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 B

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 B

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.

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

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- Councillor Ann Edgeller
- Councillor Adrian Knapper
- Dr Johnny McMahon and Councillor Robert Marshall
- Hednesford Town Council
- Staffordshire County Council
- Staffordshire Moorlands District Council
- Cannock Chase Council
- Walsall Council
- Staffordshire County Council, Healthy Staffordshire Select Committee

Continued in Volume 2, Part C

1. National Bodies

NHS
Trust Development Authority

NHS TDA response to the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals

1. This document sets out the response from the NHS Trust Development Authority to the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals. It draws on the consultation document issued on 6 August as well as a range of detailed discussions which the NHS TDA has undertaken with the Trust Special Administrators, the NHS Trusts likely to be affected by the proposals, and other partner organisations.

2. The role of the NHS TDA is to support NHS Trusts to deliver high quality, sustainable services for patients. Our particular interest in the proposed changes at Stafford and Cannock Chase hospitals therefore centres on their impact on the surrounding NHS trusts: University Hospitals of North Staffordshire, The Royal Wolverhampton Hospitals, and Walsall Healthcare. The NHS TDA recognises the need for urgent change in the Staffordshire health system and the need for NHS trusts to play a constructive part in achieving improvements for patients. Both locally and nationally, organisations will need to work together to solve the issues identified in the TSAs' draft report.

3. The NHS TDA has worked alongside the affected NHS Trusts to examine the TSAs' proposals from a clinical and financial perspective. It is clear that the proposed clinical models for both the Stafford and Cannock sites are likely to offer safe and effective services for local patients and have the potential to improve quality compared with current services provision. We believe the local NHS Trusts have the capacity and capability to deliver the proposed clinical model provided there is appropriate investment over time to support this.

4. Our current assessment of the financial implications of the TSAs' proposals does, however, give cause for significant concern. The TSAs' draft report identifies a revenue shortfall of £8.5m across the proposals, but our work with NHS Trusts indicates that in reality this shortfall is likely to be considerably higher. The difference is driven predominantly by the analysis of the impact of the transfer of the Stafford hospital site to University Hospitals of North Staffordshire, which we believe will have a net revenue cost to UHNS that is significantly higher than the £5.5m estimated in the TSAs' draft report.

5. In addition to the significant difference in revenue estimates, we support the view of the affected NHS Trusts that the cost of capital improvements at both the Stafford and Cannock sites is likely to significantly exceed the TSAs' estimates. It is clear in addition that receiving organisations will require significant transitional revenue support to cover the costs of integrating services and realising productivity opportunities, potentially over a 5 year period.

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NHS
Trust Development Authority

6. Given the importance of the TSAs' work, we have offered significant challenge to our organisations to ensure that their financial proposals are realistic and that the scale of support required has not been overstated. We are confident that potential receivers have made stretching but realistic productivity assumptions and that the bottom-up costing of the proposed clinical models is robust. Importantly, however, the detailed due diligence process remains to be undertaken and our final view on the proposals needs to be taken in light of this process.

7. It is clear therefore that significant further work is required to ensure that the proposed clinical service model can be delivered sustainably. The NHS TDA suggests that there are three core elements to this work:

   I) Potential receiver organisations need to undertake due diligence – both financial and clinical - on the proposed changes in order to come to a more definitive and shared view about the implications and to assess the precise scale of financial risk, which currently appears very high.

   II) We need to look more broadly at the potential for further savings across the health economy, and particularly to engage local community providers in this process. By bringing community services within the scope of the work, the TDA feels that further efficiencies can be generated, and

   III) In the event that these processes cannot deliver an agreed and sustainable financial position, we need to consider with commissioners what further investment is possible to support the clinical service model. This might include considering the case for a permanent tariff subsidy to support the proposed local services.

