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 Two, Part C

The consultation on the TSAs' draft recommendations

December 2013

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

Trust Special Administrators' Final Report

Volume Two, Part C

The consultation on the TSAs' draft recommendations

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.

You can download this publication from www.msft-tsa.org.uk.

Office of the
Trust Special Administrator
of MSFT

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

Annex 2.4: Formal responses to the TSAs' draft recommendations (2 of 3)

Index of formal stakeholder responses

Continued in Volume 2, Part D

7. Local Authorities and Councillors (continued)

#25

26 SEP 2013

Mid Staffordshire NHS
NHS Foundation Trust

Office of the
Trust Special Administrator
of MSFT

Maintaining high quality, safe services for the future – Consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals

6 August – 1 October 2013

Your response to the consultation

As part of the *Maintaining high quality, safe services for the future* consultation, we want to make sure that those in Mid Staffordshire have the chance to give their views and comments. We are asking people to give us their views by reading the consultation document and completing this response form. Alternatively, you can complete the same response form online at www.tsa-msft.org.uk.

We are keen to hear your views to help inform our final recommendations that go to Monitor and the Secretary of State for Health. Please bear in mind this is a consultation, not a 'vote'. We will take responses into account along with a wide range of other information. We are interested in the overall responses to the tick box questions, and your reasons for your views. If you don't have any views on a specific question, please leave the boxes blank. You do not need to answer every question. **Please only write within the boxes provided in this response form. If your comments do not fit in the box, please send your comments on a separate sheet of paper, clearly stating which question they refer to.**

We have asked Ipsos MORI to undertake the analysis of the response forms on our behalf. The findings will help to inform the Trust Special Administrators' (TSAs) final recommendations to Monitor and the Secretary of State for Health. Please read the consultation document all the way through, then give us your answers to the questions in this response form. In the response form we have shown which pages of the consultation document cover the issues raised by each of the questions. Please refer back to the relevant pages as you answer the questions. You can download a full copy of the consultation document at www.tsa-msft.org.uk.

If you want to explain any of your answers, or you feel the questions have not given you the chance to express your views fully, or if you think there are options we have not considered that we should have done, please say so in the box for question 28.

Important: Please do not provide the names of any individuals in the feedback boxes. Please do not include in your response any other information that could identify individuals.

Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send it to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG

You do not need a stamp. **Any responses received after midnight on Tuesday 1 October 2013 will not be accepted or considered. The envelope is second class, so please return your response form in plenty of time to reach us.**

If you require a large print copy please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk.

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Ipsos MORI

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13-020881-01 - Response Form - FINAL - v4 - 250713 - PUBLIC

Unless you are responding on behalf of an organisation, this form does not ask you to supply us with your name or other contact details. You will, however, be asked to supply details of your postcode and your personal circumstances; you do not have to give these details if you do not want to. This information is only being collected in order to help us analyse responses to the consultation by Clinical Commissioning Group (CCG) area and key groups of the local population. It will not be used to identify specific individuals. Any personal data that you do supply will be handled by the TSAs in accordance with their obligations under the Data Protection Act 1998. When you complete the response form please do not include any information that could identify other individuals.

We do not intend to publish or disclose any personal information that could identify any individual. A document summarising all consultation responses we receive will however be attached to the TSAs' final report and will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide whether as an individual, an organisation or group, may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Thank you for your feedback.

Questions on emergency and urgent care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 24 of the consultation document.

Recommendation 1: Emergency and urgent care at Stafford Hospital

Q1 How far do you support or oppose the recommendation around the Accident and Emergency (A&E) department at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/don't know
☐	☑	☐	☐	☐	☐

Q2 What further comments, if any, do you have on any of the proposals outlined around emergency and urgent care at Stafford Hospital in Recommendation 1 in the consultation document, including the reasons for your answer to question 1? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Please See attached Sheets.

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Questions on inpatient services for adults at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 26-27 of the consultation document.

Recommendation 2

Q3 How far do you support or oppose the recommendation around the inpatient service for adults with medical problems at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Recommendation 3

Q4 How far do you support or oppose the recommendation around a Frail Elderly Assessment service at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Recommendation 4

Q5 How far do you support or oppose the recommendation that beds should be available at Stafford Hospital for recovering patients?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Inpatient services for adults at Stafford Hospital (recommendations 2-4)

Q6 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around inpatient services for adults at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 3

Recommendations 2, 3 and 4: Inpatient services for adults at Stafford Hospital

Q7 What further comments, if any, do you have on any of the proposals outlined around inpatient services for adults in Recommendations 2, 3 and 4 in the consultation document, including the reasons for your answers to questions 3, 4, 5 and 6? Please also include any improvements you would like to suggest to these recommendations.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Please see attached sheets.

Questions on maternity services in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 28 of the consultation document.

Recommendation 5: Maternity services in Stafford

Q8 How far do you support or oppose the recommendation around maternity services in Stafford?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☐	☑	☐	☐

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Q9 What further comments, if any, do you have on any of the proposals outlined around maternity services in Stafford in Recommendation 5 in the consultation document, including the reasons for your answer to question 8? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Please see attached sheets.

Questions on services for children in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 30-31 of the consultation document.

Recommendation 6

Q10 How far do you support or oppose the recommendation around the inpatient service for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Recommendation 7

Q11 How far do you support or oppose the recommendation around the Paediatric Assessment Unit (PAU) at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Services for children in Stafford (recommendations 6-7)

Q12 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around services for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 5

Recommendations 6 and 7: Services for children in Stafford

Q13 What further comments, if any, do you have on any of the proposals outlined around services for children in Stafford in Recommendations 6 and 7 in the consultation document, including the reasons for your answers to questions 10, 11 and 12? Please also include any improvements you would like to suggest to these recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones.**

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Please see attached sheets.

Questions on major emergency surgery at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 32 of the consultation document.

Recommendation 8: Major emergency surgery at Stafford Hospital

Q14 How far do you support or oppose the recommendation around major emergency surgery at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 6

Q15 What further comments, if any, do you have on any of the proposals outlined around major emergency surgery at Stafford Hospital in Recommendation 8 in the consultation document, including the reasons for your answer to question 14? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Please see attached sheets.

Questions on critical care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 34 of the consultation document.

Recommendation 9: Critical care at Stafford Hospital

Q16 How far do you support or oppose the recommendation around the critical care unit at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 7

Q17 What further comments, if any, do you have on any of the proposals outlined around critical care at Stafford Hospital in Recommendation 9, including the reasons for your answer to question 16? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Please see attached sheets.

Questions on elective care and day cases at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 36 of the consultation document.

Recommendation 10: Elective care and day cases at Stafford Hospital

Q18 How far do you support or oppose the recommendation around elective care and day cases at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 8

Q19 What further comments, if any, do you have on any of the proposals outlined around elective care and day cases at Stafford Hospital in Recommendation 10 in the consultation document, including the reasons for your answer to question 18? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on Chapter 7 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained in Chapter 7 of the consultation document (pages 38-40).

Recommendation 11: Step down care and rehabilitation at Cannock Chase Hospital

Q20 How far do you support or oppose the recommendation that beds should be available at Cannock Chase Hospital for recovering patients?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 9

Q21 What further comments, if any, do you have on any of the proposals outlined around beds for recovering patients at Cannock Chase Hospital in Recommendation 11 in the consultation document, including the reasons for your answer to question 20? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet stating which question your comments refer to. Please do not include details that could be used to identify any individuals.

Please see attached sheets.

Recommendation 12: Elective inpatient surgery at Cannock Chase Hospital

Q22 How far do you support or oppose the recommendation around elective inpatient surgery at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Q23 What further comments, if any, do you have on any of the proposals outlined around elective inpatient surgery at Cannock Chase Hospital in Recommendation 12 in the consultation document, including the reasons for your answer to question 22? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.

Please see attached sheets.

Page No. 10

Recommendation 13: Day cases (surgical and medical) at Cannock Chase Hospital

Q24 How far do you support or oppose the recommendation around day case procedures at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Q25 What further comments, if any, do you have on any of the proposals outlined around day case procedures in Recommendation 13 in the consultation document, including the reasons for your answer to question 24? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.
If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.
Please do not include details that could be used to identify any individuals.

Please see attached sheets.

Questions on Chapter 8 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained in Chapter 8 of the consultation document (pages 42-43).

Recommendation 14: Organisational plans for Mid Staffordshire NHS Foundation Trust

Q26 How far do you support or oppose the recommendation for Mid Staffordshire NHS Foundation Trust (MSFT) to be dissolved, with the services at Stafford and Cannock Chase hospitals managed and delivered by another organisation or organisations in the future?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 11

Q27 What further comments, if any, do you have on any of the proposals outlined around Recommendation 14 in the consultation document, including the reasons for your answer to question 26? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Please See attached Sheets.

Final comments

Q28 Is there anything else you want to say about the consultation or the issues it covers? If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so here. Please also say if there are any improvements you would like to suggest to the recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Please See attached sheets.

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Background Information

Q29 Are you:
Please tick ✓ one box only

- ☐ Providing your own response or responding on behalf of another individual?
  Please go to Q30
- ☑ Submitting your response on behalf of an organisation or group?
  Please go to Q41

If you are responding on your own behalf, please complete the following questions. If you are responding on behalf of another individual, please complete the following questions about them.

Q30 Which, if any, of the following apply to you?
Please tick ✓ as many boxes as apply

- ☐ I currently work in the NHS
- ☐ I used to work in the NHS
- ☐ I currently work in the independent health sector
- ☐ I used to work in the independent health sector
- ☐ I do not work in, and have not worked in, the NHS or the independent health sector
- ☐ Prefer not to say
- ☐ Don't know

Q31 What is your closest hospital?
Please tick ✓ one box only

- ☐ Cannock Chase Hospital
- ☐ Manor Hospital
- ☐ New Cross Hospital
- ☐ Princess Royal Hospital
- ☐ Queen's Hospital
- ☐ Stafford Hospital
- ☐ University Hospital of North Staffordshire
- ☐ Other **(Please tick and write in below)**
- ☐ Don't know

Personal Details

We would be grateful if you could answer the following questions so we can establish if we have responses from a cross-section of people, and to allow us to analyse the results overall and by these different groups of people. None of the information you supply will be used by us in order to identify you. However, you should appreciate that it is possible that you could be identifiable from the information you supply in this section. Any identifiable information you do supply will be held by the TSAs securely, in confidence and in accordance with their obligations under the Data Protection Act 1998. You do not have to provide your personal details. If you do complete this section, please tick the box below to confirm that we may use your personal data for the purpose of analysing the results of the consultation.

- ☐ **I agree that the TSAs may use the details I have supplied in response to Q32-40 for the purpose of analysing the results of the consultation**

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Q32 Please can you provide your full home postcode
Please write in below

Full Postcode ☐ ☐ ☐ ☐ ☐ ☐ ☐

Q33 Are you ...?
Please tick ✓ one box only

- ☐ Male
- ☐ Female
- ☐ Prefer not To say

Q34 How old are you?
Please tick ✓ one box only

- ☐ Under 18
- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or over
- ☐ Prefer not to say

Q35 Which ethnic group do you consider yourself to belong to?
Please tick ✓ one box only

- ☐ White
- ☐ Mixed
- ☐ Asian or Asian British
- ☐ Black or Black British
- ☐ Chinese
- ☐ Other **(Please tick and write in below)**

☐

- ☐ Prefer not to say

Q36 Do you consider yourself to have a disability? [The Equality Act 2012 defines a disability as "a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities".]
Please tick ✓ one box only

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Q37 Do any of the following apply to you?
Please tick ✓ all the boxes that apply

- ☐ I have children
- ☐ I am pregnant
- ☐ I care for children under the age of 16
- ☐ None of these
- ☐ Prefer not to say

Q38 When did you last visit one of the hospitals listed in Q31, either as a patient or to visit a family member or friend?
Please tick ✓ one box only

- ☐ In the last six months
- ☐ In the last year
- ☐ More than a year ago
- ☐ Never
- ☐ Can't remember

Q39 Do you care for someone in your family or a friend because they have a health need?
Please tick ✓ all that apply

- ☐ Yes – someone aged 16 or over
- ☐ Yes – a child aged under 16
- ☐ No

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Q40 Have you or your family used any of the services below provided by the NHS within the last year?

Please tick ✓ all that apply

- ☐ GP care
- ☐ Community nursing and therapy services
- ☐ Community paediatric services (for example, health visitor)
- ☐ Mental health care
- ☐ End-of-life care
- ☐ Paediatric (children's) hospital care
- ☐ Maternity and newborn care
- ☐ Emergency or urgent care, including intensive care
- ☐ Elective care (see page 36 of the consultation document for an explanation)
- ☐ Outpatients
- ☐ Other
- ☐ None of these
- ☐ Prefer not to say

If you have answered any of questions 32-40 then please make sure you have ticked the box at the bottom of page 13 of this form so that your answers can be used to analyse the results of the consultation.

Details of your organisation or group

If you are sending us a response on behalf of an organisation or group, please complete these questions.

If you are responding on your own behalf or on behalf of another person, please go to the end of this response form.

Please be as detailed as you can. For example, if you are responding on behalf of a group or organisation, please record the name of the group or organisation. Your personal details will be handled by the TSAs in accordance with their obligations under the Data Protection Act and will not be made public. Please remember, however, that information summarising the overall response to the consultation will be attached to the TSAs' final report which will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Q41 What is your name, job position and the name and address of the organisation or group on whose behalf you are submitting this response? The name and details of your organisation or group may appear in the final report.

Steve Shilvock, Head of Environmental Health
On behalf of
The Cabinet, Cannock Chase District Council
Po Box 28, Beecroft Rd., Cannock,
Staffordshire WS11 1BG

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Q42 What category of organisation or group are you representing?
Please tick ✓ as many boxes as apply

- ☐ A professional body (e.g. a Royal College)
- ☐ An NHS trust (provider of services)
- ☐ Charity / voluntary sector group
- ☐ National patient group
- ☐ Local patient group
- ☑ Local Authority
- ☐ Trade union
- ☐ Trade body
- ☐ Academic organisation
- ☐ Political party / Political group
- ☐ Clinical Commissioning Group
- ☐ Other NHS body
- ☐ Regulatory body
- ☐ Other
- ☐ Don't know

Q43 Please write in the total number of members in your organisation or group.

41 elected members

Q44 Please tell us who the organisation or group represents and, if it applies, how you gathered and summarised the views of members.

Cannock Chase District Council is the Local Authority in whose area Cannock Chase hospital is situated. The Council represents the interests of local residents. This response is made by the Cabinet, who are the executive body of the Council.

Thank you for your comments.
Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG
You do not need a stamp. **The envelope is second class, so please return your response form in plenty of time to reach us.**

If you need help to complete this form, or if you would like to complete it in another language, please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk. The telephone number is freephone from landlines, but charges may apply for calls from mobile telephones.

If you have any queries or complaints regarding the consultation process or consultation documentation content, please contact: The Trust Special Administrators, Mid Staffordshire NHS Foundation Trust, Stafford Hospital, Weston Road, Stafford, ST16 3SA
Please note that any queries or complaints submitted via this process cannot be counted as part of the formal consultation.

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Additional Text

Consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock hospitals

Response by the Cabinet of Cannock Chase Council

Questions on emergency and urgent care at Stafford Hospital.

Recommendation 1: Emergency and urgent care at Stafford Hospital.

Question 2

The clinical safety reasons for the recommendation to retain an 8 am to 10 pm A&E service and not reinstate a 24 hour service are understood. However there is understandable public concern that the loss of a local facility will lead to extended journey times to alternative A&E facilities. The extent to which journeys will be increased varies considerably according to where someone lives, and some areas will be particularly disadvantaged. A well organised publicity and information campaign will be needed to convince residents of the clinical benefits of this recommendation.

Furthermore, residents need to be encouraged to use the facilities that are available otherwise they could be cut even more.

Recommendations 2, 3 and 4: Inpatient services for adults at Stafford Hospital

Question 7

The proposals for an enhanced Frail Elderly Assessment service are particularly welcomed. This service will need to work in tandem with Social Care & Health services much more closely than at present.

There is a general theme of patients with more serious or complex conditions being taken straight to, or transferred to, more specialist units elsewhere. The increasing centralisation of specialist units and the clinical reasoning behind this is understood. However, a well organised publicity and information campaign will be needed to explain the clinical benefits of this recommendation to patients. The return of patients to more local hospitals for recovery needs to be emphasised, particularly due to the travel distance to specialist units for many local residents.

Questions on maternity services in Stafford

Recommendation 5: Maternity services in Stafford

Question 9

The issues caused by Stafford being one of the smalest consultant delivered maternity units in the country are understood. However, the loss of

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child birth facilities at Stafford will cause transport difficulties for some women and their families.

The continuation of routine pre and post natal care is welcomed.

Questions on services for children in Stafford

Recommendations 6 and 7: Services for children in Stafford

Question 13

The clinical safety and resource reasons for the recommendations are understood.

There are concerns about the downgrading of the Paediatric Assessment Unit (PAU) from a 24 hour to an 8 am to 10 pm service.

The loss of an inpatient facility for children will cause travel problems for some families. Consideration should be given to the provision of facilities to allow parents to stay overnight with their children in the specialist centres.

The extension of the Paediatric Hospital@Home service to the south of the county would be welcomed.

Questions on major emergency surgery at Stafford Hospital

Recommendation 8: Major emergency surgery at Stafford Hospital

Question 15

At certain times of the day traffic conditions may make patient transfer more difficult.

Questions on critical care at Stafford Hospital

Recommendation 9: Critical care at Stafford Hospital

Question 17

At certain times of the day traffic conditions may make patient transfer more difficult.

Questions on Chapter 7 of the consultation document

Recommendation 11: Step down care and rehabilitation at Cannock Chase Hospital

Question 21

The provision of step down beds to allow patients to recuperate closer to home is welcomed. It is essential that proper arrangements are in place for discharge to home. Patients should be discharged at an appropriate time of day and only where any necessary home support arrangements have been put in place.

2

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Recommendation 12: Elective inpatient surgery at Cannock Chase Hospital

Question 23

The provision of more elective surgery at Stafford Hospital will impact on Cannock Chase Hospital. Accordingly, the proposed increase in the scope of elective inpatient surgery at Cannock Chase Hospital would be strongly supported. It is appreciated that this is subject to resolving the issue of safe overnight staff cover.

Recommendation 13: Day cases (surgical and medical) at Cannock Chase Hospital

Question 25

The potential increase in the range of conditions dealt with would improve the service available and assist the viability of the hospital.

Questions on Chapter 8 of the consultation document

Recommendation 14: Organisational plans for Mid Staffordshire NHS Foundation Trust

Question 27

The clinical and financial viability reasons for the recommendation to dissolve the Mid Staffs Hospital trust are understood.

There has been a prolonged period of uncertainty over the future of the Trust and the process should be concluded as soon as possible.

To secure the future viability of Cannock Chase Hospital a wide range of services needs to be provided, supported by the Cannock Chase CCG and local GPs.

Final Comments.

Question 28

The proposals consulted on maintain the provision of services at both Stafford and Cannock Chase Hospitals, and this outcome is fully supported.

There has been considerable concern for some time now concerning the gross under utilisation of Cannock Chase hospital. The recommendations being consulted on will hopefully see greater utilisation of the facilities. The consultation document does caution that the proposed expansion of services still may not fully utilise the available space. The Trust Special Administrators are urged to identify arrangements that will secure the future of Cannock Chase hospital. In pursuit of this, the proposals for the Royal Wolverhampton Hospitals NHS Trust to deliver services in Cannock Chase hospital are fully supported. We would also support further negotiations with Walsall

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Healthcare NHS Trust. They can offer a different range of services that would take up further spare capacity and complement the other services being provided.

There are concerns at the loss of local A&E, critical care, maternity and paediatric services. The clinical reasons for these recommendations are understood, but a well organised publicity and information campaign will be needed to explain the clinical benefits of this recommendation to local residents.

Stafford and Cannock hospitals are well served by public transport. Local residents may find some hospitals further afield difficult and/or expensive to reach on public transport. There have been suggestions made of the provision of a shuttle bus between Cannock and New Cross hospitals. This should be further explored. Discussions also need to take place with public transport planners and providers with a view to improving public transport links to the other hospitals that will become more involved in local healthcare services. There are still many, often vulnerable people who are reliant on public transport. Rugeley and some of the outlying areas of the District will be most affected by transport issues.

The importance of proper, well co-ordinated arrangements for discharge of patients from hospital cannot be overstated. Patients should be discharged at an appropriate time of day and only where any necessary home support arrangements have been put in place.

3 Cover Pages + Pages 1-26

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Stafford
BOROUGH COUNCIL

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Our Ref	MRH/BP
Your Ref	
Date	26 September 2013

Dear Sir

Stafford Hospital

I am attaching the Council's response to your recommendations. It is in places a harsh critique but I hope you will see in it our genuine attempt to give the issues considerable thought and to provide reasoned arguments for the positions we have taken.

The Borough Council has a simple focus which is to ensure that there are good local health services for this and for future generations of Stafford citizens. The current dilemmas of the NHS must of course be addressed but we are not satisfied that the timescale and process that you are caught up in have allowed you to find the best and most cost-effective long-term solution.

You will see that we have given prominence to two central points:

(i) Our strong opposition to the removal of maternity services and our belief that the alternative arrangements have not been properly set out and costed.

(ii) Your proposals require major additional investment and bridging funding. The total costs were not pinned down before you have had to consult and we know that there are intensive discussions still taking place within the NHS family. We lack confidence that the definitive bill has yet been established and believe when it is, it must be tested against similar investment in strengthening the existing local service. Our concerns are exacerbated by the open secret that UHNS is in significant financial distress.

I hope that there will be an opportunity to discuss our differences and that you will not close your mind to suggestions that there is a wider range of ideas than those coming from our neighbouring NHS Trusts - Trusts who can hardly be expected to put the interests of Stafford citizens at the top of their agenda. You can be assured that we will approach these discussions with the hope that we can find an agreed position to recommend to the local community - this would surely be preferable to an adversarial contest and challenge?

Continued....

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26 September 2013

Finally I would like to recognise the serious constraint that this timescale has imposed on you and your team and acknowledge the courtesy and thoroughness you have personally brought to the exercise. I am afraid you have simply not had enough time and may have spent too much of it behind closed doors with NHS managers.

.

Yours faithfully

Mike Heenan

Councillor M R Heenan
Leader of the Council

Stafford Hospital
September 2012

executive summary

In preparing this paper Stafford Borough Council (SBC) has sought to assist the TSAs in the difficult task assigned to them, there is no conflict of objectives here. All parties are in agreement that the objective is a good local health service for the citizens of Stafford. The TSAs have entered the issue with a remit to resolve the immediate difficulties of the NHS Foundation Trust, and are working within a hitherto untested framework and timetable. The Council is more concerned that the outcome of the exercise is one that will be affordable and sustainable for citizens for decades ahead. With this in mind, we have set out in this paper a number of points in response to the TSAs' draft report.

The first is that the financials do not stack up. There is acknowledgement that Stafford Hospital has now dealt with its quality issues and compares well with other hospitals in the local health economy. The Trust is to be dissolved because it is financially non-viable. The TSAs' recommendations come with a price tag of £300millions. The Council will have some difficulty in accepting the logic that spending at this level to strengthen services in neighbouring hospitals is the best response to the fact that the existing MSFT is running a budget deficit.

It is particularly worrying that, as the TSAs admit, the true costs of the proposed changes at Stoke and Wolverhampton hospitals have not yet been pinned down. Experience would lead the Council to expect these estimates to be revised upwards not down. This consultation has been launched with a number of very important issues still unresolved and the Council is concerned that this will weaken the credibility of the TSAs as the debate unfolds. We have raised a series of questions and suggest that TSAs will strengthen their position if they can be answered in their final report.

executive summary...

Not only are the costs still in motion, some important service issues are difficult to reconcile. For example, it is proposed that the obstetric service at Stafford should be discontinued because it is financially non viable but critical care which is also financially non viable is to continue. It is hard to avoid the conclusion that the TSAs have been boxed in to a restricted range of possibilities determined by the two neighbouring NHS Trusts. What can and cannot be provided at Stafford should not be the product of policy decisions by our neighbours, but follow from a clear commissioning strategy that is based on proper consultation with the public of Stafford and surrounding areas. We cannot see evidence from this report that there has been any proper consultation on the definition of the Location Specific Services drawn up by the CCGs that have formed the starting point of the TSAs recommendations.

The range of service options looked at throughout the report appears to have been unreasonably restricted. There is more than one way to achieve scale to deliver economies and provide local services (eg links to community). These options do not appear to have been explored and we believe they could well lead to a wider range of services being delivered without the people of Stafford having to travel excessive distances for their health services.

From the outset, the TSAs have leaned heavily on arguments of scale to reach the firm conclusion that Stafford hospital is too small to be successful. This confidence sits uneasily with the success of hospitals of similar size as Stafford both here in England and Europe. We contrast the example of Airedale Hospital which is a small FT that has been lauded by Monitor both for its service quality and financial stability. In France and Germany, a maternity unit of 1,500 births would be considered unexceptional and 3,000 would be among the largest. We are disappointed that the TSAs have not explored what would have to be done to transform Stafford into Airedale and compared the costs and difficulties with its own recommendations.

We hope that these comments will assist the TSAs in drafting their final report to the Secretary of State.

the future of obstetric services at mid-staffs hospital

Stafford Hospital
September 2008

is the proposal of the TSAs to discontinue obstetrics at stafford well judged?

Approximately 1,800 babies are born at Stafford Hospital each year, making it one of the smallest consultant delivered units in the country: leading national clinical advisors to the TSAs say this 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.

The TSAs' recommendations for maternity sit on weak foundations. If the obstetric service at Stafford is to be closed for financial reasons, then the failure to resolve the costs of (and describe) the additional capacity at neighbouring hospitals render the current consultation premature and meaningless? The costs of establishing additional capacity at other providers cannot be compared with a similar investment to strengthen the local service.

If on the other hand, the proposal rests upon expert clinical 'guidance' on viability, then the TSAs have failed to understand or reveal the variety and complexity of expert opinion on this controversial subject? In preliminary discussions with SBC, the TSAs leaned heavily on the alleged authority of the "Royal Colleges." It is perverse to rest upon one source of expert opinion unless this source has been chosen for its consistency with a position already decided. The counter arguments are simply not acknowledged. It could be argued that this provides a false prospectus for the public consultation.

Two points should be made at the outset; and then dealt with in greater depth:

- The relationship between size of maternity unit and outcomes is unresolved. There is as yet no conclusion possible based upon evidence. Also the definition of 'large' and 'small' is far from straightforward.
- The medical Royal Colleges are professional guild organisations and their Presidents and Councils are elected by the rank and file members. Inevitably they must reflect the interests of the membership. It is clear that the working lives of obstetricians and neonatal paediatricians would be improved if births and neonates were gathered into fewer larger units. Although valuable as sources of professional and expert advice the Colleges cannot be considered objective.

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148 NHS Trusts provide obstetric maternity services in 179 hospitals in England and of these 35 are units with <2,500 births p.a. (increasing to 56 units across the UK). The citation of this 2,500 level by the TSAs and the CAG probably originates from the RCOG who similarly use it as marker for 'smaller' units. The TSAs reference a well known RCOG/RCM paper from 1999. A more up to date representation of the RCOG position would be set out in the 2011 paper - "High Quality Women's Healthcare - A Proposal for Change." This is a manifesto for the creation of women's health networks which would cover the full spectrum of women's health issues - health education, ovarian cancer, gynaecological morbidity, etc etc, and of course, obstetrics. A careful reading of this document suggests that the TSAs may be overstating "the Colleges" as a source of authority.

Pg 173 footnote 54: "Towards safer childbirth" RCOG & RCM 1999

The RCOG is understandably focussed on the fundamental problem facing its members, how to staff a 24/7 obstetric service in the new climate which calls for an end to the tradition of leaving junior and middle grade staff to handle out of hours duty. The targets for consultant presence in the labour ward will be much easier to meet if there can be fewer larger maternity units. However, the 2011 RCOG paper stops short of advocating closure of smaller units; opting for a more elliptical statement in one of its 21 recommendations:

"With the implications of the WTR and the likely reduction in trainee numbers within obstetrics, gynaecology and neonatology, careful consideration will need to be given to the need for the current number and configuration of delivery units, the majority of which remain within a hospital setting. It is likely that there will be an increase in the number of midwife-led units, which women will be able to use after validated risk assessment, ensuring choice where appropriate. (Chapters 2 and 5)"

6.17 Summary of recommendations and findings: High Quality Women's Health - A proposal for change RCOG 2011

Whilst the RCOG membership might welcome rationalisation of the UK's maternity depts., they are unwilling to get out in front of what will be fiercely contested and unpopular proposals. Despite the wish of the TSAs to gain cover for its recommendation, nowhere does the RCOG say that existing NHS units of <2,500 are unsafe or non-viable.

The TSAs' statement cites their own advisory group (CAG) as an expert authority to support their recommendation to discontinue the Stafford maternity unit. The CAG included one representative of the RCOG on a group that varied from 12 to 17 attendees and this representative was not able to attend all the meetings. The notes provided by the TSAs do not support the conclusion that

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maternity services options were (or could have been in the time available) seriously debated.

At the final joint meeting of the Medical & Nursing advisory groups the following reference to maternity appears in the notes:

TSA Vol 2 Pg 123

Obstetrical delivery services will no longer be provided in Stafford Hospital. The TSAs recognised the GMS 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 services, women will retain a choice in the location for birth.

It was suggested that an overarching narrative to accompany the business plan between services is required. It was noted 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 NMC 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 Medical GMS was based on a review of high level information. The Nurse GMS agreed to draft a similar letter.

The meeting then concluded.

We particularly note that both the medical and nursing groups asked for a caveat that their opinions were based on a review of high level information - and this presumably information provided by the TSAs.

The position of the TSAs confuses an immaculate audit trail of meetings held with proof that the substantive issues have been reasonably discussed and that the recommendations are supported by financial and clinical evidence. The issues around maternity are certainly not specific to Stafford and the TSAs have failed to acknowledge their complexity.

It is relatively simple to find the other facets of the debate as this is widely known as a contentious issue both within the UK and across the international health sector.

RCOG Europe/Asia:
Cyprus & Greece
Kosovo
Latvia
Lithuania
Malta
Uzbekistan

The RCOG has an (over?) ambitious mission statement: *'To set standards to improve women's health and the clinical practice of obstetrics & gynaecology in the British Isles and across the world.'* their website lists Liaison Groups for 25 countries. Global affairs are grouped under 5 regions of which Europe and East Asia is one. Within "Europe" 6 countries are represented (see left.)

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There is very little reflection here of Britain's European Union partners and nearest neighbours such as Germany, France, Spain, Holland et al - some of who have better maternal and perinatal health outcomes at similar per capita incomes. (We cover the EU position later in this paper.)

The degree to which the presumption that 'smaller' maternity units are non-viable has been accepted without question is surprising and would give cause to question the validity of the consultation.

Even UK expert guidance is divided on the issues relevant to Stafford. In a paper authored by the Professor of Health Policy at Imperial College, a Midwife Director of Community Health Service, Professor of Obstetrics & Gynaecology, and a Consultant Obstetrician; we find the following recommendation:

"NHS Maternity Services" Bournquet et al; Reform, 2005

There must be an end to the drive towards larger, more centralised delivery units across the UK. The current trend to merge medium size 2,000-3,000 delivery maternity units into giant 5,000 or 6,000 plus delivery units is not evidence based. Competition between such medium-sized units should be a driver for higher standards. Although such mergers are currently often driven by the problems of staffing small neonatal intensive care units, other European countries use improved neonatal transport networks to achieve excellent outcomes without the need for an equivalent centralisation of maternity care. Although there is a driver towards further centralisation of maternity units in the form of the European Working Time Directive and its influence on medical cover, we can see no evidence of benefit to patients in closing down smaller maternity units. The German experience suggests that it is possible to provide a high quality of care in smaller units using the integrated model. The drive to centralisation in this country has often lead to maternity services being provided at a considerable distance to women, with no clear gain in improved outcome for mother or baby.

Since the publication of this report, concerns about the viability and desirability of larger maternity depts. have increased. The TSAs appear to have accepted uncritically the proposition that neighbouring maternity depts. can increase their capacity not only to absorb the existing birth numbers at Stafford but also the forecast increases both at Stafford and in their own catchment areas. This acceptance comes before clarification of the revenue and capital costs. A position at complete odds with the forensic preoccupation with cost detail in other parts of the report.

It is also at complete odds with what is happening in the real world of NHS maternity services:

The Telegraph

Maternity wards closure crisis

Maternity wards in England are shutting their doors a total of more than 1,000 times a year forcing expecting mothers to seek care elsewhere or give birth at home, according to new figures.

The simple truth that is that the NHS has been caught napping by an increase in the birth rate, which is now moving at a rate that will outstrip ability to add maternity capacity in the short term. Worse: in a drive subtly engineered by the obstetric profession (as opposed to demands by women) the NHS finds itself in the middle of a rationalisation plan which will concentrate capacity in fewer larger centres. There are proposals (mostly fiercely opposed) to close or downgrade maternity services at 18 hospitals.

Cathy Warwick, RCM chief executive, said: "The baby boom is restarting with renewed vigour. We are already at birth numbers that haven't been seen for at least a couple of generations, probably not in the working life of any midwife practising today. The demand that places on the NHS is enormous."

It seems at least likely that a change of national policy is in the offing as the polity catches up with the issue. It hardly seems the time to invest in the closure of a functioning maternity dept. that the TSAs concede now has no safety or quality issues. It would be more sensible to use the [as yet undefined] resources to expand the existing centre at Stafford. At the least, the two properly costed proposals should be compared in public discussion.

The TSAs have backed themselves into a corner here by too readily assuming that the 'small' Stafford unit has no cost-effective future - thus leaving no alternatives but those proposed by neighbouring NHS hospitals. It would hardly surprise an NHS insider that these neighbours are only interested in investment proposals that increase capacity on their own sites. The timetable has obliged the TSAs to announce this policy for consultation before the costs of the alternative arrangements are defined.

It is unlikely that this position on maternity services would pass the test set by the NHS Operating Framework 2011/12 for such proposals:

NHS England: revised operating framework 2012/13. Dept. of Health

"...service changes must comply with 4 criteria before being given authority to proceed:

i) support from GP commissioners
ii) strengthened public & patient engagement
iii) clearly on the clinical evidence base
iv) consistency with current and prospective patient choice"

The RCOG reaction to the above is worth noting:

"The RCOG Expert Advisory Group strongly supports this concept to ensure that services are designed by the local population to ensure patient centred care."

One of our principal criticisms of the TSAs' deliberations here is a failure to give due consideration to the experience of our near European neighbours who manage to combine smaller maternity units with clinical outcome figures that are better than Britain's; and this at unit costs which are comparable with the NHS. Monitor has missed an opportunity at Stafford to transform a problematic hospital into a showcase for the future of the smaller NHS hospital. Not only is this desirable but, with the scale of investment mooted in the consultation document, it is entirely possible.

The European Union published a significant report on maternity and perinatal health in 2008.

"There is an ongoing debate about the association between the size of maternity units and the quality of care...
...the concentration of births into larger units may lessen more obstetric interventions on women without complications...
...larger maternity units are defined as those with more than 2,000 births p.a. and smaller as those with 500 or less."

This last point is important as many european papers are misread and misquoted by uk commentators assuming that 'large' maternity departments are at UK levels of >4,000 births. Stafford would be a 'large' unit in most of Europe.

In Germany 80% of all births occur in units with less than 2,000 births p.a. without problems of clinical outcomes. In 2012 a suburban hospital in Berlin, (Vivantes Hospital Auguste-Viktoria) with 1,305 births was awarded a WHO and UNICEF award for the quality of its care.

France has similarly found it possible to operate what the UK would define as 'small' units but which would be considered normal by most northern europeans.

Stafford Hospital
September 2008

Holland manages to combine equivalent or better perinatal mortality outcomes with 30% home births compared with 2% in the UK.

Whilst the TSAs have been quick to see the problems facing a small maternity dept. like Stafford, there is no parallel understanding of the difficulties of larger centres. There is the obvious logistical fact that if a large centralised unit has to close (for any reason) then a larger cohort of women is forced to alternative centres, causing a knock-on effect. This is not a hypothetical scenario but one that is becoming all too familiar in today's under-provided NHS.

Nor is there any assurance that a larger unit will deliver safer services: to quote the Bosanquet paper..

"The Kennedy Commission reviewed 3 hospitals in which concerns had raised over a five year period (Martlewick Park London, New Cross Wolverhampton, and Ashford St Peters Surrey). In all three, serious deficiencies were identified including poor reporting of adverse incidents. It is implausible that similar findings would not have been made in other hospitals if they had been subject to similar detailed review."

"NHS Maternity Services", Bosanquet et al Reform, 2005

CONCLUSIONS.....

The closure of the existing maternity department at Stafford and the consequent investment to create additional capacity at neighbouring large units is poorly judged against a context of a rising birth rate nationally and the specific expected increases in families resident in Stafford (increases accepted by the TSAs') Furthermore, neither the financial arguments or clinical evidence stand scrutiny.

The TSAs have made the recommendation in advance of knowing the cost inputs required at neighbouring hospitals and cannot therefore have been able to make an informed comparison with the cost of strengthening the existing unit - this calls into question the validity of the consultation exercise.

The TSAs' report has sought to convey the impression that expert opinion is unequivocal and supportive of their recommendations. This is simply not the case. There is easily available evidence that the issues are disputed with an opposite body of professional opinion arguing against centralisation. The TSAs have not answered the question as to why neighbouring countries are perfectly able and willing to operate much smaller units than Stafford - but, worst of all, they have not even asked it.

appendix 1
NHS Obstetric units 1,000-2,500 births p.a.

Stafford Hospital
September 2012

The logical extension of the TSAs' advice re Stafford is that all of these NHS maternity units will have to close: with births moved to neighbouring hospitals. Alternatively, if some or all can be sustainable, so could Stafford.

	Births p.a
Isle of Wight	1,291
South Tyneside	1,295
Yeovil	1,545
Barnstaple	1,565
Scarborough	1,703
Hereford	1,884
Stafford	1,891
Gateshead	1,917
Salford	1,956
Dorchester	2,037
Macclesfield	2,060
Harrogate	2,100
Winchester	2,124
Yarmouth	2,190
Nuneaton	2,289
Poole	2,298
King's Lynn	2,332
Torbay	2,335
Keighley (Airedale)	2,412
Salisbury	2,447
Huntingdon	2,480

source: HES (Hospital Episode Statistics) 2011/12
Dept of Health - Maternity Table F

In 2007 and 2008 the number of births at Stafford hospital was around the 2,500 level (2,437 and 2,468 respectively). In the succeeding years, the numbers declined until 2011 but then in 2012 increased to just above 2,000. The decrease in births at Stafford occurred against a context of an increasing birth rate and is almost certainly explained by the reputational damage to Stafford Hospital. The most recent figures point to a recovery in its reputation and this is reflected in the TSA's confirmation that there are no current issues about service quality.

appendix 1 - cont
NHS Obstetric units 1,000-2,500 births p.a.

The TSAs have focused on a single year 2011 when the hospital recorded its lowest ever number of births (1,870) - we have sought to show above that the entire approach to the facts and evidence for their maternity recommendations give the impression that they began with conclusions and then looked for arguments that would support them. It is neither logical or fair to assume the lowest ever figure in a single year is a basis point on which to base future policy.

It would be more reasonable to see the combination of three trends as suggesting that births at Stafford will move back past the 2,500 level within a few years:

i) there is a general increase in the national birth rate
ii) the migration away from Stafford Hospital because of bad reputation will reverse as that reputation recovers
iii) the local population will increase significantly through new housing starts and the repatriation of troops and families to the Stafford garrison

For the record, the sequence of birth statistics at Stafford Hospital is reported as:

2007	2,437
2008	2,468
2009	2,231
2010	2,010
2011	1,870
2012	2,003

the future of paediatric services at mid-staffs hospital

Stafford Hospital
September 2013

The proposed transfer of Stafford Hospital's obstetric service would mean that there would not be a local Special Care Baby Unit (SCBU) for sick or underweight newborn babies. In addition to this, the potential transfer of inpatient children's services means that very little specialised capability would be available at Stafford with the principle services being solely for children's outpatients and a Paediatric Assessment Unit.

