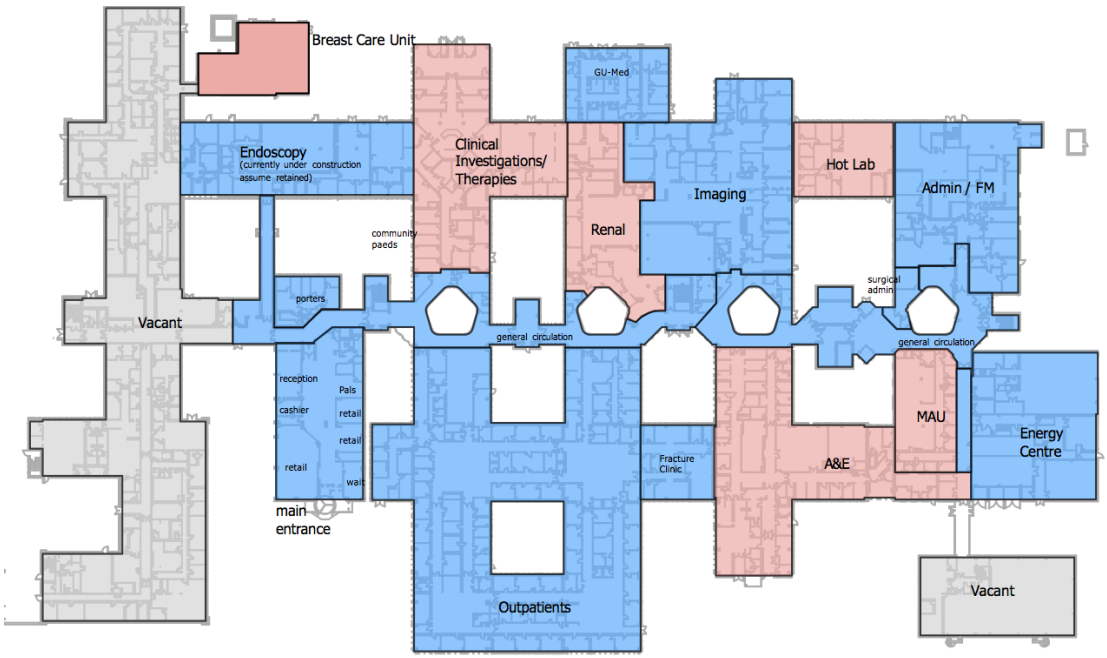
The providers have independently assessed how they would anticipate delivery of clinical services at each site which differs to the proposed TSA model, which looks specifically at MSFT activity only.

Under the providers responses, they have looked to utilise each of the sites more fully and, therefore, SHP have calculated an estimate of the capital costs required using the same bed assumptions.

This means that the vacant areas are reduced to ca. 26% for Stafford and ca. 11% for Cannock Chase.

**Stafford Hospital**


**Level one**



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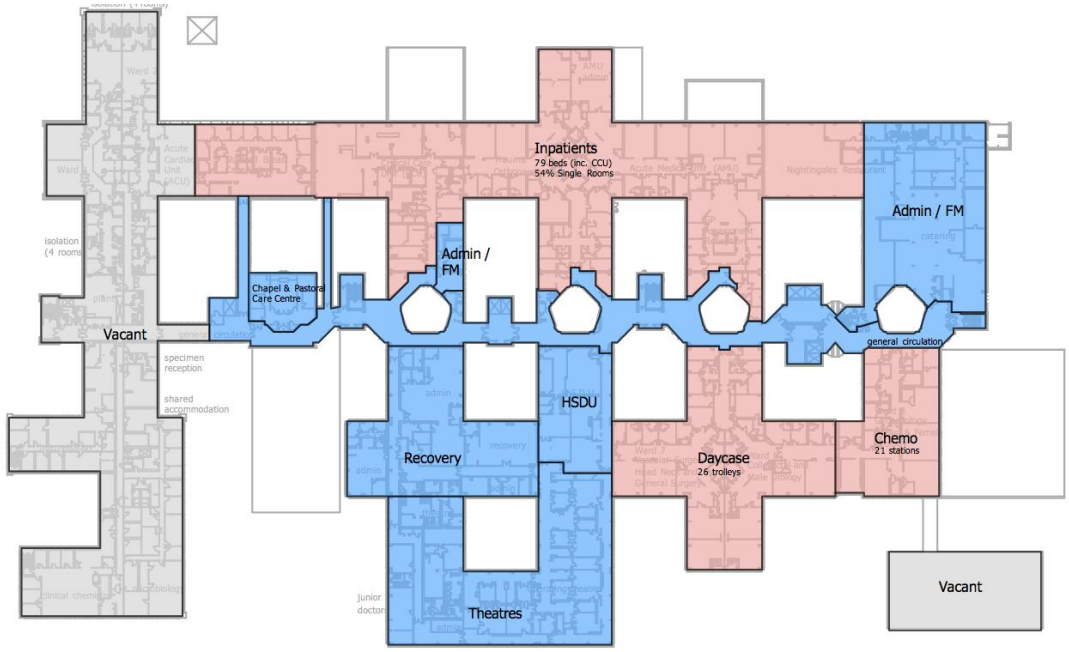