8. The TSA's proposals provide a clear vision for the future of clinical services in Staffordshire, but considerable further work is still required to ensure that the model can be delivered sustainability. The NHS TDA remains committed to achieving a viable solution through the processes proposed above and to ensuring that the affected NHS trusts continue to play a constructive role in the process.

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Public Health England

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Mr Alan Bloom
Joint Trust Special Administrator
Office of the Trust Special Administrators
Mid Staffordshire NSH Foundation Trust
Stafford Hospital
Weston Road
Stafford
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1 October 2013

Sent via email

Dear Mr Bloom

Re: Consultation on the draft recommendations on the future of services for local people using Stafford and Cannock Chase Hospitals

Thank you for your letter of 6 August 2013 seeking feedback from Public Health England regarding the consultation for the draft recommendations on the future of services for local people using Stafford and Cannock Chase Hospitals.

Public Health England has no formal feedback on the questions posed in the consultation which are a matter for local determination. We do however have an interest in the impact of the proposals on the health of the population served and in the opportunity for health improvement and the reduction of inequalities. We would like to request that we have access to the report that the Health and Equality Impact Assessment Steering group produce as a result of the proposed recommendations. We would also advise the need for public health advice and engagement in the work of this group, and if we can help in any way in respect of that, please do contact me.

Yours sincerely

Duncan Selbie
Chief Executive

NHS England

Our Ref: PW/jd

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By e-mail:

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Hugo Mascie-Taylor, Joint Trust Special Administrator
hugo@mascie-taylor.org
Mid Staffordshire NHS Foundation Trust

1 October 2013

Dear Alan and Hugo

We are writing to provide a formal response to the TSA in response to the consultation and our recent discussions on the financial modelling the TSA has carried out. We have a number of significant concerns which we would like to raise.

We accept that the TSA has had a difficult task in constructing a service configuration that will be both clinically and financially sustainable. However, the current proposal is likely to result in a system deficit of at least £10-15m, especially as the cost assumptions are not currently supported by the future provider organisations. The TSA has outlined a number of potential mitigations to this position, though on closer examination it is far from clear whether these could solve the problem. The proposed mitigations were as follows:

1. **"Creative commissioning" i.e. using payment incentives to drive efficiencies**
   This seems to confuse ends with means - if there are further efficiencies to be driven out, then these should be incorporated into the TSA's modelling.

2. **Tariff adjustments i.e. commissioners paying a premium for acute activity**
   There is no apparent justification for what would effectively be a permanent subsidy. In addition, the relevant CCGs are already under financial strain and any tariff premium would simply drive them into deficit. They would respond to this by retrenching spending in a number of areas including hospital services. This in turn would result in a reduction in hospital activity and income below that assumed in the TSA model which would potentially render the TSAs financial model unviable. The use of tariff premium does not offer a solution; it simply moves the problem from one part of the local system to another, with an inevitable negative consequence for local providers, as commissioners cut back their spending. It is worth noting that both CCGs in Mid-Staffordshire spend more than the national average on acute services and less on community and mental health services. Any proposal to increase this disparity cannot be supported by NHS England and will not be supported by the CCGs themselves.

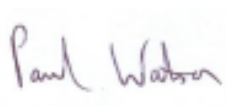
3. **Accounting treatment for capital spend**
   It is unclear whether this is feasible, and the magnitude of any resulting mitigation has not been calculated.

4. **Changes to the CCG allocation formula**
   As you know, NHS England is currently reviewing the CCG allocation formula. This may or may not benefit the Staffordshire CCGs. However, the critical point is that the financial allocations to CCGs will be driven by a formula and will not be based on the size of the financial problem in individual CCGs. This is a well understood principle that also applied to PCT allocations. It therefore does not represent a viable mitigation to the system deficit. The critical point is that NHS England cannot provide a permanent subsidy to the Staffordshire health system, and a TSA proposal that requires this does not represent a solution to the problems in the County.