However the population locally is to grow and since this growth will be partly due to an increase in the number of births, the numbers under the age of sixteen will increase. This factor will be amplified by the presence of military families who tend to have young children. The TSAs propose that that the Paediatric Assessment Unit (PAU) at Stafford operates for the same hours as A&E 8am to 10pm and that it is staffed with children's nurses supported by paediatricians from UHNS. In other words the doctors will not be at Stafford but will be providing advice from Stoke over 18 miles away.

In emergency situations the general public does not concern itself with the fine service distinctions made by the health professionals. Sick children will be brought to the Stafford PAU which will not have the immediate specialised medical capability to deal with them. This therefore imports risk where the TSAs claim they are seeking to reduce it. Worse still, the intended clinical arrangements are unresolved, there having been only "initial positive discussions with UHNS about this". Equally unresolved are the ideas that there might be a local Paediatric Hospital at Home service and enhancement of the community paediatric service.

Local residents are thus being offered a nurse-led urgent care service for 14 hours each day and access to children's outpatient services. As the TSAs say "children in need of urgent or emergency care will still go to Stafford Hospital to be assessed between 8am and 10pm every day, and will be seen by consultant emergency physicians in A&E". Note the terminology, "assessed" not necessarily treated and "consultant emergency physicians" but without a paediatrician being available to see the child. The same questions arise here as they do for the proposed cessation of the local obstetric service. Is the transfer going to offer a demonstrably better and safer service or is the reconfiguration being driven by professional needs and self-interest?

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Getting it right for Children and Young People - overcoming cultural barriers in the NHS so as to meet their needs

DoH Sept 2010
Chair Sir Ian Kennedy

Time for Training: A review of the impact of the EWTD on the quality of training

Medical Education England May 2010
Chair Prof Sir John Temple

The Royal College of Paediatrics and Child Health(RCPCH) is no less a guild than the Royal College of Obstetricians and Gynaecologists. Pressured by a critical Department of Health report on children's services and the need to respond to the European Working Time Directive, the RCPCH produced in 2010 ten service standards in "Facing the Future". In "Back to Facing the Future" published in April 2013 these were audited and the clarion call of 2010 that the standards could not be met "with the current workforce and with the current number of inpatient units" repeated. "Facing the Future" called for general acute paediatric rotas being made up of at least 10 whole time equivalent paediatricians with all being EWTD compliant. The 2013 report expressed satisfaction at having "won the hearts and minds of paediatricians'. In other words it was aimed at the profession, not at serving the wider needs of the public. Some weak evidence is cited indicating that children in hospital do better if seen soon after admission by a consultant paediatrician, which hopefully is the case, but in general the standards are based upon a professional consensus rather than researched evidence. They are the College's response to moving from a consultant-led to a consultant-based service.

So larger units provide a more acceptable working environment for paediatricians and will find it easier to comply with EU working time requirements. The TSAs claim that their proposed closure of the local paediatric service is to meet "safety guidelines" of the RCPCH. But these are service standards and in keeping with the approach of the medical royal colleges are aspirational rather than fixed minimum requirements, partly intended to drive and influence policy change. There is no body of evidence which demonstrates that larger units consistently have better outcomes than smaller units and plenty of smaller paediatric units in business today unable to boast 10 consultants or more. Furthermore no one is claiming that the Stafford unit is unsafe. If it were, it would have to close now.

Consideration appears not to have been given to operating the Stafford Paediatric Unit as an adjunct to the UHNS service, combining the consultant workforce operating across two sites. The current proposals do not appear to have been finalized and so local residents cannot be certain as to what they are being offered or for that matter consulted upon.

the future of critical care and surgical services at mid-staffs hospital

Stafford Hospital
September 2008

The term critical care refers to discrete units within a hospital where high dependency or intensive care services are provided to adults. The TSAs propose to reduce the critical care provision from level 3 to level 2. In other words, patients needing Advanced Respiratory Support or requiring a minimum of two organs being supported could not be treated safely at Stafford Hospital. This is a direct consequence of the proposals to cease emergency surgery and trauma services at Stafford and means that critically ill adults will have to be taken direct or transferred to Stoke or Wolverhampton. This represents a sharp reduction in the clinical capability of Stafford Hospital. It is perhaps for this reason that the TSAs propose a 24 hour daily presence of anaesthetists to intubate patients and supervise their ventilation prior to transfer to UHNS. The question is whether this arrangement is sustainable and what would happen to services at Stafford if it were to fail?

Medical care at both trainee and consultant level in intensive care has traditionally been supplied by anaesthetists. This model is changing slowly at consultant level but more quickly at trainee level. Other specialties can be trained to manage critically ill patients but there is a persisting requirement for high-level airway management skills at short notice for critically ill patients. In hospitals without emergency surgery it would be difficult to justify a full rota of anaesthesia trainees on-call just to run an ICU. At present, there is no system or plan to generate a large skilled workforce from within, say, medicine to support a predominantly medical ICU in a hospital with little or no surgery. Suggestions are made that other practitioners, including advanced nurse practitioners, could be trained to take on much of the work and provide a first on-call tier, especially at night. There is currently no history of their use or infrastructure to facilitate this and there are major issues around the availability of these trained nurses.

There should be a senior nurse with several year's experience and an appropriate level of qualification in charge of the unit, supported by appropriately experienced senior nursing staff. As with numbers, the appropriate level of qualification will need to be assessed for a particular unit, but post-registration education in intensive care nursing would be the desired minimum for senior staff.

It is suggested that at least 25% of senior nursing staff should hold a formal qualification related to intensive care (e.g. ENB 100, Diploma of Nursing etc.). Those units who are involved in providing members of a cardiac arrest team may require Advanced Life Support (ALS) certification, in addition to Basic Life Support (BLS) training and certification.

It follows that a level 2 Critical Care facility at Stafford will need to be operated as part of the overall critical care service provided by UHNS, otherwise the reduction in its activity and status would make it unattractive professionally to a specialised section of the workforce which can be difficult to recruit. The TSAs indicate that UHNS has proposed this sort of arrangement.

The transfer of very sick patients is not without risk. Patients being transferred require skilled care to stabilise them before transfer or senior staff capable of making the decision to 'scoop and run' when the treatment they require precludes stabilisation. Unless transfer teams are provided, transfers seriously deplete the pool of available staff to care for the remaining patients. However, whilst transfer teams are apparently the gold standard, they are suitable only for semi-elective transfers and take too long for certain patients, for example head injuries. Expertise and sound clinical judgement at Stafford Hospital will require the presence of capable, experienced senior doctors. The costs of transfer and effect on the staffing level (and therefore cost) of the Stafford Level 2 Critical Care unit of providing cover to avoid excessive depletion will need to be factored into the planning and costing. Furthermore in any discussion with the public the risks and costs of transferring critically ill adults needs to be set out. To date the TSAs do not appear to have taken these considerations into account.

The effectiveness of a Level 2 Critical Care service will determine the range of surgery undertaken at Stafford. Patients needing pre-operative optimisation, extended post-operative care and/or single organ support depend upon the availability of high dependency services. If for any reason these are not available the ability of Stafford Hospital to provide elective surgical services will be compromised and a further drift of services away from Stafford will result, with consequent diminished access for the local population. This increase in the vulnerability of services at Stafford Hospital needs to be made clear and assurances sought that there would not be further degradation of the hospital's critical care capability sometime in the future.

the future of adult services at mid-staffs hospital

Stafford Hospital
September 2013

In broad outline, the TSA's recommendations for adult inpatients are well argued and are supported by the SBC. The reduction of acute beds through the provision of alternative out-of-hospital services would be welcomed but experience elsewhere suggests that the two should be linked; ie the alternative measures should be put in place and deliver the reduced demand so that beds are reduced in synch with falling demand.

The MAU proposals are also supported, (noting that the final staffing arrangements have not been made clear.) The SBC could see that the integration of the GP out-of-hours service with the hospital A&E argued elsewhere would also have potential crossover benefits for the MAU out-of-hours. The general philosophy of integrated care is strongly supported by the SBC. Many referrals of acute-on-chronic elderly patients will be coming from local GPs and there is scope for further integration and coordination between the elderly care physicians at the hospital and local GPs in both directions - both inreach by GPs having continuing involvement in inpatient management and for specialists to visit and assess patients in primary care settings. There are successful precedents in other NHS locales - eg Brent and Torbay.

The SBC expectation is that the majority of acute elderly patients should be manageable locally, including fractured femurs resulting from falls at home. Where specialist emergency cardiac interventions are undertaken at neighbouring specialist hospitals, the patients should be quickly transferred back to Stafford and the tariff payments should properly reflect the joint responsibility.

to what degree can nearby hospitals provide services to the residents of Stafford?

Stafford Hospital
September [illegible]

Whilst the rear-view mirror shows a Stafford Hospital scene dominated by patient safety issues, the TSAs' report endorses a consensus that these problems have been overcome and care is now at the right quality.

The arguments about the future turn upon financial viability. However, it would appear that the neighbouring NHS hospitals are already operating at maximum capacity. There would be little logic in funding additional beds and facilities at a hospital in Stoke or Wolverhampton and leaving the existing hospital to stand half empty in Stafford. As a last resort perhaps, but we do not see that all the other options are yet fully considered.

In other local health economies the relationship between the local acute hospital and the surrounding health and social services have resulted in different ways of establishing financial viability by creating a more integrated local provider with greater financial and clinical scale. It is an open debate as to whether this integration should be established at a 'county' or 'district' level. There are conflicting examples of success and failure. If the TSAs' truly wish to *'develop a set of options that are clinically sustainable in the long term,'* this issue deserves more thorough debate within the local health economy?

The previous CPT report placed considerable emphasis on hospital size and very quickly defined Stafford as 'relatively small' (at 304 beds) drawing heavily on the 'Royal College' guidance that a full emergency service should serve a population of 450,000-500,000 and a minimum of 300,000.

The uniform application of this guidance by Monitor and/or NHS England would require a cohort of existing NHS hospitals in England to cease provision of a full emergency service. This is extremely unlikely for geopolitical reasons and also because some are successful in both clinical and financial terms. Both Scotland and Wales would can also present similar groups of hospitals.

Other countries draw very different conclusions about hospital size and catchment population. Some in Denmark raise opposite concerns about hospitals that are too large and a recent study by the University of South Denmark gives an 'optimum' size of hospital as 275 beds within a rang of 130-585.

to what degree can nearby hospitals provide services to the residents of Stafford?

Stafford Hospital
September 2012

This debate (about optimum hospital size) is longstanding within the NHS and produces no reliable conclusion other than that it is hotly contested. For example Monitor has itself commissioned recent research into the subject - the executive summary of the resulting report was published in August 2012 and contains the following paragraph:

"Given the importance of economies of scale and scope to so much thinking…it is perhaps surprising that so little is known about their extent and importance. A systematic literature survey as part of this study revealed very little evidence (either positive or negative) about the issue. Many of the existing studies focus on the whole hospital rather than particular services and even these studies are often very limited by poor data and methodologies."

The TSAs' may have unwittingly overstated the advantages of scale for clinical quality. The arguments for complex surgical cases and patients needing super specialist treatment in, say, the neurosciences and cardiac sciences are well established. But so are the patient flows as these patients will already bypass Stafford Hospital.

The TSAs' report suggest that UHNS is the first candidate for linkage to MSFT's future. Could Stafford's populace get more of their treatment at the UHNS hospital?

It may well be rejected by the general public. It would carry an additional social cost in both time and money to get to and from. It would contradict the CCG's aspiration to commission care locally. It would certainly be opposed politically.

Whilst linkage with UHNS offers obvious prospects, there are other ways of doing this than to transfer of significant patient activity to the UHNS site. The leverage of the greater clinical scale at UHNS will require the existing and future clinical faculty to regard the Stafford site as an important location of services, to travel there routinely. This requires careful operational management and rarely occurs naturally.

The TSA is perhaps disingenuous in its proposition that 91% of patient attendances would remain in Stafford. Whilst strictly consistent with the internal logic of the report, it overlooks the issue of relatives and visitors. An admission to UHNS is counted as one trip but in practice it mandates further trips by family members and friends.

to what degree can nearby hospitals provide services to the residents of Stafford?

Given the volumes of episodes, this is a signifcant social burden. This is very different in experience and intensity to attending an out-patient clinic. There is a good (by current UK standards) bus service to and from UHNS but our test of actual timings suggest return travel time of 2-3hours on the day:

time from hospital dept to bus stop walking = 10 mins
interval between buses = 15 mins
journey time to Stafford = 1 hour

The nominal drive time is around 30mins for the car owner but the dysfunctionality of very large hospital sites immediately arises:

Patients face park and ride bus journeys to the University Hospital of North Staffordshire

The Chief Executive of UHNS makes a revealing comment in this article :

"Our hospital is not designed for the number of people using it"

The issues for New Cross Hospital are very similar as those for UHNS. The hospital is of a similar scale and travel distances are comparable.

to what degree can nearby hospitals provide services to the residents of Stafford?

Stafford Hospital
September 2013

Here again we see that the alleged advantages of scale must be balanced to the more negative aspects of the very large hospital. New Cross is a very large and complex site with multiple entry and parking points with the inevitable long walking distances and wayfinding difficulties.

Stafford is in gap between larger hospitals. The journey times to all alternatives sit at, or above, 30minutes by car and much longer by public transport. These journey times are at the borderline of practical and will make life most difficult for the elderly and for non car-owning families.

Acceptable journey time (and cost) is a subjective issue and needs to be seen cumulatively - going once or twice a year for an important clinical episode is different from a daily round trip to visit a spouse or child. A case in point is the conflict between Banbury residents and the John Radcliffe Hospital (Oxford University Hospitals NHS Trust). The matter went to appeal to the IRP* who ruled that to travel 22miles and 36 minutes was "too far" for obstetric, paediatric and emergency patients. The IRP judgement on the (repeated and unsuccessful) proposals by Oxford University Hospitals NHS Trust to turn the Horton into something very similar to the TSAs' vision of a 'local hospital' contains much of relevance for Stafford.

*The IRP is the NHS Independent Review Panel established by the Secretary of State to give objective rulings in contested health service planning decisions. It is the final stage of a long process of consultation.

It is the SBC's view that a distinction must be drawn between the resolution of an immediate and awkward intra-NHS organisational crisis and the long term interests of the population of Stafford. It will be very difficult to row back from a hasty 'fix' that solves the first at the expense of the latter.

At a minimum therefore there should be';

- binding long term guarantees about what hospital services must be provided in Stafford, with specific and detailed arrangements for critical care, obstetrics, and paediatrics;
- the relationship between hospital and community health services in Stafford and surrounds and how the CCG's goal of integration will be secured.

finance

In many ways the most concerning area of the entire report are the finances. Stafford Borough Council has two major areas of concern:

1) The enormous level of funding identified to reprovide services elsewhere along with major levels of double running costs

2) The lack of any sort of financially balanced long term solution.

If these are combined with the confusion in the report about whether service changes are being proposed for safety reasons or financial reasons, the rationale behind these suggested changes appears increasingly fragile.

There is a strong argument that says that the largest part of the income problems that have beset Mid Staffs are directly as a result of reputational damage caused by the initial and follow on reports. Every time the hospital begins to commence the long slow climb of rebuilding its reputation and increasing the confidence that local residents have in using its services, a further report is published thrusting the negative occurences of seven years ago back into the forefront of everyone's mind. Potentially a far more satisfactory solution than that currently proposed by the TSAs would be to invest in Stafford Hospital itself and enable it to attract back patients that have been scared off, hence increasing its income and giving it a far better chance of balancing its books. The proposals currently on the table will reduce the income relating to the site still further making it less and less possible that the services provided there will wash their face financially. This can only lead to greater financial difficulties in the future and the risk that any acquiring Trust will seek to reduce further or cease services in Stafford and sell off the site for capital gain.

There are many changes that could be made to improve the finances of Mid Staffordshire NHS Trust that have nothing to do with service reconfiguration. Indeed the TSAs have included many of these in their financial proposals without identifying that service reconfiguration is not required to deliver them. These include:

"substantial cost savings will be achieved if MSFT no longer exists as an organisation and Stafford and Cannock Chase hospitals are run by other trusts"

finance

"£4.0m can be saved by reducing surplus space at both hospitals. It could be rented out or returned to the Secretary of State for Health"

"The TSAs also estimate a further £10.4m of general cost improvements, such as more bulk purchasing, can be achieved during the transition. This is in line with savings expected of all NHS trusts."

In fact the only saving that has been identified relating to service reconfiguration is £8.6m from a combination of a reduction in various clinical and ward costs! Given the capital requirements identified by UHNS and Wolverhampton this gives a pay back period for the changes of over 25 years. Hardly the financial solution the NHS is looking for.

the 'four tests' of health service reconfigurations

Stafford Hospital
September 2010

The TSA report claims that the 4 Tests for NHS reconfigurations are met by his recommendations but the Council would directly challenge this.

1 Underpinned by clear evidence.

The Council has challenged the evidence base for the TSA's recommendation on Maternity services and will argue the position that European evidence has been completely ignored and professional opinion from the UK selectively quoted to give a false impression of expert consensus.

2 Support from CCGs.

This test is passed, with the reservation that the commissioning arrangements for the NHS have been subject to disruptive reorganisation during the period of consultation. There does not appear to have been consultation with the local community about the CCGs new commissioning plans which have defined the 'core locally specified services'.

3 The public and local authorities have been genuinely engaged.

It is absolutely impossible for the TSA to claim that this test is passed. An immaculate audit trail of meetings at which the TSA has explained and re-explained the complex process cannot be confused with genuine engagement. The simple truth is that all meaningful discussions of proposals and finances have taken place behind closed doors among the NHS managerial community. The SBC, despite attempts to engage directly and through its expert advisers, has had no opportunity for substantive discussion of the possibilities. The Council will vigorously contest that this test has been passed.

4 A good choice of quality providers.

Again this test is emphatically not passed. The only realistic conclusion possible from the report is that Stafford Hospital will be passed to UHNS and that, for Stafford citizens, Stoke will be the only place that services formerly available locally can be accessed. The contextual issue that Stoke is struggling to meet its existing demand particularly in Obstetrics and A&E has been glossed over.

risk

Stafford Hospital
September 2013

On several occasions in this report the low level of existent risk surrounding the current services at Stafford Hospital has been highlighted. We have also demonstrated that several of the changes proposed by the TSAs would lead to an increased risk for the residents of Stafford, for example - the removal of 24 hour paediatrician cover for children.

The Council is aware of the reports that the TSAs have not carried out risk assessments of their proposals - if this were to be the case it would be of grave concern to the Council. We believe that a full risk assessment of many of the changes suggested would clearly demonstrate their potential to cause real harm to the most vulnerable individuals in our society. If it is true that such a basic necessity has been overlooked by the TSA, this further undermines the consultation and raises significant questions about the whole process.

The Health and Equality Impact Assessment Steering Group

The TSAs established the Health and Equality Impact Assessment Steering Group to (among other things) understand the impacts of the TSAs' draft recommendations on the health of the local population.

Stafford Borough Council understands that the final report of this group will not be published until after the close of consultation. Considering this report should contain a large amount of information that may have been of use to the Council and the public in responding to the TSAs' consultation, the Council believes it should have been published well in advance of the close of consultation.

The initial scoping report of the group published in July asks far more questions than it answers and although there are representatives on the group from various stakeholders, the Council understands that they have had to sign secrecy agreements which prevent the sharing of any information prior to the conclusion of consultation.

If there is information in this report that comes to light after the conclusion of consultation that affects the conclusions that SBC have drawn, we would consider that it negates the value and validity of the consultation completely.

governance

The primary focus of Stafford Borough Council in responding to this consultation is to safeguard the health services that are provided for the residents of Stafford into the future. The actual configuration of the organisation chosen to deliver these services is of less interest and concern. However, of major importance is the guarantee that services agreed as a product of consultation will continue to be provided after the consultation has been completed. It cannot be acceptable for a future body to decide that a service will cease because of the financial problems possessed by its host organisation.

This is of particular concern when considering the suggestion that the services should be run by an NHS organisation already known to have significant financial problems of its own making. There may be a temptation in future years to further reduce services at Stafford to enable services to continue at, for example, Stoke. There do not appear to be any safeguards included within the TSAs' proposals to prevent this happening. This situation has been witnessed many times over in health economies across the country and we are unable to support proposals that do not include cast-iron guarantees about the ongoing provision of services within Stafford for the reasonable future.

William Leslie Trigg

Town Clerk

Stone Town Council

Q2

Stafford should return to a 24 hour A & E Department.

Q9

Stafford hospital should continue to provide a full maternity service.

It is important to Stone that a fully viable service is maintained at both Stafford and North Staffordshire hospitals.

Q13

The Paediatric Assessment Unit (PAU) should have access to consultants based at Stafford hospital, not UHNS.

It should be open at Stafford for the same hours as A & E.

Recommendation 7 could only be supported if recommendation 6 is implemented. There is no provision within the questionnaire to express this opinion, other than just within comments, which are unlikely to receive full consideration.

Q15

Major surgery should continue to be provided at Stafford hospital.

It is important to Stone that a fully viable service is maintained at both Stafford and North Staffordshire hospitals.

Q17

Again the questions, as presented in this document, does not allow a full opinion to be expressed.

We think it is important to retain a full critical care facility at Stafford. However, if this is not done, the proposed small facility is the least that should be provided.

The questions do not allow us to express this opinion, only the comments, which are unlikely to receive full consideration.

Q19

The full range of current services should remain at Stafford hospital.

It is important to Stone that a fully viable service is maintained at both Stafford and North Staffordshire hospitals.

Q27

The organisational structure is unimportant compared with the range of services to be delivered to the public.

It is important to put in place an organisational structure which will deliver viable services to the residents of the area in the long term.

Q28

We are concerned that the nature of the questions in this document have not allowed opinions to be expressed fully.

In particular, where a service is proposed to change, and an alternative put in its place, opposing the change does not allow a comment on the alternative service if the change happens anyway. For example, opposing recommendation 6 means that opposition must also be indicated to recommendation 7. This does not allow meaningful consideration of recommendation 7. Recommendation 7 should allow for two responses - one if recommendation 6 goes ahead and one if it does not.

for two responses - one if recommendation 6 goes ahead and one if it does not.

This weakness appears in a number of areas of the document and undermines the validity of the consultation.

30 SEP 2013

Mid Staffordshire NHS
NHS Foundation Trust

Office of the
Trust Special Administrator
of MSFT

Maintaining high quality, safe services for the future – Consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals

6 August – 1 October 2013

Your response to the consultation

As part of the *Maintaining high quality, safe services for the future* consultation, we want to make sure that those in Mid Staffordshire have the chance to give their views and comments. We are asking people to give us their views by reading the consultation document and completing this response form. Alternatively, you can complete the same response form online at www.tsa-msft.org.uk.

We are keen to hear your views to help inform our final recommendations that go to Monitor and the Secretary of State for Health. Please bear in mind this is a consultation, not a 'vote'. We will take responses into account along with a wide range of other information. We are interested in the overall responses to the tick box questions, and your reasons for your views. If you don't have any views on a specific question, please leave the boxes blank. You do not need to answer every question. **Please only write within the boxes provided in this response form. If your comments do not fit in the box, please send your comments on a separate sheet of paper, clearly stating which question they refer to.**

We have asked Ipsos MORI to undertake the analysis of the response forms on our behalf. The findings will help to inform the Trust Special Administrators' (TSAs) final recommendations to Monitor and the Secretary of State for Health. Please read the consultation document all the way through, then give us your answers to the questions in this response form. In the response form we have shown which pages of the consultation document cover the issues raised by each of the questions. Please refer back to the relevant pages as you answer the questions. You can download a full copy of the consultation document at www.tsa-msft.org.uk.

If you want to explain any of your answers, or you feel the questions have not given you the chance to express your views fully, or if you think there are options we have not considered that we should have done, please say so in the box for question 28.

Important: Please do not provide the names of any individuals in the feedback boxes. Please do not include in your response any other information that could identify individuals.

Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send it to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG

You do not need a stamp. **Any responses received after midnight on Tuesday 1 October 2013 will not be accepted or considered. The envelope is second class, so please return your response form in plenty of time to reach us.**

If you require a large print copy please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk.

1000008652

Ipsos MORI

Page No. 1

13-020881-01 - Response Form - FINAL - v4 - 250713 - PUBLIC

Unless you are responding on behalf of an organisation, this form does not ask you to supply us with your name or other contact details. You will, however, be asked to supply details of your postcode and your personal circumstances; you do not have to give these details if you do not want to. This information is only being collected in order to help us analyse responses to the consultation by Clinical Commissioning Group (CCG) area and key groups of the local population. It will not be used to identify specific individuals. Any personal data that you do supply will be handled by the TSAs in accordance with their obligations under the Data Protection Act 1998. When you complete the response form please do not include any information that could identify other individuals.

We do not intend to publish or disclose any personal information that could identify any individual. A document summarising all consultation responses we receive will however be attached to the TSAs' final report and will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide whether as an individual, an organisation or group, may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Thank you for your feedback.

Questions on emergency and urgent care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 24 of the consultation document.

Recommendation 1: Emergency and urgent care at Stafford Hospital

Q1 How far do you support or oppose the recommendation around the Accident and Emergency (A&E) department at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/don't know
☐	☑	☐	☐	☐	☐

Q2 What further comments, if any, do you have on any of the proposals outlined around emergency and urgent care at Stafford Hospital in Recommendation 1 in the consultation document, including the reasons for your answer to question 1? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

PUBLIC CONCERN ABOUT THE LOSS OF A LOCAL FACILITY WILL LEAD TO EXTENDED JOURNEY TIMES TO ALTERNATIE FACILITIES.

Page No. 2

Questions on inpatient services for adults at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 26-27 of the consultation document.

Recommendation 2

Q3 How far do you support or oppose the recommendation around the inpatient service for adults with medical problems at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Recommendation 3

Q4 How far do you support or oppose the recommendation around a Frail Elderly Assessment service at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Recommendation 4

Q5 How far do you support or oppose the recommendation that beds should be available at Stafford Hospital for recovering patients?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Inpatient services for adults at Stafford Hospital (recommendations 2-4)

Q6 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around inpatient services for adults at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 3

Recommendations 2, 3 and 4: Inpatient services for adults at Stafford Hospital

Q7 What further comments, if any, do you have on any of the proposals outlined around inpatient services for adults in Recommendations 2, 3 and 4 in the consultation document, including the reasons for your answers to questions 3, 4, 5 and 6? Please also include any improvements you would like to suggest to these recommendations.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

THE PROPOSALS ARE WELCOMED FOR FRAIL ELDERLY ASSESSMENT.

RECOVERY AT LOCAL HOSPITALS SHOULD BE ENCOURAGED.

Questions on maternity services in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 28 of the consultation document.

Recommendation 5: Maternity services in Stafford

Q8 How far do you support or oppose the recommendation around maternity services in Stafford?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☐	☐	☑	☐

Page No. 4

Q9 What further comments, if any, do you have on any of the proposals outlined around maternity services in Stafford in Recommendation 5 in the consultation document, including the reasons for your answer to question 8? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

THE CASE IS NOT MADE REGARDING BIRTH NUMBERS.

LOSS OF FACILITIES WILL CAUSE MAJOR TRANSPORT DIFFICULTIES

CONTINUATION OF ROUTINE PRE + POST NATAL CARE WELCOMED.

Questions on services for children in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 30-31 of the consultation document.

Recommendation 6

Q10 How far do you support or oppose the recommendation around the inpatient service for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Recommendation 7

Q11 How far do you support or oppose the recommendation around the Paediatric Assessment Unit (PAU) at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Services for children in Stafford (recommendations 6-7)

Q12 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around services for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 5

Recommendations 6 and 7: Services for children in Stafford

Q13 What further comments, if any, do you have on any of the proposals outlined around services for children in Stafford in Recommendations 6 and 7 in the consultation document, including the reasons for your answers to questions 10, 11 and 12? Please also include any improvements you would like to suggest to these recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones.**

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

CONCERNS ABOUT DOWNGRADING OF PAU FROM 24HR TO 08:00-22:00.

LOSS OF INPATIENT FACILITY FOR CHILDREN WILL CAUSE TRAVEL PROBLEMS. CONSIDERATION SHOULD BE GIVEN TO ALLOW PARENTS TO STAY OVERNIGHT.

Questions on major emergency surgery at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 32 of the consultation document.

Recommendation 8: Major emergency surgery at Stafford Hospital

Q14 How far do you support or oppose the recommendation around major emergency surgery at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 6

Q15 What further comments, if any, do you have on any of the proposals outlined around major emergency surgery at Stafford Hospital in Recommendation 8 in the consultation document, including the reasons for your answer to question 14? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

TRAFFIC CONDITIONS COULD MAKE PATIENT TRANSPORT MORE DIFFICULT

Questions on critical care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 34 of the consultation document.

Recommendation 9: Critical care at Stafford Hospital

Q16 How far do you support or oppose the recommendation around the critical care unit at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 7

Q17 What further comments, if any, do you have on any of the proposals outlined around critical care at Stafford Hospital in Recommendation 9, including the reasons for your answer to question 16? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

TRAFFIC CONDITIONS MAY MAKE PATIENT TRANSPORT MORE DIFFICULT

Questions on elective care and day cases at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 36 of the consultation document.

Recommendation 10: Elective care and day cases at Stafford Hospital

Q18 How far do you support or oppose the recommendation around elective care and day cases at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 8

Q19 What further comments, if any, do you have on any of the proposals outlined around elective care and day cases at Stafford Hospital in Recommendation 10 in the consultation document, including the reasons for your answer to question 18? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on Chapter 7 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained in Chapter 7 of the consultation document (pages 38-40).

Recommendation 11: Step down care and rehabilitation at Cannock Chase Hospital

Q20 How far do you support or oppose the recommendation that beds should be available at Cannock Chase Hospital for recovering patients?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 9

Q21 What further comments, if any, do you have on any of the proposals outlined around beds for recovering patients at Cannock Chase Hospital in Recommendation 11 in the consultation document, including the reasons for your answer to question 20? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

THE PROVISION OF STEP DOWN BEDS IS WELCOMED. (ALLOWING RECUPERATION CLOSER TO HOME).

PROPER DISCHARGE ARRANGEMENTS SHOULD BE IN PLACE.

Recommendation 12: Elective inpatient surgery at Cannock Chase Hospital

Q22 How far do you support or oppose the recommendation around elective inpatient surgery at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Q23 What further comments, if any, do you have on any of the proposals outlined around elective inpatient surgery at Cannock Chase Hospital in Recommendation 12 in the consultation document, including the reasons for your answer to question 22? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

HAVING MORE ELECTIVE SURGERY AT SDGH WILL IMPACT ON CANNOCK HOSPITAL.

THE PROPOSED INCREASE IN THE SCOPE OF ELECTIVE SURGERY AT CANNOCK WOULD BE SUPPORTED.

Page No. 10

Recommendation 13: Day cases (surgical and medical) at Cannock Chase Hospital

Q24 How far do you support or oppose the recommendation around day case procedures at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Q25 What further comments, if any, do you have on any of the proposals outlined around day case procedures in Recommendation 13 in the consultation document, including the reasons for your answer to question 24? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.
If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.
Please do not include details that could be used to identify any individuals.

THE POTENTIAL INCREASE IN THE RANGE OF CONDITIONS DEALT WITH WOULD IMPROVE THE SERVICE AVAILABLE & ASSIST THE VIABILITY OF THE HOSPITAL

Questions on Chapter 8 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained in Chapter 8 of the consultation document (pages 42-43).

Recommendation 14: Organisational plans for Mid Staffordshire NHS Foundation Trust

Q26 How far do you support or oppose the recommendation for Mid Staffordshire NHS Foundation Trust (MSFT) to be dissolved, with the services at Stafford and Cannock Chase hospitals managed and delivered by another organisation or organisations in the future?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 11

Q27 What further comments, if any, do you have on any of the proposals outlined around Recommendation 14 in the consultation document, including the reasons for your answer to question 26? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

PROLONGED PERIOD OF UNCERTAINTY IS UNWELCOME

A WIDE RANGE OF SERVICES SHOULD BE PROVIDED AT CARROW TO IMPROVE PATIENT CARE AT A VIABLE LOCAL LEVEL.

Final comments

Q28 Is there anything else you want to say about the consultation or the issues it covers? If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so here. Please also say if there are any improvements you would like to suggest to the recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

CONCERN AT THE LOSS OF LOCAL SERVICES, ESPECIALLY THE 24 HR A+E AND MATERNITY SERVICES.

Page No. 12

Background Information

Q29 Are you:
Please tick ✓ one box only

- ☐ Providing your own response or responding on behalf of another individual?
  Please go to Q30
- ☐ Submitting your response on behalf of an organisation or group?
  Please go to Q41

If you are responding on your own behalf, please complete the following questions. If you are responding on behalf of another individual, please complete the following questions about them.

Q30 Which, if any, of the following apply to you?
Please tick ✓ as many boxes as apply

- ☐ I currently work in the NHS
- ☐ I used to work in the NHS
- ☐ I currently work in the independent health sector
- ☐ I used to work in the independent health sector
- ☐ I do not work in, and have not worked in, the NHS or the independent health sector
- ☐ Prefer not to say
- ☐ Don't know

Q31 What is your closest hospital?
Please tick ✓ one box only

- ☐ Cannock Chase Hospital
- ☐ Manor Hospital
- ☐ New Cross Hospital
- ☐ Princess Royal Hospital
- ☐ Queen's Hospital
- ☐ Stafford Hospital
- ☐ University Hospital of North Staffordshire
- ☐ Other **(Please tick and write in below)**
- ☐ Don't know

Personal Details

We would be grateful if you could answer the following questions so we can establish if we have responses from a cross-section of people, and to allow us to analyse the results overall and by these different groups of people. None of the information you supply will be used by us in order to identify you. However, you should appreciate that it is possible that you could be identifiable from the information you supply in this section. Any identifiable information you do supply will be held by the TSAs securely, in confidence and in accordance with their obligations under the Data Protection Act 1998. You do not have to provide your personal details. If you do complete this section, please tick the box below to confirm that we may use your personal data for the purpose of analysing the results of the consultation.

- ☐ **I agree that the TSAs may use the details I have supplied in response to Q32-40 for the purpose of analysing the results of the consultation**

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Q32 Please can you provide your full home postcode
Please write in below

Full Postcode ☐ ☐ ☐ ☐ ☐ ☐ ☐

Q33 Are you ...?
Please tick ✓ one box only

- ☐ Male
- ☐ Female
- ☐ Prefer not To say

Q34 How old are you?
Please tick ✓ one box only

- ☐ Under 18
- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or over
- ☐ Prefer not to say

Q35 Which ethnic group do you consider yourself to belong to?
Please tick ✓ one box only

- ☐ White
- ☐ Mixed
- ☐ Asian or Asian British
- ☐ Black or Black British
- ☐ Chinese
- ☐ Other **(Please tick and write in below)**

☐

- ☐ Prefer not to say

Q36 Do you consider yourself to have a disability? [The Equality Act 2012 defines a disability as "a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities".]
Please tick ✓ one box only

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Q37 Do any of the following apply to you?
Please tick ✓ all the boxes that apply

- ☐ I have children
- ☐ I am pregnant
- ☐ I care for children under the age of 16
- ☐ None of these
- ☐ Prefer not to say

Q38 When did you last visit one of the hospitals listed in Q31, either as a patient or to visit a family member or friend?
Please tick ✓ one box only

- ☐ In the last six months
- ☐ In the last year
- ☐ More than a year ago
- ☐ Never
- ☐ Can't remember

Q39 Do you care for someone in your family or a friend because they have a health need?
Please tick ✓ all that apply

- ☐ Yes – someone aged 16 or over
- ☐ Yes – a child aged under 16
- ☐ No

Page No. 14

Q40 Have you or your family used any of the services below provided by the NHS within the last year?

Please tick ✓ all that apply

- ☐ GP care
- ☐ Community nursing and therapy services
- ☐ Community paediatric services (for example, health visitor)
- ☐ Mental health care
- ☐ End-of-life care
- ☐ Paediatric (children's) hospital care
- ☐ Maternity and newborn care
- ☐ Emergency or urgent care, including intensive care
- ☐ Elective care (see page 36 of the consultation document for an explanation)
- ☐ Outpatients
- ☐ Other
- ☐ None of these
- ☐ Prefer not to say

If you have answered any of questions 32-40 then please make sure you have ticked the box at the bottom of page 13 of this form so that your answers can be used to analyse the results of the consultation.

Details of your organisation or group

If you are sending us a response on behalf of an organisation or group, please complete these questions.

If you are responding on your own behalf or on behalf of another person, please go to the end of this response form.

Please be as detailed as you can. For example, if you are responding on behalf of a group or organisation, please record the name of the group or organisation. Your personal details will be handled by the TSAs in accordance with their obligations under the Data Protection Act and will not be made public. Please remember, however, that information summarising the overall response to the consultation will be attached to the TSAs' final report which will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Q41 What is your name, job position and the name and address of the organisation or group on whose behalf you are submitting this response? The name and details of your organisation or group may appear in the final report.

PARISH CLERK
HEATH HAYES + WIMBLEBURY PARISH COUNCIL.

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Q42 What category of organisation or group are you representing?
Please tick ✓ as many boxes as apply

- ☐ A professional body (e.g. a Royal College)
- ☐ An NHS trust (provider of services)
- ☐ Charity / voluntary sector group
- ☐ National patient group
- ☐ Local patient group
- ☑ Local Authority
- ☐ Trade union
- ☐ Trade body
- ☐ Academic organisation
- ☐ Political party / Political group
- ☐ Clinical Commissioning Group
- ☐ Other NHS body
- ☐ Regulatory body
- ☐ Other
- ☐ Don't know

Q43 Please write in the total number of members in your organisation or group.

13

Q44 Please tell us who the organisation or group represents and, if it applies, how you gathered and summarised the views of members.

HEATH HAYES + WIMBLEBURY PARISH COUNCIL.
COUNCIL MEETING.

Thank you for your comments.
Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG
You do not need a stamp. **The envelope is second class, so please return your response form in plenty of time to reach us.**

If you need help to complete this form, or if you would like to complete it in another language, please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk. The telephone number is freephone from landlines, but charges may apply for calls from mobile telephones.

If you have any queries or complaints regarding the consultation process or consultation documentation content, please contact: The Trust Special Administrators, Mid Staffordshire NHS Foundation Trust, Stafford Hospital, Weston Road, Stafford, ST16 3SA
Please note that any queries or complaints submitted via this process cannot be counted as part of the formal consultation.

Page No. 16

Office of the
Trust Special Administrator
of MSFT

Mid Staffordshire NHS
NHS Foundation Trust

30 SEP 2013

Maintaining high quality, safe services for the future – Consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals

6 August – 1 October 2013

Your response to the consultation

As part of the *Maintaining high quality, safe services for the future* consultation, we want to make sure that those in Mid Staffordshire have the chance to give their views and comments. We are asking people to give us their views by reading the consultation document and completing this response form. Alternatively, you can complete the same response form online at www.tsa-msft.org.uk.

We are keen to hear your views to help inform our final recommendations that go to Monitor and the Secretary of State for Health. Please bear in mind this is a consultation, not a 'vote'. We will take responses into account along with a wide range of other information. We are interested in the overall responses to the tick box questions, and your reasons for your views. If you don't have any views on a specific question, please leave the boxes blank. You do not need to answer every question. **Please only write within the boxes provided in this response form. If your comments do not fit in the box, please send your comments on a separate sheet of paper, clearly stating which question they refer to.**

We have asked Ipsos MORI to undertake the analysis of the response forms on our behalf. The findings will help to inform the Trust Special Administrators' (TSAs) final recommendations to Monitor and the Secretary of State for Health. Please read the consultation document all the way through, then give us your answers to the questions in this response form. In the response form we have shown which pages of the consultation document cover the issues raised by each of the questions. Please refer back to the relevant pages as you answer the questions. You can download a full copy of the consultation document at www.tsa-msft.org.uk.

If you want to explain any of your answers, or you feel the questions have not given you the chance to express your views fully, or if you think there are options we have not considered that we should have done, please say so in the box for question 28.

Important: Please do not provide the names of any individuals in the feedback boxes. Please do not include in your response any other information that could identify individuals.

Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send it to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG

You do not need a stamp. **Any responses received after midnight on Tuesday 1 October 2013 will not be accepted or considered. The envelope is second class, so please return your response form in plenty of time to reach us.**

If you require a large print copy please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk.