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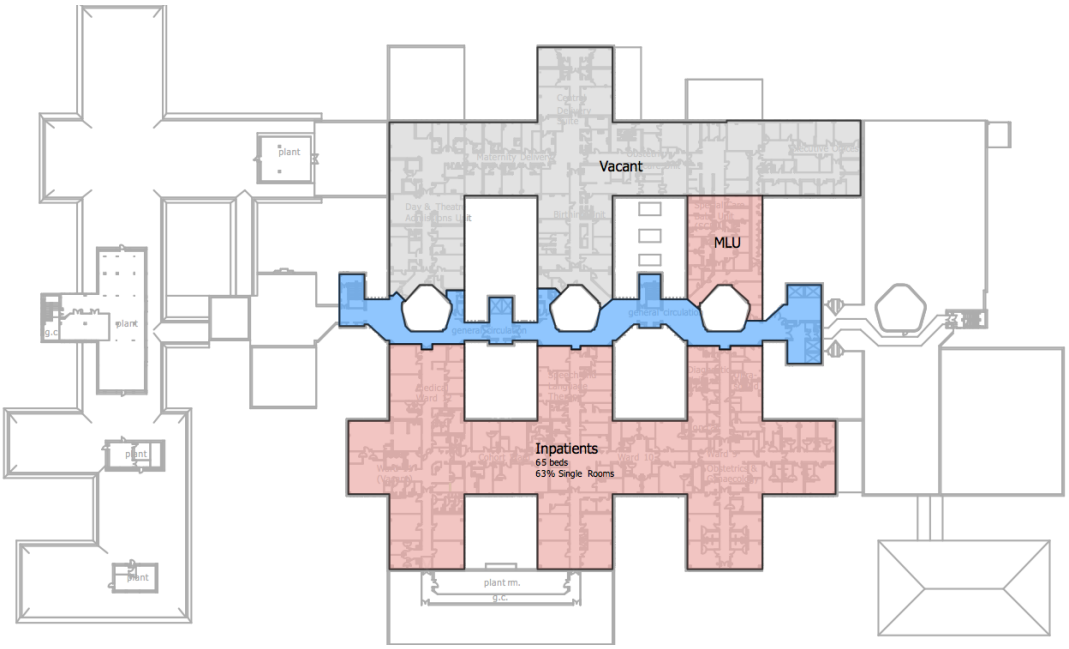
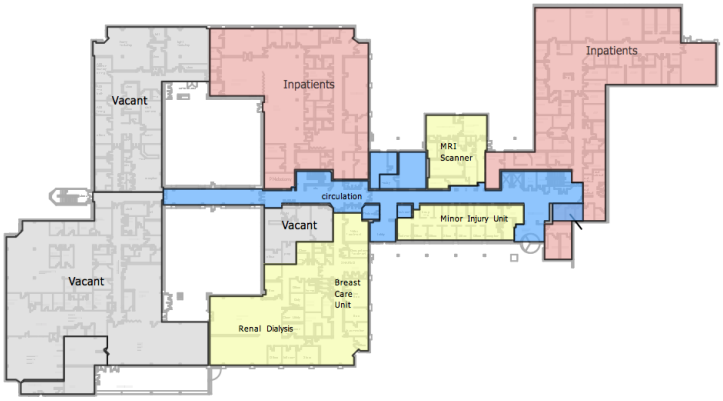