The mitigations outlined above thus do not offer a viable solution. There was a fifth potential mitigation mentioned, namely a whole health economy reconfiguration. We understand that the remit of the TSA is limited, and this is why the TSA has not modelled this possible solution. We would agree that a whole health economy solution would be a sensible way of tackling the remaining problem. However, until this work is done, we simply do not know what such a whole health economy solution would look like and its impact on the shape of the acute sector. It would thus seem very unwise to embark on a significant hospital capital programme until this work is done. We would be very concerned about a TSA recommendation to Monitor that the proposed programme of acute sector reconfiguration should proceed without this wider piece of work being completed first.

We do understand that as TSA you have been necessarily limited by your terms of reference. However, you will also understand that NHS England cannot support a proposal that leaves the local health economy in significant deficit with no viable solution to this deficit being proposed.

Yours sincerely



Dr. Paul Watson
Regional Director (Midlands and East)

Paul Baumann
Chief Financial Officer, NHS England

c.c. David Flory, Chief Executive, NTDA

High quality care for all, now and for future generations

2. Royal Colleges and Professional Bodies

From the Office of the President
Dr Jane Barrett BSc FRCP FRCR

5 September 2013

Professor Hugo Mascie-Taylor
Office of the Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford ST16 3SA

Dear Professor Mascie-Taylor

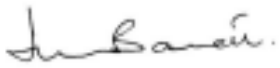
Consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals

The Royal College of Radiologists is responding to the above consultation in relation to our specialty areas of radiology and cancer services.

We would not object to the proposals as they stand, provided that the impact on the surrounding centres and hospitals is properly assessed and appropriate systems are put in place to accommodate the increased demand. These must be set up according to RCR clinical standards and guidelines and suitable levels of resourcing and, where relevant, education and training systems, must be properly established.

With kind regards,

Yours sincerely



Dr Jane Barrett
President
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Direct tel: 020 7772 6238
Direct email: president@rcog.org.uk

17 September 2013

Royal College of
Obstetricians and Gynaecologists

Bringing to life the best in women's health care

Professor Hugh Mascie-Taylor
Joint Trust Special Administrator
Office of the Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Neston Road
Stafford ST16 3SA

Our reference: ADF/KC

Dear Professor Mascie-Taylor

RE: CONSULTATION ON THE TRUST SPECIAL ADMINISTRATORS' DRAFT RECOMMENDATIONS ON THE FUTURE OF SERVICES FOR LOCAL PEOPLE USING STAFFORD AND CANNOCK CHASE HOSPITALS

Thank you for your email inviting the RCOG to comment on the above consultation. It was also very helpful to see the letter from the National Medical Clinical Advisory Group to the TSA which helped to inform the draft recommendations.

We have reviewed the proposals in the consultation and there appears to be nothing that would fall outside any recommendations in our own published standards and guidance. We are pleased to note Professor Robert Shaw's continued involvement in the development of your plans for the future and are satisfied that he will continue to ensure that through the CAG, the TSA is kept appraised of any relevant College standards and guidance.

Best wishes

Yours sincerely

Dr Anthony Falconer FRCOG
President

Cc Professor Robert Shaw

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The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
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24 September 2013

Dear Professor Hugo Mascie-Taylor, Mr Bloom and Mr Hudson,

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

I am writing to you on behalf of the Board of the UK Faculty of Intensive Care Medicine as part of the consultation process concerning the disposition of services at Mid Staffordshire Trust, with a particular focus on acute and critical care. We have submitted a response via the website, but the format of the web pages does not allow us to provide a sufficiently nuanced response to a very complex problem.

Our response to the Trust's Special Administrators' (TSA) consultation is complicated by the absence of detailed information about current acute services and about patient volumes (including admissions to the ICU). The lack of an impact assessment or projections based on the proposed changes to service provision also makes it difficult to formulate an evidence-based response. You do not explain why it is apparently acceptable to offer an emergency service for acute medical and surgical admissions, but not to provide a level 3 intensive care unit. Conversely, you do not offer an alternative model in which all emergency services are moved to other centres.