Page No. 1

1000010532

Ipsos MORI

13-020881-01 - Response Form - FINAL - v4 - 250713 - PUBLIC

Unless you are responding on behalf of an organisation, this form does not ask you to supply us with your name or other contact details. You will, however, be asked to supply details of your postcode and your personal circumstances; you do not have to give these details if you do not want to. This information is only being collected in order to help us analyse responses to the consultation by Clinical Commissioning Group (CCG) area and key groups of the local population. It will not be used to identify specific individuals. Any personal data that you do supply will be handled by the TSAs in accordance with their obligations under the Data Protection Act 1998. When you complete the response form please do not include any information that could identify other individuals.

We do not intend to publish or disclose any personal information that could identify any individual. A document summarising all consultation responses we receive will however be attached to the TSAs' final report and will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide whether as an individual, an organisation or group, may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Thank you for your feedback.

Questions on emergency and urgent care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 24 of the consultation document.

Recommendation 1: Emergency and urgent care at Stafford Hospital

Q1 How far do you support or oppose the recommendation around the Accident and Emergency (A&E) department at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/don't know
☐	☐	☐	☐	☑	☐

Q2 What further comments, if any, do you have on any of the proposals outlined around emergency and urgent care at Stafford Hospital in Recommendation 1 in the consultation document, including the reasons for your answer to question 1? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Stafford should have 24/7 A&E
WITH NEESSARY SUPPORT SERVICES

Page No. 2

Questions on inpatient services for adults at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 26-27 of the consultation document.

Recommendation 2

Q3 How far do you support or oppose the recommendation around the inpatient service for adults with medical problems at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Recommendation 3

Q4 How far do you support or oppose the recommendation around a Frail Elderly Assessment service at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Recommendation 4

Q5 How far do you support or oppose the recommendation that beds should be available at Stafford Hospital for recovering patients?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Inpatient services for adults at Stafford Hospital (recommendations 2-4)

Q6 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around inpatient services for adults at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 3

Recommendations 2, 3 and 4: Inpatient services for adults at Stafford Hospital

Q7 What further comments, if any, do you have on any of the proposals outlined around inpatient services for adults in Recommendations 2, 3 and 4 in the consultation document, including the reasons for your answers to questions 3, 4, 5 and 6? Please also include any improvements you would like to suggest to these recommendations.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on maternity services in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 28 of the consultation document.

Recommendation 5: Maternity services in Stafford

Q8 How far do you support or oppose the recommendation around maternity services in Stafford?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 4

Q9 What further comments, if any, do you have on any of the proposals outlined around maternity services in Stafford in Recommendation 5 in the consultation document, including the reasons for your answer to question 8? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Questions on services for children in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 30-31 of the consultation document.

Recommendation 6

Q10 How far do you support or oppose the recommendation around the inpatient service for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Recommendation 7

Q11 How far do you support or oppose the recommendation around the Paediatric Assessment Unit (PAU) at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Services for children in Stafford (recommendations 6-7)

Q12 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around services for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 5

Recommendations 6 and 7: Services for children in Stafford

Q13 What further comments, if any, do you have on any of the proposals outlined around services for children in Stafford in Recommendations 6 and 7 in the consultation document, including the reasons for your answers to questions 10, 11 and 12? Please also include any improvements you would like to suggest to these recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones.**

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

HAVING LOCAL ASSESSMENT & SPECIALIST CARE ELSEWHERE SEEMS A GOOD THING.
ONLY CAVEAT IS THAT ASSESSMENT SERVICE NOT AVAILABLE 24/7

Questions on major emergency surgery at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 32 of the consultation document.

Recommendation 8: Major emergency surgery at Stafford Hospital

Q14 How far do you support or oppose the recommendation around major emergency surgery at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 6

Q15 What further comments, if any, do you have on any of the proposals outlined around major emergency surgery at Stafford Hospital in Recommendation 8 in the consultation document, including the reasons for your answer to question 14? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

REASONING BEHIND MAJOR EMERGENCY CASES GOING ELSEWHERE SEEMS GOOD

Questions on critical care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 34 of the consultation document.

Recommendation 9: Critical care at Stafford Hospital

Q16 How far do you support or oppose the recommendation around the critical care unit at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 7

Q17 What further comments, if any, do you have on any of the proposals outlined around critical care at Stafford Hospital in Recommendation 9, including the reasons for your answer to question 16? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

IF EMERGENCY SURGERY GOING ELSEWHERE SEEMS LOGICAL THAT CRITICAL CARE. SHOULD BE TREATED ON SAME BASIS

Questions on elective care and day cases at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 36 of the consultation document.

Recommendation 10: Elective care and day cases at Stafford Hospital

Q18 How far do you support or oppose the recommendation around elective care and day cases at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 8

Q19 What further comments, if any, do you have on any of the proposals outlined around elective care and day cases at Stafford Hospital in Recommendation 10 in the consultation document, including the reasons for your answer to question 18? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

RETAINING PLANNED ELECTIVE SURGERY AT STAFFORD SEEM A GOOD IDEA

Questions on Chapter 7 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained in Chapter 7 of the consultation document (pages 38-40).

Recommendation 11: Step down care and rehabilitation at Cannock Chase Hospital

Q20 How far do you support or oppose the recommendation that beds should be available at Cannock Chase Hospital for recovering patients?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 9

Q21 What further comments, if any, do you have on any of the proposals outlined around beds for recovering patients at Cannock Chase Hospital in Recommendation 11 in the consultation document, including the reasons for your answer to question 20? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet stating which question your comments refer to. Please do not include details that could be used to identify any individuals.

WOULD SUPPORT RETENTION OF LOCAL SERVICES AT CANNOCK

Recommendation 12: Elective inpatient surgery at Cannock Chase Hospital

Q22 How far do you support or oppose the recommendation around elective inpatient surgery at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Q23 What further comments, if any, do you have on any of the proposals outlined around elective inpatient surgery at Cannock Chase Hospital in Recommendation 12 in the consultation document, including the reasons for your answer to question 22? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.

WELCOME ENHANCED RANGE OF ELECTIVE SURGICAL PROCEDURES AT CANNOCK

Page No. 10

Recommendation 13: Day cases (surgical and medical) at Cannock Chase Hospital

Q24 How far do you support or oppose the recommendation around day case procedures at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Q25 What further comments, if any, do you have on any of the proposals outlined around day case procedures in Recommendation 13 in the consultation document, including the reasons for your answer to question 24? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.
If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.
Please do not include details that could be used to identify any individuals.

CANNOCK IS A FRIENDLY HOSPITAL
WITH REASONABLE ACCESS

Questions on Chapter 8 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained in Chapter 8 of the consultation document (pages 42-43).

Recommendation 14: Organisational plans for Mid Staffordshire NHS Foundation Trust

Q26 How far do you support or oppose the recommendation for Mid Staffordshire NHS Foundation Trust (MSFT) to be dissolved, with the services at Stafford and Cannock Chase hospitals managed and delivered by another organisation or organisations in the future?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 11

Q27 What further comments, if any, do you have on any of the proposals outlined around Recommendation 14 in the consultation document, including the reasons for your answer to question 26? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

FIXING THE CURRENT ORGANISATION SEEMS IMPOSSIBLE SO DISSOLUTION SEEMS A GOOD OPTION, BUT CARE MUST BE TAKEN THAT DISSOLUTION DOES NOT LEAD TO FURTHER DOWNGRADING & EVENTUAL CLOSURE.

Final comments

Q28 Is there anything else you want to say about the consultation or the issues it covers? If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so here. Please also say if there are any improvements you would like to suggest to the recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

IT SEEMS THAT THE MAJORITY OF STAFF AT BOTH HOSPITALS WERE NOT CONSULTED PRIOR TO THE PROPOSAL BEING WRITTEN. THIS SEEMS TO HAVE BEEN A MISTAKE ON THE PART OF THE ADMINISTRATION LEADING INEVITABLY TO THE ACCUSATION THAT THE PROPOSALS WERE DETERMINED IN ADVANCE.

IT REMAINS TO BE SEEN IF ANY CHANGES WILL BE MADE AS A RESULT OF THIS CONSULTATION PROCESS ALTHOUGH THE PATIENT CARE & SPECIALITIES AT N. STAFFS FAR OUTWEIGH THOSE AT STAFFORD, IT REMAINS A FACT THAT THE N. STAFFS SITE ITSELF IS A MISHMASH OF BUILDINGS WITH A VERY VERY POOR LAYOUT FROM THE VISITORS VIEWPOINT. AND ABSOLUTELY APPALLING PARKING PROVISION. A LOT OF MONEY NEEDS TO CONTINUE TO BE SPENT ON UPGRADING THE PHYSICAL ASPECTS OF N. STAFFS

Page No. 12

Background Information

Q29 Are you:
Please tick ✓ one box only

- ☐ Providing your own response or responding on behalf of another individual?
  Please go to Q30
- ☑ Submitting your response on behalf of an organisation or group?
  Please go to Q41

If you are responding on your own behalf, please complete the following questions. If you are responding on behalf of another individual, please complete the following questions about them.

Q30 Which, if any, of the following apply to you?
Please tick ✓ as many boxes as apply

- ☐ I currently work in the NHS
- ☐ I used to work in the NHS
- ☐ I currently work in the independent health sector
- ☐ I used to work in the independent health sector
- ☐ I do not work in, and have not worked in, the NHS or the independent health sector
- ☐ Prefer not to say
- ☐ Don't know

Q31 What is your closest hospital?
Please tick ✓ one box only

- ☐ Cannock Chase Hospital
- ☐ Manor Hospital
- ☐ New Cross Hospital
- ☐ Princess Royal Hospital
- ☐ Queen's Hospital
- ☐ Stafford Hospital
- ☐ University Hospital of North Staffordshire
- ☐ Other **(Please tick and write in below)**
- ☐ Don't know

Personal Details

We would be grateful if you could answer the following questions so we can establish if we have responses from a cross-section of people, and to allow us to analyse the results overall and by these different groups of people. None of the information you supply will be used by us in order to identify you. However, you should appreciate that it is possible that you could be identifiable from the information you supply in this section. Any identifiable information you do supply will be held by the TSAs securely, in confidence and in accordance with their obligations under the Data Protection Act 1998. You do not have to provide your personal details. If you do complete this section, please tick the box below to confirm that we may use your personal data for the purpose of analysing the results of the consultation.

☐ **I agree that the TSAs may use the details I have supplied in response to Q32-40 for the purpose of analysing the results of the consultation**

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Q32 Please can you provide your full home postcode
Please write in below

Full Postcode ☐ ☐ ☐ ☐ ☐ ☐ ☐

Q33 Are you ...?
Please tick ✓ one box only

- ☐ Male
- ☐ Female
- ☐ Prefer not To say

Q34 How old are you?
Please tick ✓ one box only

- ☐ Under 18
- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or over
- ☐ Prefer not to say

Q35 Which ethnic group do you consider yourself to belong to?
Please tick ✓ one box only

- ☐ White
- ☐ Mixed
- ☐ Asian or Asian British
- ☐ Black or Black British
- ☐ Chinese
- ☐ Other **(Please tick and write in below)**

☐

- ☐ Prefer not to say

Q36 Do you consider yourself to have a disability? [The Equality Act 2012 defines a disability as "a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities".]
Please tick ✓ one box only

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Q37 Do any of the following apply to you?
Please tick ✓ all the boxes that apply

- ☐ I have children
- ☐ I am pregnant
- ☐ I care for children under the age of 16
- ☐ None of these
- ☐ Prefer not to say

Q38 When did you last visit one of the hospitals listed in Q31, either as a patient or to visit a family member or friend?
Please tick ✓ one box only

- ☐ In the last six months
- ☐ In the last year
- ☐ More than a year ago
- ☐ Never
- ☐ Can't remember

Q39 Do you care for someone in your family or a friend because they have a health need?
Please tick ✓ all that apply

- ☐ Yes – someone aged 16 or over
- ☐ Yes – a child aged under 16
- ☐ No

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Q40 Have you or your family used any of the services below provided by the NHS within the last year?

Please tick ✓ all that apply

- ☐ GP care
- ☐ Community nursing and therapy services
- ☐ Community paediatric services (for example, health visitor)
- ☐ Mental health care
- ☐ End-of-life care
- ☐ Paediatric (children's) hospital care
- ☐ Maternity and newborn care
- ☐ Emergency or urgent care, including intensive care
- ☐ Elective care (see page 36 of the consultation document for an explanation)
- ☐ Outpatients
- ☐ Other
- ☐ None of these
- ☐ Prefer not to say

If you have answered any of questions 32-40 then please make sure you have ticked the box at the bottom of page 13 of this form so that your answers can be used to analyse the results of the consultation.

Details of your organisation or group

If you are sending us a response on behalf of an organisation or group, please complete these questions.

If you are responding on your own behalf or on behalf of another person, please go to the end of this response form.

Please be as detailed as you can. For example, if you are responding on behalf of a group or organisation, please record the name of the group or organisation. Your personal details will be handled by the TSAs in accordance with their obligations under the Data Protection Act and will not be made public. Please remember, however, that information summarising the overall response to the consultation will be attached to the TSAs' final report which will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Q41 What is your name, job position and the name and address of the organisation or group on whose behalf you are submitting this response? The name and details of your organisation or group may appear in the final report.

DEBORAH BRUMWELL, CLERK TO STONE BY
CHARTLEY PARISH COUNCIL
C/O 14 STONEY BROOK CL
HIXON
STAFFORD ST18 0FQ

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Q42 What category of organisation or group are you representing?
Please tick ✓ as many boxes as apply

- ☐ A professional body (e.g. a Royal College)
- ☐ An NHS trust (provider of services)
- ☐ Charity / voluntary sector group
- ☐ National patient group
- ☐ Local patient group
- ☑ Local Authority
- ☐ Trade union
- ☐ Trade body
- ☐ Academic organisation
- ☐ Political party / Political group
- ☐ Clinical Commissioning Group
- ☐ Other NHS body
- ☐ Regulatory body
- ☐ Other
- ☐ Don't know

Q43 Please write in the total number of members in your organisation or group.

7 MEMBERS REPRESENTING 228 MEMBERS

Q44 Please tell us who the organisation or group represents and, if it applies, how you gathered and summarised the views of members.

PARISH COUNCIL WITH PUBLIC PARTICIPATION.

Thank you for your comments.
Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG
You do not need a stamp. **The envelope is second class, so please return your response form in plenty of time to reach us.**

If you need help to complete this form, or if you would like to complete it in another language, please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk. The telephone number is freephone from landlines, but charges may apply for calls from mobile telephones.

If you have any queries or complaints regarding the consultation process or consultation documentation content, please contact: The Trust Special Administrators, Mid Staffordshire NHS Foundation Trust, Stafford Hospital, Weston Road, Stafford, ST16 3SA
Please note that any queries or complaints submitted via this process cannot be counted as part of the formal consultation.

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30 SEP 2013

Mid Staffordshire NHS
NHS Foundation Trust

Office of the
Trust Special Administrator
of MSFT

Maintaining high quality, safe services for the future – Consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals

6 August – 1 October 2013

Your response to the consultation

As part of the *Maintaining high quality, safe services for the future* consultation, we want to make sure that those in Mid Staffordshire have the chance to give their views and comments. We are asking people to give us their views by reading the consultation document and completing this response form. Alternatively, you can complete the same response form online at www.tsa-msft.org.uk.

We are keen to hear your views to help inform our final recommendations that go to Monitor and the Secretary of State for Health. Please bear in mind this is a consultation, not a 'vote'. We will take responses into account along with a wide range of other information. We are interested in the overall responses to the tick box questions, and your reasons for your views. If you don't have any views on a specific question, please leave the boxes blank. You do not need to answer every question. **Please only write within the boxes provided in this response form. If your comments do not fit in the box, please send your comments on a separate sheet of paper, clearly stating which question they refer to.**

We have asked Ipsos MORI to undertake the analysis of the response forms on our behalf. The findings will help to inform the Trust Special Administrators' (TSAs) final recommendations to Monitor and the Secretary of State for Health. Please read the consultation document all the way through, then give us your answers to the questions in this response form. In the response form we have shown which pages of the consultation document cover the issues raised by each of the questions. Please refer back to the relevant pages as you answer the questions. You can download a full copy of the consultation document at www.tsa-msft.org.uk.

If you want to explain any of your answers, or you feel the questions have not given you the chance to express your views fully, or if you think there are options we have not considered that we should have done, please say so in the box for question 28.

Important: Please do not provide the names of any individuals in the feedback boxes. Please do not include in your response any other information that could identify individuals.

Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send it to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG

You do not need a stamp. **Any responses received after midnight on Tuesday 1 October 2013 will not be accepted or considered. The envelope is second class, so please return your response form in plenty of time to reach us.**

If you require a large print copy please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk.

Page No. 1

1000021513

Ipsos MORI

13-020881-01 - Response Form - FINAL - v4 - 250713 - PUBLIC

Unless you are responding on behalf of an organisation, this form does not ask you to supply us with your name or other contact details. You will, however, be asked to supply details of your postcode and your personal circumstances; you do not have to give these details if you do not want to. This information is only being collected in order to help us analyse responses to the consultation by Clinical Commissioning Group (CCG) area and key groups of the local population. It will not be used to identify specific individuals. Any personal data that you do supply will be handled by the TSAs in accordance with their obligations under the Data Protection Act 1998. When you complete the response form please do not include any information that could identify other individuals.

We do not intend to publish or disclose any personal information that could identify any individual. A document summarising all consultation responses we receive will however be attached to the TSAs' final report and will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide whether as an individual, an organisation or group, may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Thank you for your feedback.

Questions on emergency and urgent care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 24 of the consultation document.

Recommendation 1: Emergency and urgent care at Stafford Hospital

Q1 How far do you support or oppose the recommendation around the Accident and Emergency (A&E) department at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/don't know
☐	☑	☐	☐	☐	☐

Q2 What further comments, if any, do you have on any of the proposals outlined around emergency and urgent care at Stafford Hospital in Recommendation 1 in the consultation document, including the reasons for your answer to question 1? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

We support the retention of A+E at Stafford Hospital but as the population increases then the hours need to be extended.

Page No. 2

Questions on inpatient services for adults at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 26-27 of the consultation document.

Recommendation 2

Q3 How far do you support or oppose the recommendation around the inpatient service for adults with medical problems at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Recommendation 3

Q4 How far do you support or oppose the recommendation around a Frail Elderly Assessment service at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Recommendation 4

Q5 How far do you support or oppose the recommendation that beds should be available at Stafford Hospital for recovering patients?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Inpatient services for adults at Stafford Hospital (recommendations 2-4)

Q6 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around inpatient services for adults at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 3

Recommendations 2, 3 and 4: Inpatient services for adults at Stafford Hospital

Q7 What further comments, if any, do you have on any of the proposals outlined around inpatient services for adults in Recommendations 2, 3 and 4 in the consultation document, including the reasons for your answers to questions 3, 4, 5 and 6? Please also include any improvements you would like to suggest to these recommendations.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on maternity services in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 28 of the consultation document.

Recommendation 5: Maternity services in Stafford

Q8 How far do you support or oppose the recommendation around maternity services in Stafford?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☐	☐	☑	☐

Page No. 4

Q9 What further comments, if any, do you have on any of the proposals outlined around maternity services in Stafford in Recommendation 5 in the consultation document, including the reasons for your answer to question 8? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

We do not think that sufficient account has been taken in the amount of housing development that will take place in Stafford, aimed predominantly at young people, which will increase the birth rate and the need for a full maternity service

Questions on services for children in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 30-31 of the consultation document.

Recommendation 6

Q10 How far do you support or oppose the recommendation around the inpatient service for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☐	☐	☑	☐

Recommendation 7

Q11 How far do you support or oppose the recommendation around the Paediatric Assessment Unit (PAU) at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Services for children in Stafford (recommendations 6-7)

Q12 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around services for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☐	☑	☐	☐

Page No. 5

Recommendations 6 and 7: Services for children in Stafford

Q13 What further comments, if any, do you have on any of the proposals outlined around services for children in Stafford in Recommendations 6 and 7 in the consultation document, including the reasons for your answers to questions 10, 11 and 12? Please also include any improvements you would like to suggest to these recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones.**

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

We think that not enough account has been taken of population growth, and the increase in young children. The Council are proposing building another primary school so a full children's ~~sa~~ hospital service will be required.

Questions on major emergency surgery at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 32 of the consultation document.

Recommendation 8: Major emergency surgery at Stafford Hospital

Q14 How far do you support or oppose the recommendation around major emergency surgery at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☐	☐	☑	☐

Page No. 6

Q15 What further comments, if any, do you have on any of the proposals outlined around major emergency surgery at Stafford Hospital in Recommendation 8 in the consultation document, including the reasons for your answer to question 14? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Not enough account has been taken of population growth and the difficulty in accessing Wolverhampton and Stoke-on-Trent at peak times by road.

Questions on critical care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 34 of the consultation document.

Recommendation 9: Critical care at Stafford Hospital

Q16 How far do you support or oppose the recommendation around the critical care unit at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 7

Q17 What further comments, if any, do you have on any of the proposals outlined around critical care at Stafford Hospital in Recommendation 9, including the reasons for your answer to question 16? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on elective care and day cases at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 36 of the consultation document.

Recommendation 10: Elective care and day cases at Stafford Hospital

Q18 How far do you support or oppose the recommendation around elective care and day cases at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 8

Q19 What further comments, if any, do you have on any of the proposals outlined around elective care and day cases at Stafford Hospital in Recommendation 10 in the consultation document, including the reasons for your answer to question 18? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on Chapter 7 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained in Chapter 7 of the consultation document (pages 38-40).

Recommendation 11: Step down care and rehabilitation at Cannock Chase Hospital

Q20 How far do you support or oppose the recommendation that beds should be available at Cannock Chase Hospital for recovering patients?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 9

Q21 What further comments, if any, do you have on any of the proposals outlined around beds for recovering patients at Cannock Chase Hospital in Recommendation 11 in the consultation document, including the reasons for your answer to question 20? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet stating which question your comments refer to. Please do not include details that could be used to identify any individuals.

Recommendation 12: Elective inpatient surgery at Cannock Chase Hospital

Q22 How far do you support or oppose the recommendation around elective inpatient surgery at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Q23 What further comments, if any, do you have on any of the proposals outlined around elective inpatient surgery at Cannock Chase Hospital in Recommendation 12 in the consultation document, including the reasons for your answer to question 22? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.

Page No. 10

Recommendation 13: Day cases (surgical and medical) at Cannock Chase Hospital

Q24 How far do you support or oppose the recommendation around day case procedures at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Q25 What further comments, if any, do you have on any of the proposals outlined around day case procedures in Recommendation 13 in the consultation document, including the reasons for your answer to question 24? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on Chapter 8 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained in Chapter 8 of the consultation document (pages 42-43).

Recommendation 14: Organisational plans for Mid Staffordshire NHS Foundation Trust

Q26 How far do you support or oppose the recommendation for Mid Staffordshire NHS Foundation Trust (MSFT) to be dissolved, with the services at Stafford and Cannock Chase hospitals managed and delivered by another organisation or organisations in the future?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 11

Q27 What further comments, if any, do you have on any of the proposals outlined around Recommendation 14 in the consultation document, including the reasons for your answer to question 26? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

The MSFT is now tainted by past events, and therefore a new management structure is required. If this is from existing structures then hopefully there will be less cost by not having to pay a new management board.

Final comments

Q28 Is there anything else you want to say about the consultation or the issues it covers? If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so here. Please also say if there are any improvements you would like to suggest to the recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

We are not sure or convinced that growth projections for the Stafford area have been taken care of in the proposals.

Page No. 12

Background Information

Q29 Are you:
Please tick ✓ one box only

- ☐ Providing your own response or responding on behalf of another individual?
  Please go to Q30
- ☑ Submitting your response on behalf of an organisation or group?
  Please go to Q41

If you are responding on your own behalf, please complete the following questions. If you are responding on behalf of another individual, please complete the following questions about them.

Q30 Which, if any, of the following apply to you?
Please tick ✓ as many boxes as apply

- ☐ I currently work in the NHS
- ☐ I used to work in the NHS
- ☐ I currently work in the independent health sector
- ☐ I used to work in the independent health sector
- ☐ I do not work in, and have not worked in, the NHS or the independent health sector
- ☐ Prefer not to say
- ☐ Don't know

Q31 What is your closest hospital?
Please tick ✓ one box only

- ☐ Cannock Chase Hospital
- ☐ Manor Hospital
- ☐ New Cross Hospital
- ☐ Princess Royal Hospital
- ☐ Queen's Hospital
- ☐ Stafford Hospital
- ☐ University Hospital of North Staffordshire
- ☐ Other **(Please tick and write in below)**
- ☐ Don't know

Personal Details

We would be grateful if you could answer the following questions so we can establish if we have responses from a cross-section of people, and to allow us to analyse the results overall and by these different groups of people. None of the information you supply will be used by us in order to identify you. However, you should appreciate that it is possible that you could be identifiable from the information you supply in this section. Any identifiable information you do supply will be held by the TSAs securely, in confidence and in accordance with their obligations under the Data Protection Act 1998. You do not have to provide your personal details. If you do complete this section, please tick the box below to confirm that we may use your personal data for the purpose of analysing the results of the consultation.

- ☐ **I agree that the TSAs may use the details I have supplied in response to Q32-40 for the purpose of analysing the results of the consultation**

Page No. 13

Q32 Please can you provide your full home postcode
Please write in below

Full Postcode ☐ ☐ ☐ ☐ ☐ ☐ ☐

Q33 Are you ...?
Please tick ✓ one box only

- ☐ Male
- ☐ Female
- ☐ Prefer not To say

Q34 How old are you?
Please tick ✓ one box only

- ☐ Under 18
- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or over
- ☐ Prefer not to say

Q35 Which ethnic group do you consider yourself to belong to?
Please tick ✓ one box only

- ☐ White
- ☐ Mixed
- ☐ Asian or Asian British
- ☐ Black or Black British
- ☐ Chinese
- ☐ Other (**Please tick and write in below**)

☐

- ☐ Prefer not to say

Q36 Do you consider yourself to have a disability? [The Equality Act 2012 defines a disability as "a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities".]
Please tick ✓ one box only

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Q37 Do any of the following apply to you?
Please tick ✓ all the boxes that apply

- ☐ I have children
- ☐ I am pregnant
- ☐ I care for children under the age of 16
- ☐ None of these
- ☐ Prefer not to say

Q38 When did you last visit one of the hospitals listed in Q31, either as a patient or to visit a family member or friend?
Please tick ✓ one box only

- ☐ In the last six months
- ☐ In the last year
- ☐ More than a year ago
- ☐ Never
- ☐ Can't remember

Q39 Do you care for someone in your family or a friend because they have a health need?
Please tick ✓ all that apply

- ☐ Yes – someone aged 16 or over
- ☐ Yes – a child aged under 16
- ☐ No

Page No. 14

Q40 Have you or your family used any of the services below provided by the NHS within the last year?

Please tick ✓ all that apply

- ☐ GP care
- ☐ Community nursing and therapy services
- ☐ Community paediatric services (for example, health visitor)
- ☐ Mental health care
- ☐ End-of-life care
- ☐ Paediatric (children's) hospital care
- ☐ Maternity and newborn care
- ☐ Emergency or urgent care, including intensive care
- ☐ Elective care (see page 36 of the consultation document for an explanation)
- ☐ Outpatients
- ☐ Other
- ☐ None of these
- ☐ Prefer not to say

If you have answered any of questions 32-40 then please make sure you have ticked the box at the bottom of page 13 of this form so that your answers can be used to analyse the results of the consultation.

Details of your organisation or group

If you are sending us a response on behalf of an organisation or group, please complete these questions.

If you are responding on your own behalf or on behalf of another person, please go to the end of this response form.

Please be as detailed as you can. For example, if you are responding on behalf of a group or organisation, please record the name of the group or organisation. Your personal details will be handled by the TSAs in accordance with their obligations under the Data Protection Act and will not be made public. Please remember, however, that information summarising the overall response to the consultation will be attached to the TSAs' final report which will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Q41 What is your name, job position and the name and address of the organisation or group on whose behalf you are submitting this response? The name and details of your organisation or group may appear in the final report.

PAUL BERWICK
CLERK TO HOPTON AND COTON PARISH COUNCIL
BUMBLE BANK
41 KINGS DRIVE
HOPTON. STAFFORD. ST18 0AJ

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Q42 What category of organisation or group are you representing?
Please tick ✓ as many boxes as apply

- ☐ A professional body (e.g. a Royal College)
- ☐ An NHS trust (provider of services)
- ☐ Charity / voluntary sector group
- ☐ National patient group
- ☐ Local patient group
- ☑ Local Authority
- ☐ Trade union
- ☐ Trade body
- ☐ Academic organisation
- ☐ Political party / Political group
- ☐ Clinical Commissioning Group
- ☐ Other NHS body
- ☐ Regulatory body
- ☐ Other
- ☐ Don't know

Q43 Please write in the total number of members in your organisation or group.

7

Q44 Please tell us who the organisation or group represents and, if it applies, how you gathered and summarised the views of members.

The Parish Council is an elected body and Councillors have spoken to residents in the Parish of Hopton and Coton

Thank you for your comments.
Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG
You do not need a stamp. **The envelope is second class, so please return your response form in plenty of time to reach us.**

If you need help to complete this form, or if you would like to complete it in another language, please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk. The telephone number is freephone from landlines, but charges may apply for calls from mobile telephones.

If you have any queries or complaints regarding the consultation process or consultation documentation content, please contact: The Trust Special Administrators, Mid Staffordshire NHS Foundation Trust, Stafford Hospital, Weston Road, Stafford, ST16 3SA
Please note that any queries or complaints submitted via this process cannot be counted as part of the formal consultation.

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Mid Staffordshire NHS
NHS Foundation Trust

Office of the
Trust Special Administrator
of MSFT

20 SEP 2013

Maintaining high quality, safe services for the future – Consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals

6 August – 1 October 2013

Your response to the consultation

As part of the *Maintaining high quality, safe services for the future* consultation, we want to make sure that those in Mid Staffordshire have the chance to give their views and comments. We are asking people to give us their views by reading the consultation document and completing this response form. Alternatively, you can complete the same response form online at www.tsa-msft.org.uk.

We are keen to hear your views to help inform our final recommendations that go to Monitor and the Secretary of State for Health. Please bear in mind this is a consultation, not a 'vote'. We will take responses into account along with a wide range of other information. We are interested in the overall responses to the tick box questions, and your reasons for your views. If you don't have any views on a specific question, please leave the boxes blank. You do not need to answer every question. **Please only write within the boxes provided in this response form. If your comments do not fit in the box, please send your comments on a separate sheet of paper, clearly stating which question they refer to.**

We have asked Ipsos MORI to undertake the analysis of the response forms on our behalf. The findings will help to inform the Trust Special Administrators' (TSAs) final recommendations to Monitor and the Secretary of State for Health. Please read the consultation document all the way through, then give us your answers to the questions in this response form. In the response form we have shown which pages of the consultation document cover the issues raised by each of the questions. Please refer back to the relevant pages as you answer the questions. You can download a full copy of the consultation document at www.tsa-msft.org.uk.

If you want to explain any of your answers, or you feel the questions have not given you the chance to express your views fully, or if you think there are options we have not considered that we should have done, please say so in the box for question 28.

Important: Please do not provide the names of any individuals in the feedback boxes. Please do not include in your response any other information that could identify individuals.

Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send it to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG

You do not need a stamp. **Any responses received after midnight on Tuesday 1 October 2013 will not be accepted or considered. The envelope is second class, so please return your response form in plenty of time to reach us.**

If you require a large print copy please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk.

1000076644

Page No. 1

Ipsos MORI

13-020881-01 - Response Form - FINAL - v4 - 250713 - PUBLIC

Unless you are responding on behalf of an organisation, this form does not ask you to supply us with your name or other contact details. You will, however, be asked to supply details of your postcode and your personal circumstances; you do not have to give these details if you do not want to. This information is only being collected in order to help us analyse responses to the consultation by Clinical Commissioning Group (CCG) area and key groups of the local population. It will not be used to identify specific individuals. Any personal data that you do supply will be handled by the TSAs in accordance with their obligations under the Data Protection Act 1998. When you complete the response form please do not include any information that could identify other individuals.

We do not intend to publish or disclose any personal information that could identify any individual. A document summarising all consultation responses we receive will however be attached to the TSAs' final report and will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide whether as an individual, an organisation or group, may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Thank you for your feedback.

Questions on emergency and urgent care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 24 of the consultation document.

Recommendation 1: Emergency and urgent care at Stafford Hospital

Q1 How far do you support or oppose the recommendation around the Accident and Emergency (A&E) department at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/don't know
☐	☐	☐	☑	☐	☐

Q2 What further comments, if any, do you have on any of the proposals outlined around emergency and urgent care at Stafford Hospital in Recommendation 1 in the consultation document, including the reasons for your answer to question 1? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Need for a basic service from 10pm to 8am as the alternatives are too far to go to & do not have adequate capacity.
In addition the GP service should be improved with all GPs required to take part in a rota covering 24 hrs 7 days a week like Vets.

Page No. 2

Questions on inpatient services for adults at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 26-27 of the consultation document.

Recommendation 2

Q3 How far do you support or oppose the recommendation around the inpatient service for adults with medical problems at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Recommendation 3

Q4 How far do you support or oppose the recommendation around a Frail Elderly Assessment service at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Recommendation 4

Q5 How far do you support or oppose the recommendation that beds should be available at Stafford Hospital for recovering patients?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Inpatient services for adults at Stafford Hospital (recommendations 2-4)

Q6 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around inpatient services for adults at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 3

Recommendations 2, 3 and 4: Inpatient services for adults at Stafford Hospital

Q7 What further comments, if any, do you have on any of the proposals outlined around inpatient services for adults in Recommendations 2, 3 and 4 in the consultation document, including the reasons for your answers to questions 3, 4, 5 and 6? Please also include any improvements you would like to suggest to these recommendations.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on maternity services in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 28 of the consultation document.

Recommendation 5: Maternity services in Stafford

Q8 How far do you support or oppose the recommendation around maternity services in Stafford?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☐	☐	☑	☐

Page No. 4

Q9 What further comments, if any, do you have on any of the proposals outlined around maternity services in Stafford in Recommendation 5 in the consultation document, including the reasons for your answer to question 8? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Problem with travelling to Stoke or Wolverhampton or Walsall, is that journey times are too long & subject to traffic congestion, eg. M6, Trentham & the outskirts of Wolverhampton

Questions on services for children in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 30-31 of the consultation document.

Recommendation 6

Q10 How far do you support or oppose the recommendation around the inpatient service for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☐	☐	☑	☐

Recommendation 7

Q11 How far do you support or oppose the recommendation around the Paediatric Assessment Unit (PAU) at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Services for children in Stafford (recommendations 6-7)

Q12 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around services for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☐	☑	☐	☐

Page No. 5

Recommendations 6 and 7: Services for children in Stafford

Q13 What further comments, if any, do you have on any of the proposals outlined around services for children in Stafford in Recommendations 6 and 7 in the consultation document, including the reasons for your answers to questions 10, 11 and 12? Please also include any improvements you would like to suggest to these recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones.**

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

It is essential that a Paediatric inpatient service is retained in conjunction with Maternity services.
Delays in transit to Wolverhampton or Stoke could also put young patients at risk.
The Paediatric Assessment Unit should be able to consult with N. Staffs Consultants via a video link so that they can see the patient being assessed.

Questions on major emergency surgery at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 32 of the consultation document.

Recommendation 8: Major emergency surgery at Stafford Hospital

Q14 How far do you support or oppose the recommendation around major emergency surgery at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☑	☐	☐	☐

Page No. 6

Q15 What further comments, if any, do you have on any of the proposals outlined around major emergency surgery at Stafford Hospital in Recommendation 8 in the consultation document, including the reasons for your answer to question 14? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

The advantage of a more experienced surgical team have to be weighed against the risk of longer transit times to the hospital.

Questions on critical care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 34 of the consultation document.

Recommendation 9: Critical care at Stafford Hospital

Q16 How far do you support or oppose the recommendation around the critical care unit at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 7

Q17 What further comments, if any, do you have on any of the proposals outlined around critical care at Stafford Hospital in Recommendation 9, including the reasons for your answer to question 16? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Again the benefits of treatment by a larger & more experienced team, have to be compared with the dangers of a longer transit time.

Questions on elective care and day cases at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 30 of the consultation document.

Recommendation 10: Elective care and day cases at Stafford Hospital

Q18 How far do you support or oppose the recommendation around elective care and day cases at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 8

Q19 What further comments, if any, do you have on any of the proposals outlined around elective care and day cases at Stafford Hospital in Recommendation 10 in the consultation document, including the reasons for your answer to question 18? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on Chapter 7 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained in Chapter 7 of the consultation document (pages 38-40).

Recommendation 11: Step down care and rehabilitation at Cannock Chase Hospital

Q20 How far do you support or oppose the recommendation that beds should be available at Cannock Chase Hospital for recovering patients?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 9

Q21 What further comments, if any, do you have on any of the proposals outlined around beds for recovering patients at Cannock Chase Hospital in Recommendation 11 in the consultation document, including the reasons for your answer to question 20? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet stating which question your comments refer to. Please do not include details that could be used to identify any individuals.

In addition to the cost & time to travel to Stoke or Wolverhampton or Walsall for visitors, there are difficulties finding parking spaces there.
Travel by public transport is virtually impossible.

Recommendation 12: Elective inpatient surgery at Cannock Chase Hospital

Q22 How far do you support or oppose the recommendation around elective inpatient surgery at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Q23 What further comments, if any, do you have on any of the proposals outlined around elective inpatient surgery at Cannock Chase Hospital in Recommendation 12 in the consultation document, including the reasons for your answer to question 22? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.

Page No. 10

Recommendation 13: Day cases (surgical and medical) at Cannock Chase Hospital

Q24 How far do you support or oppose the recommendation around day case procedures at Cannock Chase Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Q25 What further comments, if any, do you have on any of the proposals outlined around day case procedures in Recommendation 13 in the consultation document, including the reasons for your answer to question 24? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on Chapter 8 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained in Chapter 8 of the consultation document (pages 42-43).

Recommendation 14: Organisational plans for Mid Staffordshire NHS Foundation Trust

Q26 How far do you support or oppose the recommendation for Mid Staffordshire NHS Foundation Trust (MSFT) to be dissolved, with the services at Stafford and Cannock Chase hospitals managed and delivered by another organisation or organisations in the future?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☐	☑	☐	☐	☐

Page No. 11

Q27 What further comments, if any, do you have on any of the proposals outlined around Recommendation 14 in the consultation document, including the reasons for your answer to question 26? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Final comments

Q28 Is there anything else you want to say about the consultation or the issues it covers? If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so here. Please also say if there are any improvements you would like to suggest to the recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Concern at the accuracy of predictions of future patient numbers at Stafford.
Inaccurate patient number data in consultation document.
Failure to give adequate risk analysis for the proposed changes.

Page No. 12

Background Information

Q29 Are you:
Please tick ✓ one box only

- ☐ Providing your own response or responding on behalf of another individual?
  Please go to Q30
- ☑ Submitting your response on behalf of an organisation or group?
  Please go to Q41

If you are responding on your own behalf, please complete the following questions. If you are responding on behalf of another individual, please complete the following questions about them.

Q30 Which, if any, of the following apply to you?
Please tick ✓ as many boxes as apply

- ☐ I currently work in the NHS
- ☐ I used to work in the NHS
- ☐ I currently work in the independent health sector
- ☐ I used to work in the independent health sector
- ☐ I do not work in, and have not worked in, the NHS or the independent health sector
- ☐ Prefer not to say
- ☐ Don't know

Q31 What is your closest hospital?
Please tick ✓ one box only

- ☐ Cannock Chase Hospital
- ☐ Manor Hospital
- ☐ New Cross Hospital
- ☐ Princess Royal Hospital
- ☐ Queen's Hospital
- ☐ Stafford Hospital
- ☐ University Hospital of North Staffordshire
- ☐ Other **(Please tick and write in below)**
- ☐ Don't know

Personal Details

We would be grateful if you could answer the following questions so we can establish if we have responses from a cross-section of people, and to allow us to analyse the results overall and by these different groups of people. None of the information you supply will be used by us in order to identify you. However, you should appreciate that it is possible that you could be identifiable from the information you supply in this section. Any identifiable information you do supply will be held by the TSAs securely, in confidence and in accordance with their obligations under the Data Protection Act 1998. You do not have to provide your personal details. If you do complete this section, please tick the box below to confirm that we may use your personal data for the purpose of analysing the results of the consultation.