## Cannock Chase Hospital

Key

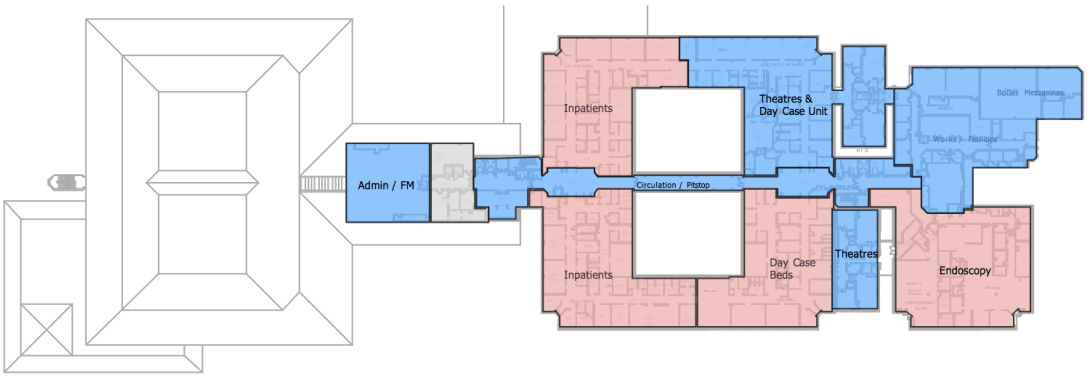
- Existing
- Remodelled
- Existing occupied by others
- Vacant

### Level one




### Level two

**Level three**


Inpatients
Theatres &
Day Case Unit
Admin / FM
Circulation / Pitstop
Inpatients
Day Case
Beds
Theatres
Endoscopy

Office of the
Trust Special Administrator
of MSFT

# The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust

## Annex 3.7: TSAs' proposed approach to implementation

December 2013

# 1. Introduction

Following the Secretary of State's final decision in respect of the TSAs' recommendations, should it be decided to implement those recommendations, it is envisaged that this could take up to three years (note however this timetable will be reassessed throughout the process). During the transition period, the TSAs will continue to run the Trust and will play a key role in the implementation of the approved recommendations, until such time as MSFT is dissolved. This will involve working closely with key stakeholders in the local health economy, including the receiving providers and the CCGs.

The TSAs recognise that the CCGs have commissioning freedom and will build on the TSA model as part of ongoing commissioning processes. However, in order for the TSAs to fulfil their objective to secure continued provision of essential local services, the TSAs propose their recommendations are implemented quickly and they are aiming for dissolution and transfer on 1 October 2014. The TSAs have assessed which providers should deliver the TSAs' proposed service recommendations and concluded that:

- Stafford Hospital should be operated by the University Hospital of North Staffordshire NHS Trust (UHNS); and
- Cannock Chase Hospital should be operated by Royal Wolverhampton NHS Trust (RWT).

A detailed implementation methodology will need to be developed to ensure both the continuing provision of safe clinical services to patients during the implementation phase, and that clinical, operational and financial sustainability is achieved following this. It is important that there is minimal day to day disruption to patient care throughout this process.

This Annex sets out the TSAs' initial views on the implementation approach. Further work will be carried out in conjunction with the Trust and other key stakeholders to develop and refine the proposed approach.

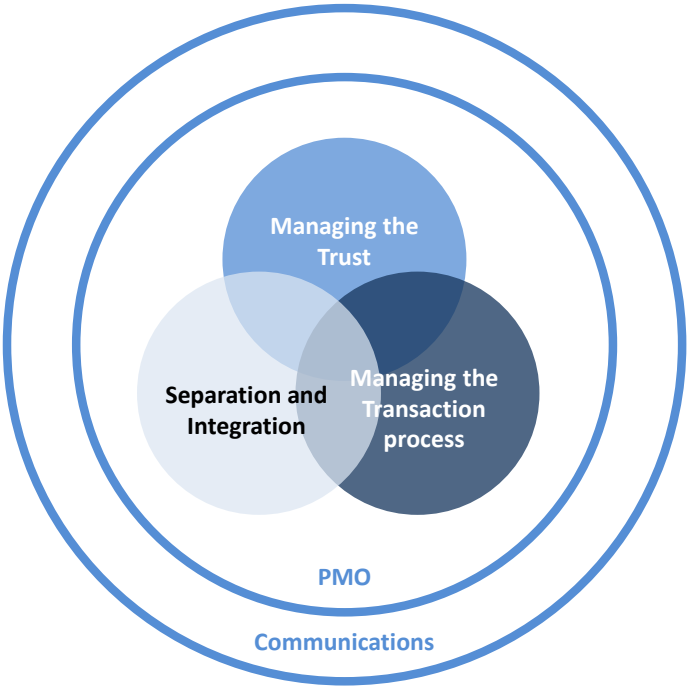
# 2. Overview of the implementation programme