Given this position, the members of the Board of the Faculty of Intensive Care Medicine have serious reservations about the proposal to limit intensive care support at Stafford to a short-term level-2 facility while retaining an emergency department receiving acute medical and surgical admissions, and in-patients, a proportion of whom will deteriorate requiring intensive care support. This does not mean that we are opposed to the concept of regionalisation of intensive care – far from it – but to achieve this outcome requires a much more detailed examination of the current problem at Mid Staffs, and of the various options which might permit service reconfiguration without an adverse impact on quality of patient care.

As far as the intensive care unit (ICU) at Mid Staffs is concerned, we note that the first Francis Report included several highly complementary references from patients and relatives to the quality of intensive care at the hospital. The Healthcare Commission's report (2009) also noted excellent care and teamworking, but a significant problem with pressure on beds and under-resourcing, resulting in delays to admission to the unit. The

standardised mortality ratio for the ICU for the period April 2011 to March 2013 is 0.95 (ICNARC Case Mix Programme data). We therefore assume that the proposal to close the ICU is driven primarily by non-clinical considerations.

You have proposed that critically ill patients be stabilised on site in the Level-2 facility before being transferred out to another centre such as Stoke or Wolverhampton. At the same time you propose that the current Mid Staffs critical care staff can be rotated with these other centres in order to maintain skills for supporting such patients on-site before transfer out.

The Faculty has the following concerns with these proposals:

1. Demand for intensive care: mainly unplanned emergency admissions from the wards.

    a. Critically ill patients from the Emergency Department: No ambulance triage system will reliably identify, and thereby divert to other centres, all patients likely to need intensive care support. Moreover, nationally only 6% of ICU admissions come directly from the ED, so this is not the main problem in terms of managing demand for ICU services.

    b. Critically ill patients from the operating theatres or wards: This is the largest source of ICU admissions. Nationally, 75% of ICU admissions are emergencies, of whom 55% are non-surgical (medical), and 20% are emergency surgical admissions. Only 25% of ICU admissions are elective post-surgical patients, and these are the ones who often require only level 2 care. If the Trust continues to receive emergency admissions and care for in-patients, there will be a continuing supply of critically ill patients from wards and theatres requiring level 3 care.

2. Initial stabilisation: requires advanced medical and nursing skills in intensive care medicine.

    a. The first hours of intensive care support are the most critical for assuring good outcomes. This is not merely a matter of securing a patient's airway and instituting mechanical ventilation. It requires high-level skills in organ system support, diagnosis, and timely initial therapy, and team working between intensive care doctors and nurses. It can be more difficult to provide quality care in the absence of a level 3 unit.

    b. The TSAs propose that this service could be provided by anaesthetists. This is correct, provided that they have acquired at least Level 2 training in ICM – which will be the case for the majority of senior specialist trainees. It will not be the case for Core trainees, and it might not be the case for some anaesthetic consultants.

3. Transport of critically ill patients:

    a. There is a large literature on the hazards of inter-hospital transport of critically ill patients. Risks are diminished if the transfer is conducted by an intensive care

trained physician supported by a trained nurse and paramedics with access to suitable equipment.

b. The TSAs refer to the regional paediatric retrieval service. This would indeed be a suitable approach, but to replicate it for adult retrieval would require funding, dedicated staffing and governance structures (eg: a service director). It is most unlikely that this would be a cost-effective approach for a single centre (Mid Staffs), though it could usefully be proposed as a region-wide development.

4. Receiving Centres: must guarantee adequate ICU provision.

a. Despite an increase in intensive care resources in England since 2000, the service remains under significant pressure, with occupancy rates well above 80%. The TSAs do not explain how they will secure guaranteed admission to other centres for level 3 patients from Mid Staffs. The transfer of patients will add to the practical and emotional burden on families who will then be obliged to travel to Stoke or Wolverhampton, or further afield if the ICUs in these hospitals are full.

b. This problem will become particularly acute during the winter period with the seasonal increase in respiratory infection, starting in December and ending around May each year.

c. The TSAs will therefore need to secure service level agreements with receiving Trusts, with appropriate penalties for failure to receive patients from Mid Staffs when required.