☐ **I agree that the TSAs may use the details I have supplied in response to Q32-40 for the purpose of analysing the results of the consultation**

Page No. 13

Q32 Please can you provide your full home postcode
Please write in below

Full Postcode ☐ ☐ ☐ ☐ ☐ ☐ ☐

Q33 Are you ...?
Please tick ✓ one box only

- ☐ Male
- ☐ Female
- ☐ Prefer not To say

Q34 How old are you?
Please tick ✓ one box only

- ☐ Under 18
- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or over
- ☐ Prefer not to say

Q35 Which ethnic group do you consider yourself to belong to?
Please tick ✓ one box only

- ☐ White
- ☐ Mixed
- ☐ Asian or Asian British
- ☐ Black or Black British
- ☐ Chinese
- ☐ Other **(Please tick and write in below)**

☐

- ☐ Prefer not to say

Q36 Do you consider yourself to have a disability? [The Equality Act 2012 defines a disability as "a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities".]
Please tick ✓ one box only

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Q37 Do any of the following apply to you?
Please tick ✓ all the boxes that apply

- ☐ I have children
- ☐ I am pregnant
- ☐ I care for children under the age of 16
- ☐ None of these
- ☐ Prefer not to say

Q38 When did you last visit one of the hospitals listed in Q31, either as a patient or to visit a family member or friend?
Please tick ✓ one box only

- ☐ In the last six months
- ☐ In the last year
- ☐ More than a year ago
- ☐ Never
- ☐ Can't remember

Q39 Do you care for someone in your family or a friend because they have a health need?
Please tick ✓ all that apply

- ☐ Yes – someone aged 16 or over
- ☐ Yes – a child aged under 16
- ☐ No

Page No. 14

Q40 Have you or your family used any of the services below provided by the NHS within the last year?

Please tick ✓ all that apply

- ☐ GP care
- ☐ Community nursing and therapy services
- ☐ Community paediatric services (for example, health visitor)
- ☐ Mental health care
- ☐ End-of-life care
- ☐ Paediatric (children's) hospital care
- ☐ Maternity and newborn care
- ☐ Emergency or urgent care, including intensive care
- ☐ Elective care (see page 36 of the consultation document for an explanation)
- ☐ Outpatients
- ☐ Other
- ☐ None of these
- ☐ Prefer not to say

If you have answered any of questions 32-40 then please make sure you have ticked the box at the bottom of page 13 of this form so that your answers can be used to analyse the results of the consultation.

Details of your organisation or group

If you are sending us a response on behalf of an organisation or group, please complete these questions.

If you are responding on your own behalf or on behalf of another person, please go to the end of this response form.

Please be as detailed as you can. For example, if you are responding on behalf of a group or organisation, please record the name of the group or organisation. Your personal details will be handled by the TSAs in accordance with their obligations under the Data Protection Act and will not be made public. Please remember, however, that information summarising the overall response to the consultation will be attached to the TSAs' final report which will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Q41 What is your name, job position and the name and address of the organisation or group on whose behalf you are submitting this response? The name and details of your organisation or group may appear in the final report.

Dr A. Andrews - Parish Clerk
Ingestre with Tixall Parish Council

Page No. 15

Q42 What category of organisation or group are you representing?
Please tick ✓ as many boxes as apply

- ☐ A professional body (e.g. a Royal College)
- ☐ An NHS trust (provider of services)
- ☐ Charity / voluntary sector group
- ☐ National patient group
- ☐ Local patient group
- ☑ Local Authority
- ☐ Trade union
- ☐ Trade body
- ☐ Academic organisation
- ☐ Political party / Political group
- ☐ Clinical Commissioning Group
- ☐ Other NHS body
- ☐ Regulatory body
- ☐ Other
- ☐ Don't know

Q43 Please write in the total number of members in your organisation or group.

358 electors and their children

Q44 Please tell us who the organisation or group represents and, if it applies, how you gathered and summarised the views of members.

Discussed at Parish Council Meeting by the elected Councillors

Thank you for your comments.
Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG
You do not need a stamp. **The envelope is second class; so please return your response form in plenty of time to reach us.**

If you need help to complete this form, or if you would like to complete it in another language, please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk. The telephone number is freephone from landlines, but charges may apply for calls from mobile telephones.

If you have any queries or complaints regarding the consultation process or consultation documentation content, please contact: The Trust Special Administrators, Mid Staffordshire NHS Foundation Trust, Stafford Hospital, Weston Road, Stafford, ST16 3SA
Please note that any queries or complaints submitted via this process cannot be counted as part of the formal consultation.

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Mrs C Hammond, Parish Clerk, Brocton Parish Council

The Parish Council,comprising seven Councillors, represents the population of the Parish of Brocton, approx. 1100 people of all ages. Our response has been prepared as a result of ongoing discussion at Parish Council Meetings and attendance by Councillors at various public meetings before Administration and during.

Q2

Daily A&E provision between 8.00 am and 10.00pm is a better option than no A&E provision at all. However should the Paediatric Assessment Unit close as recommended, then A&E would provide the only service for adults and children. Presently we at least have 24 hour provision for Paediatrics (not 17 hours as stated elsewhere in your document). Ideally there should be total 24 hour A&E provision. The recommendations widen health inequalities for all people in the area served by Stafford and Cannock Hospitals with particular negative impact on vulnerable groups: low income single people and families, children, elderly and mentally/physically disabled.

The recommendations present significant obstacles to provision of care and availability of family/community support due to the logistics of travel and contact. The travel distances, lack of public transport, journey times, cost, will be prohibitive to many and difficult for all, particularly the vulnerable groups quoted above. The practical criteria to be considered include accompanying an emergency; having to follow an ambulance along an unfamiliar route in a car; returning home after treatment, often in the early hours with no public or any other form of transport, or the funds to pay for it; being unable to visit inpatients at distant hospitals due to difficult access by public transport and the additional time element of arranging child care or care for other dependents remaining at home. These factors will inflict stress and anxiety on patients, families and dependents and will disadvantage all concerned.

Q7

Our comments specifically relating to questions 3 – 5 are:

Q3.The term "Medical problems" cannot be readily evaluated by a lay person. However we strongly support retention but would see this as requiring the retention also of a Critical Care Level 3 service as surely any medical condition can rapidly deteriorate at any time to a critical level requiring immediate back up to ensure patient safety. This would seem to be a circumstance where patients could not safely be transported a considerable distance to an alternative hospital putting them at risk and widening health inequality. Thisservice, easily accessible both for patients and visitors, close to home would offer patient choice and from the public opinion voiced locally is what people want to retain.

Q4. This is a service that, with an ageing population, should be embraced nationally and is not particular to Stafford and Cannock. The information on this recommendation is sparce, confusing and could be construed as misleading the public. It refers to a 14/7 service staffed by geriatricians and "senior specialist nurses will take over at night". Is there then the potential for frail elderly people to be discharged late at night to return to the unsafe environment of an empty, cold, home where immediate ongoing care has not been put in place? It is unclear what choice patients would have and what procedure for community care would be implemented to make every effort to

prevent re-hospitalisation with attendant financial burden. It is therefore difficult to arrive at an informed decision.

Q5. As in Q4 there is insufficient information on this proposal to make an informed decision. The current practice is that patients be discharged as soon as possible to return home for convalescence with community care where appropriate or necessary. Does it mean that following treatment at a hospital other than Stafford, Stafford people would be moved nearer to home? If so, this would seem to limit access to their consultant, bringing with it health inequality and concerns over safety. If the proposal is to use this facility to care for elderly or vulnerable people who cannot be safely discharged to their own homes, does this mean patients in this category from Stoke or Wolverhampton hospitals would be moved to Stafford? In which case the previous argument of people being disadvantaged by being moved out of their familiar locality and away from family and friends has to be re-iterated as being unacceptable practice.

Overall, we tend to support these recommendations as an addition to the services we have now but not as a step down to the services that, in effect, are provided by a community hospital.

Stafford and its surrounds has a growing population that needs the services of an acute hospital including Critical Care Level 3 even if we have to accept the reduced A&E hours we currently have.

Overall, these recommendations imply a "community" hospital rather than an acute hospital with CCL3, which is what this community needs and wants. To prevent health inequality, removal of choice and social disadvantage we are entitled to at least equal or preferably better facilities than those at present provided.

Q9

The TSA recommendations are totally unacceptable. Based on a figure of 1800 births per year, although the figure in 2012 was, it is understood, 2003. the TSA statistics appear to be flawed. This brings into doubt the background information on which these recommendations are based.

No account appears to have been taken of the Plan for Stafford Borough currently under examination and which outlines development and housing in the Borough for the period 2014 – 2031. The Plan states "With regards to the future demand for new housing in the Stafford Borough area, national statistics from the Government provide information on population growth forecasts and the number of new households likely to form. For Stafford Borough the latest 2010 population projections show an increase of 19,900 residents from 126,100 to 146,000 people in 2035. These figures include natural change and migration from other areas. The latest 2008 household projections to 2033 show an increase of 11,523 households from 52,999 to 64,522 households looking for houses in our area. This is an average of approximately 500 new houses per year." The in-migration element of this is 70% mainly from surrounding areas, the majority being Cannock Chase District, South Staffordshire District and City of Stoke on Trent.

A separate provision for up to 400 service family accommodation units will also be delivered to facilitate military personnel returning from abroad which is not included in the above information. This gives a clear indication that birth rates will be more probable to rise rather than fall in the years up to 2031.

Neighbouring areas including the City of Stoke on Trent can anticipate similar population rises which their own hospitals will have to accommodate without the additional need to provide for the people from Mid Staffs.

If women are denied the patient choice to give birth in hospital in Stafford where they have received continuous, up to that point, ante-natal care, this is widening health inequality, prejudicing the rights of the unborn child, and putting lives at risk. Expecting women in labour to travel to UHNS from anywhere within the Mid Staffs area will be dangerous. Women will be totally dependent on a number of factors totally beyond, their, or any health workers, control – on ambulances being available; on being able to travel unhindered, which will be governed by frequent closures of the M6 motorway diverting traffic into Stafford and along the A34 main road from Stafford – Stoke and daily gridlocks and hold ups at peak times all along the route. A woman in labour would not want to start a journey to Stoke from Stafford on a Friday afternoon or any morning between 8.00 – 10.00 am, or, in fact, any time as it is always an unknown quantity.

The social deprivation to the families concerned has not been considered. The care of other dependent children while their mother and father are a distance away. The difficulty for children and families to visit mothers who have to stay in hospital overnight. Travel time, lack of transport and cost will often be prohibitive. Return home with a new born baby, and not all people have their own transport available, will be costly and extremely difficult.

Financial considerations seem to have completely overtaken the rights of women and the safety of both mothers and new born babies in this instance. Stoke hospital will require more facilities to accommodate the extra capacity. This will require more money. Surely it would be a better use of resources to utilise the capacity at Stafford more effectively, to reduce the pressure on Stoke, to cater for the growing population in this area, and to protect the interests, safety and freedom of choice that Mid Staffs women are entitled to.

Q13

Q.10 The suggestion that children's inpatient services 24/7 at Stafford will end is extremely worrying and is reducing not improving the health care of children in this area. It will greatly impact on the the well being of children and their families in removing a service which is close to home, easily accessible and in familiar surroundings.

This proposal is unsafe, widens health inequality and would incur immense anxiety on children and families at an already extremely stressful time. This would be particularly relevant to vulnerable groups including low income households and physically/mentally disabled. Travel is difficult as already explained, children tend to become sick very quickly and often require urgent attention at night. Families who have children with ongoing health needs will be particularly affected by these proposals. This would have a huge negative impact on child care in our area.

Q.11 This is misleading, by the TSA's own admission. They refer to PAU being available 14/7 when it is currently 24/7. Whilst an addendum sheet has been circulated on a limited basis, not everyone will see this and will assume the proposals do not reduce the existing service. If the PAU us run by nurses only. How will they consult with paediatricians at UHNS? By phone? By email? This would be unacceptable and unsafe. What would be the time lapse in paediatricians responding when they

already presumably have a full workload at UHNS. There seems to be a real risk to patient care leading to an unsafe service.

Q15

This question is misleading. The lay man cannot understand the definitions of "major" or "minor" surgery so cannot make an informed comment.

Specialised treatment centres for major specialist problems, i.e. heart attack or stroke with specialist consultants and equipment are generally accepted as having a better outcome for patients and make financial sense. However there cannot be "specialist" centres for every individual surgical procedure and through a system of networking with other hospitals it would seem possible to retain a significant surgical service at Stafford. This would presumably be dependent on the retention of CCL3 which in any event is deemed to be a requirement to maintain medical care.

Q17

Generalised statements lacking detail make this recommendation difficult to comment on. With recommendations to stop emergency surgical treatment, withdraw 24/7 children's care, close A&E between 10.00pm and 8.00am, the lay man could ask "why do we need 24/7 availability of anaesthetists"? What constitutes a "small critical care area"? How will an "urgent transfer service" operate in the difficult road network problems the area presents? Patients and their families would be forced to travel under very traumatic circumstances making this a very unsafe procedure and widening health inequality for the reasons we have previously outlined. Particularly at certain times of year, all Critical Care Units come under extreme pressure with lack of capacity. It seems very unsafe therefore to close a CCU3 which is up and operating, can support other services that are seen as essential to remain at Stafford, whilst at the same time working in conjunction with neighbouring hospitals and providing valuable and required CCU3 availability. Stafford hospital has a very effective critical care unit and to remove it would leave Stafford with a service not equal to or better than we currently have.

Q19

This question is confusing and potentially misleading. We would tend to support the proposal if it includes all current elective services and there were no proposals to remove procedures from the list over time. As all surgery, elective or otherwise, carries with it a degree of risk, how can elective care and day cases continue without a Critical Care Unit 3. This would impact on patient choice and again, over time, result in an underused service leading to closure.

Relating to orthopaedic surgery currently carried out at Cannock being transferred to Stafford. How does this impact on Cannock? The proposal does not seem to be addressed in Section 7. This is again unclear and potentially misleading.

Q21

As with Question 5 there is insufficient information on this proposal to make an informed decision. The current practice is that patients be discharged as soon as possible to return home for convalescence with community care where appropriate or necessary. Does it mean that following

treatment at a hospital other than Cannock, Cannock people would be moved nearer to home? If so, this would seem to limit access to their consultant, bringing with it health inequality and concerns over safety. If the proposal is to use this facility to care for elderly or vulnerable people who cannot be safely discharged to their own homes, does this mean patients in this category from Stafford, Stoke or Wolverhampton hospitals would be moved to Cannock? In which case the previous argument of people being disadvantaged by being moved out of their familiar locality and away from family and friends has to be re-iterated as being unacceptable practice.

Overall, we tend to support these recommendations as an addition to the services we have now but not as a step down.

Q23

This recommendation is assuming that "the ongoing discussions with the National CAGs regarding safe overnight staff cover can be successfully resolved." (Consultation booklet). There seem to be a number of unresolved questions over the provision and scope of elective surgery at Cannock. Until there is more definite information available it is difficult and unwise to comment.

Q25

Again there is a lack of information and it is difficult to make an informed response. We would strongly support the recommendations to maintain and if possible increase day case procedures providing adequate care safeguards were in place.

Q27

Partnership working in many areas of public services is proving to be a good and accepted way to help finances, to better manage staff time and to utilise public buildings, sharing facilities, experiences and knowledge. The emphasis being on "sharing" and "partnership", not "take-over" and "bail-out". All hospitals, nationally and also our neighbouring hospitals have problems, both financial and with capacity. Mid Staffs is not unique in this, our hospitals and their staff have a lot to offer and past events should not reflect its' future as a provider of health services at Stafford and Cannock for the people living and working in the area. Patient voice and people power has shown this to be the case and if a partnership with other organisations is taken as a positive step we would tend to support this as a way forward.

Q28

As a local authority representing a population of approx. 1100 people in 445 households in a rural area in Stafford Borough, we have followed closely the fortunes of Stafford and Cannock hospitals over recent years. Our community has strongly supported the public march and been represented at the various public meetings held both by MSFT and the TSAs. We have considered the consultation booklet and, above all, we have listened to the thoughts and opinions of local people. We have been very concerned at the questions which have been posed by health professionals about the validity of underlying facts used to produce the consultation document. The TSA's have continuously given the impression they have not listened to what local people are saying. As a result of all of this we would sum up our responses as follows:

We have many serious concerns about the recommendations which primarily are about finance, not about people. Many of the recommendations are arrived at with a seemingly overwhelming lack of practical knowledge of the demography of Stafford and surrounding areas, a total misunderstanding of the transport network in the area and the problems and delays this causes. The recommendations, if implemented, will cause health inequality, removal of patient choice, unsafe provision of health care, social and financial disadvantage to all and especially women, children and vulnerable groups within our community. They will leave our community with a much reduced service to that which it now receives. Emphasis has been put totally on removing services from Stafford hospital in an expectation that neighbouring hospitals have the capacity to fulfil the demand. It seems both Stoke and Wolverhampton do not support this expectation and that those hospital Trusts will need to find more money to increase their own capacity. No attempt appears to have been made to incorporate the facilities and capacity available at Stafford and Cannock to work together in partnership with neighbouring hospitals to provide an overall excellent health service. Stafford is a town with considerable growth expectancy in the next 20 years and the future of our health service should be assessed and provided for accordingly. This means arriving at a sustainable management and financial structure that will support and retain existing services, at the same time restoring confidence for staff and for patients. We do not consider that some of the steps contained in these recommendations are the correct way to achieve this.

Helen Peach

Marston Parish Clerk

Marston Parish Meeting

Marston

Stafford

Q2

We would prefer a 24 hour service to provide a full service for the large catchment area.

Q7

Given the size of the catchment area, the age profile of the population and the planned expansion of the population with new housing being built, we want a fully functional service for inpatients at Stafford Hospital.

Q9

The unit is modern and purpose built. It was upgraded over the last few years. It would be a waste of money to not continue to use it.

We would question the number of births currently being used as a basis for any decisions. The bad publicity recently has impacted on people choosing Stafford as a hospital. This should gradually change as Stafford is shown to be a safe and fully functioning hospital.

Q13

We would require more detailed information in order to make a fully informed decision.

With regards to question 11 the Parish meeting was not aware of the inaccuracy in the consultation papers when answering this section.

Q15

A major emergency surgery department is required to support a fully functioning A&E.

We are concerned about the viability and safety of 'remote consultation'.

Q17

The critical care unit has just been upgraded and is working effectively. We would prefer a fully operational critical care unit to support a fully functional major emergency surgery department.

Q21

We would support a fully staffed fully functional Cannock Hospital. It has recently been refurbished and has good facilities.

Q23

We would support a fully staffed fully functional Cannock Hospital. It has recently been refurbished and has good facilities.

Q25

We would support a fully staffed fully functional Cannock Hospital. It has recently been refurbished and has good facilities.

Q27

We believe MSFT should remain as a trust.

Splitting the Trust up would result in resources gradually draining away from Stafford and Cannock towards the main hospitals in the other Trusts.

Q28

We feel Stafford and Cannock hospitals should be fully functional hospitals. We want the facilities retained and resourced appropriately.

Consultation on the future of Mid Staffordshire NHS Foundation Trust

North Staffordshire perspective

NEWCASTLE UNDER LYME BOROUGH COUNCIL

city of stoke on trent

Introduction

This document has been compiled by Newcastle-under-Lyme Borough Council and Stoke-on-Trent City Council as a formal response to draft recommendations by Trust Special Administrators (TSA) for Mid Staffordshire Foundation Trust – appointed by Monitor – which include the transfer of key services from Stafford Hospital to the University Hospital of North Staffordshire (UHNS).

Maternity, emergency surgery, critical care and some paediatrics would move to UHNS under proposals to make Stafford Hospital more clinically and financially viable.

We recognise that reconfiguration of services needs to be considered in the context of rising demands on the NHS and social care, improving management of long-term conditions, recruiting and training specialist staff, improving quality of care and generating efficiencies.

But while recognising the need for change and potential benefits such as attracting new capital funding and increasing the catchment population for specialised services, we have serious concerns over a number of clinical, financial and organisational issues which impact on residents who use UHNS.

These include the:

1. Potential impact on the clinical quality of services in particular maternity, paediatrics and A&E.
2. Impact on targets particularly relating to A&E, emergency admissions and elective waiting times.
3. Impact on the existing health and social care transformational plans in North Staffordshire and capacity assumptions across the wider economy.
4. Financial assumptions underpinning the recommendations as the scale of the system-wide financial gap is not clear, neither is the detail on how it will be managed.
5. Lack of detailed planning on how the transition will be managed with particular regard to due diligence, governance and risk management.

We are seeking assurances that:

1. Patients in North Staffordshire will not have to travel to Stafford for care.
2. Robust transitional governance arrangements are put in place with representation from local councils and clinical commissioning groups representing the views of residents in North Staffordshire.

Councillor Gareth Snell

Leader of Newcastle-under-Lyme Borough Council

Councillor Mohammed Pervez

Leader of Stoke-on-Trent City Council

University Hospital of North Staffordshire

UHNS's main site is the City General Hospital, located in Stoke-on-Trent. From here a full range of general acute hospital services are provided for approximately half a million people living in and around North Staffordshire. The UHNS NHS Trust also provides specialised services such as trauma for three million people in a wider area including neighbouring counties and North Wales.

Each year more than 700,000 people attend the hospital for emergency treatment, planned operations and medical care.

Specialised services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care and paediatric intensive care. The hospital is also recognised for expertise in trauma, respiratory conditions, spinal surgery, upper gastro-intestinal surgery, complex orthopaedic surgery, laparoscopic surgery and the management of liver conditions.

In 2012/13 more than 116,000 patients (an increase of more than 10,000 from the previous year) attended A&E. Many are brought in from a wide area by both helicopter and land ambulance because of the hospital's major trauma centre status.

During 2012/13 84,184 emergency inpatients were treated at the hospital, an increase from 68,962 the previous year.

Almost 6,000 babies are born at the hospital every year. The maternity unit has 16 delivery rooms and a further 11 suites in the birth centre. There are 112 beds on two wards. The neonatal intensive care unit can provide care for up to 23 babies and their families.

Our ref: JS/GS

1 October 2013

NEWCASTLE UNDER LYME
BOROUGH COUNCIL

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Merrial Street
Newcastle-under-Lyme
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ST5 2AG

01782 717717

The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Public consultation re: draft recommendations for Stafford Hospital

The NHS is changing and the future of hospital provision in Staffordshire, as a result of the tragedy at Stafford Hospital, needs to change.

In responding to the Trust Special Administrators' consultation on the future of Stafford Hospital, Newcastle-under-Lyme Borough Council sought to provide a platform allowing our residents' voices to be heard by running a "mini" campaign from Thursday, 12 September to Wednesday, 25 September 2013.

Council leader Gareth Snell tabled a motion at Full Council for a campaign encouraging borough residents to have their say about the potential impact of the proposals after it was revealed Trust Special Administrators could not legally hold a public event outside of their boundaries.

With Stafford Hospital likely to see significant changes as a result of the administrators' consultation the borough council felt it was important that any proposals affecting the provision of existing services for the people of North Staffordshire were debated and scrutinised thoroughly.

The borough council worked with North Staffordshire Clinical Commissioning Group to organise and publicise a public meeting on Monday, 23 September 2013 which was attended by Mark Hackett, Chief Executive of UHNS, and several senior members of staff. This allowed for questions about the current financial state of both Stafford and UHNS to be probed while specific concerns about the capacity of UHNS to deal with maternity, night-time A&E, paediatrics and acute surgery were also on the minds of those who attended.

The borough council collected the following online comments from Newcastle residents via high profile web presence at www.newcastle-staffs.gov.uk/hospital - a link was also available from the UHNS's website throughout the period.

I think the proposed move will put a huge pressure on the hospital and the services affected. I've recently had a baby and received excellent care from the team on both the midwife birthing centre and one of the wards where I was later moved to. To expect this team to also deal with the maternity care transferred from Stafford is ridiculous. They are already very busy yet still manage to provide an excellent service, these proposed changes can only result in a huge and unrealistic burden to the services producing an inevitable decline in the level of care provided. This will be especially true for services such as A&E and maternity. I really feel for people that this would affect in Stafford, especially those in need of urgent and emergency care - it's a long journey which I believe will only result in a higher number of fatalities due to the delay in receiving the care needed. It will also put a massive pressure on the ambulance services meaning that they are having to be with patients for longer due to the distance, ultimately affecting the amount of people who will the ambulance service can come out to. It will also affect those in North Staffordshire in terms of receiving prompt urgent care, and of course waiting times will obviously increase. Surely investing in Stafford Hospital to create a better service would be much more preferable rather than trying to sweep it under the carpet. I believe these changes are a bad mistake and would implore the powers that be to rethink this. It will be of detriment both to those who live in North Staffs and Stafford, will affect the level of care currently provided and will place too high a burden on the services.

Emma Wignall, *26 Hereford Avenue, Newcastle*

I am apalled at the bad practice that has taken place at Stafford hospital. But it is time to move on. Whilst I can see the argument for cost effectiveness and economies of scale by moving services to large sites, I do not believe that this is in the best interest of patients. I have a rare medical condition and the national research centre is in Leeds; my condition affects only a small number of people world-wide, so I have no objection to Leeds being the centre of excellence. But on matters of maternity and critical care the patient needs to be near to home; it is a lonely experience to be seriously ill in a hospital many miles away from home, where friends and family may not be able to make the journey to visit. It may sometimes be necessary, but should not be the norm. How on earth the existing staff at Stafford hospital have the resources and the will to carry on the the face of the relentless barrage of bad press, I have no idea; it isn't all bad!. If the changes go ahead I am sure that UHNS staff will cope admirable, but that is not the point. Stafford needs its hospital

ST5 3NX

Its a bloody joke, last year I had to have 2 hip operations, had to go to Leighton at Crewe as uhns could not fit me in' so more people coming to uhns is going to cause more problems on the waiting lists

Sue Smith, *Newcastle*

I'm deeply concerned about the pressure this will put on what has been a great maternity service at UHNS. I'm due to have my first baby in January 2014 and this news worries me very much. Will my care be compromised as I approach my third trimester and due date? Will this be a problem for expectant mothers in North Staffordshire? The new maternity block has had some positive reviews and I worry this will be the downfall of maternity care at UHNS.

Leanne Kemp, *May Bank resident*

Hundreds of official consultation forms were made available at the Civic Offices, Guildhall, Jubilee2, Borough Museum and Art Gallery and library in Newcastle, Kidsgrove Town Hall and the Madeley Centre (four responses from Madeley are enclosed). They were also given out to 60 councillors at a Full Council meeting.

The borough council publicised the above actions in the local media including the Sentinel, Radio Stoke, Signal Radio, Cross Rhythms Radio and BBC News Online as well as our Twitter and Facebook accounts.

The residents of Newcastle and North Staffordshire enjoy a first class service from UHNS and we have been privileged to see investment in our hospital – it is clear that the financial strain placed on both Stafford Hospital and UHNS is unlikely to be solved by the proposals outlined by the Trust Special Administrator. Serious consideration must be given to how the ongoing deficits are dealt with and where the extra capital investment will come from.

UHNS is also a well-respected regional trauma centre and as it seeks to consolidate this specialism to underwrite its financial position, it would be unacceptable for patients to find themselves compelled to access services in Stafford which they currently enjoy at the UNHS.

Finally, there remain unanswered questions over how transitional arrangements would support the patients and services at both hospitals, how this would be funded and how any arrangements would be monitored and held to account.

Newcastle residents understand the need for change to support Stafford Hospital, but this support cannot come at the expense of the current provision they access at UHNS.

city of
stoke
on trent

**Stoke-on-Trent City Council Response To
Trust Special Administrator: Consultation on the future
of Mid Staffordshire NHS Foundation Trust**

Stoke-on-Trent City Council
Civic Centre
Glebe Street
Stoke
ST4 1HH

Tel: 01782 234234
www.stoke.gov.uk

Our ref: ZI/RC/TO/MP
1 October 2013

PRIVATE AND CONFIDENTIAL
The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
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ST16 3SA

Introduction

The Trust Special Administrators (TSA) for Mid Staffordshire Foundation Trust appointed by Monitor have put out a number of recommendations for public consultation on the future of Stafford and Cannock Hospitals.

They recommend that Mid Staffordshire Foundation Trust (MSFT) is dissolved and Stafford Hospital is run by the University Hospital of North Staffordshire NHS Trust (UHNS). Cannock Hospital would be taken into the Royal Wolverhampton Foundation Trust.

The reasons set out are:

- MSFT provides services to relatively small numbers of patients
- it is difficult to attract and retain enough doctors and nurses
- the cost of running the hospital is far too high for the number of patients it serves

Their conclusion is that the MSFT is not clinically and financially sustainable, therefore the TSA are looking for a solution that is ***clinically and financially sustainable.***

The proposals for the Stafford and Cannock hospitals include a reconfiguration of services across two sites, respectively. The consultation document asks questions related to the main proposals for reconfiguration, and these are dealt with in the attachment to this response (appendix A).

Rationale

Stoke-on-Trent City Council understands that at a national policy level:

- reconfiguration of services across hospital sites is not a new strategy;
- the driver for change is to improve the quality of care, primarily;
- there is a huge potential financial benefit;
- but success assumes integration with excellent community services and first class primary care.

We agree that "reconfiguration of hospital services can provide a powerful means of improving quality in an environment where money and skilled health care workers are scarce. In some places, reconfiguration is needed urgently, in order to protect patient safety."[1]

We know that the 21st century's challenge is dealing with long term conditions. The prevalence of diabetes, for example, is predicted to double over the next 20 years. Many more people have both physical and mental health challenges. This is particularly the case in the deprived and diverse communities of North Staffordshire where levels of health inequalities are high.

We also know that the wider economic context presents a serious challenge to the NHS. While demand for healthcare and the costs of healthcare are rising, public sector funding is reduced and will not be increased over the next decade, at least. This means the NHS needs innovative models of healthcare delivery that radically improve value for the patients.

Main concerns

Stoke-on-Trent City Council has posed four main questions through the Overview and Scrutiny Committee, which are echoed by the other organisations, and also reflect the questions posed by the public:

1. What are the financial assumptions which are being made by the TSA? Given the financial challenges already faced by UHNS, the need for capital investment, and the need to invest in the community services, the high-level financial projections are not convincing. We have yet to see a robust model and the underlying data.

2. What are the assumptions in respect of the impact of the service reconfiguration on existing UHNS services which are serving the residents of Stoke-on-Trent, Newcastle-under-Lyme, and Staffordshire Moorlands?

3. What impact will these changes have on the cross economy transformation plan? Presumably a lot of the success of this scheme will depend on UHNS, together with the SSOTP, achieving significant transformational changes to service delivery over the next few years as agreed with the CCGs (e.g. greater provision of preventive and community based services to reduce need for emergency admission to hospital). The history of the Fit for the Future project, and the perceived lack of impact as a result of that project, does not provide any confidence that these proposals will succeed. We understand that the development of community services in Stafford and the surrounding area is arguably behind that in North Staffordshire and this would impact on UHNS and therefore our residents.

4. How will the transition be managed to ensure UHNS is 'ready' to take on the additional patients from Stafford? The consultation paper recognises that UHNS is not likely to be ready to do this for two-to-three years because of current difficulties but does not set out the key milestones etc. We set out our proposals on accountability and managing the transition below.

Specific concerns

These are also addressed in the table below, in respect of some of the specific proposals. However the Councils and CCGs have identified the highest risks in terms of quality of care to be changes to maternity services, the impact on UHNS A&E, and elective waiting times. We would like to see a risk assessment which feeds a plan to manage the risk in order to avoid a negative impact on patients living in Stoke-on-Trent or the two districts.

Although a guarantee has been given that Stoke-on-Trent patients will not have to travel to Stafford, this remains a concern. It is vital that levels of access for local people are not compromised, especially in regard to waiting times. We seek reassurance on these issues.

UHNS states the hospital is running at 100% occupancy which is unsustainable, and has a goal to reduce to 92% occupancy. There is no assurance that this goal can be achieved. We recommend that there be a set of pre-conditions in place which have to be achieved before transition can begin.

The paramount concern is that the quality of care, service by service, improves and is not jeopardised by the changes. This is the stated aim of UHNS but will require very close monitoring.

Managing the transition

The accountability for managing the process of change is said to rest with the NHS Trust Development Board and NHS England. We would want to see the governance of the reconfiguration process assured in a number of ways, as suggested by the King's Fund.[2]

The Health & Wellbeing Boards with Healthwatch should ensure the quality of public engagement. Health and wellbeing boards should host the conversation between clinicians and local populations with active involvement of the clinical commissioning groups.

The Overview and Scrutiny committees should focus on the management of the identified risks.

In particular, attention must be given to clarifying roles, responsibilities and accountabilities with respect to reconfiguration decisions. A cross-economy Board should be established co-chaired by the County and City Councils who will lead strategic reconfiguration planning and decide how to resolve any conflicting views from the many different statutory bodies. This Board would include clinical commissioning groups, health and wellbeing boards, Monitor, and NHS England.

Plan B

We understand from the TSAs and UHNS there is no Plan B.

However a pan-Staffordshire Acute Trust has been proposed as an alternative.

An immediate response to the proposal is that it would create a huge and unwieldy organisation that would be hard to govern; but we believe this is a flawed idea for these reasons:

Although reconfiguration can deliver improvements in quality and safety without significant additional cost, overall there is little evidence to demonstrate that significant cost savings can be achieved from reconfiguration in the short to medium term, and significant change
frequently requires transitional and capital support. The business case for the "super Trust" lead by Kings Health Partners in London estimated a cost of 0.2% of turnover to fund the new business. The costs of implementing the current proposal are unknown but a larger Trust would require proportionally more funding diverted to the mergers.

There is simply a lack of hard evidence around clinical benefits.

The Co-operation and Competition Panel (CCP) published its review of a proposed NHS merger and concluded that 'the merger is inconsistent with Principle 10 of the Principles and Rules, that is *Mergers, including vertical integration, between providers are permissible when there remains sufficient choice and competition or where they are otherwise in patients' and taxpayers' interests, for example because they will deliver significant improvements in the quality of care.*'

This raises the concern that a pan-Staffordshire Acute Trust would reduce competition and choice for patients receiving elective and non-elective care in Staffordshire. This is in contrast to the national policy assertion that choice and competition will deliver a wide range of benefits, including improvements in quality and safety, population health, and value for money.

The pan-Staffordshire Acute Trust would involve establishing a large enterprise running several sites, and clinical networks. This is akin to one American model of delivery where a single organisation owns and manages several healthcare sites. The NHS does not grow the leaders with the necessary business and strategic skills to make a success of such an enterprise. We believe this would open the door to an independent company to take responsibility.

Finally, the populations in the different districts of Staffordshire are different in their health and social care needs, and historic utilisation of healthcare provision. This would present a huge challenge to both commissioners and a large Trust. We believe a more credible merger is the integration of acute and community care for North Staffordshire.

Conclusions

1. The Council understand the reasons for the proposals, and agree that MSFT is not sustainable.

2. The Council has serious concerns about the clinical risks – in particular maternity services, A&E and emergency admissions; the lack of a robust projection of the financial implications; and the timescales given that there are some major building requirements. We are seeking reassurances on these issues.

3. The Council believes that there are no obvious alternatives. The One Staffordshire Trust solution is not feasible or deliverable for reasons set out above, and simply is not desirable.

4. The Council seeks assurance on the governance of the transition period and a commitment for partners to work together to develop a system-wide implementation plan.

5. The Council asks that the decision on these proposals is in line with the previous Secretary of State's four principles:

- there is support from GP commissioners
- it demonstrates strengthened public and patient engagement
- there is clarity on the clinical evidence base
- it is consistent with current and prospective patient choice.

Your reference
Our reference
Date 25 September 2013

city of
stoke-on-trent

TSA
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Corporate Services
Civic Centre
Glebe Street
Stoke-on-Trent
ST4 1HH

Assistant Chief Executive
Charles Stewart

Dear Sir/Madam

Stoke on Trent Overview and Scrutiny Committee – Response to TSA Consultation

On behalf of the committee I would like to thank the TSA, University Hospital North Staffs (UHNS) and the Stoke on Trent CCG for attending the Stoke on Trent Overview and Scrutiny meeting on 11 September to discuss the future proposals for Mid Staffordshire Hospital.

Following the debate at the meeting, I would like to submit the following response:

The Committee understand that the current arrangements at Mid Stafford and UHNS are not sustainable and proposals to address the move of patients' needs to be put onto a formal footing. The committee is concerned that the infrastructure at the UHNS isn't currently adequate to cater for increased patient numbers. There was no evidence presented to the committee to show that patient volume, infrastructure or transitional plans had been developed enough to reassure us that this had been adequately considered. The committee would have liked to have seen evidence that the financial modelling had been carried out and the patient forecasts and phasing had been considered in more detail. The committee appreciate that the proposals are part of a transitional plan and on a phased basis but the lack of information on these phases and how services are going to be affected causes some concern.

The possibility of a Staffordshire wide approach was briefly discussed. It was felt that this would be unmanageable and that the proposed UHNS and Cannock proposals were more realistic.

The UHNS has been built and planned around very specific geographical needs of the local population and the proposed additional patients' needs are relatively unknown. The populations in the county districts of Staffordshire are different in their

health and social care needs to that in the City. This would present a huge challenge to commissioners.

Reassurances that the cross economy transformation work, which is happening in North Staffordshire will not be affected, can't be guaranteed. Is similar work being explored in the Stafford area to reduce some of the potential pressure on the acute services? This seems unclear.

The TSA consultation paper recognises that UHNS are not likely to be ready to take on all the proposed services for two to three years because of current difficulties. The document does not set out the key milestones. How will the transition be managed to ensure UHNS are 'ready' to take on the additional patients from Stafford?

Although a guarantee was given at the meeting that patients will not have to travel to Stafford, this remains a concern. It is vital that levels of access for local people are not compromised, especially in regard to waiting times.

The Committee heard from the TSAs and UHNS there is no Plan B. This is a concern and puts the committee in a difficult position when faced with no alternative.

The Committees paramount concern is that the quality of care, service by service, improves and is not jeopardised by the changes.

Again, I thank you for attending the Overview and Scrutiny meeting and ask that you consider the above concerns of the committee when considering your proposals.

Yours,

Cllr Bagh Ali
Chair of the Adult and Neighbourhoods Overview and Scrutiny committee

Putting patients first

NHS
Stoke-on-Trent
Clinical Commissioning Group

Our Ref: AB/akb/LB

1st October 2013

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PRIVATE AND CONFIDENTIAL
The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
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ST16 3SA

Dear Colleague

Stoke-on-Trent CCG has considered the TSA draft recommendations on the future services for local people using Stafford and Cannock Chase hospitals and the potential impact that this will have on the population and local health and social care services in Northern Staffordshire.

We have been involved in the work of the TSA and in UHNS planning and recognise that MSFT is not sustainable and the need for service reconfiguration. We are broadly in support of the rationale and draft proposals for the following reasons:

- UHNS providing services over a bigger footprint with approximately one million population will create economies of scale and bring in additional resource that will have a positive impact for the population of Stoke-on-Trent as it will support UHNS to:
  - Improve quality of services with more consultant provision over 7 days, for example in maternity, some surgical specialties.
  - Sustain and potentially increase the range of specialised services that they provide, meaning that the population of Stoke-on-Trent will be able to access these services closer to home.
  - Sustain and potentially increase their teaching, education and research status.
- There will be a plan to manage the change in service provision which is far less of a risk than an unplanned shift of activity from Stafford to UHNS.
- Planned growth of services appropriately funded will support the financial sustainability of UHNS.

However, we do have a number of concerns and questions that we wish to be considered and seek assurance on:

- That the changes won't have a negative impact on the Quality and Safety of the service provision for the patients of Stoke-on-Trent.
- That the right capacity will be in place so that there isn't a detrimental impact on access, in particular; on A&E, non-elective pathways, cancer waits and 18 week RTT. We are particularly concerned about the capacity for the planned increase in demand for A&E, Maternity and Children's services.
- Patients in Stoke-on-Trent will be able to access services in Northern Staffordshire and not have to travel to Stafford unless they choose to do so.
- That Community step down services / infrastructure are brought on line in Stafford to enable Stafford patients to be discharged in a safe and timely manner to support flow of patients through the acute beds and deliver the productivity gains at UHNS.
- UHNS has an underlying financial deficit and we would like assurance that the financial position at Stafford won't have a further negative impact on this.