**Approach to the transition**

The implementation approach outlined below will focus on five key areas of work to carry out planning, preparation and implementation of the recommendations over the course of the transition period. The TSAs will play a key role in this transition until MSFT is dissolved and its activity moves to other providers. The TSAs will work with local and national stakeholders to ensure the appropriate approach, risk appraisal, management and governance structure is put in place to ensure stability over the transition period.

In order to achieve a stable transition, the implementation approach will be divided into five connected workstreams:

1. Managing the Trust (operational, financial and clinical)
2. Separation and Integration (i.e. the separation of Stafford and Cannock Chase Hospitals, the clinical transformation/redesign and integration with receiving providers)
3. Managing the Transaction process
4. PMO
5. Communications




The implementation programme will be carried out alongside and in conjunction with Trust staff, engaging other key individuals and stakeholders from across the local health economy. An experienced Transition Director will be appointed to manage change within the Trust in order to provide oversight and

support to staff during the transition period, working alongside the TSAs, Chief Executive and other senior Trust staff.

The Separation and Integration, 'Managing the Transaction process' and 'Managing the Trust' areas of work will be supported by the PMO and communications workstreams, operating in a connected manner. A full team structure will be developed.

The local CCGs, as well as NHS England, will be closely involved throughout the implementation period. NHS England has commented in their letter dated 11 December 2013 that it supports the first important steps which have been undertaken by the TSAs, however, it is recognised that the CCGs have commissioning freedom and will build on the TSA model as a part of ongoing commissioning processes.

NHS England has confirmed in this letter that it will "*continue to support the work of local commissioners with providers to develop those long term solutions, while also supporting them in the interim as they work to deliver immediate and necessary improvements in services for the people of Stafford and Cannock*."

In managing the implementation and transition of assets and services to receiving providers, in parallel to the CCGs wider work, the TSAs will ensure continued close cooperation with the CCGs as part of the delivery and governance of the plan.

**1. Managing the Trust**

A key part of the implementation approach will be the TSAs' continued operational, financial and clinical support of day to day operations at the Trust.

The TSAs and Trust senior management will remain in place up to the point of dissolution and continue to take full responsibility for all activity at MSFT. At the point of transfer, the receiving trusts will take accountability and responsibility for activity at the respective hospitals.

One of the key aspects of MSFT not being clinically or financially sustainable, is its inability to attract and retain sufficient qualified and experienced permanent staff. The staffing position at the Trust (with increasing staff vacancies and difficulty in recruiting suitably qualified and experienced permanent staff) is not unique, but is far more pronounced than at many other trusts given its particular circumstances.

Given this, contingency plans to manage this shortfall in staffing, are being developed and deployed in conjunction with neighbouring providers. This approach of working with other local stakeholders will continue throughout the transition phase and any measures deployed will be temporary, pending recruitment of more staff and implementation of the longer term solution.

Key areas of focus for the TSAs in managing the Trust are as follows:

**Clinical**

- Maintaining clinical quality and safety of services during implementation;

- Ensuing the ongoing provision of safe clinical services to patients;
- Engaging and involving partner organisations, patients and other stakeholders, nationally and within the local health economy;
- Continued work with the commissioners and the LAT to ensure service provision in line with commissioning intentions, including negotiating the 2013 / 2014 contract close out and the 2014 / 2015 (which will straddle dissolution); and
- Engagement with the CQC.

**Operational**

- Support of day to day operations to support Trust stabilisation;
- Ensuring appropriate governance arrangements are in place and operating effectively; and
- Supporting the Trust in reporting to Monitor / other key stakeholders to ensure potential risks and issues will be assessed, addressed, documented and escalated on a regular basis.

**Financial**

- Ensuring continued financial rigour during the transition period;
- Meeting ongoing financial responsibilities and other corporate and statutory obligations; and
- Continued oversight of the CIP programme.

**2. Separation and Integration**

The TSAs recommend dissolution of MSFT and that therefore Stafford and Cannock Chase Hospitals should be run by other providers. This workstream will focus on achieving the separation of MSFT and the steps required to operationally transfer services so they can be integrated into the other providers. The separation will therefore be carried out in close conjunction with the receiving providers and other key stakeholders in the local health economy.