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NHS
Stoke-on-Trent
Clinical Commissioning Group

Mid Staffordshire Hospitals Consultation
1st October 2013

- The plans for Cannock need to be considered alongside UHNS plans for Stafford to ensure there are no unintended consequences. The potential loss of elective care provision and increase in non-elective activity at Stafford could have a negative impact on the financial modelling and sustainability for UHNS.
- HM Treasury 2013 Spending Round requires commissioners to work towards the creation of Integrated Transformation Funds which will impact on future acute commissioning intentions and financial planning from 2014/15 onwards.
- We would like to understand more of the under-pinning assumptions in terms of the productivity gains at UHNS to understand whether these are in fact viable and sustainable solutions, or whether this places a further burden on the North Staffordshire Local Health System to resolve, bearing in mind that as CCGs we commission less than 50% of services now at UHNS given the fragmented nature of commissioning.
- Stoke-on-Trent CCG will continue to fund services at UHNS at tariff and in accordance with the national business rules, but should not be expected to pay at 'tariff plus' for services at UHNS
- That there is a whole plan for Staffordshire that has an acute sector solution aligned with the community model of care that is being designed and implemented in Northern Staffordshire and has full involvement of Stoke-on-Trent CCG.
- That there is robust deliverable workforce plans. We would like to seek assurance that junior doctors will continue to be placed at Stafford as if not this will further compound the problems.
- A robust risk assessment on impact in Northern Staffordshire is completed and included in the risk register.
- What the impact will be on the transition if there is a judicial review.

In summary, Stoke-on-Trent CCG is broadly supportive of the draft proposals that are being consulted subject to consideration and assurance been given on the issues that we have set out above.

We would particularly like to draw out that we have a number of significant concerns that relate to the impact the planned changes will have on Northern Staffordshire, most notably the financial planning assumptions and the delivery and sustainability of key targets. We are therefore really keen that we are engaged in the transition period to ensure that the impact and any unintended consequences relating to Stoke-on-Trent is recognized and managed. We also wish to be noted that the system within Northern Staffordshire is already feeling the impact of a shift in activity from Stafford to UHNS, in particular, A&E and non-elective admissions and that UHNS has not achieved the 4 hour A&E target for four of the past quarters for the current demand and prior to any increased demand.

Yours sincerely

Dr Andrew Bartlam
Clinical Accountable Officer
Stoke-on-Trent Clinical Commissioning Group

Your reference
Our reference
Date 25 September 2013

city of
stoke-on-trent

TSA
Stafford Hospital
Weston Road
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health and social care needs to that in the City. This would present a huge challenge to commissioners.

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The Committees paramount concern is that the quality of care, service by service, improves and is not jeopardised by the changes.

Again, I thank you for attending the Overview and Scrutiny meeting and ask that you consider the above concerns of the committee when considering your proposals.

Yours,

Cllr Bagh Ali
Chair of the Adult and Neighbourhoods Overview and Scrutiny committee

8. Unions

Mid Staffordshire NHS
NHS Foundation Trust

Chartered Society of Physiotherapy (CSP) Union Representative Response to the TSA Consultation Document for Midstaffordshire Foundation Trust (MSFT).

Dear TSA,

CSP members were alarmed by the absence of any reference to physiotherapy/rehabilitation in the consultation proposals that were published by the TSAs on the 31st July 2013. They were worried that this signalled that the important role of physiotherapy in optimising patient recovery had not been recognised by the administrators.

We were somewhat reassured when, during the meeting between yourselves and the trade union reps on Thursday 15th August, you clarified that the report only focussed on services where changes were anticipated not on all services currently provided at Stafford and Cannock Hospitals. However, in view of the fact that physiotherapists do work in areas where changes are anticipated members were keen to still highlight the important contribution physiotherapists make across a wide range of clinical specialities, particularly as this has sometimes been overlooked in previous organisational changes at the trust. They have asked us to send you the attached document which provides further details.

There was no criticism of physiotherapy staff contained within the Francis Report and CSP members have always sought to provide the best service possible to the community they serve and are keen to be given the opportunity to continue to do so in future. They have been distressed by the way all staff who work for Mid Staffordshire NHS trust have been stigmatised by the conduct of a minority and remain anxious and fearful because of the uncertainty about the future arrangements.

Staff hope that you will be able to ensure that the people of Stafford can still access broad range of health services locally and employees of Mid Staffordshire Foundation Trust can enjoy employment security providing NHS services to their local community.

Yours sincerely,

Natalie Deakin
CSP Representative

Becausewecare

Mid Staffordshire NHS
NHS Foundation Trust

We want to make you aware of our services here at MSFT, how well they work and just how crucial physiotherapy impacts the patients of MSFT. The attached appendices will demonstrate our importance as a provider as there are a variety of different specialities within physiotherapy that are highly specialised to treat patients with different conditions using highly developed clinical reasoning, here at MSFT.

Physiotherapy rehabilitation aims to optimise patient function and well-being, to help integrate that patient back into their chosen lifestyle activities whether at home, work or leisure. Rehabilitation should focus on changes to functional disability and lifestyle restrictions based on the patient's own goals for functional improvement (Randall 2000). Rehabilitation can be used for recovery from injury or disease and also for the management of long-term conditions. Rehabilitation should start as soon as possible to speed recovery. The programs that combine many different components are likely to be most effective.

However we would like to make you aware of the **national guidelines** behind therapy intervention following certain conditions.

Randall KE, McEwen IR. Writing patient-centered functional goals. Physical Therapy. 2000; 80(12):1197-203

Appendices:

Appendix	Content
I	Neurological Services across MSFT
II	Elderly Care Services across MSFT
III	Respiratory Services across MSFT
IV	Orthopaedic Services across MSFT

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Appendix I – Neurological Services across MSFT

Neurological therapy

The national stroke and NICE guidelines 2007 made it clear that stroke patients should be having specialised physiotherapy input from neurologically trained physiotherapists as soon as possible following stroke. The stroke strategy in 2007 highlighted the need for ongoing specialist rehabilitation following a stroke, this is what our current stroke unit provides following on from the hyperacute treatment at UHNS. There is also a move for early supported discharge into the community (stroke association, Saka et al 2009) with rehabilitation being closer to home. We currently run a community support facility at Cannock as part of the outpatient services which helps to support the community stroke services with more complex rehabilitation patients.

The other group of patients that fall into the Neurological group are patients who have long term conditions such as multiple sclerosis (MS), motor neurone disease (MND), Parkinson's disease (PD), Huntingdons, Ataxia and conversion disorder to name a few. All these conditions will come under the umbrella term of the 'long term conditions' outlined in the (National Service framework 2005).

Examples of long term conditions include high blood pressure, depression, dementia and arthritis as well as neurological disorders.

Long term conditions can affect many parts of a person's life, from their ability to work and have relationships to housing and education opportunities. Care of people with long term conditions accounts for 70% of the money we spend on health and social care in England. Physiotherapy is an integral part of improving quality of life and reducing disability in this group of patients.

The quality requirements 4,5,6,and 7 in NSF 2005 discuss that patients with neurological conditions require specialist rehabilitation form a neurologically specialised physiotherapist. There should be community support with access to a range of rehabilitation settings to deal with their changing needs. Multiple Sclerosis patients who form part of this group have their own research and guidelines again suggesting that Physiotherapists provide a unique contribution to the management of people with MS through the improvement and maintenance of functional abilities and management of the long term symptoms. Physiotherapists provide specific rehabilitation programs, facilitate self management and coordinate care. For people with more complex needs physiotherapy should where possible be delivered within a multidisciplinary specialist team/service where regular evaluation and assessment can be provided.

Currently the trust has highly rated neurological teams within the two hospitals – Outpatients service at CCH and SGH (specifically for Neurological patients), Rehabilitation Day unit (CCH) with opportunity to look at vocational activities (pottery, gardening, kitchen skills,) specialised ward teams to treat and rehabilitate stroke patients and any other neurological patients admitted to the hospitals on both sites who require ongoing rehabilitation or treatment following new diagnosis of symptoms, undiagnosed symptoms or suffering a relapse. We are able to treat more complex patients in these outpatient areas as we have the correct specialist equipment and sufficient space to use these larger pieces of equipment, that isn't possible within a person's own home.

References:

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Appendix I – Neurological Services across MSFT

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Appendix II – Elderly Care services across MSFT

Elderly Care:

Age Uk reports falls cost the NHS over £4.6 million each day (Mitchell M 2010) and half of the people who fall will fall again within the next 12 months (DoH 2009). Physiotherapists are recognised in NICE guidance (2004) to treat patients who have had falls including strength and balance training. Furthermore, they suggest falls prevention programmes should be set up to prevent hospital admission. Physiotherapists have advanced knowledge and skilled in reablement to allow them to prevent frailty using exercise programmes, restore independence, lead falls clinics (giving assessment and specific advice) and identify any underlying pathology to allow signposting to the correct service (Martin 2008).

Dementia is another large problem in the UK with 750,000 in UK living with dementia (DoH 2009), with the Stafford area having a greater proportion of elderly people it is very prevalent to this health economy. Physiotherapists are key in delivering the National Dementia Strategy UK wide(Doh 2009). Physiotherapists, as autonomous practitioners, can undertake detailed, individually tailored assessments of the impairments, activity restrictions and participatory limitations faced by people with dementia. Physiotherapists work as part of a multi-disciplinary team ensuring the delivery of high quality, effective care, in line with the NICE Quality Standard (NICE 2006 amended 2011) for people with dementia. NICE 2006 and SIGN 2006 guidelines recommend physiotherapy for promoting and maintaining independence for this client group. Physiotherapists contribute to multi-disciplinary team discharge planning. Early discharge planning is a key component of reducing length of stay for patients with dementia (Alzheimer society 2009).

The average hospital stay for a common hip fracture is seven days. However, over 85% of dementia patients with this injury stay for up to 14 days, and 34% for over a month; the extra cost is estimated as £5,950 per patient (Alzheimer society 2009). Falls are the most common reason for hospital admissions, and account for 14% of all admissions for people with dementia.

Poor balance, known to increase the risk of falls, can be improved by physiotherapy-led exercise (Christofoletti et al 2008). Exercise can have a significant and positive impact on behavioural and psychological symptoms of dementia (Cerga-Pashoja et al 2010), improving cognitive function and mood, which can reduce the need for pharmacological intervention (Lawlor B et al 2002).

Physiotherapy is a cost effective and accessible intervention, it preserves and promotes activity for people who have dementia. Physiotherapy interventions improve the quality of life and reduce the burden on the care system and other health systems within the NHS (Alzheimer's Society 2007).

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Appendix III – Respiratory service across MSFT

Respiratory:

Although there is still some debate whether patients should be managed in their own homes or in a hospital environment there is a clear recognition that specialist respiratory trained physiotherapy input is required as part of a patients recovery from an exacerbation of a chest problem (BTS guidelines non cf bronchiectasis management 2010-http://www.brit-thoracic.org.uk/Portals/0/Guidelines/Bronchiectasis/non-CF-Bronchiectasis-guideline.pdf)

Physiotherapists are an essential part of running effective pulmonary rehabilitation programmes, which are advised in NICE and British Thoracic Society guidelines for lung patients. Pulmonary rehabilitation should begin and become established within the hospital setting before discharge (NICE guidelines). Pulmonary rehabilitation can significantly improve health by providing ways of disease control and improving patients abilities to carry out daily activities, therefore reducing number of admissions to hospital. As well as pulmonary rehabilitation physiotherapists are essential at providing support with breathing exercises and chest clearance. These have already been implemented at Midstaffs and as part of the Chronic Obstructive Pulmonary Disease (COPD) CQUIN physiotherapists have been involved with the clinical workgroups to improve the pathway of COPD patients.

Critically ill patients suffer from long term physical and psychological complications. For patients who are mechanically ventilated for more than 7 days; 25% display significant muscle weakness (de Jonghe et al 2009) and 90% of long term survivors have ongoing muscle weakness (Fink et al 2008). Due to this problem physiotherapists are an integral part of the multi disciplinary team in critical care. They have unique skills and expertise to assess and manage respiratory complications and physical neuromuscular and musculoskeletal conditions. There is substantial evidence that supports the role of the physiotherapy within the critical care environment (Denehy et al 2006)and early mobilisation is crucial for weaning and reducing length of stay (NICE 2009).

References:

- de Jonghe B, Lacherade JC, Sharshar T, et al. Intensive care unit-acquired weakness: risk factors and prevention. Critical Care Medicine. 2009;37(10 Suppl):S309-15.
- Fink H, Helming M, Unterbuchner C, et al. Systemic inflammatory response syndrome increases immobility-induced neuromuscular weakness". Critical Care Medicine. 2008;36(3):910.
- Denehy L, Berney S. Physiotherapy in the intensive care unit. Physical Therapy Reviews. 2006;11(1):49.
- National Institute for Health and Clinical Excellence. Rehabilitation after critical illness, CG83. London: National Institute for Health and Clinical Excellence; 2009. URL: http://www.nice.org.uk/CG83

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Appendix V – Orthopaedic Services across MSFT

Orthopaedic:

Following orthopaedic surgery there is often a requirement for physiotherapy intervention to ensure full recovery. In Elective surgery, the introduction of Enhanced Recovery has demonstrated the benefits of early physiotherapy, for example getting patients out of bed on the day of their surgery. This has led to some patients at Cannock being able to leave hospital on the day following their hip or knee replacement operation – in effect making joint replacement an overnight stay procedure.
Enhanced Recovery also places great emphasis on pre-operative preparation and education of the patient. Physiotherapists play a large part in pre-operative education in exercise and expectation management, to prepare the patient for their post-operative rehabilitation.
Physiotherapists are also instrumental in enabling Day Case surgery on Lea Hall ward, by offering exercises and mobility training a few hours after the patient returns from theatre.
The Hilton Main Elective Surgery unit has physiotherapy cover seven days a week, including Bank Holidays; this weekend service is crucial to length of stay, and ensures equality of treatment for all patients regardless of the day of surgery. It is vital that this service continues to be appropriately staffed in years to come.

Back pain is one of the most common health problems affecting society, with up to 70% of the population experiencing pain at some point in their lifetime. It is associated with significant healthcare use and societal cost in terms of work loss and disability, and has been addressed using a variety of management approaches. Early intervention is considered critical to the management of low back pain to ensure that treatment occurs during the acute phase, before the condition deteriorates and becomes chronic.

Part of the low back pain NICE guideline (NICE 2009) includes education, posture management, activity, acupuncture, manual therapies and electrotherapy. Physiotherapists are excellently placed to be able to deliver on all of these areas and have specialised skills in this area. Specialist musculoskeletal physiotherapists are often trained in acupuncture and or manual therapy, whereas intermediate care teams will not be specialised and therefore not able to offer these services. This is also true of the whiplash guidelines 2001, where modalities such as range of movement and postural advice along with motor control, TENS, acupuncture and manipulations are all treatment modalities supported by the guidelines. These are performed by trained health practitioners, within physiotherapy there are specialised musculoskeletal practitioners who have these skills to provide patients.

Following hip fractures specific therapeutic procedures, such as those implemented by physiotherapists and occupational therapists have the potential to accelerate the recovery of mobility (NICE 2011). The guidelines recommend based on evidence patients have a physiotherapy assessment, unless medically or surgically contraindicated, mobilisation on the day after surgery.

Hydrotherapy is another modality that is physiotherapy specifically driven. It is used to treat a variety of different conditions within the different specialities of physiotherapy including musculoskeletal, rheumatological and neurological (Geytenbeek 2008). The
National Aquatic Physiotherapy Group have conducted a review and produced guidelines to demonstrate the effectiveness of hydrotherapy for all this range of conditions. This again is a highly specialized skill that qualified specialized physiotherapists have. Some lead therapists are trained additionally in hydrotherapy courses.

Arthritis is another common problem seen in the NHS. Exercise can help to manage some of the symptoms of arthritis. Physios provide advice and education on exercise, pain relief and ways to manage your condition. They can teach you how to improve your joint movement and your walking, as well as how to strengthen your muscles.

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Your physio may offer exercise in water, at perhaps your local swimming pool. They may also offer acupuncture for some conditions. Being active can really help you to stay mobile and independent. They are core clinicians as outlined in the NICE 2008 and SIGN 2011 guidelines for treating peopir with arthritis and rheumatology conditions.

References:

- HTA Programme: HTA Systematic Review 1~ May 2008. Service delivery organisation for acute low back pain. Healthcare Improvement Scotland 2008.
- NICE 2011: The management of hip fracture in adults
- National Institute for Health and Care Excellence, 27 May 2009 - Publisher: NICE - Publication type: Full Guidance
- Motor Accident authority 2001. Guidelines for the management of whiplash-associated disorders.
- Geytenbeek, Jenny 2008. Aquatic physiotherapy evidence-based practice.
- National Aquatic Physiotherapy Group.
- NICE 2008. The care and management of osteoarthritis in adults : CG59

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Mid Staffordshire NHS
NHS Foundation Trust

MSFT
Weston Road
Stafford
ST16 3SA
1st October 2013

By email only: TSAconsultation@midstaffs.nhs.uk

Office of the Trusts Special Administrator
MSFT

Dear Sirs

Response to TSA Public and Staff Consultation

As you will now be aware, the Local Negotiating Committee (LNC) is the recognised forum at the Trust and a BMA accredited Committee for collective consultation and negotiation on behalf of all medical and dental staff employed by the Mid Staffordshire NHS Foundation Trust.

On behalf of medical and dental staff employed at the Trust, the LNC would request that the following concerns are formally considered as part of the current public and staff consultation on the TSA proposals for future clinical services in the Stafford and surrounding areas:-

Role and remit of the Clinical Advisory Groups (CAGs)

- Since the publication of the TSA's draft report, it has been publicly stated by the TSAs that the CAGs are in full support of the proposed model of care being recommended. However, we believe that the CAG has not been consulted adequately and that this is a misrepresentation of their views. The CAG believe that the TSAs recommendations would be clinically safe and sustainable, on the evidence that was presented to them. The clinical teams at MSFT doubt the integrity and interpretation of the data used in evidence by the TSA, therefore making the CAGs belief of safety and sustainability unsound. We believe that the TSAs use of the CAG was not in the spirit of the terms of reference and that this has led to Trust staff and the public being misled.

- It is understood that the CAG representatives were required to comment on three proposed models of clinical services provided by the TSAs rather than they be given the opportunity to offer additional and alternative proposals based on their clinical knowledge and professional experience. There is concern amongst medical staff employed by the Trust that the CAGs have not been given sufficient autonomy to consider the requirements of the local population of Stafford or offer suggestions to the TSAs with regard to alternative clinical models which will still ensure future clinical and financial sustainability.

- It is noted that in recent correspondence to the TSAs, (letter dated 22 July 2013), the CAG representatives have sought more details of the TSAs broad proposals and requested the opportunity to comment further on any future proposals. We would encourage the TSA to ensure that the CAGs are fully consulted on any future proposals and that their professional advice and recommendations are fully considered by the TSAs in their final report to Monitor.

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NHS Foundation Trust

Engagement with Medical Staff as part of the Formal Consultation Process

- Concern remains with regard to the TSAs consultation and engagement with key medical staff within the Trust. It is imperative that employees who have been providing a safe service (as per a recent CQC report) to the local community are fully engaged. Specifically their professional view and opinion on the effect the TSA proposals will have on clinical care and patient experience as well as to consider their views and the evidence available on how future services can be provided across Stafford and surrounding areas. The LNC recommends that local clinicians are included in finding local solutions.

- There appears to have been very little direct engagement with training grade doctors at the Trust or consideration given as to how the proposed changes outlined in the TSA draft report will affect the future training of junior grade doctors. The draft report does not address this issue in the detail required and the LNC would encourage the TSA to ensure training grade doctors and their training needs are addressed in the final report. It is imperative that training grade doctors, the Trust clinical supervisors and the West Midlands Deanery are fully consulted and any concerns taken into account as part of the formal consultation process. The LNC remain concerned that this has not taken place to-date.

- Full consultation is also required with SAS doctors and the LNC would question what arrangements have been made by the TSAs to meet with this group of employees at the Trust? SAS doctors are senior clinicians within the Trust with much experience of local services. The LNC would request that the TSAs ensure that the views of SAS doctors are actively sought and taken into account as part of the consultation process.

Future clinical services for the population of Stafford and surrounding areas

- The LNC is concerned that the draft report has failed to meet the requirements of Monitor in ensuring that future services in the Stafford area are either as good as the current services offered or improved upon. From the representations made by medical staff from each of the main specialties affected by the proposed changes, concern remains within the medical profession that an inferior service will be provided to the people of Stafford both in the short and long term if the TSA proposals are implemented in the current format. The LNC would press for the TSA to fully consider the submissions made by each of the clinical specialties including the presentations made during the Consultant Staff Committee (CSC) meeting held on 25 September 2013 as part of the current consultation process.

Requirements of local Commissioners/CCGs

- The CCG has presented their Location Specific Service, as their minimum requirement for local services, without consultation of the local population/patients they have come to represent. The LNC would question the legality of the CCGs remit, which seems to undermine the TSA process.

- The LNC remains concerned that the TSAs have indicated that the draft proposals have been endorsed and agreed with the CCG(s) however, during a recent meeting of the Consultant Staff Committee (CSC) and representatives from the Stafford and Surrounding Areas CCG and local GP representatives it was made very clear that this is not the case and that the CCGs remain of the view that the commissioning of future local services has yet to be determined and finalised. There appears to be a difference of opinion on the position of the CCGs in particular when taking into account the TSA formal video presentation given on 7 August 2013 as part of the consultation process when CCG Chairs (Margaret Jones, Chair of Stafford and Surround CCG and Johnny McMahon, Chair of Cannock Chase CCG) confirmed their support for the draft TSA proposals. The LNC is concerned that there is

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inaccurate and misleading information being provided to medical staff at the Trust as part of the consultation process. The LNC would request that further discussion and consideration of the CCG requirements based on the local needs of patients is undertaken by the TSA prior to any final recommendations being published.

- The CCGs have not completed their due diligence on the financial implications of the TSA proposals, however maintain that whatever model is implemented, it will have to be within budget, and it will therefore be within their gift to commission services locally as they see fit. The LNC would challenge the acceptance of the proposal which is projected to cost in excess of £300 million in Capital and Transitional expenses over 10 years, to overcome an annual shortfall of £21 million.

Clinical Data used as part of TSA review

- The LNC is aware that concerns have previously been raised with the TSAs that inaccurate and misleading clinical data has been considered by both the TSA and the CAGs in arriving at the current proposals for the Trust. The LNC understands that steps have been taken by the TSAs to ensure that medical and nursing staff are given the opportunity to outline any data inaccuracies and provide up-to-date data which reflects the current position within the Trust. The LNC would request that the TSAs ensure, as part of the formal consultation process, that all Trust clinical data is accurate and re-examined by the CAGs before the final TSA report and recommendations to Monitor.

Professional Accountability

- All doctors' performance and conduct is judged by their regulating body (The General Medical Council), for their actions and omissions, which lead to patient harm or place them at risk. There is currently a lack of clarity of professional accountability in the TSA process, when several medical groups (e.g. CCGs; TSA; CAGs), are recommending or advising service changes in the best interest of patients.
- In the event of failure of any implemented proposal, it is the TSAs view that the future provider of services will be held to account for any such failure. This is a bizarre view that will not instil public confidence in the regulation of doctors who should rightly be held to account if identified as risking patient safety or driving down standards of medical care.
- The LNC insist that the TSA defines a clear line of accountability of all professionals who are proposing; recommending and advising on the various models of healthcare at MSFT.

The LNC would request that the issues raised within this letter are fully considered as part of the formal public and staff consultation process.

Yours faithfully

Mr Ishan Bhoora
LNC Chair,
MSFT

9. Education

NHS

Health Education West Midlands

GP Education (Staffordshire and Shropshire)
St Chads Court
213 Hagley Road
Edgbaston
Birmingham
B16 9RG

Professor Hugo Mascie-Taylor
The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

16 September 2013

To Professor Hugo,

RE: Stafford and Cannock Hospitals: Retention and Recruitment of GP trainees

I am writing this letter regarding the provision of medical education at Stafford and Cannock Hospitals under the Mid-Staffordshire Foundation Trust. I am a Stafford GP as well as Associate Dean for GP Education for Staffordshire and Shropshire.

The hospital has obviously been one of the most scrutinised hospitals in the country since the Francis and other reports into patient care. There have been many positive visits to Foundation School, plus other specialities.
My remit is GP training where the Trust provides 18m of the 36m of GP training currently needed for MRCGP and Completion of Training. The Stafford and Cannock Vocational Training Scheme is a well-established scheme with 36-40 trainees, about 12-14 each year. Even though GP training is in a state of flux and evolution, there will continue to be a requirement for good hospital based teaching in many specialist areas.

50% of foundation trainees will soon need to become GP trainees. There will be additional conversion of hospital jobs over to GP training especially in paediatrics, A/E, psychiatry but also in other specialities. In addition, there will also need to be innovative posts developed using other finance streams to increase GP training.

NHS

Health Education West Midlands

In the local area, there is a potential shortage of GPs in North and South Staffordshire. Many of the Stafford and Cannock trainees when they qualify end up working as salaried doctors in both North and South Staffordshire, hopefully before settling down as partners in the area. In the Stafford/Cannock area as well as in Stoke, there are many GPs who will retire in the next few years adding to an increasing crisis in recruitment. The local GP community relies on retention of local trainees becoming future salaried doctors and partners. It is obviously more reliable to interview and select a doctor who has been at a practice for 6-12 months rather than select a doctor at interview alone.

Changes in the provision of services offered by MSGH will greatly impact on the training of speciality trainees as well as GP trainees. This will shift training away from the Stafford and Cannock areas. The end result will be increased difficulties recruiting salaried doctors and future GPs in future years at a time when the GP workforce needs to be expanding.

I appreciate that this is a secondary factor when looking at the clinical and financial sustainability of the Stafford and Cannock Hospitals but it will have an important future impact on the local GP community.

Yours sincerely,

DJL Palmer

Dr David Palmer
Associate Dean
Staffordshire and Shropshire Area

I'm not convinced the additional free text I submitted as part of my on-line response was saved and therefore received by you. I have reproduced this narrative and attach it to this email. Please confirm receipt and inclusion with this narrative, which forms an integral part of the response on behalf of Keele University.

Andy Garner

--

Professor Andy Garner
Pro Vice Chancellor & Dean of the Faculty of Health
David Weatherall Building
Keele University
ST5 5BG

General Comments

This response to the consultation is provided on behalf of Keele University's Faculty of Health and represents a synthesis of the views of the senior leadership comprising the Dean (Prof Garner), Heads of the four professional Schools of Medicine (Prof Wass), Nursing & Midwifery (Ms Walsh), Pharmacy (Prof Ratcliffe) and Physiotherapy (Dr Bucher), Director of Undergraduate Studies in the Medical School ((Prof Hassell) and the Directors of the two Research Institutes (Prof Hay and El Haj). The Schools are responsible for undergraduate and postgraduate education across Staffordshire and beyond while the two Institutes undertake applied research of international quality in the fields of Primary Care and Biomedical Sciences.

The proposed restructuring is likely to have a major impact on the design and delivery of undergraduate teaching, particularly in medicine, in the various branches of nursing and in midwifery. One is tempted to ask what, if any, provision has been made for this in NHS commissioning budgets that support the education of future clinicians in this area of the West Midlands. At present we are already trying to cope with a 34% reduction in funding for medical undergraduate clinical teaching from about £10.6 to £7 million as a result of the new SIFT tariff that supports clinical placements for Keele medical students.

The School of Nursing & Midwifery uses UHNS as its principle clinical partner for placement of undergraduate students and does not use Mid Staffs hospital. Mid Staffs does however serve as one of two DGHs for students on nursing courses at Staffordshire University. Transfer and/or downsizing of clinical services at Mid Staffs is likely to impact on placement capacity for Staffs University students resulting in more demand for placements at UHNS, something which happened to a limited extent following the Francis Enquires. As such, it seems likely that significant reorganisation of courses, curricula and placement programmes will be required on the part of the two universities, with potential to impact on the number of student places commissioned by the WM-LETB and the design of the experiential part of nurse training spent in clinical practice. The Staffordshire & Shropshire LETC brings nursing workforce commissioning, NHS providers of healthcare services and the two Universities together providing a forum to plan the provision of an integrated workforce.

The issues for Medicine are in many ways even more significant, particularly since many of the questions posed by the Consultation relate to consultant-led services. The Medical School at Keele which was established just 10 years ago is performing well as evidenced by its position in the top third of the various league tables for UK medical schools, including 2nd place in the latest NSS. Continued development of the School and in particular the retention of graduates in Staffordshire, is absolutely vital as part of the long term solution to the problems of healthcare in this part of the country. At present retention is adversely affected by the perception that postgraduate training in tis area would result in appearance of MSFT on future CVs. In reality the quality of the UG experience of Keele students who have spent time at Mid Staffs hospital has been good as stated in evidence to the Francis Enquiry. We continue to diligently monitor the quality of UG placements as described in detail in our written response to the draft Francis report. Nevertheless, dissolution of the

Whilst we may be able to accommodate obstetric placements at UHNS, the basis of some clinical placements, notably in paediatrics, would have to change since in the absence of any paediatric in-patient experience for fourth year students at MSFT. It would also be a major challenge to provide enough placements for final year secondary care assistantships. These assistantships have been a strong part of our curriculum, helping ensure our graduates are prepared for practice as newly qualified doctors. These changes will inevitably lead to additional costs, result in more student travel, necessitate establishing placements in new clinical areas, training staff and ensuring the appropriate infrastructure exists.

Notwithstanding the challenges that implementation of the draft recommendations would pose to the School of Medicine, there are some significant positives. The proposed retention of acute and in-patient medicine and daytime A&E at Stafford Hospital are all important for medical student learning. Indeed we have recognised that MSFT offers a good learning environment for more junior clinical students in general medicine. These largely 3rd year placements remain viable and, indeed, might be expanded. There may also be scope for some medical (but not surgical or critical care) final year assistantships at the newly configured hospital.

Finally, whilst recognising that difficulties over recruitment and retention of consultant staff may be temporary, the School is very concerned at the apparent effect that current reviews have on staff at MSFT, reflected by the disproportionately high number of locum doctors in the Trust. The impact of the recruitment crisis is twofold firstly, some of our clinical teachers are leaving the hospital to work elsewhere and secondly, we are concerned that the quality of care may become jeopardised in areas from which staff are leaving. If care was adversely impacted upon, clearly, we would not place students in such areas.

#32

Mid Staffordshire NHS
NHS Foundation Trust

Office of the
Trust Special Administrator
of MSFT

01 SEP 2013

Maintaining high quality, safe services for the future – Consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals

6 August – 1 October 2013

Your response to the consultation

As part of the *Maintaining high quality, safe services for the future* consultation, we want to make sure that those in Mid Staffordshire have the chance to give their views and comments. We are asking people to give us their views by reading the consultation document and completing this response form. Alternatively, you can complete the same response form online at www.tsa-msft.org.uk.

We are keen to hear your views to help inform our final recommendations that go to Monitor and the Secretary of State for Health. Please bear in mind this is a consultation, not a 'vote'. We will take responses into account along with a wide range of other information. We are interested in the overall responses to the tick box questions, and your reasons for your views. If you don't have any views on a specific question, please leave the boxes blank. You do not need to answer every question. **Please only write within the boxes provided in this response form. If your comments do not fit in the box, please send your comments on a separate sheet of paper, clearly stating which question they refer to.**

We have asked Ipsos MORI to undertake the analysis of the response forms on our behalf. The findings will help to inform the Trust Special Administrators' (TSAs) final recommendations to Monitor and the Secretary of State for Health. Please read the consultation document all the way through, then give us your answers to the questions in this response form. In the response form we have shown which pages of the consultation document cover the issues raised by each of the questions. Please refer back to the relevant pages as you answer the questions. You can download a full copy of the consultation document at www.tsa-msft.org.uk.

If you want to explain any of your answers, or you feel the questions have not given you the chance to express your views fully, or if you think there are options we have not considered that we should have done, please say so in the box for question 28.

Important: Please do not provide the names of any individuals in the feedback boxes. Please do not include in your response any other information that could identify individuals.

Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send it to: Freepost Plus RSGR-CRGE-EHLE, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG

You do not need a stamp. **Any responses received after midnight on Tuesday 1 October 2013 will not be accepted or considered. The envelope is second class, so please return your response form in plenty of time to reach us.**

If you require a large print copy please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk.

Page No. 1

1000008126

Ipsos MORI

13-020881-01 - Response Form - FINAL - v4 - 250713 - PUBLIC

Unless you are responding on behalf of an organisation, this form does not ask you to supply us with your name or other contact details. You will, however, be asked to supply details of your postcode and your personal circumstances; you do not have to give these details if you do not want to. This information is only being collected in order to help us analyse responses to the consultation by Clinical Commissioning Group (CCG) area and key groups of the local population. It will not be used to identify specific individuals. Any personal data that you do supply will be handled by the TSAs in accordance with their obligations under the Data Protection Act 1998. When you complete the response form please do not include any information that could identify other individuals.

We do not intend to publish or disclose any personal information that could identify any individual. A document summarising all consultation responses we receive will however be attached to the TSAs' final report and will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide whether as an individual, an organisation or group, may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Thank you for your feedback.

Questions on emergency and urgent care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 24 of the consultation document.

Recommendation 1: Emergency and urgent care at Stafford Hospital

Q1 How far do you support or oppose the recommendation around the Accident and Emergency (A&E) department at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/don't know
☑	☐	☐	☐	☐	☐

Q2 What further comments, if any, do you have on any of the proposals outlined around emergency and urgent care at Stafford Hospital in Recommendation 1 in the consultation document, including the reasons for your answer to question 1? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Important to maintain an A+E Service

Rotation of senior medical + nursing staff between Stafford and Stoke good for care quality

Page No. 2

Questions on inpatient services for adults at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 26-27 of the consultation document.

Recommendation 2

Q3 How far do you support or oppose the recommendation around the inpatient service for adults with medical problems at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Recommendation 3

Q4 How far do you support or oppose the recommendation around a Frail Elderly Assessment service at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Recommendation 4

Q5 How far do you support or oppose the recommendation that beds should be available at Stafford Hospital for recovering patients?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Inpatient services for adults at Stafford Hospital (recommendations 2-4)

Q6 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around inpatient services for adults at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 3

Recommendations 2, 3 and 4: Inpatient services for adults at Stafford Hospital

Q7 What further comments, if any, do you have on any of the proposals outlined around inpatient services for adults in Recommendations 2, 3 and 4 in the consultation document, including the reasons for your answers to questions 3, 4, 5 and 6? Please also include any improvements you would like to suggest to these recommendations.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Strongly support frail elderly unit
Cautious about all the transfers of patients between Stafford and Stoke which may be required in terms of safety and cost

Questions on maternity services in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 28 of the consultation document.

Recommendation 5: Maternity services in Stafford

Q8 How far do you support or oppose the recommendation around maternity services in Stafford?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 4

Q9 What further comments, if any, do you have on any of the proposals outlined around maternity services in Stafford in Recommendation 5 in the consultation document, including the reasons for your answer to question 8? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

A Midwife led unit should be trialled on the basis of 'use it or lose it' for a 'reasonable' period - perhaps 2 years to turn around

Questions on services for children in Stafford

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained on pages 30-31 of the consultation document.

Recommendation 6

Q10 How far do you support or oppose the recommendation around the inpatient service for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Recommendation 7

Q11 How far do you support or oppose the recommendation around the Paediatric Assessment Unit (PAU) at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Services for children in Stafford (recommendations 6-7)

Q12 Overall, thinking about all of the recommendations together, how far do you support or oppose the recommendations around services for children at Stafford Hospital?

Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 5

Recommendations 6 and 7: Services for children in Stafford

Q13 What further comments, if any, do you have on any of the proposals outlined around services for children in Stafford in Recommendations 6 and 7 in the consultation document, including the reasons for your answers to questions 10, 11 and 12? Please also include any improvements you would like to suggest to these recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones.**

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Rotation of expertise between sites welcomed

Questions on major emergency surgery at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 32 of the consultation document.

Recommendation 8: Major emergency surgery at Stafford Hospital

Q14 How far do you support or oppose the recommendation around major emergency surgery at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 6

Q15 What further comments, if any, do you have on any of the proposals outlined around major emergency surgery at Stafford Hospital in Recommendation 8 in the consultation document, including the reasons for your answer to question 14? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

major emergency surgery should be at a Centre of Excellence but how far is travel time from Stafford to Stoke offset benefits from going to a specialist centre?

Questions on critical care at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 34 of the consultation document.

Recommendation 9: Critical care at Stafford Hospital

Q16 How far do you support or oppose the recommendation around the critical care unit at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 7

Q17 What further comments, if any, do you have on any of the proposals outlined around critical care at Stafford Hospital in Recommendation 9, including the reasons for your answer to question 16? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Support rotation of staff.
What will be the impact of travel time from Stafford to Stoke?

Questions on elective care and day cases at Stafford Hospital

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained on page 36 of the consultation document.

Recommendation 10: Elective care and day cases at Stafford Hospital

Q18 How far do you support or oppose the recommendation around elective care and day cases at Stafford Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 8

Q19 What further comments, if any, do you have on any of the proposals outlined around elective care and day cases at Stafford Hospital in Recommendation 10 in the consultation document, including the reasons for your answer to question 18? Please also include any improvements you would like to suggest to this recommendation.

Please answer within the box below and if you are commenting on specific elements please indicate which ones.

If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.

Questions on Chapter 7 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendations explained in Chapter 7 of the consultation document (pages 38-40).

Recommendation 11: Step down care and rehabilitation at Cannock Chase Hospital

Q20 How far do you support or oppose the recommendation that beds should be available at Cannock Chase Hospital for recovering patients?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☐	☑	☐	☐	☐	☐

Page No. 9

Q21 What further comments, if any, do you have on any of the proposals outlined around beds for recovering patients at Cannock Chase Hospital in Recommendation 11 in the consultation document, including the reasons for your answer to question 20? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet stating which question your comments refer to. Please do not include details that could be used to identify any individuals.

Recommendation 12: Elective inpatient surgery at Cannock Chase Hospital

Q22 How far do you support or oppose the recommendation around elective inpatient surgery at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Q23 What further comments, if any, do you have on any of the proposals outlined around elective inpatient surgery at Cannock Chase Hospital in Recommendation 12 in the consultation document, including the reasons for your answer to question 22? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.

Safe overnight cover essential.

Page No. 10

Recommendation 13: Day cases (surgical and medical) at Cannock Chase Hospital

Q24 How far do you support or oppose the recommendation around day case procedures at Cannock Chase Hospital?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Q25 What further comments, if any, do you have on any of the proposals outlined around day case procedures in Recommendation 13 in the consultation document, including the reasons for your answer to question 24? Please also include any improvements you would like to suggest to this recommendation.
Please answer within the box below and if you are commenting on specific elements please indicate which ones.
If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to.
Please do not include details that could be used to identify any individuals.

Questions on Chapter 8 of the consultation document

Please read the consultation document all the way through, then give us your answers to the following questions. These questions refer to the recommendation explained in Chapter 8 of the consultation document (pages 42-43).

Recommendation 14: Organisational plans for Mid Staffordshire NHS Foundation Trust

Q26 How far do you support or oppose the recommendation for Mid Staffordshire NHS Foundation Trust (MSFT) to be dissolved, with the services at Stafford and Cannock Chase hospitals managed and delivered by another organisation or organisations in the future?
Please tick ✓ one box only

Strongly support	Tend to support	No views either way	Tend to oppose	Strongly oppose	Not sure/ don't know
☑	☐	☐	☐	☐	☐

Page No. 11

Q27 What further comments, if any, do you have on any of the proposals outlined around Recommendation 14 in the consultation document, including the reasons for your answer to question 26? Please also include any improvements you would like to suggest to this recommendation. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

The Trust needs to be dissolved and the hospital re-badged / new name

Final comments

Q28 Is there anything else you want to say about the consultation or the issues it covers? If you want to explain any of your answers, or you feel the questions have not given you the chance to give your views fully, or if you think there are options we have not considered that we should have done, please say so here. Please also say if there are any improvements you would like to suggest to the recommendations. **Please answer within the box below and if you are commenting on specific elements please indicate which ones. If you want to provide a longer comment please complete on a separate sheet clearly stating which question your comments refer to. Please do not include details that could be used to identify any individuals.**

Academic links for medicine are at Keele
Benefit of academic links for nursing + midwifery + AHPs at Staffordshire University - excellent provision etc.
Trusts taking over services should be required to continue to provide placement capacity for Staffs Uni students. Importance of students in clinical area for future workforce provision

Page No. 12

Background Information

Q29 Are you:
Please tick ✓ one box only

- ☐ Providing your own response or responding on behalf of another individual?
  Please go to Q30
- ☑ Submitting your response on behalf of an organisation or group?
  Please go to Q41

If you are responding on your own behalf, please complete the following questions. If you are responding on behalf of another individual, please complete the following questions about them.