This workstream focus on the following areas: clinical, clinical support and corporate, taking account of; employees, finance, processes, systems, assets, liabilities and contracts. There will be individual clinical workstreams for all key specialities where Trust staff will play a critical role, whose focus will be on splitting and redesigning the services. The separation and integration and 'managing the Trust' workstreams will be closely aligned to ensure continuity of services to patients at the Trust during the transition.

We will be working closely with the main receiving providers (UHNS and RWT), as well as other providers impacted in the LHE, to ensure they are in a position to take the transferring activity and continue provision of safe clinical services. The NHS Trust Development Authority (TDA) will play a key role in obtaining the relevant assurances prior to dissolution of MSFT.

**3. Managing the Transaction process**

The transaction element will focus on supporting the transaction process, in particular continued engagement with receiving providers to ensure they have the information they require to complete their integration plans and business cases. The workstream will also support due diligence activities, including dataroom management and reviewing the data to ensure the key issues (in respect of financial information and other due diligence areas such as HR, IT, tax, clinical and estates) are understood. This workstream also includes agreeing the terms of the transfers with receiving providers and other stakeholders.

Stakeholder support will a key objective of this workstream, including supporting Monitor and the Department of Health (DH) / Secretary of State with the dissolution, engaging with commissioners, receiving and other impacted providers, and the TDA and supporting any relevant competition process.

In order to implement the transfer to other providers, the form of the transaction is likely to be a statutory transfer of MSFT's assets and liabilities to the Secretary of State for Health under Section 65LA of the National Health Service Act 2006 (legislation does not permit the transfer of assets/liabilities from a Foundation Trust to an NHS Trust directly). The Secretary of State would subsequently make an order transferring the relevant assets and liabilities to the receiving NHS Trust provider(s). Further work will include the identification of the assets/liabilities that will be transferred to new providers and any assets/liabilities which may not be transferred (if any).

**4. PMO**

The PMO will continue to be responsible for overall governance of the transition and reporting of the transition process. This includes managing workstream progress and monitoring risks and issues that arise, in addition to managing legal input. This will include the provision of a regular reporting pack to Monitor, monitoring key inputs and outputs and progress against transition milestones. The detailed milestones will be set at the outset by each of the workstreams such that these can be regularly monitored to ensure interdependencies between workstreams are clear and understood and implementation deadlines are being met.

**5. Communications**

Close engagement between all stakeholders, both managing and impacted by the transition process, is imperative to the successful continuity and transfer of services. The TSAs' communications team will continue to manage the TSA website, email enquiries and telephone calls as well as management of local and national media and communication with key internal and external stakeholders.

The communications teams at both MSFT and the receiving providers will need to work closely together to ensure consistent and timely messages are distributed to key stakeholders, including patients, public and staff.

**6. Managing risk**

As part of the approach to implementation, a full risk assessment will be undertaken prior to the transfer of services. This will ensure the safe and sustainable transition and delivery of services, should Secretary of State approval be received. This will cover all aspects of governance and operations at the Trust and should include detailed planning, written processes, experiences and lessons, workforce engagement and patient pathway work when developing the new organisational and service options for the Trust.

Whilst the TSAs have current responsibility for the Trust, and will do during the transition, it is envisaged that UHNS in relation to Stafford and RWT in relation to Cannock Chase will own the risks associated with the development, implementation and operation of those services following dissolution. It is anticipated these organisations will use an approved risk assessment methodology (e.g. the NHS Litigation Authority risk management methodology) in order to carry out a thorough risk assessment.

# 3. Key milestones

Given an assumed dissolution date of 1 October 2014, the key steps that need to be achieved over the transition period include:

- Detailed separation planning (by TSAs/MSFT) and Integration Planning (by receiving providers)
- Design and implement governance structure for the transition period, prior to dissolution
- Prepare and manage dataroom; commence DD process and support provider DD
- Draft and approve Heads of Terms with receiving providers
- Receiving providers to draft business cases; receive approval of business cases
- Contract negotiation with commissioners
- Complete transfer order schedules
- Update financial models
- Legacy management

This will all be carried out in close coordination with the Trust, receiving providers and other local health economy stakeholders. Further work will be carried out prior to the Secretary of State's decision to develop and refine these milestones.