Q30 Which, if any, of the following apply to you?
Please tick ✓ as many boxes as apply

- ☐ I currently work in the NHS
- ☐ I used to work in the NHS
- ☐ I currently work in the independent health sector
- ☐ I used to work in the independent health sector
- ☐ I do not work in, and have not worked in, the NHS or the independent health sector
- ☐ Prefer not to say
- ☐ Don't know

Q31 What is your closest hospital?
Please tick ✓ one box only

- ☐ Cannock Chase Hospital
- ☐ Manor Hospital
- ☐ New Cross Hospital
- ☐ Princess Royal Hospital
- ☐ Queen's Hospital
- ☐ Stafford Hospital
- ☐ University Hospital of North Staffordshire
- ☐ Other **(Please tick and write in below)**
- ☐ Don't know

Personal Details

We would be grateful if you could answer the following questions so we can establish if we have responses from a cross-section of people, and to allow us to analyse the results overall and by these different groups of people. None of the information you supply will be used by us in order to identify you. However, you should appreciate that it is possible that you could be identifiable from the information you supply in this section. Any identifiable information you do supply will be held by the TSAs securely, in confidence and in accordance with their obligations under the Data Protection Act 1998. You do not have to provide your personal details. If you do complete this section, please tick the box below to confirm that we may use your personal data for the purpose of analysing the results of the consultation.

- ☐ **I agree that the TSAs may use the details I have supplied in response to Q32-40 for the purpose of analysing the results of the consultation**

Page No. 13

Q32 Please can you provide your full home postcode
Please write in below

Full Postcode ☐ ☐ ☐ ☐ ☐ ☐ ☐

Q33 Are you ...?
Please tick ✓ one box only

- ☐ Male
- ☐ Female
- ☐ Prefer not To say

Q34 How old are you?
Please tick ✓ one box only

- ☐ Under 18
- ☐ 18 to 24
- ☐ 25 to 34
- ☐ 35 to 44
- ☐ 45 to 54
- ☐ 55 to 64
- ☐ 65 to 74
- ☐ 75 or over
- ☐ Prefer not to say

Q35 Which ethnic group do you consider yourself to belong to?
Please tick ✓ one box only

- ☐ White
- ☐ Mixed
- ☐ Asian or Asian British
- ☐ Black or Black British
- ☐ Chinese
- ☐ Other **(Please tick and write in below)**

☐

- ☐ Prefer not to say

Q36 Do you consider yourself to have a disability? [The Equality Act 2012 defines a disability as "a physical or mental impairment which has a substantial and long term adverse effect on your ability to carry out normal day to day activities".]
Please tick ✓ one box only

- ☐ Yes
- ☐ No
- ☐ Prefer not to say

Q37 Do any of the following apply to you?
Please tick ✓ all the boxes that apply

- ☐ I have children
- ☐ I am pregnant
- ☐ I care for children under the age of 16
- ☐ None of these
- ☐ Prefer not to say

Q38 When did you last visit one of the hospitals listed in Q31, either as a patient or to visit a family member or friend?
Please tick ✓ one box only

- ☐ In the last six months
- ☐ In the last year
- ☐ More than a year ago
- ☐ Never
- ☐ Can't remember

Q39 Do you care for someone in your family or a friend because they have a health need?
Please tick ✓ all that apply

- ☐ Yes – someone aged 16 or over
- ☐ Yes – a child aged under 16
- ☐ No

Page No. 14

Q40 Have you or your family used any of the services below provided by the NHS within the last year?

Please tick ✓ all that apply

- ☐ GP care
- ☐ Community nursing and therapy services
- ☐ Community paediatric services (for example, health visitor)
- ☐ Mental health care
- ☐ End-of-life care
- ☐ Paediatric (children's) hospital care
- ☐ Maternity and newborn care
- ☐ Emergency or urgent care, including intensive care
- ☐ Elective care (see page 36 of the consultation document for an explanation)
- ☐ Outpatients
- ☐ Other
- ☐ None of these
- ☐ Prefer not to say

If you have answered any of questions 32-40 then please make sure you have ticked the box at the bottom of page 13 of this form so that your answers can be used to analyse the results of the consultation.

Details of your organisation or group

If you are sending us a response on behalf of an organisation or group, please complete these questions.

If you are responding on your own behalf or on behalf of another person, please go to the end of this response form.

Please be as detailed as you can. For example, if you are responding on behalf of a group or organisation, please record the name of the group or organisation. Your personal details will be handled by the TSAs in accordance with their obligations under the Data Protection Act and will not be made public. Please remember, however, that information summarising the overall response to the consultation will be attached to the TSAs' final report which will be published on the TSA website. **Submissions made by or on behalf of organisations and groups may be published in full on an attributed basis.** You should also be aware that the information you provide may be subject to publication or disclosure under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004.

Q41 What is your name, job position and the name and address of the organisation or group on whose behalf you are submitting this response? The name and details of your organisation or group may appear in the final report.

Professor Michael Gunn
Vice Chancellor

Hilary Jones
Dean - Faculty of Health Sciences

Staffordshire University
Beaconside
Stafford
ST18 0AD

Page No. 15

Q42 What category of organisation or group are you representing?
Please tick ✓ as many boxes as apply

- ☐ A professional body (e.g. a Royal College)
- ☐ An NHS trust (provider of services)
- ☐ Charity / voluntary sector group
- ☐ National patient group
- ☐ Local patient group
- ☐ Local Authority
- ☐ Trade union
- ☐ Trade body
- ☑ Academic organisation
- ☐ Political party / Political group
- ☐ Clinical Commissioning Group
- ☐ Other NHS body
- ☐ Regulatory body
- ☐ Other
- ☐ Don't know

Q43 Please write in the total number of members in your organisation or group.

Q44 Please tell us who the organisation or group represents and, if it applies, how you gathered and summarised the views of members.

Thank you for your comments.
Please return your completed response form by midnight on **Tuesday 1 October 2013** in the envelope supplied, or send to: Freepost Plus RSGR-CRGE-EHLF, MSFT-TSA Consultation, Ipsos MORI, Research Services House, Elmgrove Road, Harrow, HA1 2QG
You do not need a stamp. **The envelope is second class, so please return your response form in plenty of time to reach us.**

If you need help to complete this form, or if you would like to complete it in another language, please telephone 0800 408 6399 or email TSAconsultation@midstaffs.nhs.uk. The telephone number is freephone from landlines, but charges may apply for calls from mobile telephones.

If you have any queries or complaints regarding the consultation process or consultation documentation content, please contact: The Trust Special Administrators, Mid Staffordshire NHS Foundation Trust, Stafford Hospital, Weston Road, Stafford, ST16 3SA
Please note that any queries or complaints submitted via this process cannot be counted as part of the formal consultation.

Page No. 16

10. Staff

Response to Volume 2 of the TSA Draft Report

I am writing in response to the TSA draft report volume two – specifically to page 145, in the opportunities to deliver savings section.

I am concerned to read there is a suggestion to close the pharmacy aseptic unit and the impact this would have on providing quality patient care and the general running of the cancer services element of Stafford Hospital's work.

The report states – "*Aseptic unit – MSFT has an on-site aseptic unit which prepares chemotherapy and TPN. As it is unusual for a site of this size to have its own on-site facility it has been assumed that this service could be provided by another provider. The savings estimated from this are £78k.*"

There are three main points I would like to raise with the TSA team with regard to this short statement.

"It is unusual for a site of this size to have its own on-site facility":

I do not believe this statement is true. There are 27 small Trusts throughout England with a similar number of beds as Mid Staffordshire NHS Foundation Trust (MSFT) frequently used for peer review purposes. An internet search of these 27 trusts websites identified that of the 27 trusts; 18 have an aseptic unit, 1 definitely does not and in 8 it was not possible to obtain the information via the website. These 8 units have been subsequently been contacted directly and all have an aseptic unit. So therefore 26 of 27 or **96.3** % of small trusts of a similar size to MSFT do have an aseptic unit proves therefore it is **not** unusual for smaller Trusts to have an on-site aseptic facility. **Indeed it is unusual not to have one.**

It is assumed that this service could be provided by another provider:

It is wrong to *assume* such a fact. No-one from the TSA team visited the pharmacy department or communicated in any way to obtain the facts with regard to the service the pharmacy aseptic unit provides, and whether this could practically be outsourced. I appreciate there are always potential opportunities to work with neighbouring trusts and commercial providers to make cost savings. However, as all needs cannot be met and the on-site facility is vital for patient care and clinical responsiveness, it has been assessed as more cost-efficient to use the current facility to capacity rather than to under-utilise.

There are elements of the service that I do not believe can be provided by another provider; these include (not an exhaustive list):

- Short dated products, for example intravenous chemotherapy with stability less than 8 hours once prepared.
- Intrathecal chemotherapy and the logistics of maintaining adherence to the national and NPSA guidelines associated with providing intrathecal chemotherapy injections.

- Responsiveness to clinical needs of acutely unwell patients, for example those admitted to intensive care requiring ganciclovir infusions, or fluid restricted/ fat free parenteral nutrition.
- Responsiveness to changing clinical requirements, for example deterioration in renal or liver function for both for chemotherapy and parenteral nutrition.
- Provision of clinical trial products, due to the regulations for conducting trials being different from usual practice. This is also likely to have a knock-on impact on clinician recruitment.
    - MSFT has a substantial clinical trial portfolio of national non-commercial and some commercial trials. Both visiting and on –site clinicians and the Chemotherapy and Treatment Unit (CTU) are active in recruiting into clinical trials. National trials seek substantial numbers of patients from 'ordinary' hospitals, so that the results are representative of the whole population.
    - It is likely that many commercial companies would not consider Stafford as a suitable site to conduct some clinical trials without an on site aseptic facility

"The savings estimated from this are £78k"

It is not clear from the report how this figure has been arrived at. The aseptic unit element of MSFT's 'medicines management' cost improvement program (CIP) has made substantional savings. These have been both in terms of running costs by negotiating competitive contract prices for consumables and drug costs by vial sharing. Novel approaches such as specific treatments being co-ordinated onto certain days of the week has allowed savings to be maximised, for example Herceptin treatments on a Monday – produced drug savings of around £50k per annum. I doubt that these have been considered and whether they would be sustainable if the service were to be outsourced.

The amount of wasted doses of both chemotherapy and parenteral nutrition would increase significantly if aseptic services on site were discontinued, has the cost of this been considered?

Transport costs need to be considered which are likely to be significant.

Some difficulties created by off site provision will result in delay or cancellation of treatment. Quite apart from the upset to patients this will have extra costs associated with it.

It is a truism that the more steps, personnel or sites that are involved in a process, the more errors there will be. These have costs.

Timeliness of treatment will be affected (with knock on costs)

Impact generally on Stafford Hospital site and its patients:

Closure of the on-site aseptic unit on the Stafford site would have a detrimental effect on patient care. The NHS constitution specifically states that patients should insist on quality and providers should strive to get the basics of quality of care including safety, effectiveness and patient experience right every time. I am not convinced this would be achievable without the aseptic unit facility on site for the reasons given above i.e;

Access to current treatment options available at Stafford would not be available, resulting in patients having to travel to alternative hospitals or be admitted overnight to distant hospitals.

Waiting times for patients would increase or patients would have to attend on multiple occasions if dose adjustments were required.

Opportunities for entry into clinical trials would reduce (as mentioned above) – contrary to NCRI policy.

Patients may not be able to start treatment in the timeliest manner.

All of these points are particularly relevant, as the local CCG has specifically protected chemotherapy services. It is not unreasonable to assume that they would wish these to be provided in a high quality way

In view of the above my suggestion is to remove the 'aseptic unit' paragraph from the final report as it is wholly inaccurate and inadequately researched.

Response prepared by:

Miss Alice Wright – Principal pharmacist cancer services

Agreed by on site chemotherapy leads:

Dr Paul Revell – Consultant Haematologist
Mrs Sarah Leah – CNS Haematology
Miss Kerry Pearson – CTU manager
Mrs Tracey Weetman – Macmillan lead cancer nurse

August 2013

Mid Staffordshire NHS
NHS Foundation Trust

Stafford Hospital
Weston Road
Stafford
ST16 3SA

Tel: 01785 257731

juliehowden@midstaffs.nhs.uk
Pauline.meir@midstaffs.nhs.uk

Monday, 16 September 2013

Therapy Services Department
Stafford and Cannock Hospitals

This letter has been compiled on behalf of the Occupational Therapy and Physiotherapy staff working at Stafford and Cannock Hospitals. As a team we have spent time reading the TSA draft recommendations for the future of Mid Staffordshire NHS Hospitals and wish for our thoughts, questions and concerns to be considered as part of the consultation process.

Therapy Services work across both hospital sites and in doing so ensure that we provide a significant service to both inpatients and outpatients facilitating avoidance of admission into hospital. We also facilitate expedient and safe discharge for patients leaving the acute setting from acute medical, surgical, orthopaedic and older care wards. We also provide a therapy outpatient service supporting patients recovering Proposals made by the TSA are based upon staffing numbers and skills provided by doctors and nurses with little consideration of Allied Health Professionals. In the formation of the National Clinical Advisor Group there is no representation of clinical experts for Occupational Therapy or Physiotherapy.

In the future working across additional sites inclusive of UHNS and New Cross Hospitals will significantly impact upon our team if we are split making the logistical planning for this very difficult and so serve to de-stabilise our service. Clinical networking underpins all the proposed recommendations to resolve issues at the root of the Trusts problems however the key feature of 'integrated working' within the Governments NHS Plan in 2000 has still not

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been successfully achieved within the past 13 years and there is a lack of clarity regarding how better collaboration with GP's and community services will be achieved within the TSA recommendations. Therapy staff are understandably unsettled by the uncertainty as we rotate across both hospitals as part of our learning and development and provision of appropriate skill mix, if we are then required to continue to do this across UHNS and New Cross Hospitals there needs o be a clear amalgamation of trust policies, procedures, protocols, standards of care and referral criteria which have not been detailed to date. An example of a concern where Mid Staffordshire's services can be compromised as services become more integrated is relating to our Outpatient work. The Contingency Planning Team reviewed our outpatient work and concluded that comparable CCG's only allow one to two treatment sessions post assessment when we offer more according to individual patient need. In the present financial climate this is not looked upon favourable despite our outcomes supporting the need for greater input.

The loss of Critical Care beds, Paediatrics, and the downgrading of surgical procedures will serve to de-skill our therapy staff coupled with the medical work becoming more generalised. We have evidence of achieving good patient outcomes within our existing specialties across both hospital sites and are concerned that such outcomes will be lost as teams become more dilute and generic despite the TSA recommending that no services should be reduced or downgraded. Therapy Services dispute this as Retention and Recruitment of our staff has seen an increase in resignations of experienced staff and an ongoing turnover of therapists with difficulty in recruiting back to vacant posts. This has resulted in our Respiratory on Call rota being put onto the organisations 'At Risk Register' and a reduction in our A&E service in this financial year increasing the risk of patient longer length of stay in hospital, increased disability and increased pressure upon our community services.

Therapy Services welcome the development of a Frail Elderly Unit allowing patients who have received specialist treatment elsewhere to be repatriated to Cannock and Stafford however outcomes of repatriations have been slow and disjointed to date and a much more robust standard operational procedure is needed if this is to be successful in the future. Further investment needed to ensure the TSA's recommendation of a 'step down' facility is evident however this contradicts the need to de-invest services to maintain financial stability in the future. A lack of detail regarding the future of the Acute Stroke Unit and further investment into the existing community services and the development of a Frail

Becausewecare

Elderly Unit needs to be given before therapists feel assured these are viable recommendations.

The degree of impact the TSA recommendations have upon Therapy Services remain unclear due to the lack of detail which makes it difficult to assess the true impact upon the delivery of patient care within our locality in the future. As the majority of our staff are local residents and have family and friends who remain regular users of Stafford and Cannock Hospitals we lack assurances that the TSA recommendations are within the best interests of local patients and staff using and working at our hospitals.

Yours sincerely

Mrs. Julie Howden
(Therapy Services Site Lead. Stafford)

Mrs. Pauline Meir
(Therapy Services Site Lead. Cannock)

Becausewecare

Monday, 16 September 2013

Therapy Services Department
Stafford and Cannock Hospitals

This letter has been compiled on behalf of the Occupational Therapy staff and Physiotherapy staff working at Stafford and Cannock Hospitals. As a team we have spent time reading the TSA draft recommendations for the future of Mid Staffordshire NHS Hospitals and wish for our thoughts and concerns to be considered as part of the consultation process.

Therapy Services work across both hospital sites and in doing so ensure that we cover the required staffing skill mix, annual leave, and training between us. In the future working across additional sites inclusive of UHNS and New Cross Hospitals will make the logistical planning for this very difficult and serve to de-stabilise our service. This will require management of change and could require staff having to re-interview for their current posts. Our present staff also rotates across both hospitals as part of their learning and development, if we are then required to continue to do this across UHNS and New Cross Hospitals there will need to be a clear amalgamation of trust policies, procedures, protocols, standards of care and referral criteria.

Yours sincerely

Mrs. Julie Howden
(Therapy Services Site Lead. Stafford)

Mrs. Pauline Meir
(Therapy Services Site Lead. Cannock)

Becausewecare

For the attention of the TSA from the Corporate Nursing Team.

Following a Corporate Nursing Team meeting below is our response to the TSA report;

After reading the full report and attending staff briefings we would like to register our support with regards to the concerns raised by our colleagues from those services that are proposed to be cut. In particular our concerns are regarding patient safety given the additional travelling time to access emergency services and the patient's potential deterioration during this period.

We note The Corporate Nursing Team are cited in the report (Practice Development) as a 'Support Function' where savings could be made.

The TSA have stated on many occasions through global and staff briefing sessions that individual 'At Risk Teams' will be met with prior to the 1st October deadline; however we are still awaiting communication regarding this opportunity, given a now very short deadline.

One of the main roles of our team is, implementing initiatives and monitoring of the quality and safety of care provided to our patients. It is important that this is sustained for those patients attending the Stafford site. Any compromises made to the team will jeopardise this.

Regards
Corporate Nursing Team

Corporate Nursing (1st Floor)
Stafford General Hospital
Mid Staffs Foundation Trust
Weston Road
Stafford
ST16 3SA

Mid Staffordshire Postgraduate Medical Centre (Education)

(Registered Charity No. 1037735)

Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Tel : 01785 230634
Fax: 01785 230618

23rd September 2013

The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

TSAconsultation@midstaffs.nhs.uk

Dear Sir

As Chairman of the The Mid Staffordshire Medical Education Centre at Stafford Hospital I feel the following comments should be considered in the consultation. The Education Centre is a charitable facility for undergraduate medical students from Keele University and postgraduate doctors in many disciplines.

Junior doctors are a very important part of the medical staffing of the hospital, as they provide much of the routine care of patients. Unlike consultants, they are on site for the whole of their hours and are very important in the continuity of care in their own discipline, as well as interdepartmental liaison. Their existence and contribution seem not to have been recognised in the Consultation documentation, when considering the viability of the Hospital.

Any loss of Obstetric services will almost certainly result in the loss of the Junior Doctors who work in that discipline, as well as to Gynaecology. The two services run together so closely as to be coterminous. There would also be knock-on effects to the Paediatric department, which is also under threat in the report. At present, both Departments (Obstetrics/Gynaecology and Paediatrics) are fully staffed and providing excellent service.

The argument for non-viability of any services, using data from Royal College and other recommendations needs to be considered realistically and critically. Numbers of Consultants and patient workload quoted are widely recognised to be questionably evidence-based, idealistic and actually unnecessary.

For many years, certain Surgical and Medical services have been provided at Stoke (usually with their Outpatient Clinics at Stafford – Cardiothoracic Surgery, Radiotherapy, complex Plastic Surgery, Neurosurgery for example). More recently major Upper Gastro-intestinal and Vascular Surgery have also been transferred. Further reduction in Surgery and Medicine on the Stafford site are also likely to threaten the training and availability of Junior Doctors. This would result in the reduction in medical staff providing patient care and reduced ability in attracting good Consultants.

/Continued. . .

- 2 -

This Centre's viability will also be threatened and this would be a loss, not only to the Hospital, but to the District as a whole and to the Region, as we provide education, library and research facilities for General Practitioners, Dentists and Nurses. Indeed, we are one of very few Centres in the Midlands to have a "hands on" dental unit with phantom heads enabling specialist dental courses to be run. Other specialist courses are also held at the Centre, e.g. Basic Surgical Skills, Basic Practical Skills in Obstetrics & Gynaecology, ALSO Courses and Perineal Repair & FGM Courses, all of which are approved by their Royal Colleges. Regular ALS and Sepsis courses also take place and these are very popular not just with Stafford Hospital staff but also with staff from other hospitals. In addition the Centre provides facilities for local Patient Support Groups and National Charities to hold patient meetings and seminars.

We also must not forget that we have a very active Undergraduate Department at Stafford, providing medical training and education facilities for Keele Medical Students. We consistently get excellent feedback regarding their experience at Stafford.

The loss of this Centre is a genuine possibility if the proposed reductions in services at Stafford Hospital proceed as suggested in the Draft recommendations. This would result in the loss of a valuable resource for the community as a whole and make Continuing Education, which is a requirement of the General Medical Council, much more difficult to obtain locally.

Yours faithfully

J Lotz FRCS
Chairman – Governing Council

Dear Sirs,

Thank you for the opportunity to make comments about your draft recommendations.

The majority of the document talks about specialities that I have little direct knowledge of. I will therefore confine my comments to sections that directly affect epilepsy patients.

I have concerns about the level of critical care provision that will be available in Stafford. This has an impact on people with epilepsy because the most serious admissions due to the condition involve lengthy seizures known as status epilepticus. If these cannot be stabilised with the use of intravenous benzodiazepines or intravenous Phenytoin within 60 to 90 min of the start of the seizure, the patient will need to be intubated and anaesthetized. I am concerned that any delay from the transportation to an adjacent hospital could have serious adverse effects on these patients. I think it is entirely appropriate that epilepsy patients are seen acutely at their local hospital where I would also be available to give advice and support to people who I will largely know and I am very pleased to see epilepsy in seizures included in the list of conditions that the local emergency department will continue to treat. However, I think it is essential that the backup of a critical care unit capable of looking after intubated patients over a period of time is maintained.

The bulk of my work is long term management of people with epilepsy and it is critically important that the service sits within an NHS organisation that can cover all geographical areas of the local population. Therefore, the proposal that the Cannock area is managed by one acute trust whilst the Stafford area is managed by another does give me some cause for concern. There clearly need to be formal links with whichever trust ends up running the neurology Department currently sited within MSFT and with a regional tertiary centre. The attached document (thoughts on the delivery of ep service after TSA) outlines how I could see this working in practice with the epilepsy service itself being run by SSOTPT. I have spoken to the relevant clinical stakeholders who are supportive of the principles. I also enclose a copy of the CCG service specification for epilepsy as additional reference material (although I did submit this right at the start of the TSA process).

Best wishes

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MODULE B – PERFORMANCE REQUIREMENTS – SPECIFICATION, QUALITY AND PRODUCTIVITY

SECTION 1 – SPECIFICATION

Care Pathway/Service	**A Community Epilepsy Service**
Commissioner Lead	
Provider Lead	
Period	
Applicability of Module E (*Acute Services Requirements*)	**N/A**

1. Purpose

1.1 Aims

The Service, described in this Service Specification, aims to provide a Community Epilepsy Service (CES) to Service Users registered with the following Clinical Commissioning Groups (CCG's): Stafford and Surrounds (SaS) and Cannock Chase (CC). CCG's will work in shadow form, prior to their authorisation as statutory organisations. CCG's are sub committees of PCT Cluster Boards; they have delegated responsibility to manage their assigned commissioning budget to enable the design and commissioning of services which best meet the needs of their population.

The term *Epilepsies* is used interchangeably with *Epilepsy*, throughout this service specification. The term refers to the fact epilepsy is not a single condition but rather a series of separate conditions presenting in different ways and requiring different management, diagnostic tests and treatment.

- To provide Service Users and their families/carers with an accessible source of specialist advice, care and support for the epilepsies across Stafford and Surrounds (SaS) and Cannock Chase (CC).
- To minimise the impact that any type of epilepsy has on the lives of Service Users and their families/carers.

1.2 Evidence Base

There are a number of studies that may be summarised for the delivery of a *Community Epilepsy Service*. The Provider will work to:

- Operate in both a comprehensive and integrated manner across services (cf. Bradley & Lindsay, 2008);
- Target support to both those who display a poor management of their epilepsy, and those who have epilepsy that is unresponsive to medication (cf. Bradley & Lindsay, 2001; 2008; WHO, 2003 and Mantri, 2008);
- Provide a point of contact, education and support (cf. Stokes *et al*, 2004).
- "The epilepsies: diagnosis and management of the epilepsies in adults in primary and secondary care", NICE Clinical Guideline 20, 2004.

These points should be read in conjunction with the *General Overview* and *Service Objectives*.

The Local Evidence Base
The epilepsies form the most common serious neurological condition within the United Kingdom (cf. MacDonald *et al*, 2000; Chadwick, 1994). There are 2,060 patients within SaS and CC aged 18 and

over who are receiving drug treatment for a type of epilepsy (Source: The Quality and Outcomes Framework Outturn for March 2011 20-June 2011).

The non-elective admission data for SaS and CC patients demonstrates that the admission rate is relatively low when comparing against other PCTs and CCG's of similar size (SUS data extract from the 2010-11 activity for all SaS and CC patients who had been non-electively admitted to all Providers with a diagnosis attributed to Epilepsy shows 95 spells of activity).

The Quality and Outcomes Framework
Each of the GP practices within the SaS and CC CCG's submits data against the Quality and Outcomes Framework (QOF). The framework includes a number of indicators for epilepsy. For 2010/11 an overall mean percentage of 75.5% was achieved as the 'percentage of patients aged 18 and over on drug treatment for epilepsy who have been seizure free for the last 18 months recorded in the last 15 months' for the 45 General Practices within SaS and CC. This does mask two factors: the actual displayed data range and the level of 'exception reporting'. The level of 'exception reporting' determines the patients who are eligible to be measured as part of the indicator and therefore determines the size of the dominator for the indicator. When the levels of 'exception reporting' are taken into account the actual mean percentages (for 2010/11) drop to roughly 62%.

1.3 General Overview

There are approximately 2,060 patients aged 18 and over with epilepsy in SaS and CC (The Quality and Outcomes Framework Outturn for March 2011 20-June 2011). As the Community service will accept referrals for patients aged 16 and over, it must be acknowledged that the expected patient population with epilepsy will be greater than the number recorded by the Quality and Outcomes Framework.

The Provider will work in partnership with Service Users, carers, health professionals and other agencies to promote positive outcomes for people with epilepsy referred into the service. On referral to the service, Service Users will be allocated a named staff member who will be responsible for co-ordinating their care throughout their duration with the service. As part of the care received Service Users will have one-to-one appointments where they will be given extensive advice and education on the management of their epilepsy and will aim to have improved symptom control and confidence in managing their condition. Service users can access the service via self-referral or referral from a health care professional.

Patients who have been newly diagnosed with epilepsy within Secondary Care will be referred to the community service for their future management.

1.4 Objectives

The overarching objectives expected of a *Community Epilepsy Service* are to deliver the markers of good practice for a comprehensive service, namely:

- To provide local nurse-consultant led specialist epilepsy care from local clinics;
- To provide an accessible and trustworthy source of advice, information, and interventions of support across SaS and CC for the Target Population;
- To work with local care services to target support to both those who display a poor management of their epilepsy, and those whose epilepsy is unresponsive to medication;
- To support Service Users to develop, consolidate and reinforce their methods of treatment adherence and lifestyle management;
- To support Service Users to exercise the maximum levels of independence and lifestyle choice possible;
- To liaise with local care services to provide specialist advice, education and guidance on treatment adherence and lifestyle management;

- To work with local care services to ensure that Service Users receive appropriate and tailored packages of care.

1.5 Expected Outcomes

The Provider will work to a number of set outcomes for Service Users. The Provider shall evidence fulfilment of the service outcomes to the Commissioner on a quarterly basis in an Activity Report that shall be provided to the commissioner within 20 Operational Days from quarter end. Service Users will be assessed upon entering the Service using a validated tool and assessment survey agreed by the Commissioner. Upon discharge, Service Users will be re-assessed and their outcomes will be measured and reported within the Activity Report, Outcomes to be measured include, but are not limited to at the request of the Commissioner:

- Service Users display improved symptom control and management e.g. Evidence to show the reduction of seizure frequency and the severity;
- Service Users report an increase in their quality of life as evidenced via a nationally recognised validated tool;
- Information on the Service Users ability to work before and after the Service intervention;
- The Provider will use its reasonable endeavours to ensure non-elective admission rates will remain low;
- Service Users and their families/carers are satisfied with the type and level of support that they receive as measured by the Service User satisfaction survey;
- Service Users report in the Service User satisfaction survey that the location of the service is accessible.

Whole systems approach – desirable outcomes:

- Deliver a service that will contribute an increase to 70% of the target population to become seizure free for 12 months under the Quality and Outcomes Framework;
- Up skill local care services to have the capability and expertise to support individuals to manage their epilepsy; and,
- Support a reduction in the numbers misdiagnosed with a type of epilepsy.

1.6 The Target Population

The target population for the Provider is centred on those individuals aged 18 and over, who are registered with a Stafford and Surrounds or Cannock Chase GP. This may be detailed as:

- Individuals (with their families/carers) who wish to receive advice, education and support for their (diagnosed) epilepsy;
- Individuals who have been referred by a Stafford and Surrounds or Cannock Chase GP to Secondary Care following a suspected epileptic seizure;
- Individuals who, following a diagnosis of epilepsy in Secondary Care require post-diagnosis support;
- Individuals that have been diagnosed with Non-Epileptic Seizures (NES) who require additional support in managing their seizures;
- Individuals who display a poor management of their epilepsy;
- Individuals who experience epilepsy that is unresponsive to medication;
- Individuals who, with a diagnosis of epilepsy are approaching their 18th birthday.

It is acknowledged, given the nature of the epilepsies that there may be individuals under the age of

18 who would benefit from the *Community Epilepsy Service*. Service Users aged 16 and over, may access the service if considered clinically appropriate and given the Service Clinician and Paediatrician have a robust transitional plan in place.

2. Scope

2.1 Service Description

The Service will be nurse-consultant led. There will be additional nurse support.

The Provider will deliver a *Community Epilepsy Service (collectively described and referred to as the "Services", throughout this specification)* that provides an enhanced and specialist level of care for the epilepsies. Partnership working with Service Users and other Providers will ensure this Epilepsy Service:

- Uses a holistic evidence based approach to assess and identify health needs and appropriate individualised interventions;
- Identifies those with comorbidities, or at potential risk of increased morbidity or mortality who may require enhanced interventions;
- Liaises and integrates with other health professionals and agencies to implement best practice;
- Enhance and complement the existing structured management system for the epilepsies in primary care;
- Inform the on-going development of the local care model for the diagnosis and the management of the epilepsies;
- Carries out individualised comprehensive epilepsy assessments to a variety of people;
- Will operate a telephone and e-mail advice line for Service Users, their carers and family to access support between appointments.

The Provider will work to and be guided by a number of set service principles.

The Provider shall:

- Treat Service Users and their families/carers as active partners in how their care is negotiated and agreed;
- Support the validation of seizure and syndrome types using the International League Against Epilepsy (ILAE) multi-axel classification system;
- Adopt a counselling approach at all times, the counselling approach supports a 'non-uniform policy' for staff members;
- Develop a model to measure the progress of Service Users to the Service Outcomes;
- Support the delivery of all of the stated Service Objectives and Service Outcomes;
- Provide care plans with time-limited goals and actions mapped to the stated Service Outcomes;
- Ensure Service Users understand in general terms the condition of epilepsy and the personal implications, plus manifestations;
- Inform Service users, their families and carers about safety and lifestyle implications of epilepsy.

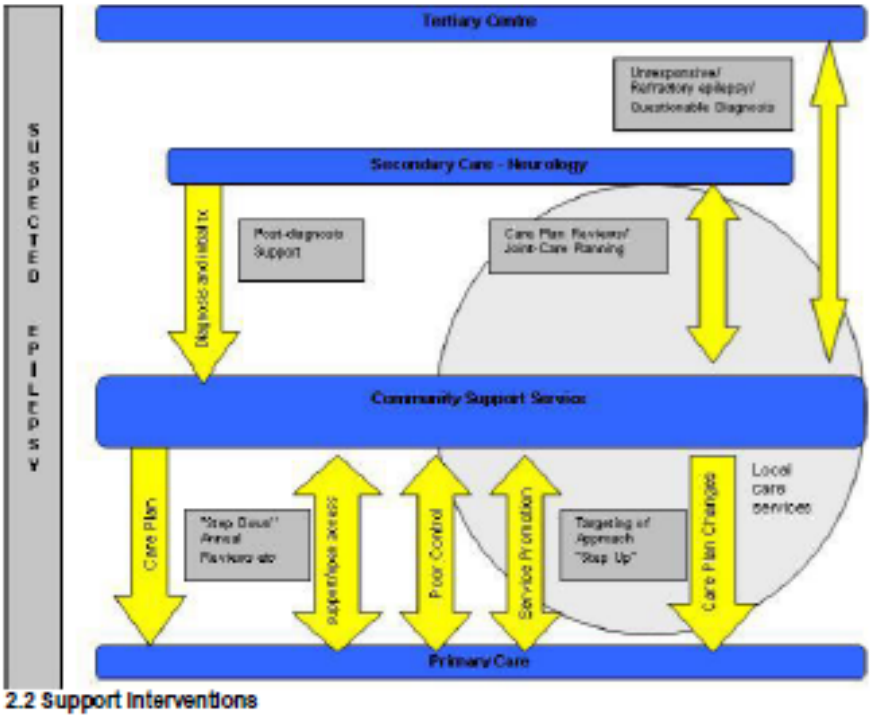
This may include, but not be limited to driving, employment, leisure activities and where appropriate Sudden Unexpected Death in Epilepsy (SUDEP);

- The Provider will deliver basic psychological interventions for people with non epileptic seizures (NES), referring to and liaising with local and tertiary psychiatric and psychological services as required for people needing more intensive support;
- Provide a level of post-diagnosis support that monitors seizures and provides distinct interventions of support.

The Provider will:

- Ensure the Clinician's workload maintains an active 60:30:10% split between the activities spent on the service's caseload AND phone clinics for the provision of advice and information[1] AND admin, research and audit which in the long term will use the findings to educate and advance local care services. The split of time may be flexible; however, at least 50% of the clinician's time will be spent on the service's caseload on a weekly basis.
- Be able to record all service and care planning activity to allow for direct reporting to the Commissioner and open communication with local care services;
- Work with the Commissioner to review its approach to deliver a service model that meets the set requirements and Service Outcomes of this Service Specification.

This is shown in the below diagram. Urgent Care Services should be considered throughout this diagram.



2.2 Support Interventions

[1] As part of the 30% split for the provision of advice and information, the intention would be to discuss with Secondary Care the delivery of in-reach clinics provided by the community service clinician's to ensure holistic care to ward patients.

The Provider will:

- Be able to demonstrate the link between the identified needs and the advice, education and support interventions offered and their intended duration;
- Minimise the side effects of medications and their interactions for Service Users;
- Facilitate and support the structured withdrawal from medication following a suitable seizure free period (usually at least four years) as discussed with a Consultant Neurologist;
- Support the incidences where a medication is being trialled;
- Provide pre-conceptual counselling for women planning pregnancy;
- Provide support interventions that focus on the educational and behavioural aspects of a Service User's treatment adherence and lifestyle management;
- Support the use of "Service User diaries", or similar method for Service Users to collect information that can benefit clinical decisions;
- Work to deliver to the Target Population an approach to the shared care management of the epilepsies that supports a structured approach to management (call, recall, audit and outcome) across local care services;
- Signpost Service Users' to community groups to support their care plans, and upon discharge to maintain the changes they have achieved.

2.3 Accessibility/acceptability

The Provider will:

- Provide an open source of advice and information for the Target Population and their families/carers;
- Promote a referral system to the Target Population, their families/carers and local care services for the provision of support interventions and care plan reviews;
- Deliver distinct support interventions to the Target Population, following a referral and assessment;
- Support local care services to access the service for advice, education and guidance on treatment adherence and lifestyle management;
- Provide a service model that is accessible and timely to the Target Population.

The Provider will:

- Promote the service, against the points stated under the "Service Description" to local care services and the Target Population;
- Provide assessments and support interventions in locations that minimise the travelling burdens on Service Users and their families/carers.

2.4 Whole System Relationships

The Provider is to ensure that it co-operates and liaises with any organisation that has an interest in the management of Service Users with epilepsy, including, but not limited to:

- Commissioners and any other providers, contractors or agents of the Commissioners
- GPs
- Referrers
- Secondary Care
- Tertiary Centres
- Social Care providers
- Staffordshire Neurological Alliance
- Third sector organisations, particularly Epilepsy Action
- National and International professional bodies (Joint Epilepsy Council – JEC, Epilepsy Nurses Association – ESNA, International League Against Epilepsy - ILAE)

2.5 Interdependencies

These are as per the points made under the *Service Description* and *Whole System Relationships*

sub-sections.

2.6 Training/education

- Participates in the education of NHS health care professionals, and promote awareness of epilepsy and its potential complications and co-morbidities;
- Delivers a general epilepsy awareness course for Service Users and their families/carers on the service's caseload subject to a minimum of 10 delegates with a maximum frequency of 4 annually. Paid and unpaid carers are welcome to such events.

3. Service Delivery

3.1 Service model

The Community Epilepsy Service delivered by the Provider shall at all times comply with the terms and conditions of the Agreement of which this Service Specification forms part of Schedule 2 part 1. Nothing in this Service Specification shall in any way waive or alter the obligations of the Provider, or the rights if the Commissioners, under the terms and conditions of the Agreement.

The Provider will:

- Assess all referrals against the Referral Criteria (see 4.4) in accordance with this Service Specification and, where appropriate, arrange an appointment for the Service User;
- Acknowledge the referral and who it has been allocated to within a maximum of 2 Operational Days of the receipt of the referral to the referrer;
- Prioritise referrals, 10 Operational Days referral time for Service Users newly diagnosed from Secondary Care requiring a First Outpatient Appointment, 20 Operational Days referral time for Service Users with an existing diagnosis experiencing new problems (see 8);
- Secondary Care and other Health Care Professional referrals are to be sent in writing to the Provider. Referral letters should contain at a minimum the demographic detail as identified in 4.4;
- The Provider shall not reject referrals on the grounds that the referral contains insufficient detail. Within 2 Operational Days of receipt of the referral the Provider shall contact the referrer regarding any insufficiently informative referrals;
- Referrals made by potential Service Users shall be via telephone, letter or email. If a Service User has not accessed the Service within a 6 month period, the referral shall be accepted and the Service Users GP informed of the referral;
- The administrator of the Service will telephone Service Users within 3 Operationalal Days of the appointment to confirm their attendance. Where Service Users have confirmed they will not be attending the appointment, the Provider will endeavour to fill the appointment slot.

3.1.1. First Outpatient Appointments (FOA)

Where clinically appropriate the FOA will include, but is not limited to, the following:

- Education provided to Service Users regarding their epilepsy;
- Options to be provided to Service Users regarding their treatment/Care Plan;
- Initiation of medication regime.

It is recognised by the Commissioner that not all FOA's will be for Service Users newly diagnosed, some will be for Service Users who are re-engaging with the service. Examples of such circumstances are:

- Service Users who have been seizure free for 5 years and are considering the withdrawal of their medication;
- Pre-conceptual counselling and advice during pregnancy;
- Service Users experiencing seizures who have previously been 12 months seizure free;
- Service Users experiencing difficulties with medication;
- Service Users who require advice on their change of social circumstance or lifestyle;

- Service Users previously diagnosed elsewhere who have moved into the local area.

3.1.2 Subsequent Outpatient Appointments (SOA)

Subsequent to the FOA, any physical attendance follow up outpatient appointments (the "Subsequent Out Appointments" (SOA)) will only be provided to Service Users where clinically necessary and the scope of intervention is beyond the Service Users GP. The SOA must be made available to each Service User, as necessary, promptly taking into account the Service Users clinical condition.

Where clinically appropriate the SOA will include, but is not limited to, the following:

- Adjustment of medication regime to optimal dosage;
- Monitoring of seizure frequency;
- Advise on the social implications of epilepsy, including but not limited to, leisure, employment, co-morbidities, pre-conceptual counselling and advice during pregnancy;
- Monitoring for those who are refractory to their medication regime and examining alternative treatment modalities (for example complementary approaches, referrals for epilepsy surgery or Vagal Nerve Stimulation). Referrals to a Tertiary Centre should be discussed with a Consultant Neurologist

3.1.3 Urgent Appointments

Where there is a clinical need for an Urgent Appointment, Service Users will be seen as per the NICE guidelines (within 20 Operationalal Days). Once fully operationalal, the service will aspire to see urgent patients within five operationalal days.

3.1.4 Clinic Letters

Following each FOA and SOA, the Provider shall communicate, by way of a written letter, the outcome of the appointment, including without limitation the outcome on all the above matters to the Service User, the Service User's GP and Referrer. This communication constitutes a Clinic Letter in the context of this Service Specification and shall be issued by the Provider within 10 Operationalal Days following the Service User's appointment. The Provider shall issue letters by Royal Mail or via a secure internet based, or electronic, solution, such as NHS Net Mail. In addition to the above the Provider shall ensure that each Clinic Letter, where applicable, contains:

- A clear diagnosis if possible, or as a minimum a working diagnosis;
- A Care Plan;
- A clear description, and justification, of what further Services the Service User is being offered by the Provider and the intended clinical outcome;
- The correct Service User's and GP's details. The letter should also plainly state what further action the Service User's GP is being requested to undertake and the underpinning rationale, in particular where this relates to the initiation or continuation of medication prescribing.

3.1.5 Discharge Letters

Upon Discharge the Provider shall write (Clinic Letter) to the Referrer, Service User and their GP to communicate the fact that the Service User has been Discharged and confirm the details of any Care Plan in a clear and unambiguous form. The letter should clearly state how the Service User may re-engagement with the Service. This communication will be issued by the Provider within 10 Operationalal Days of Discharge.

3.2 Care Pathway(s)

The Provider will:

- Support the collection of witness checklists and statements, as part of the *Care Pathway for the Diagnosis of the Epilepsies in Adults*;
- Support the refinement and the development of care pathways that form part of the local care model for the diagnosis and the management of the epilepsies;
- Agree any service-specific pathways with the Commissioner before their implementation.

4. Referral, Access and Acceptance Criteria

4.1 Geographic coverage/boundaries

The Provider will:

- Provide a service for the Target Population (see 1.6);
- Provide assessments and support interventions in local health centres to minimise the travelling burdens on Service Users.

4.2 Location(s) of Service Delivery

The Provider will:

- Have a recognised service base for administrative and operationalal reasons;
- Operate from a variety of locations to provide interventions at distinct points of the local care model and to minimise the travelling burdens on Service Users and their families/carers;
- Be responsible for the undertaking of any location risk assessments.

The Provider shall provide the Community Epilepsy Service at Provider Premises, within a community setting, in each of the following areas:

- Stafford
- Cannock
- TBA
- TBA

By entering into this Agreement, the Provider agrees to add further locations to the above list by way of a formal Variation to the Agreement, as may be proposed by the Commissioner from time to time, subject to suitable premises being available to the Provider. To avoid doubt, the Commissioner shall be under no obligation to make such a Variation Proposal or to accept any Variation Proposal, concerning the above list of locations, from the Provider.

The written consent of the Commissioner must be obtained prior to any of the Provider Premises being used to deliver any element of the Services.

In addition to meeting the standards set out elsewhere in this Agreement, the Provider Premises shall also be:

- Within 250 metres of a public transport link and suitable sufficient car parking facilities.
- Able to accommodate family and carers who may accompany Service Users.

4.3 Days/Hours of operational

The Provider will:

- Supply the service to Service Users on Operational Days (between the hours of 0900 – 1700 hours);
- Provide alternative methods for care plan reviews based on the choice and availability of Service Users';
- Publicise and promote the days/hours of operational;
- Respond to requests for advice and information outside of the service's core working hours, from both local care services and the Target Population by at least the next calendar/working day;
- Be operationalal for every Operationalal Day taking into account annual leave and training.

4.4 Referral criteria & sources

The diagnosis element of epilepsy will be Provided within a Secondary Care setting. Service Users will be referred to the Service post diagnosis.

The Provider will:

- Not seek to exclude any referral for the stated Target Population (see 1.6);
- Operate an "open" system of referrals that accepts both self and professional referrals;
- Operate a model of clinical triage within their single-point of contact system;
- Maintain an administrative system that collates and reports the following minimum demographic detail: age, NHS number, gender, ethnicity, registered GP, postcode of residence, referral source and the reason for referral for all received referrals;

4.5 Referral route

The Provider will:

- Promote and ensure that local care services and the Target Population are aware of the "Service Accessibility";
- Ensure that Service Users are aware, from the point of referral onwards that they may leave the service and that this will not affect their re-engagement with the service;
- Develop and publicise a referral route for local care services and the Target Population that highlights the method for referral, with the "Days/Hours of operational" and the points identified within the "Service Description" section;
- Ensure that there is an applied method, where necessary for gaining Service User's consent prior to referral;

4.6 Exclusion criteria

The Provider will:

- Deem an inappropriate referral as one that does not meet one of the stated points under the Target Population (see 1.6);
- In the case of an inappropriate referral provide advice on the remit of the service and signpost the referrer to the appropriate service/s;
- For avoidance of doubt, the Commissioner shall not be liable for any costs for patients who meet the exclusion criteria.

5. Assessment, Discharge Criteria and Planning

5.1 Assessment Tool

The Provider will:

- Adopt an assessment process that includes an initial assessment tool and a process of review. Part of the initial assessment tool will be used as a benchmark to assess improved symptom control achieved with Service Users;
- Work to the "Functional Model of Health" (WHO, 1984), or similar model to underpin the initial assessment and any other developed assessment tools;
- Use an initial assessment tool that is able to identify and scale the health, social and support needs of Service Users';
- Jointly undertake, where appropriate initial assessments and their reviews in partnership with local care services and social care;
- Ensure that the initial assessment is revisited on a timescale that is agreed with the Service User

as part of their care plan;
- Establish as part of the initial assessment the full, voluntary and informed consent of the Service User to share assessment and care planning information with local care services;
- Be open to the on-going monitoring and refinement of the assessment tool with the Commissioner;
- Ensure that a robust assessment of risk is undertaken and that this is communicated and understood by all partners.

5.2 Relationship Building

The Provider will allocate each Service User a named staff member who is responsible for co-ordinating their care. The Provider will ensure that where possible and appropriate, the Service User will have their appointment with their named staff member.

5.3 Care Plan

The Provider will ensure that the Care Plan will address the following areas as a minimum:

- Develop comprehensive agreed care plans, following an initial assessment, with Service Users that detail Specific, Measurable, Action-orientated, Realistic, and Timely goals, for all planned interventions;
- Develop goals that are meaningful to Service Users and their families/carers and that reflect the stated Service Outcomes;
- Develop and agree care plans, where appropriate with other local care services;
- Be able, as part of the goal setting process to broker care interventions in a timely manner on behalf of Service Users;
- Apply a frequency of review to the care plan that is agreed with the Service User, and where appropriate other local care services;
- Jointly undertake, where appropriate care plan reviews in partnership with local care services.

5.4 Discharge Criteria

- The Provider will discharge the Service User when they have been 12 months seizure free with no medication issues, or;
- The Service User has not been seizure free for 12 months but are in agreement with the Provider that no further intervention is possible, desired or required, or;
- Service Users are experiencing unresponsive/refractory epilepsy and require an onward referral to a Tertiary Centre. Service Users will be informed about re-engaging with the service as per 5.5 Discharge Planning.

5.5 Discharge Planning

The Provider will:

- Provide each Service User, upon discharge a Discharge Letter (see 3.1.5);
- Upon discharge, Service Users will be asked to complete a Service User's satisfaction survey which will include questions regarding the Service User's satisfaction of the service and how they regard their symptom control;
- Provide to primary care, and where necessary to another local care service a copy of a Service User's Discharge Letter, where their consent has been given.

6. Prevention, Self-Care and Patient and Carer Information

The Provider shall provide to the Service User the appropriate information relating to their diagnosis, care and lifestyle changes that will support the Service User to self-manage.

The Provider shall at all times on Operational Days, between the hours of 0900-1700hrs, keep in

operational a telephone contact number Service Users, their families/carers and referrers to discuss matters relating to the Community Epilepsy Service. The Provider shall ensure a suitably qualified clinician is available to respond to all calls within 1 Operational Day. If the telephone is not mandated, there will be an answer machine message that will outline the timeframe for responses,

The administrator will be able to respond to Service Users their families/carers and referrers who have non-clinical enquiries.

For the avoidance of doubt, the telephone contacts outlined in this part of the Service Specification are not chargeable activities and shall be provided at no cost to the Commissioner.

7. Information/Data requirements

To the extent not already covered by other provisions of this Agreement, the Provider will report against a number of data requirements to inform a continual service improvement/innovation plan.

Please refer to Schedule 5 Part 3 for all information requirements relating to this service.
All datasets submitted will comply with:

Clause 27 – Date Protection/Freedom of Information/Transparency
Clause 29 – Information Requirements

The Provider will comply with all reasonable requests for information and provide performance reporting information in the manner and format to be agreed with service commissioners.

CES – Community Epilepsy Service

Quality and Performance Indicators	***Indicator***	***Threshold***	***Method of Measurement/Frequency of reporting***	***Consequence of breach***
Patients referred to be seen	Provider to ensure that all newly diagnosed Service Users referred to the CES, attend their FOA within 10 Operational Days of the Provider receiving the referral from secondary care.	95% of Service Users referred will be seen within 10 Operational Days from receipt of referral from secondary care. 100% of Service Users referred will be seen within 20 Operational Days from receipt of referral from secondary care.	Activity Report/Monthly – will detail the number of patients referred to be seen The Provider shall report by exception any instances where the threshold has been breached and the circumstances of each contributory breach.	Each breach of this threshold may be regarded by the Commissioner to be a material breach of this Agreement and clause 32 may be invoked in the Commissioner's sole discretion.
Patients referred to be seen	Provider to ensure that all Service Users referred to the CES with an existing diagnosis of epilepsy who are experiencing new problems, attend their FOA within 20 Operational Days of the Provider receiving the referral.	95% of Service Users referred will be seen within 20 Operational Days from receipt of referral from secondary care. 100% of Service Users referred will be seen within 30 Operational Days from receipt of referral from secondary care.	Activity Report/Monthly – will detail the number of patients referred to be seen The Provider shall report for each month by exception any instances where the threshold has been breached and the circumstances of each contributory breach	Each breach of this threshold may be regarded by the Commissioner to be a material breach of this Agreement and clause 32 may be invoked in the Commissioner's sole discretion.
Cancelled appointments	Provider shall ensure that it avoids cancelling Service User appointments and	Provider to ensure that no more than 1% of all Service Users have their	Activity Report/Monthly	Each breach of this threshold may be regarded by the Commissioner to be a

	where appointments have to be cancelled adequate notice should be given to Service Users.	appointments cancelled within 1 month of the appointment date, for reasons of a non-clinical or operationalal nature.	Each month the Provider shall inform the Commissioner of the number of Service Users who have their appointments cancelled less than 1 month before the appointment date.	material breach of this Agreement and clause 32 may be invoked in the Commissioner's sole discretion.
Number of DNA's		Provider will ensure that the number of DNA's is kept below 10% within the first contractual year, with a further 1% reduction in the subsequent 2 years to follow.	Activity Report/Monthly	Each breach of this threshold may be regarded by the Commissioner to be a material breach of this Agreement and clause 32 may be invoked in the Commissioner's sole discretion.
Appointment reminder system	The Provider will contact Service Users within 3 Operationalal Days of the appointment to confirm their attendance.		TBA	
Service User and referrer queries	The Provider shall answer all Service User and Referrer queries within 2 Operational Days of the initial contact.	100% of queries should be answered within 2 Operational Days of the initial contact.	TBA	Each breach of this threshold may be regarded by the Commissioner to be a material breach of this Agreement and clause 32 may be invoked in the Commissioner's sole discretion.
Clinic letters	Provider ensures that Clinic Letters will be typed and sent out to the Service User.	100% of clinic letters will be sent out within 10 Operational Days of the	Monthly exception reporting	Each breach of this threshold may be regarded by the Commissioner to be a

	their GP and other people relevant to their care needs within 10 Operational Days of their consultation. The detail of Clinic Letters is set in 3.1.4.	Service Users consultation.		material breach of this Agreement and clause 32 may be invoked in the Commissioner's sole discretion.
Telephone advice line	The Provider shall ensure a suitably qualified clinician is available to respond to all calls within 1 Operational Day.		Monthly exception reporting	Each breach of this threshold may be regarded by the Commissioner to be a material breach of this Agreement and clause 32 may be invoked in the Commissioner's sole discretion.
Discharge	The Provider will discharge the Service User when they have been 12 months seizure free with no medication issues (see 5.4)		Monthly exception reporting	Each breach of this threshold may be regarded by the Commissioner to be a material breach of this Agreement and clause 32 may be invoked in the Commissioner's sole discretion.
Discharge letters	Provider ensures that Clinic Letters will be typed and sent out to the Service User, their GP and other people relevant to their care needs within 10 Operational Days of their consultation. The detail of Discharge Letters is set out in 3.1.5.	100% of clinic letters will be sent out within 10 Operational Days of the Service Users consultation.	Monthly exception reporting	Each breach of this threshold may be regarded by the Commissioner to be a material breach of this Agreement and clause 32 may be invoked in the Commissioner's sole discretion.
Outcome –	Provider will ensure that	TBA	Activity Report/Quarterly	

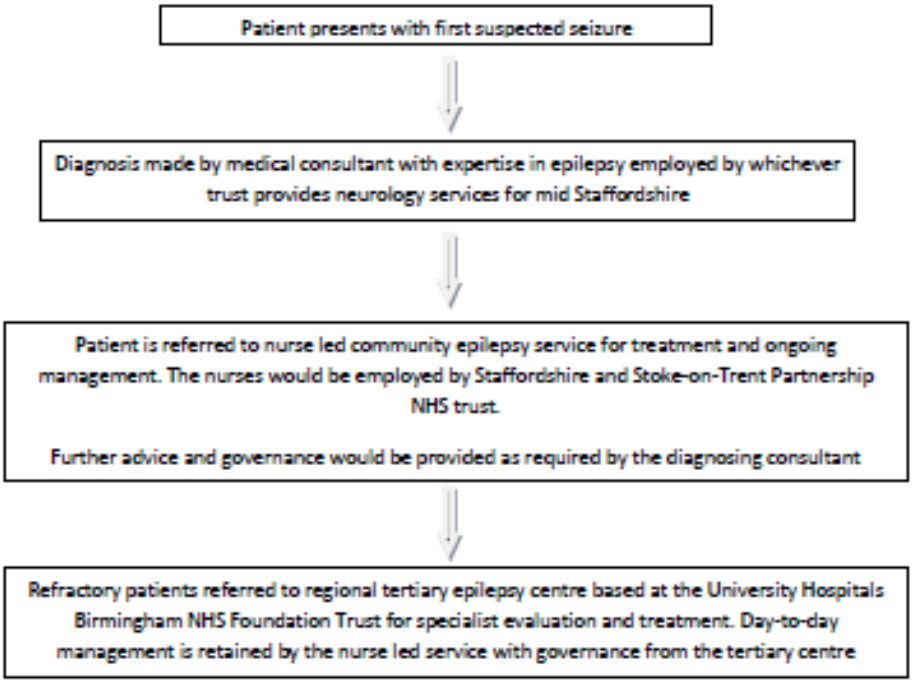
Service User improvement using the validated assessment tool as agreed by Commissioners.	Service Users experience an improvement in their self reported "Symptom" score.		Provider to submit survey results to the Commissioner each quarter. Results of the survey are to be compared to Service Users initial assessment results. Information on lessons learnt and actions taken to be included within the report.	
Outcome – Service User improvement using the validated assessment tool as agreed by Commissioners	Provider will report a reduction in the Service Users seizure frequency and severity		Activity Report/Quarterly Provider to submit survey results to the Commissioner each quarter. Results of the survey are to be compared to Service Users initial assessment results. Information on lessons learnt and actions taken to be included within the report.	
Outcome - Service User improvement using the validated assessment tool as agreed by Commissioners	The Provider will ensure that the Quality of Life (including the ability to work where appropriate) for Service Users increases following access to the service.		Activity Report/Quarterly Provider to submit survey results to the Commissioner each quarter. Results of the survey are to be compared to Service Users initial assessment results. Information on lessons learnt and actions taken to be included within the report.	
Outcome – Non-elective admission rates	The Provider will ensure that non-elective admission rates	The number of non-elective admission spells divided by		

within Secondary Care	for epileptic patients remain below the specified threshold.	the epilepsy population (as defined by the QOF) will remain below 5%.		
Outcome – Service User satisfaction	The Provider shall ensure that Service Users are satisfied with the services provided within the CES.	Provider will ensure that 90% of Service Users responding to the Service User Satisfaction questionnaire report a satisfactory experience.	Provider to submit survey results to the Commissioner each quarter. Results of the survey are to be compared to Service Users initial assessment results. Information on lessons learnt and actions taken to be included within the report.	
Outcome – Service User satisfaction	The Provider shall ensure that Service Users are satisfied with the Provider Premises and that they are accessible.	Provider will ensure that 90% of Service Users responding to the Service User Satisfaction questionnaire report a satisfactory response to the provider premises.	Provider to submit survey results to the Commissioner each quarter. Results of the survey are to be compared to Service Users initial assessment results. Information on lessons learnt and actions taken to be included within the report.	

Thoughts on the delivery of the CCG's epilepsy service specification within the parameters of the current TSA proposals for the future of MSFT.

The following thoughts are based on the premise that Stafford and Surrounds and Cannock Chase CCG's wish to commission an epilepsy service based on their service specification and that MSFT will cease to exist with its current services being provided by other acute trusts.

Plan outline



Explanation and detail

For a number of years clinicians in the West Midlands have advocated a 'hub and spoke' system for the management of people with epilepsy. The hub would be based at the tertiary centre at University Hospitals Birmingham NHS Foundation Trust (UHB) dealing directly with the most challenging cases and providing governance, advice and support to local community based services which would be responsible for providing most of the long term care. The outline of this system is already incorporated into the CCG's service specification but more thought needs to be given if MSFT ceases to exist. The following patient journey would comply with NICE epilepsy guidelines, be cost-effective for the CCG's, improve the quality of care offered to people with epilepsy in the area and work equally well with whichever acute trust or trusts provide neurology services to the people of mid Staffordshire in the long term.

This outline could work equally well with other neurological long-term conditions such as Parkinson's disease and multiple sclerosis where there are already well established nurse led services operating in mid Staffordshire.

Patient journey

Diagnosis - patient should be seen within two weeks of referral (NICE 2012).	NICE guidelines state that this should be made by a medical practitioner with expertise in epilepsy. In most cases this will be a consultant neurologist but could also be a psychiatrist or suitably trained elderly care or paediatric physician. The patient would see the consultant once or twice to establish their diagnosis and organise appropriate investigations (blood tests, MRI, EEG, ECG). This clinician would be employed by whichever organisation provides neurology, psychiatric, elderly care or paediatric services in the mid Staffordshire area. If epilepsy is confirmed the patient would be referred to the nurse led community epilepsy service for ongoing management. It should be noted that there is no paediatric epilepsy nurse provision at the moment so the patient would have to be sixteen years of age or over at the time of referral.
Ongoing management - patient should have an initial appointment within four weeks of referral with regular routine appointments and a facility for urgent contact and appointments if problems arise (NICE 2012)	This is provided by a nurse led service based in various locations throughout mid Staffordshire with clinics running as close as possible to the patient's address. Treatment may have been started by the consultant with the nurse titrating medication as required or if a decision has been made to delay treatment than the nurse may initiate antiepileptic drugs after further discussion with the patient. Approximately fifty percent of people with epilepsy will not have their seizures controlled by the first medication that is tried and the nurse led service would be expected to initiate different treatment as required. If there is doubt about the syndromic diagnosis then the nurse may request further local tests to clarify the nature of the patient's epilepsy before embarking on further treatment. This could include serial or sleep deprived EEGs or MRI (if not previously performed). In addition to medical treatment the nurse led service would also be responsible for the giving of information, discussion of risk including SUDEP, preconceptual counselling and the management of women with epilepsy through pregnancy, employment and benefit advice, as well as the initiation and management of rescue medication if appropriate. The nurse will also give advice about the non-drug treatment of epilepsy ranging from simple avoidance of seizure triggers to more complex interventions particularly if the patient also experiences Psychogenic Non Epileptic Seizures. There is the provision of a telephone or email advice service for queries between appointments.

	Medical governance for this part of the nurse led service would be provided by the diagnosing consultant. The nurse led service would also be expected to be involved in audit and research. The current post holder is presently principal investigator for two large MRC funded multicentre trials ('Empire' which is concerned with antiepileptic drug management of women through their pregnancies and 'SANAD 2' which is a comparison of standard versus new antiepileptic medication in newly diagnosed patients). Involvement with such trials brings benefits for local patients as well as contributing to the body of knowledge gathered by the wider epilepsy community. As soon as the patient has achieved twelve month seizure freedom they would be discharged to the care of their general practitioner.
Refractory epilepsy	Approximately 70 percent of people with epilepsy will have their seizures completely controlled by medication within two years of diagnosis. NICE (2012) states that if the patient has tried two different antiepileptic drugs suitable for their type of epilepsy at maximal tolerated doses over two years without seizure freedom being achieved then a referral should be made to a tertiary centre for confirmation of diagnosis (up to one in five patients referred to tertiary centre will not have the condition) and to assess their suitability for more specialist treatment such as epilepsy surgery or vagal nerve stimulation. In the case of mid Staffordshire this would be the neurosciences centre at University Hospitals Birmingham NHS Foundation Trust (see appendix 1 for rationale). The patient's care would remain with the nurse led service during the tertiary assessment period. The tertiary centre would provide ongoing governance as required to the nurse led service for this refractory cohort of patients. It is likely that this group of patients, making up approximately thirty percent of the total number of epilepsy patients in the area, will require input from the nurse led epilepsy service in the long term.
Remission - should have an appointment within four weeks of referral	The patient would be managed by the GP until they were five years seizure free. The GP would then refer back to the nurse led service for the consideration of antiepileptic drug withdrawal providing the patient is in agreement. Depending on the type of epilepsy further EEG investigations would be initiated by the nurse consultant at this point.
Diagnosed patient who runs into difficulties - should have an appointment within four weeks of referral (NICE 2012)	This could include refractory patients who have moved into the area, patients with breakthrough seizures, women with epilepsy who become pregnant or contemplate pregnancy, co-morbidities impacting upon epilepsy treatment (for example liver or kidney disease) or epilepsy related social difficulties. These patients should be referred to the nurse led epilepsy service for assessment and ongoing management.

Patient numbers required to maintain competence.

This has been a concern for the TSA in some specialties. It does not apply for epilepsy. Epilepsy Action have published recommendations that each epilepsy nurse should have a caseload no greater than 500 people with epilepsy or 250 people with active epilepsy depending how statistics are measured in the local area. There are currently just under 2800 patients known on the epilepsy nurses database with between 700 and 800 of these patients currently active.

Appendix 1

Analysis of epilepsy services available at trusts within reasonable travelling distance of mid Staffordshire

Trust	MRI	Basic EEG	Video telemetry	Epileptologist	Epilepsy surgery	Vagal nerve stimulation
UHNS	√	√	√	√		
Royal Wolverhampton	√	√				
Walsall Healthcare	√	√				
UHB	√	√	√	√	√	√

Appendix 2

Cost analysis

The costs are based on the personnel requirements outlined in the CCG service specification for a nurse led community epilepsy service.

Costs to the CCG's associated with an epilepsy service run by a single nurse under the PBR system.

I have analysed the number of patients and therefore the PBR costs for the first quarter of the last four years and extrapolated (table 1).

Table 1

Year	Actual first quarter PBR cost	Projected annual PBR cost
2010	£34,718.09	£138,872
2011	£51,042.20	£204,168
2012	£49,904.90	£199,620
2013	£50,476.01	£201,904

Costs to the CCG's associated with a nurse led epilepsy service outside the PBR system with the nurse employed by Staffordshire and Stoke-on-Trent Partnership NHS Trust.

Resource	Annual cost (staff figures include on costs and are estimated at the top of the banding scale)
1 wte lead epilepsy nurse band 8A	£57,976
1 wte epilepsy specialist nurse band 6 (band 7 when competencies achieved)	£42,064 (Band 7 £49,696)
1 wte admin band 3	£23,246
Clinical room hire (estimate forty-five pounds per session, eight sessions per week)	£18,720
Travelling expenses (estimate maximum 150 miles per week at 61p per mile)	£4,758
Governance from diagnosing consultants trust or UHB (half a clinical session per week in total)	£4,974
Total maximum cost to CCG **(total maximum cost to CCG when specialist nurse achieves band seven)**	**£151,738** **(£159,370)**

All other expenses (tests, computers, stationery etc) would be the same whichever model was used. Based on MSFT figures produced last year the total cost of office sundries would be £10,824. The estimate for EEG would be £14,200. If these costs were also born wholly by the CCG than the total maximum cost for the service would be £184,394 annually.

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Maternity Department Response to the Trust Special Administrators

August 2013

Mid Staffordshire NHS
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Maternity Department Response to the Trust Special Administrators

This report is written in response to the Trust Special Advisors (TSA) recommendations to the Secretary of Health for the future for Mid Staffordshire Hospital's Maternity Department.

The argument to reconfigure the Maternity Services has been largely based on the department's inability to obtain financial and clinical sustainability in the long term with the additional concern that the Clinical Commissioning Groups (CCG'S) failed to commission the services.

The Maternity Department acknowledges that changes in the way maternity services are provided is vital, however was disappointed to learn there was no other offer proposed apart than to close. The general consensus from within the department is that the report failed to:

- Consider the population growth in Stoke-on-Trent
- Realistically estimate population growth in Stafford and Stone
- Consider population growth beyond a 10 year plan
- Produce evidence to support the need for 24 hour consultant cover
- Acknowledge the impact of care on units delivering women over 6000 and 8000 births respectively
- Provide a service equal to services already provided
- Factor birthing outcomes as a potential for cost saving
- Undertake a health equality impact assessment prior to making recommendations
- Consider the emerging evidence of the impact of larger units
- Provide the Clinical Commissioning Group's (CCG) with information to make an informed decision

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- Consider other opportunities aside from closure
- Make suitable arrangements to challenge evidence used by the Clinical Advisory Group (CAG)

Staff from the Maternity Unit acknowledge the option of a midwifery birthing unit and fully supports the care such units provide for women. However the consensus of opinion is that they agree with the TSA that the concept of a birthing unit is not a long term financially viable option. It is also acknowledged that the Clinical Commissioning may choose to commission this service and accept any possible financial loss.

It is the intention of this report to review each of the points highlighting both the strengths and weakness and to submit a proposal to the TSA for their consideration.

Size of Unit

One of the major contentions within the report is that the basis for closure includes the Royal College of Obstetricians and Gynaecologists (RCOG) suggestion that a Maternity Department with a delivery rate below 2500 per year is neither clinically or financially sustainable. Yet there is no consideration that the RCOG goes on to say that those delivery units above 6000 per year would deliver impersonal care, given that one of the key messages of the 2012 NHS Mandate[1] was the promise to deliver personal care we would be interested to hear Mr Cameron's views on this. The RCOG goes on to say that above 8000 per year would be neither clinically or financially stable[2]. When asked regarding the evidence to support this statement the TSA consultant admitted that they assumed the RCOG would have been able to substantiate their findings and provide evidence if required. In a report submitted by the RCOG in 2012, to the

[1] Department of Health (2012) *The Mandate A Mandate forum the Government to the NHS Commissioning Board: April 2013 to March 2015*, DOH London
[2] Royal College of Midwives, Royal College of Obstetricians Gynaecologist,. 2007 *Safer Childbirth – Minimum Standards for Organisation and Delivery of Care in Labour*

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London Healthcare Trust Special Administrator the RCOG representative stated that there is no published "evidence" on the ideal size for a maternity unit[3]. We believe therefore that the report failed to consider the contradiction in these statements and have based their recommendations with a lack of evidence. It may be prudent to point out that the Prime Minister; Mr Cameron is reported to have said "*there will be no reconfiguration without evidence*"[4].

Consultant Cover

One of the main concerns that has emanated from the RCOG's advice to the TSA is the fact that a smaller unit such as Mid Staffordshire would not be able to support the Safer Childbirth[5] recommendations for 24 hour consultant presence. When questioned, the TSA reiterated that they accepted the advice as given to them by the expert panel and that they assumed the advice would be evidence based. However, evidence to support this recommendation as a means of improving outcomes is still not available. Macfarlane[6] criticises the "evidence" to support the necessity of 24 hour consultant presence, stating that it "falls short" of what would be expected to provide for an evidence based policy.

Ironically since the inception of Safer Childbirth it is suggested that only 2 maternity units have full obstetric presence. According to the Royal College of Midwives (RCM) it is still considered to be aspirational and should not be used as the main driver for change[7]. Given that we are now six years further down the line this surely brings into question whether this aspiration will ever be realised and raises the question, is this now the time to reconsider our options?

[3] Royal College of Obstetricians Gynaecologist, (2012) Submission to South London Healthcare Trust Special Administrator Consultation, RCOG
[4] http://news.bbc.co.uk/1/hi/health/8439360.stm
[5] Royal College of Obstetricians and Gynaecologists, Royal College of Midwives, Royal College of Anaesthetists, Royal College of Paediatrican and Child Health, (2007) Safer Childbirth. Minimum standards for the organisations and delivery of care in Labour. London: RCOG Press 2007
[6] Macfarlane A. (2008) *Reconfiguration of maternity units – what is the evidence?* London
[7] Royal College of Midwives (2012) Response to *Securing sustainable NHS services*: the consultation on the Trust Special Administrator's draft report for South London Healthcare NHS Trust and the NHS in south east London.

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Bosanquet et al (2005) do suggest however we should aspire to the model of care, as used in our neighbouring European countries, where maternity units deliver 2,000-3,000 births per year.[8] The Prime Minister is obviously in favour of this model having being quoted as saying:

> *"Labour's policies have given us bigger and bigger baby factories where mothers can often feel neglected, with some even being turned away on the doorstep while they are in labour, --- parts of Europe have systems that are more flexible and local with more choices and they have lower rates of mortality".*[9]

In recognising that there will be some women that will undoubtedly benefit from the facilities afforded at a larger tertiary unit, the Maternity Unit at Mid Staffordshire already has robust protocols in place that allow for the strict risk assessment of individual women, directing their care into the most appropriate setting, thereby reducing the number of both intra uterine and extra uterine transfers. This has allowed the transfer rates to be low at 2%.

The Maternity Services at Mid Staffordshire has lower than both local and national perinatal mortality rates, lower caesarean section rates and is rated by the ROCG as one of the top 10 performing units in the country and yet this is achieved on the basis of 40 hours obstetric presence. It may be argued that the TSA have missed an opportunity to attempt to understand why the clinical outcomes for Stafford are good rather than enforcing closing a unit without any real evidence to do so.

[8] Bosanquet et al, (2005) Maternity services in the NHS, REFORM.
[9] *London Borough of Lewisham and Save Lewisham Hospital Campaign Limited v Secretary of State for Health and the Trust Special Administrators appointed to South London Hospitals NHS Trust* [2013] EWHC 2329 (Admin)

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Local Demographics

The TSA states that they are aware that the local population is forecast to increase. Stafford Borough covers an area of over 230 square miles. It is predominately a rural district with Stafford and Stone the key urban centres.

The TSA recognises that there is a planned relocation of a number of UK armed forces to the Military of Defence (MoD) in Stafford by the end of 2015. This is estimated to include approximately 420 families, which the TSA acknowledges may increase the number of deliveries per annum by 100.

The TSA also recognises that Stafford Borough Council has given permission for 2,911 new houses to be built over the next six years, which is consistent with the planning provision of 500 houses per year. However this planning provision actually extends until 2031, which will provide a total of 10,000 new houses in the area.[10] This is a further 17,089 new houses not included in the report's consideration.[11]

The distribution of the 10,000 houses is 7,200 in Stafford Town, 800 in Stone Town, 1200 in key service villages and a further 800 in other Borough areas.[12] The Strategic Housing Land Availability Assessment has identified that there is sufficient building land in all these areas to meet the provision and it is considered that this will be deliverable in the time period[13].

[10] http://www.staffordbc.gov.uk/the-plan-for-stafford-borough
[11] 'Improving Stafford Borough' Stafford Borough Council Corporate Plan 2012 - 2015
[12] The Plan for Stafford Borough. www.staffordbc.gov.uk/lp at 6.45
[13] The Plan for Stafford Borough. www.staffordbc.gov.uk/lp at 6.55

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It is planned that 30%-40% of the houses provided will be 'affordable housing' having 2, 3 and 4 bedrooms. This will therefore undoubtedly increase the birth rate in the Borough.

If it is assumed that the affordable housing (4,000 houses) are accommodated by families, using the TSA calculation that 420 families will produce 100 births then the 'affordable housing' included in the long term plan for the Borough will increase the birth rate by at least a further 950 per year.

The further 6,000 houses will undoubtedly also result in further births, if as a conservative estimate 10% of these households result in one birth per year , a further 600 deliveries will occur.

Therefore we suggest that a very conservative estimate is that the birth rate in the Borough will increase by 1,600 plus the 100 as estimated by the TSA for the MoD. There are currently 1,200 women per year who live within the Borough who deliver at Stafford Hospital. This would result therefore in a minimum 2,900 extra births at the UHNS per year.

Alternatively these women, along with the women from Cannock, Rugeley etc, who currently deliver at Stafford, could all be offered a choice of delivering their babies at Stafford, which would equate to 3,600 deliveries, making a clinical and financially sustainable unit.

Additionally there has recently been planning permission granted for a further development of 250 new houses in Barlaston on the Wedgewood Estate which would also result in a further increase in the birth rate.

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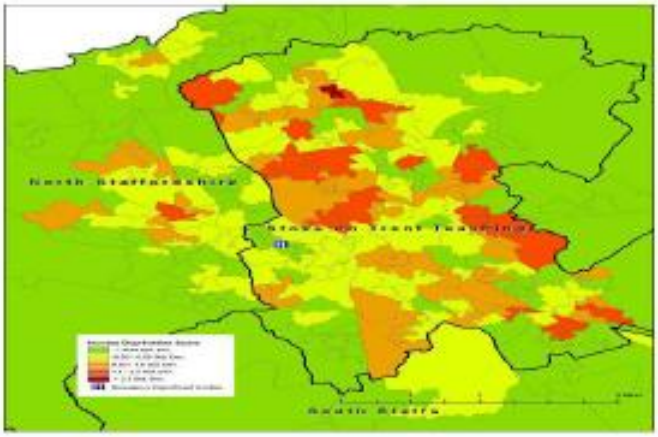
It is acknowledged that a new hospital is being built at Telford which would offer an alternative to UHNS. This would be most accessible for women living in Gnosall and Eccelshall for which there is approximately 120 deliveries per year.

Currently the UHNS has 5,800 deliveries per year, therefore the impact on the unit would be the necessity to provide for at least 8,450-8,600 deliveries a year by 2031. This will result in a service that is neither personal or a financially / clinically sustainable.

These estimates do not take into account any increase in the birth rate in the population in Stoke-on-Trent, Newcastle-under-Lyme and the surroundings areas which are served by UHNS.



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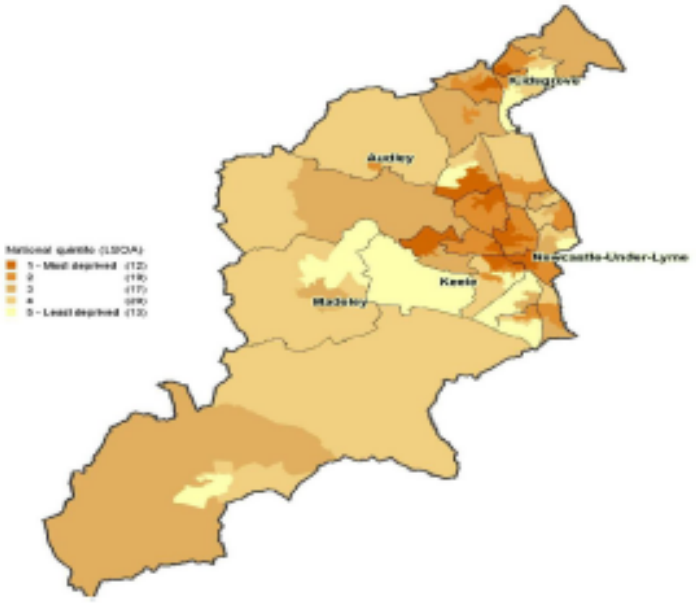
Stoke-on-Trent is located in the North East corner of the West Midlands, Stoke-on-Trent lies midway between the cities of Birmingham and Manchester. Forming the larger part of North Staffordshire, the population has remained stable at around 240,000 following an extended period of decline – bolstered largely by international migration and an increased birth rate. [14]

Stoke-on-Trent is rated within 10% of the most deprived areas in Staffordshire. It is ranked 16th out of 354 English districts across national indices of multiple deprivation (2007). This is a deterioration from its previous position of 18th most deprived district in the 2004 indices. The city is ranked as the 3rd most deprived in the West Midlands out of 34 Local Authority districts; behind Birmingham (ranked 12th nationally), and Sandwell (Ranked 10th).[15]



[14] www.healthycities.org.uk/.../Healthy%20Cities%20online%20Spread_30-31.pdf
[15] www.stoke.gov.uk/cm/navigation/councilland- democracy/statistics/indices-of-deprivation

The 2010 mid-year population estimate for Newcastle was 124,500.[16] The overall population of Newcastle-under-Lyme is forecast to rise by 2.7% over the next 20 years.[17] The Borough Council has updated the Strategic Housing Land Availability Assessment and a finalised SHLAA Report has been produced. The report has identified deliverable sites over the next five years that have a capacity of 1,553 dwellings and a 15 year developable sites with a capacity of 4,890 homes.[18] With regards to the provision of new "affordable housing" It has been estimated that over the next 20 years, there could be a need of 269 new affordable units each year and the majority needed in the Borough is considered to be "social" housing. [19] This would equate to a further 1,380 houses.

While agreeing with the TSA the fact that there will be growth within the ageing population of Stafford Borough at the final meeting with the TSA they conceded that if women returned to Stafford there was the probability that the unit could reach 2600 deliveries.

Financial

The Maternity Department has always recognised the difficulties faced when trying to balance the budgets within a constrained financial climate. They are equally aware that there are many other external pressures either directly or indirectly impacting upon the ultimate decision making the financial consideration complex. In the past payment for maternity services has been through a combination of tariffs for deliveries, outpatient activity (eg obstetric antenatal clinics) and unscheduled attendances; with block contracts/payments for midwifery delivered antenatal and postnatal care in the community (including in GP surgeries, children's centres and women's homes). It has therefore been accepted that there is a wide variation in the levels of these block payments and

[16] Health and wellbeing profile for Newcastle-under-Lyme Borough Council. May 2012 Population Health Intelligence Staffordshire Public Health
[17] Stoke-on-Trent Joint Strategic Needs Assessment JSNA 2010 – 2015 Draft: Version 4.4 February 2011.
[18] Newcastle-under-Lyme Local Investment Plan 2011-14
[19] Affordable Housing Supplementary Planning Document – January 2009

that accounts for the variation across the country in spend per birth[20]. Given the recognised complexity between hospitals it is difficult to understand how the TSA can make a judgement on the financial status.