# 4. Other considerations during transition

There are a number of key stakeholders that have expressed views on additional considerations that need to be further developed as a part of the transition and the implementation approach. Underpinning the transition will be ongoing engagement with staff at MSFT and receiving provider organisations, as well as engagement with the wider local health economy participants.

In the letter received by the TSAs from NHS England dated 11 December 2013, there are a number of additional areas identified that will be further explored during transition. An excerpt of the letter, summarising these areas for further work, is included below.

*"We believe that there are a number of measures that could be applied to the recommended service model that would mitigate the current estimates of excess cost. We recognise that some of these may need further engagement or consultation with local stakeholders. These measures include;*

*1. The integrated use of North Staffordshire community beds to increase overall system productivity and reduce reliance on new capital spend at UHNS.*

*2. The refurbishment of spare capacity at Bradwell Community Hospital, to avoid capital expenditure on the acute site.*

*3. The requirement for all new capital expenditure to have a signed off business case that takes full account of commissioning capacity plans - thus ensuring all new capital spend is genuinely unavoidable.*

*4. Without changing the TSA recommended clinical model, commissioners will review case mix and patient flow to determine whether the proposed provider specification is necessary at all sites (for example with regard to the number of single rooms and requirement for operating theatre upgrades)*

*5. The TSA model is currently based on current income levels - this will need to be updated to reflect future commissioning intentions and QIPP plans.*

*6. The CCGs taking responsibility for the negotiation of revision to the ambulance contract and patient transport with a view to minimising the impact on patients and reducing the ambulance services proposed cost increase.*

*7. Cannock Chase Hospital being subject to a placed based scheme developed with the local authority to fully explore the possibility of a landmark regeneration scheme that fully exploits the current site.*

*8. The implementation of the TSA recommendations will need to reflect CCG responsibilities and enable them to exercise their commissioning intentions through service procurement where appropriate.*

*9. We view the TSA clinical model as a start point for a wider-ranging Strategic Review that will ensure that both commissioning and provision across Staffordshire is placed on a clinically and financially sustainable footing for the long term.*

*10. NHS England, Monitor and the NHS TDA will need to review proposed capital spend to ensure the most appropriate accounting treatment is consistently applied.*

*11. All parties will need to be incentivised through the implementation arrangements to secure best value for money for the taxpayer.*

*We recognise that all of these actions will need extensive further engagement and we will work local commissioners to support and help them develop these plans."*

The Health and Equality Impact Assessment Steering Group also identified further areas to be considered during implementation:

- Direct engagement with key stakeholder groups that currently use proposed affected services, for example children with learning disabilities and / or special needs, their families and carers. This will ensure they are involved in the design and implementation of the future of these services in order to proactively manage their needs.
- In order to engage with the key stakeholder groups, consider the use of focus groups to ensure wider engagement with the implementation.
- Further implementation considerations in respect of carer, staff and visitor journeys, for example capacity and availability of car parking (including disabled parking) and continued support for voluntary transport schemes. This also includes considerations for the receiving Trusts, such as signage and seating to assist with negotiating unfamiliar / larger sites.

These considerations will be taking into account as the implementation plan is developed.

# 5. Transition costs

The implementation programme requires transition costs to be funded during the three year period. Further details of the expected transition costs are included in Annex 3.5: TSAs' financial evaluation.

The total funding requirement of £220.2m is detailed further below.

| TSA Baseline CAPEX | TSA | | | |
|---|---|---|---|---|
| **Year** | Y1 | Y2 | Y3 | **Total** |
| **Transition costs** | | | | |
| Forecast Deficit (Excluding depreciation) | £17.4m | £11.4m | £3.5m | **£32.3m** |
| Implementation costs | £6.0m | £6.0m | £6.0m | **£18.0m** |
| Redundancy costs | £1.3m | £1.3m | £2.7m | **£5.3m** |
| Double running costs | - | £3.0m | £5.0m | **£8.0m** |
| **Total transition costs** | **£24.7m** | **£21.7m** | **£17.2m** | **£63.6m** |
| CAPEX (TSA baseline) | £45.6m | £65.1m | £19.5m | **£130.2m** |
| Maintenance | £7.2m | £8.6m | £10.6m | **£26.4m** |
| **TOTAL** | **£77.5m** | **£95.4m** | **£47.3m** | **£220.2m** |

Any transition costs must be fully funded in order to ensure successful transition and implementation of the TSAs' recommendations. Funding for the transition will be provided by a combination of financing from the Department of Health and income from NHS England to be paid via the CCGs.

# 6. Managing the programme during implementation

As with the first stage of the TSA process, the TSAs will continue to work alongside key local and national stakeholders during the implementation process. This includes the CCGs, NHS England, Monitor, DH, TDA, Trust staff, receiving trusts and other local health economy providers.

In order to ensure a seamless transition into implementation, and to draw these stakeholders together, further work will be undertaken prior to the Secretary of State's decision, on the appropriate governance structure to manage the implementation process. The below highlights the proposed groups which will form part of this governance structure; however this will be refined following submission of the final report up until the Secretary of State's decision.

**Successor to the Joint Oversight Group**

The successor to the Joint Oversight Group would facilitate an integrated approach to implementation and timely resolution of any issues that arise, across the primary national stakeholders. This may include representatives from Monitor, the TSAs, NHS England (on behalf of the commissioners) and DH. The group act as a consultative forum for addressing key issues between these stakeholders, in addition to acting as a "resolution" forum.

**Transitional Services Board (successor of the Sustaining Services Board)**

The TSAs created a Sustaining Services Board (SSB) to promote system accountability and oversee the identification and management of system-wide risks associated with the delivery of patient care during the TSAs tenure. This board includes Chief Executive and senior Director membership from the Trust and all adjacent provider organisations. We anticipate the SSB will transform into the Transitional Services Board (TSB). The TSB would act as the implementation 'steering group' that informs the implementation programme to ensure continuity of patient care in the local health economy in light of the organisational and clinical changes. Membership is anticipated to continue from that outlined above, in addition to commissioners by invitation.

Underpinning the organisational and clinical changes, and critical to successful implementation, are workforce and employee considerations. Through the TSB, HR Directors and other key representatives of the local health economy workforce would continue to work together to ensure continuity in the workforce, together with continuing workforce engagement.

**'Executive Transition Management Team'**

This group, consisting of the TSAs, Chief Executive and Trust senior Director membership, would act as a successor of the current Senior Management Team. It would include a 'Transition Director' and act as a forum for the Trust's Executive team to continue to manage the Trust to ensure continuity of patient care at the Trust in light of the changes.

**Project Steering Group**

This Steering Group would act as a forum to report on TSAs progress, enabling the TSAs to report to Monitor (and DH). These project management meetings could be held on a regular basis, drawing together updates on the five workstreams outlined above.

# 7. Risks and mitigations to implementation

The table below outlines potential risks to implementation and suggested mitigations.

| Risk | Mitigation |
|---|---|
| De-stabilisation of the Trust during the implementation programme | • Close working with the MSFT senior management team and the key representatives from other providers, through the SSB and its successor the TSB, will ensure key quality and safety issues are identified and mitigated at an early stage. |
| Future procurement programme by the CCGs could cause disruption to the transition | • The TSAs are recommending that Stafford and Cannock Chase transfer to other providers as soon as possible, prior to the completion of any procurement process.<br>• The implementation programme, proposed to be overseen by the Transitional Services Board, must continue to run alongside any procurement process to ensure a timely transition.<br>• Close liaison with CCGs to understand their plans. |
| Extent of committed resources required for the implementation programme to ensure timely delivery of milestones | • Ensure that key stakeholders are brought into the process and are held accountable (e.g. through the successor to the Joint Oversight Group).<br>• Ensure that each stakeholder group has a named representative who is responsible for leading the delivery of the plan. |
| Decision-making across the local health economy system is not effectively aligned | • Regular stakeholder meetings (e.g. the successor to the Joint Oversight Group) would be held to ensure that key representatives are working together and sharing issues. |
| Further review and changes in commissioning intentions across the local health economy could cause delay to the transition | • The TSAs recognise the commissioners right to review ongoing service provision.<br>• Given the operational issues of the Trust, this must not delay the implementation programme. |
| Improvements to operational efficiency are not delivered | • There are operational efficiencies which can be clearly outlined and implemented. Having a dedicated team working on this will ensure that this important area continues to have the appropriate focus whilst the transaction(s) is / are implemented and the clinical changes are being made. |

| Risk | Mitigation |
|---|---|
| Retention and recruitment of staff during implementation | • The Transitional Services Board would continue the work of the Sustainable Services Board in working across the local health economy to ensure the early identification of any risks to services and plan for the continued safe and sustained delivery of high quality healthcare services by member organisations. |