Maternity Services have now entered a new payment system where payment will be as a result of pathways and all Maternity Units nationally will be on the same system by 2013/4. If that is the case then surely the tariff would be the same wherever the woman delivered. Furthermore each maternity unit is obliged to provide a midwifery workforce in accordance with Safer Childbirth recommendations and this is based on activity, therefore the same number of midwives would be required wherever their care was delivered.

Might this explain why at the Nuffield Trust Annual Health Summit in 2010 Mr Andrew Taylor, Director. NHS Co-operating and Competition Panel stated that:

"Analysis does not seem to show that larger hospitals are more efficient or have a lower cost base than smaller hospitals"[21]

The TSA goes some way to address some issues however appears to have adopted a one dimensional approach by failing to consider the monies to be gained from maintaining good birthing outcomes, such as lower caesarean section rates, low Perinatal mortality rates thereby a reduction in litigation claims.

In addition while recognising the financial impact of transfer arrangements through the use of ambulance services, the TSA fail to acknowledge the impact this will have on our most vulnerable women. Stafford's local population does

[20] Tyler, S (2012) Commissioning Maternity Services: A Resource Pack to Support Clinical Commissioning Groups, NHS. London

[21] Taylor A (2010) Competition in the NHS: progress and prospects www.nuffieldtrust.org.uk/talks/audio/andrew-taylor-nhs-co-operation-and- competition

have small pockets of deprived areas that will have difficulty in accessing care[22]. The extra financial burden on social services for travel expenditure, car parking facilities, child care arrangements not to mention a convoluted bus journey may discourage these women from accessing they care the need. Asking for a Health and Wellbeing Impact Assessment after the submission of their report seems to be questionable practice on the part of the TSA.

The TSA have suggested the development of an Early Pregnancy Assessment Unit that will care for women less than 23 weeks gestation without providing any suggestion on how this would work, presumably there would be direct access to a consultant or senior registrar but whether this would be a result of a referral to another hospital by ambulance or a consultant on site is not clear. The TSA suggests that women above 23 weeks gestation would be required to attend other units. This amounts to an extra 3500 episodes of care that are seen annually. Mid Staffordshire's current pathways of care support and encourage the majority of these women to return home thereby limiting the number of ante natal admissions. Geography and travel times do influence women in their decision making. It may be considered likely therefore that some women and indeed midwives would be reluctant to enable their return home in the knowledge of the substantially increased travel time. Given the overnight tariff is £500 per episode this is likely to have an increased financial burden on the Trust not withstanding the capacity to deliver care.

It has been suggested that our neighbouring Trusts may need additional monies afforded to them to undertake a new build to accommodate the extra demand on capacity. This being the case given the long term predicted rise in the population growth and the length of time new builds would take, would it not make more sense to invest in a unit already in existence?

Implications of Trust Mergers

[22] Stafford Borough Council Local Investment Plan 2011 – 2016

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Since the publication of the documents Safer Childbirth[23] and The Future Role of the Consultant[24] we have seen an increasing amount of maternity hospitals closing and merging with other hospitals. According to Macfarlane et al[25] there were 527 Maternity units in 1973 while the Birth Place Study[26] identified that by 2007 the number had halved to 262. Since then we have seen the further decline in the number of Maternity units with the integration of units in London, Birmingham and Manchester being the most recent. This is compounded by the insidious rise in the birth rate which according to the Office of National Statistic was 813,200 births in the UK in the year ended June 2012 – the largest since 1972[27]. It is no wonder then that in a recent survey carried out by the Royal College of Midwives it was found that 52.7% of Heads of Midwifery (HoM) reported to having to close their units in the last 12 months due to not being able to cope with the demand with some reporting closing on 7 separate occasions[28]. In addition the RCM survey found that 12.8% of HoMs reported reductions in services that their unit provides and 9.7% of HoMs who have a midwife led birthing unit in their trusts reported that it was in danger of closing. It is clear that the sporadic emergences of birthing units have not had the desired effect as suggested and we are seeing a "bottle neck" in services. At what point has it become acceptable to turn women away from the maternity unit they have attended for the duration of their pregnancy particularly when they are at their most vulnerable, in labour? Ironically there is little being publicised as to the numbers of women involved or the dangers and outcomes of care afforded to these women. With news of more hospital mergers how many more women are we prepared to place at risk?

[23] Royal College of Obstetricians and Gynaecologists (2007)Safer Childbirth: Minimum Standards for the Organisation and Delivery of Care in Labour
[24] Royal College of Obstetricians and Gynaecologists (2005) *The Future Role of the Consultant* RCOG. London
[25] Macfarlane et (2000). *Birth counts: statistics of pregnancy and childbirth*, HMSO.
[26] National Perinatal Epidemiology Unit. The Birthplace in England Research Programme. http://www.npeu.ox.ac.uk/birthplace
[27] Office for National Statistics
[28] Royal College of Midwives (2012) *Submission to NHS Pay Review Body*. RCM London

Maternity Department Response to the Trust Special Administrators 13

Mid Staffordshire NHS
NHS Foundation Trust

Consultation

There have been a variety of consultation meetings held separately for the public and staff in numerous venues to allow for a wide and varied attendance. During one of the staff meetings the Maternity Department were informed that their decision to close the department was based on the advice given to them from the Clinical Advisory Group (CAG) and they had made the assumption the advice was evidence based. A meeting therefore was to be arranged that was to be held prior to the final meeting with the TSA, between Head of Midwifery along with the Lead Obstetric Consultant and the CAG with the expectation that there would be an opportunity for both parties to discuss the "evidence" available. At the request of the TSA a fully referenced paper was made ready for the day of the meeting to support the discussion. With great expectation the Maternity Department waited to be informed of the date, time and venue and were somewhat surprised to be informed at 17.30hrs on the 12th September that representatives of the CAG team were visiting at 11.00hrs the following day.

In spite of the short notice, understanding the importance of this meeting, senior members of the team made arrangements to meet with the CAG only to be greatly disappointed by the outcome. In the first instance the CAG refused to sit down stating they "preferred to take a walk around the department in order to get a feel of it". They stated categorically that it was not their remit to answer questions or to review evidence provided by the team and stood by their decisions based on the options given to them by the TSA. When asked about the process they followed and evidence used they were vague and uninformative stating only that they had been given options to look at and from those they had made their recommendations to the TSA. They refused to listen to details within the paper made available to them and to be challenged on any "evidence" they may have looked at to support them in their decision making. It was only after great persuasion that one member of the CAG accepted the paper which he said he "would look at later". They did however advise the team to give the paper to

the TSA as "they would be the group making the final decision". The visit took approximately 20 minutes which included a tour round the department.

On meeting with the TSA on the 18th September those present expressed their disappointment of the meeting only to be informed by the TSA that the purpose and intention of the CAG meeting on the 13th September was to get a "feel for the place" and it was still the intention that the Head of Midwifery and Clinical Lead would meet with the CAG in London. The TSA went on to explain that they had arranged their final meeting with the CAG in October and it was intended that the Maternity team would meet with them on the same day. When asked if the TSA were to meet with the CAG team before or after the Maternity team the TSA stated that "the times had not yet been set".

The team are now left confused and disappointed and have been left to draw their own conclusion. In fairness the TSA have asked that a copy of this report is forwarded to them both in hard and soft copy however it does appear futile as the CAG, by their own admission, will not be drawn into discussions and do not see it as their remit to review any further evidence and yet the TSA are basing their proposal on information provided by the CAG!

Future Consideration

The Maternity Department recognises the need for change and that to survive moving forward within the new world of Clinical Commissioning Groups (CCGs) change is inevitable. We accept that the CCG's refusal to commission Maternity Services weakens our argument to retain the Maternity Unit at Stafford. When asked what the process for informing the CCGs of which services they would consider for commissioning, the TSA stated that they were provided with a list of options one of which included the prospect of providing care for around 1800 women to be delivered at Stafford. It is therefore not unsurprising that the CCGs refused to commission the services. The TSA again missed the opportunity to consider the potential of developing the services and to regain women within its

geographical boundaries which if taken along with the predicted population growth would undoubtedly reach the "magical" 2500 figure with the potential to approach 2800 by 2030.

The Maternity Department feel this could be achieved by forming an alliance with one of our neighbouring Trusts. We feel there is an opportunity for clinicians and managers to open up discussions on the reality and potential of providing a long term sustainable solution.

Benefits would be:

- Mapping of geographical needs and increased understanding of population needs
- Cohesive approach to reconfiguration of workforce to comply with locality needs
- Integrated pathways of care that would enable the smooth transition of women and babies throughout the geographical area
- Joint training opportunities with skills and competencies being maintained
- Provide real choice to women
- Stop unnecessary new builds and save money long term
- Provide a long term solution rather than a short term fix
- Maintain low perinatal mortality and morbidity rates

Conclusion

The Maternity Department feels that the TSA have produced a short-sighted report that lacks evidence. This we believe will ultimately place tremendous pressure on our neighbouring units that will not only comprise quality but also safety of care. We recommend that the Maternity Unit is given the opportunity to work alongside our neighbouring units to consider an alliance that will provide long term stability.

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Mr ref: BRG.ajo

24 September 2013

The Trust Special Administrators of MSFT

TSAconsultation@midstaffs.nhs.uk

Dear Sirs

Medical Education at Stafford Hospital

The Medical Education Centre at Stafford Hospital is a charitable facility which has been the centre of post-graduate and under-graduate education since 1986. During that time, the Centre has enlarged many times to accommodate the increasing number of under-graduate students, mainly from Keele University, but also from many other parts of the World, and around 150 post-graduate trainee doctors who work at Stafford and Cannock Hospitals. Trainee doctors are a very important part of the medical staffing of any hospital as they provide much of the routine day-to-day care of patients. Unlike consultants, they are on the Hospital sites for the whole of their hours of work and are very important to the continuity of care of patients in their own specialty. They also provide a vital contribution to the emergency care of the acutely unwell patients presenting to the Hospital.

The TSA's recommendations do not seem to have acknowledged the existence and contributions these doctors make to the running of Stafford and Cannock Hospitals in their consultation document. One of the major recommendations in the consultation document is a loss of the obstetric services. If this is to occur, then it is almost certain that the Obstetric and Gynaecology Department will lose training recognition for their trainee doctors and this would make the future of the gynaecology part of the service also non-viable. Trainees in obstetrics and gynaecology need the obstetric part of their training and, as training is time limited, any time spent without that training is likely to be viewed poorly by the education authorities and trainees are unlikely, therefore, to be placed in Stafford Hospital at all.

Furthermore, there will be an immediate knock on effect to the training of both paediatrics and to anaesthetics in particular, if an obstetric department is not present in our Hospital.

It is a requirement of anaesthetic training that trainees have an obstetric exposure as a part of their training programme. If such an exposure is not present, then it is unlikely that anaesthetic trainees will be sent to Stafford Hospital for their post-graduate experience.

Over the last 15 years, since the formation of Keele University Medical School, Stafford Hospital has become a very popular site for under-graduate trainees from this medical school and from other medical schools throughout the World. Students report an enormous, clinical exposure which is frequently on a one-to-one basis and this is unique to their under-graduate experience when, frequently, groups of many students participate together with fewer patients and the learning experience, therefore, tends not to be so great. Students tend to regard their training time at Stafford as some of the best of their whole under-graduate experience and, feedback from them over the years has reported how they feel included in the clinical teams.

These are just two of the many responses received over recent years by medical students attending Stafford Hospital for their undergraduate education.

"I love this hopsital so much! Never have consultants given so much time and effort to teach and encourage a student to learn and be a better doctor for the future".

"Thank you for making our year at Stafford such a great experience! You provided such a welcoming and comfortable atmosphere to learn and practice in, ensuring we will never forget the warmth of Stafford Hospital."

The consultation document also places some surgical and some medical services under threat of continuing at Stafford, particularly emergency surgical admissions. For many years, certain surgical and medical services have been provided at other hospitals, particularly UHNS and in Birmingham, but these are specialist services which usually have their outpatient clinics at Stafford and include cardiothoracic surgery, radiotherapy, plastic surgery, neurosurgery, paediatric surgery etc. More recently, major upper gastro-intestinal surgery and arterial surgery have also been transferred to larger units, but these services continue to be provided in Stafford, and ensure valuable training opportunities for both undergraduates and post-graduates.

However, one of the key elements to both post- and under-graduate training in surgery is the exposure to an assessment of the unselected acute surgical take and if this is absent then further denigration of surgical trainees will occur and there will be a failure of recognition for this Hospital by the medical teaching authorities. The Hospital's consultant medical staff of the future is usually dependent upon the experience that under- and post-graduates have within the Hospital. Any diminution in the education received by trainees at this Hospital will have a knock on effect in ensuring that the Hospital is unable to attract consultants of the future.

The future survival of the Medical Education Centre at Stafford, which is widely regarded as being one of the most attractive centres in the UK will, by necessity, be threatened by the loss of trainees. This would not only be a loss to the Hospital and its staff but also the district as a

whole as this Centre provides medical education facilities for GPs, dentists, nurses, and many paramedical technical services beyond the hospital services.

We see this loss as a genuine possibility as much of the funding of the Centre comes from the Hospital and associated district and if the proposed reduction in services at Stafford Hospital proceeds as suggested in the consultation document, it is unlikely that subsequent funding of the Post-Graduate Medical & Education Centre will be sufficient to maintain viability. You will be aware that continuing medical education is a requirement of the GMC and, as such, this would then become difficult to obtain locally.

The Board of the Mid Staffs Medical Education Centre would like to see some recognition of this remarkable facility by the TSA in it's consultation document and the consequences of its proposals on the future of this centre.

With kind regards

Yours sincerely

Brian R Gwynn MD FRCS FRCS (Edin)
Consultant Surgeon and
Trustee and Director of the Mid Staffs Medical Education Centre

Dear Alan, and Hugo,

I have one or two concerns about your proposals which I would like to share with you please.

I understand that none of our local "partner" hospital were willing to commission a maternity service here at Stafford but my wife and I are very concerned that local women and babies will be placed at considerable risk if the journey for their labour is prolonged as a result of having to go to another hospital, rather than Stafford. This is particularly the case for "at risk" pregnant mothers.

I am also somewhat concerned about the plan to reorganise/relocate the paediatric service. This is an excellent service here at Stafford providing a good local service for families in this area.

My major concern is the plan to open only a few level II beds in the Emergency Department and lose the excellent High Dependency Unit which we currently have. About once a month I am the manager on call and I know at times how difficult it is to obtain high dependency beds for all the patients who come through the Emergency Department and for those few who require intensive care support who are already in-patients.

During a recent on-call session we transferred to patients away from the Emergency Department because our intensive care unit was full of patients and could accept no more. I fully understand that I'm not a clinically-based person and therefore don't have the background knowledge, perhaps , however I feel that this is not a good move.

Neither can I properly understand the rationale that led you to the decision to close the Aseptic Unit in pharmacy. Is this hospital is still to provide an oncology/chemotherapy service I would have thought that this aseptic unit was still required?

I am also a little puzzled as to your modelling of the local health economy and in particular the demographics within Stafford. I would have thought that, as the borough increases in size. there would be more need for locally-based services as a clinically networked and increasingly financially stable hospital rather than less.

We have all seen a recent upsurge in work, as this hospital's reputation (rightly) recovers and I feel this demonstrates a need for comprehensive services on this site. I recognise that according to your statistics, more than 91% of patient visits would remain the same, but I am uncertain whether your model will truly accommodate the changes that are going on in our vicinity.

I am also a little worried about how much modelling you have done in the other two areas, that is, Stoke and the surrounding towns and Wolverhampton/Walsall where there are similar changes going on, I'm sure. I am concerned that if this work has not been conducted. We may simply be putting the burden on other local health economy is and not actually helping them all ourselves.

For myself and my colleagues in Histo pathology, we have long been resigned to the "cold laboratories" moving off-site up to the University Hospital of North staffs, and this seems to make sense, particularly as we are having recruitment difficulties for both technical and medical staff within pathology. I am however somewhat sceptical about the volume of savings claimed for the overall changes to the pathology department in your proposal.

Regards

Glyn

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Ref: TP/DS/

26 September 2013

Professor Hugo Mascie-Taylor
Trust Special Administrator
Stafford General Hospital
Weston Road
Stafford.

Dear Professor Mascie-Taylor

The Rheumatology Department at Cannock Chase Hospital has a national reputation for excellence in the care of patients with rheumatic disease. It is also highly regarded as a centre for translational research in its Clinical Trials Unit.

As a department, we have discussed the TSA's recommendations for the future of the Foundation Trust, and in particular the proposals for Cannock Chase Hospital, in our multidisciplinary monthly meeting. We are broadly supportive of the TSA's recommendations, including those relating to day case procedures, both medical and surgical, and the suggestion that beds continue to be used for recovering patients, making best use of the excellent rehabilitation facilities. We are in the process of consulting our patients about their views through the forum of our Rheumatology Users Group. Preliminary discussions suggest that they would also support the TSA's plan in respect of the department and the hospital.

We should like as a department to record our decided preference for a partnership with the Royal Wolverhampton Hospital NHS Trust (RWT), rather than the Walsall Healthcare NHS Trust. We feel that RWT would provide the best opportunities to develop our services and in particular, to further our research aims.

We have discussed a possible merger of our rheumatology department with our colleagues at RWT. They are also in favour of the plan, which would enable the development of a centre of excellence for the management of rheumatic disease, and of a research unit of the highest order, which would make best use of the links with the immunology team at Wolverhampton University.

Our principle concern about the process is the length of time that it would take to manage the merger. A period of two to three years has been discussed, which would potentially stifle any discussions about new initiatives and developments in our departments, as well as preventing necessary expenditure on maintaining the fabric of Cannock Chase Hospital.

We will continue to see our patients in peripheral clinics. This includes mour patients in Stafford and all our other outreach clinics.

We should like the TSA therefore, to take note of our support for a merger with RWT, and in particular the merger of the rheumatology departments, with the creation of an enlarged research unit under the umbrella of the Local Clinical Research Networks, the organisation of which is to be coordinated from Wolverhampton. We should also urge the TSAs to do all in their power to ensure that we can start to develop our respective units and to make best use of the excellent facilities at Cannock Chase Hospital, without delay.

Yours sincerely,

Dr T P Sheeran, MD, FRCP.
Clinical Lead for Rheumatology.

Dr T Price, FRCP.
Consultant Rheumatologist.

Diarmuid Mulherin, MD, FRCPI .
Consultant Rheumatologist.

Dr S V Chalam, MD, FRCP.
Consultant Rheumatologist

Dr Sangeetha Baskar MBChB, MRCP.
Consultant Rheumatologist.

Dr M Amissah-Arthur MBChB, MRCP.
Locum Consultant Rheumatologist.

Dr T Dimitroulas MD, MSc, PhD.
Locum Consultant Rheumatologist.

MSFT Cardiology Department Response to TSA Recommendations

Authors: Dr Ian Crossley Consultant Cardiologist/Clinical Lead
Mrs Kathy Harding Cardiology Service Manager
Sr Lesley Sprason Cardiac Cath Lab Manager

There was an open meeting on Friday 20th September and this response is based on comments and opinions of staff attending. There was representation from cardiac catheter lab, consultant cardiologists, cardiac nurses, cardiac physiologists (for cardiac diagnostics), cardiac rehab & admin and clerical to the above services.

The services of cardiology are fundamental to the provision of safe & effective care to patients across all disciplines within Mid Staffordshire Foundation Trust and also to the local population via comprehensive GP open access services. These services have been developed to provide access to safe & effective care close to patients' homes. The belief is that the TSA's recommendations will lead to inequality of access to cardiac services for the population of Stafford and surrounding areas.

It is necessary to say that the overall opinion of the department is that the outcome of this process is predetermined.

Response to Recommendations
Emergency and urgent care at Stafford Hospital
It is agreed that Stafford should have an A & E department & it is recognised that to enable 24 hour access, it will require partnership working with neighbouring Trusts. The reduction in service has already led to inequalities of access. This has resulted in sick people being delayed or discouraged from attending A&E which will be further compounded by the TSA proposals with the inevitable down grading of A & E ultimately leading to its closure.

In-patient services for adults at Stafford Hospital
The TSA report suggests that all patients with cardiac problems such as 'heart attacks' currently go straight to UHNS. Whilst this is certainly the case for patients suffering from ST segment elevation Myocardial Infarctions who are taken directly to Heart Attack Centres at neighbouring Trusts, this is not the case for all other acute coronary syndromes and any other cardiac conditions.

There must remain provision for in-patients with cardiac conditions including those with acute coronary syndromes. This will require a coronary care unit where patients will be monitored by specialist cardiac trained nurses & reviewed on a daily basis by a consultant cardiologist. In addition there must remain specialist cardiology service to facilitate a safe and effective patient experience including timely access to cardiac diagnostics. There must also remain the ability to provide pacemaker implantation.

Maternity services & Services for children at Stafford
This will have a minimal impact as the majority of services provided by cardiology is on an outpatient basis.

Major emergency surgery at Stafford Hospital
As this service is closely linked with critical care this will further compound the effects of the recommendations to downgrade acute services as it will not only affect critical care but also A&E services.

Critical care at Stafford Hospital
The staff of cardiology strongly believes that the maintenance of critical care services at Stafford Hospital is fundamental to its future as an acute hospital. Downgrading the critical care to providing level 2 care and transferring those patients who need level 3 care will radically affect the type of patient that can be admitted/managed at Stafford Hospital.

There are also concerns around the sustainability of the resuscitation team with the downgrading of this service.

Elective care and day cases at Stafford Hospital
If this is to remain in its current form then there will be no impact on cardiology services, however, if there is an increase in activity then this impact will have to be assessed as it may have an effect on cardiac diagnostics.

Step down care and rehabilitation, Elective in-patient surgery & Day cases (surgical & medical) at Cannock Chase Hospital
If there is an increase in activity at Cannock Hospital then this impact will have to be assessed as it may have an effect on cardiac diagnostics & rehabilitation.

Organisational plans for Mid Stafford NHS foundation Trust
It is accepted that networking solutions are inevitable and can work for the benefit of patients. This however should not have the negative impact that the proposals currently suggest of downgrading essential services i.e. acute & emergency care at Stafford Hospital. This will maintain equality of access to these services for the local population.

Concerns were raised around the cost of preparing neighbouring Trusts to facilitate these proposals and that this money could have been invested into Stafford & Cannock hospital sites. According to the TSA the best financial outcome is that there will remain a financial deficit of £8.5million.

Final comments:
The staff within the Cardiology Department are forward thinking & innovative. There are already established patient pathways that span two sites within MSFT and neighbouring Trusts. Change is inevitable in a progressive speciality however; there will always be resistance when this change is to the detriment of the patients to which it serves.

25th September 2013

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Trust Special Administrator
c/o Mid Staffordshire NHS Foundation Trust
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30 September 2013

Dear Mr Bloom

Re: Maintaining high quality, safe services for the future

Thank you for the opportunity to respond to the Trust Special Administrators' ('TSAs') draft recommendations on the future of services currently provided at Stafford and Cannock Chase Hospitals.

The Secretary of State's decision later this year will represent the culmination of several years of uncertainty for our community and our staff. It is not necessary to revisit here the painful lessons of our past other than to say that, whatever the future holds, we are confident that our staff will continue to put our patients' interests first. Our patients tell us, and the indicators show, that good progress is being made. We have addressed the quality and safety of our services and continue to rebuild trust with our community. The priority now is to maintain our resilience and not to lose momentum or the gains we have made.

The TSAs' recommendations represent a unique opportunity for the NHS in Staffordshire. The changing needs of our population, technological and scientific advances and the relentless economic challenges underline the case for change. We strongly believe that standing still and standing alone is not a realistic option. Working together with our local partners represents the best way forward.

We have left it to others to comment on the detail of the recommendations and will confine our comments to matters which will be relevant to implementation, should the Secretary of State endorse the changes.

Before we do that, we would like to take this opportunity to thank everyone involved in the development of the options and the consultation process. Firstly, our staff who, through this period of uncertainty, have continued to work tirelessly to improve services to our patients. Their commitment and loyalty have been unwavering and many have taken the opportunity presented by the TSAs to engage and contribute to the consultation process.

Becausewecare

Secondly, our community and community leaders for their support and to the many who have also contributed to the consultation process. We are confident this support will continue into the future.

Finally, the TSAs for listening to our community and staff. We know the TSAs will give their fullest consideration to their deeply felt views about our services and recommended changes and use it to help shape the final recommendations to be submitted to the Secretary of State.

We have already touched on the impact of the recent period of uncertainty. Whilst we recognise that there will be those who do not agree with all of the recommendations, we are confident that we speak for the majority when we ask that a clear decision is made and that this decision is made quickly. This will give certainty to everyone and allow staff to get on with the job of providing high quality and safe care to our patients.

Any temptation to delay a decision should be resisted. We hope everyone involved will recognise that continued uncertainty will have a debilitating effect on our work to improve standards and to recruit and retain the very best people. We believe a safe transition and continued safe care is best achieved by the early introduction of a new organisational structure.

Inevitably there will be a sense amongst some staff at Stafford and Cannock Chase Hospitals that they will be treated as second class citizens by our future partners. The recommendations will offer an opportunity to reappraise how services can be best organised, clinically led and managed and to select the very best people to lead the NHS in Staffordshire. We would ask our new partners to ensure those associated with Stafford and Cannock Chase Hospitals are treated equitably and fairly.

The current Executive Team members were brought into the Trust with the specific objectives of improving services and rebuilding trust with the local community. We have, we believe, made solid progress and, we remain committed to this process. We are confident that this good work will be built upon and the people of Staffordshire will be able to enjoy some of the very best services offered by the NHS.

You have our assurance that our focus is firmly on supporting the health economy plans for the coming winter months and maintaining the safety and wellbeing of our patients.

Yours sincerely,

Maggie Oldham

Maggie Oldham
Chief Executive
Signed for and on behalf of the Executive Team

Becausewecare

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Medical Division
Clinical Director: Dr Charles Spencer MD, FRCP
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30th September 2013

Submission to the Public Consultation on the TSA's Proposals for restructuring services at Stafford and Cannock Hospitals on behalf of the Medical Division.

Dr Charles Spencer MD, FRCP –Clinical Director, Medical Division.

Scope

This response covers acute and specialist Medicine. Separate responses have been submitted on behalf of A&E and Paediatrics which are part of the Division.

Assumptions that other services are removed or downgraded should not be taken as an endorsement of such reductions.

We recognise that there is a case against the overall scope and scale of proposed service reconfiguration to achieve safe, sustainable hospital services in mid Staffordshire. It is noted that the proposals involve major disruption of services, vast (up to £300 million) one off costs and do not achieve financial break even. My colleagues and I have views on the overall process which we may wish to express as part of the consultation but these do not fall within the scope of this document.

The TSA has requested that financial calculations are not included at this stage (Prof Mascie-Taylor, Consultant Staff Committee meeting 25th September 2013).

Methodology

This response takes into account formal and informal consultations with staff and clinical leaders in the departments that make up the division.

The Current Model

Stafford Hospital currently runs a safe, clinically sustainable, largely unselected (with the exception of ST elevation myocardial infarctions and acute stroke) acute medical take. Patients are admitted via A&E between 8am and 10pm 7 days a week and pathways are in place for admissions via GPs and some selected patients from the ambulance service 24 hours a day although the latter are not well used.

Despite the temporary overnight closure of A&E in December 2011 and uncertainties around the future of the hospital the number of patients using the service has not fallen with a similar number being admitted in 14 hours now compared to in 24 hours previously. Currently around 25 patients are admitted under Medicine each day and further ~10 patients are assessed by physicians but not admitted. Further patients with medical conditions are assessed by A&E doctors but not referred on.

Radical changes to the service have been made, led by senior clinicians since the well-publicised failings of care at Stafford between 2005 and 2009. The service is largely delivered by consultants with a consultant on site, leading the acute take between 8am and 8.30pm.

The model is based on an Acute Medical Unit rather than a Medical Assessment Unit. Patients requiring a stay of 72 hours or less are treated in a single area with intensive consultant input from acute physicians and specialists to progress their management in a safe, efficient manner. The majority of patients are treated in this area with a smaller number needing longer stays or intensive specialist input being transferred to speciality wards.

The service is safe with statistically significantly lower standardised hospital mortality rates than would be expected over the last 4 years. Its mortality rates have been lower than any other hospital in the West Midlands over the same period. Mortality rates for every single one of the 56 diagnostic groups that make up the HSMR have been lower than expected over the last year. These rates are adjusted for casemix and cannot be attributed to sicker patients being treated elsewhere.

The service has high rates of patient satisfaction.

Statements in the consultation document that all 'heart attacks' and suspected meningitis are not currently treated at Stafford are inaccurate and misleading.

The service is sustainable with 16 consultants making up the on take rota. Until the Trust went into special administration there were no significant difficulties with consultant recruitment. Over the last 5 years we have made consultant appointments in all the major specialities that make up the directorate including Cardiology, Gastroenterology, Respiratory Medicine, Elderly Care and Stroke Medicine, Haematology, Endocrinology and Acute Medicine.

The service trains large numbers of junior doctors from the West Midlands Deanery and has good training reports. These doctors make up a large part of the workforce.

The service trains significant numbers of undergraduate medical students from Keele University.

The service is operationally sustainable. Although like many acute hospitals we have challenges around demand and capacity our A&E 4 hour performance is just below the 95% target this year, and comparable with many peer organisations.

We have some of the best ambulance turnaround performance both regionally and nationally.

The service operates within its allocated budget.

The service relies on other departments within the hospital to be sustainable. These include, in particular, Critical Care, General and Orthopaedic Surgery, Imaging and Pathology.

The TSA's Proposed Model

The model proposed under the TSA model envisages a significantly reduced medical take dependent on very careful case selection to maintain clinical safety. No figures are advanced for the number of patients felt to be suitable for this reduced service.

The model has no on site ITU with very limited facilities for sicker patients and a model of immediate transfer for any patients requiring critical care. No example of a successful such model is advanced. Careful patient selection is required to avoid patients needing or likely to need critical care being brought to Stafford.

The model has no access to a surgical opinion for medical patients at Stafford except telephonically. Any patients needing to see a surgeon would be transferred whether they needed an operation or not.

The model is based on a Medical Assessment Unit which is significantly different from the current Acute Medical Unit. This is described as being staffed by Geriatricians during the day and Nurse Practitioners (not doctors) at night. Overall the model envisages 70% of emergency admissions (not just medicine) going elsewhere.

Critique of the TSA's Model

The model is too small

The TSA's model envisages that around 30% of patients who live to the South of Stafford's catchment area will, in future be treated at hospitals in Walsall and Wolverhampton. This would fit with Cannock Hospital being transferred to another provider. This alone would reduce the number of patients admitted under medicine to around 17.

The TSA estimates that 10% of patients would be too sick to be admitted under the proposed model. My colleagues and I believe this is a significant underestimate that is not backed by detailed analysis.

Although only a small proportion of the medical patients are admitted to ITU currently, a much larger number have conditions that could rapidly deteriorate to need ITU admission. It is generally accepted by Intensive Care specialists that the transfer of acutely ill patients requiring ITU is undesirable and compromises patient outcomes. To avoid this happening a much larger patient group would have to bypass Stafford to prevent the routine transfer of sick, unstable patients.

For example, patients with chronic obstructive pulmonary disease may need invasive ventilation and ITU care. The overall numbers are small but a much larger number need non-invasive ventilation (NIV). If NIV fails, immediate institution of invasive ventilation may be needed. A further, larger group are unwell on admission and have respiratory acidosis. Current guidelines require these patients to be given NIV if they fail to respond to optimal medical treatment within one hour. A further group are unwell but not acidotic but this can only be confirmed once they are in A&E. Thus, although only a small number of patients are ventilated on ITU, an exponentially larger number of patients would have to be treated elsewhere to make the model work within acceptable parameters of safety. There would be an understandable tendency for paramedics and GPs to err on the side of caution and send patients elsewhere. Of the remaining patients, a large number could be treated in

their own homes under proposals to expand community care. Similar examples exist in other specialities.

A proportion of medical patients require access to a surgeon. These include those with proven or suspected GI bleeding, inflammatory bowel disease and diabetic vascular disease. Most of these could not be treated within acceptable parameters of safety under the proposed model.

Overall, the highly selected nature of the medical patients who would be suitable for admission under the proposed model and reduction in catchment area would significantly reduce the number of patients using the service. This number could be as low as 12 in 24 hours. My colleagues and I do not believe it would be viable or sustainable to provide a service for such a small number.

The model could not be made to work

No example of a similar model is advanced by the TSA. There are significant differences between the model and examples of a medical take in a multi-site trust we have examined in Canterbury and Solihull. In particular we are not aware of a credible, unselected acute medical take on a site without an ITU.

Although there are models of a critical care retrieval services in paediatrics and trauma, there is not one for adult medicine. These services operate on the basis that transfer is the exception rather than the rule and are a back up to careful case selection (with the exception of trauma in remote areas). They work because all hospitals in a region use them. An adult model of retrieval would only be sustainable if all small to medium hospitals in the larger area ran without ITUs and transferred sicker patients. We do not advocate such a model.

The proposal to mitigate this risk by having an anaesthetist based in Stafford just in case they were needed would leave them with no work at all on most shifts and does not seem to make practical or financial sense. If they are to be on site it would be better to use them to actually provide critical care.

The proposed model could not be staffed

The TSA states that it would be possible to staff the model at a consultant level. They make no statement as to middle grades and trainees. The clinical advisory group (CAG) in a heavily caveated letter states that if doctors in training are to be included in the model that it must be ensured that they have the required learning and experience. The CAG do not state that they believe this would be the case.

With no ITU and a highly selected medical take it would not be possible to retain specialist registrars in the major medical specialities due to insufficient breadth and complexity of cases seen except perhaps, in elderly care. Middle grade doctors are essential to maintaining a safe effective medical take unless the huge expense and recruitment difficulties of a 24-hour consultant delivered take are envisaged. In the current immigration climate it is highly unlikely that staff grades could be recruited to fill the gap. Although we use nurse practitioners extensively, we do not believe a service without a middle grade physician on site at night to be clinically safe.

For similar reasons the core medical trainees, foundation doctors and General Practice trainees would be highly unlikely to be able to fulfil their training requirements in a highly selected take at Stafford.

Even with rotation with Stoke it is unlikely that posts that involve a significant time in a clinical setting that does not meet training requirements would be approved by Health Education West Midlands.

With no junior doctors it is highly unlikely the service could be sustained on consultants and specialist nurses alone.

The Proposed model is not what patients want

The proposed model consists of a highly selected medical take aimed mainly at elderly patients. Although younger patients are not excluded there is no evidence that they would find such a service acceptable. There is a significant risk that they would self present elsewhere.

Similarly, although Elderly Care is a skilled speciality in its own right, the trend over the last 2 decades is a move away from an age-stratified service with a risk of second class access to advanced medicine for older patients. Even frail elderly patients can benefit from carefully considered advanced medical interventions. Today's savvy, internet using elderly are unlikely to find a downgraded, age stratified service acceptable.

We believe, for the reasons outlined above that it would be very difficult to establish the acute medical service as proposed in the TSA's recommendations. Even if established, we believe that there is a high risk of failure within a short period of time due to safety concerns, staffing difficulties or low use. The risk of failure would be particularly high in any transition period and could be highly destabilising to the whole health economy. Even with such a unit in place large numbers of patients would have to be treated elsewhere and significant capital and staffing investment would be needed. Significant space at Stafford would be underutilised but still subject to capital charges, maintenance and depreciation.

Our Proposed Better Model

My colleagues and I believe that change is both needed and desirable to make services at Stafford Hospital fit for the future.

We believe that by modest advances on the TSA's proposed model a safe, sustainable Medical Take can be retained at Stafford. This would avoid the major capital costs of moving large numbers of cases elsewhere and would be consistent with the principle of providing services close to patients wherever it is clinically and financially possible.

The Royal College of Physicians' Future Hospital Commission Report should be the blueprint for such services. This places the Medical Division at the heart of the future hospital. Future services should be built around the Acute Care Hub as envisaged by the Royal College. The core of this should be Acute Medicine and Elderly Care but with extensive input from the major medical specialties. The unit should include ambulatory care. The service should be embedded in the community with vertical integration of specialist medical and nursing services.

The key to a safe sustainable model is access to on site Critical Care and senior surgical decision makers. This could only be done in partnership with a larger hospital which almost certainly would be the University Hospital of North Staffordshire (UHNS). The model envisages a full integration of clinical services on the basis of 'one hospital, two sites' rather than the looser concept of a network. There should be a single clinical management and governance structure across both sites with the patients' best interests as the key principle in deciding where they are treated.

The model should not be constrained by conventional views of a District General Hospital critical care unit and may require a degree of innovative thinking. Nevertheless, it should be recognised as safe, sustainable and staffable by the Royal Colleges and the Intensive Care Society. The unit needs to be affordable within the context of the larger model even if it costs more than the original TSA model. Any additional cost needs to be offset against reduced capital spend on reconfiguration and better usage of existing estate.

The detailed description of the proposed unit is being worked up and submitted to the consultation by my Critical Care Colleagues. The unit should be a key part of the Acute Care Hub described in the Royal College of Physicians' Future Hospital Commission Report. In summary, all patients needing higher than ward level care should be concentrated in a single clinical area for sicker patients staffed by a single, multidisciplinary team led by intensivists but with major, 7 day a week input from Cardiologists, Respiratory Physicians and where needed, other specialities. This service would include not only patients who would use the current critical care unit but also those requiring non-invasive ventilation, cardiac care and level 1 care who are currently cared for in dispersed locations around the building. The unit would have the capability to treat patients needing invasive ventilation and organ support recognising that in some complex cases planned transfer to the larger unit at Stoke may be appropriate. Conversely some Stafford residents requiring prolonged ventilatorary support after an episode of complex critical care could be transferred to the Stafford site to be more appropriately treated with rehabilitation, including friends and family being a major part of their therapies. There would be 24 hour middle grade medical and intensivist presence on site. Management decisions would be made by consultants from a single critical care department with appropriate rotas covering each site in conjunction with respiratory, cardiology and other colleagues. These are well described in the Critical Care proposal submitted.

Nursing staff would likewise maintain their skills and portfolio as a part of a cross hospital nursing cohort and have the appropriate skill mix to enable them to care for the wider variety of patients with rotations between units. This would give breadth of experience and resilience of staffing rotas.

Bringing together all the sicker patients on the Stafford site into one location has obvious benefits for patient safety as well as bringing economies of scale that would improve its financial viability. The presence of such a unit would give GPs and the ambulance service confidence in bringing patients to Stafford Hospital and would reassure the public.

The TSA envisages the provision of day case surgery at Stafford and recommends that a range of elective surgical procedures are retained. We believe UHNS to be interested in providing a range of elective in-patient general, orthopaedic gynaecological and other surgery on the Stafford site. This would bring senior surgeons to the site on a daily basis and would require out of hours cover for elective surgical in-patients. While much of this cover could be provided by a hospital at night team

especially if it included an intensive care middle grade there would have to be a senior surgical decision maker on call with the ability to attend the Stafford site. We recognise that surgery is increasingly sub-specialised. It would not be best practice, for example to seek the opinion of a breast surgeon on an abdominal problem. The majority of calls for surgical input to medical patients are gastroenterological. With a large combined surgical department for the two sites it would be possible to job plan a GI surgeon to be available to give an opinion on a daily or twice daily basis. Consultants and their teams from most other major surgical specialties would be present on the Stafford site on most days and available to see ward patients. This could be incorporated into the job plans of surgeons who are primarily based in Stoke. It is recognised that a small number of patients who need immediate surgical assessment would have to be transferred urgently to Stoke however, the vast majority of medical patients who need input form a surgical team such as those with inflammatory bowel disease could be retained in Stafford. While our critical care model is not dependent on surgical patients, its presence would enable a wider variety of elective surgical and orthopaedic patients to be treated on the Stafford site if that were considered desirable.

We believe that with a credible critical care solution and access to surgical decision makers in a one hospital, two site model the vast majority of medical patients currently treated in Stafford can be retained. The service would be regarded as safe and attractive to patients and could take some patients from areas such as Stone who have previously used Stafford but chosen Stoke following the now rectified failings in care at Stafford. It would give a single organisation the ability in conjunction with ambulance service, to flex the medical take across the two sites at times of high demand. It would reduce the need for major capital investment on the crowded Stoke site and could be implemented rapidly.