5. Maintaining skills:

a. The TSAs propose that networked rotations could be developed with other Trusts to support continuing professional development of critical care staff who would then be equipped to provide short-term rescue level 3 care at Mid Staffs before the patients are transferred out to these other centres.

b. The Trust will need to review case mix and patient throughput with the Faculty Regional Advisor in order to make a secure judgement about the training capacity for the ICU as it is currently configured.

c. In principle we strongly support rotational training as part of reflective learning and peer review, and would endorse this approach. However, the TSAs will need to determine whether their current ICU staff will wish to work in this way, or whether they might prefer to transfer their place of employment wholesale to other centres.

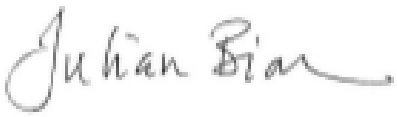
6. The ICU as a quality hub for the rest of the hospital:

a. We have already drawn attention to the Francis report (2009) and the Healthcare Commission's report (2009) referring to the ICU at Mid Staffs as providing quality care. Internal rotational training of staff within the hospital could help to

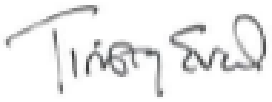
develop the skills of ward staff and foster that essential quality of personal leadership.

In summary, the Board of the UK Faculty of Intensive Care Medicine has serious concerns about the current proposal to retain acute services on site without the support of a level 3 ICU. Alternative options would be to establish a comprehensive regional adult critical care retrieval service with service level agreements with other Trusts, or to close Mid Staffs to acute admissions. The Faculty is willing to assist whichever organisation assumes responsibility for Mid-Staffordshire Hospital in undertaking a detailed options appraisal.

Yours sincerely



Professor Julian Bion MBBS FRCP FRCA MD, FMedSci
Dean, Faculty of Intensive Care Medicine Medicine



Professor Tim Evans DSc FRCP FRCA
Vice Dean, Faculty of Intensive Care

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1st October 2013

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Response of the Royal College of Nursing to *Maintaining high-quality, safe services for the future*: the consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals

Dear Sir or Madam

On behalf of the Royal College of Nursing (RCN), I am writing to present the RCN's response to the consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals.

I understand there is no requirement for responses to the consultation to be submitted via the advertised response form, and that all responses will be taken into consideration by the TSAs. Accordingly, the RCN's observations are set out in this letter.

For ease of reference, the RCN's observations are segmented into the same numerical order as the draft recommendations in the published consultation document.

By way of introduction to our response, however, I also have set out a number of over-arching observations on general principles and conditions that the RCN believes must be satisfied in the process of determining the future provision of services currently available at Stafford and Cannock hospitals.

In addition, given the scale and significance of the implications of the draft recommendations for inter-dependent acute services in the Stafford area as a whole, and the concern expressed by many people in the local community about the ramifications for patients of emergency, urgent and critical care services, I have summarised the RCN's comments in relation to this range of services in a further separate section immediately before our observations on each specific recommendation.

Background

The RCN is the main trade union and the professional body for nursing in the UK. We represent around 410,000 nurses, health care assistants and nursing students, around 3,700 of whom belong to our South Staffordshire branch, including those members employed by Mid Staffordshire NHS Foundation Trust (MSFT) who will be directly affected by any reorganisation of services at Stafford and Cannock Hospitals.

In developing its response to this consultation exercise, the RCN has engaged with members in the South Staffordshire branch, and also with members in the neighbouring Black Country and North Staffordshire branches due to the strong likelihood that hospitals in Stoke-on-Trent and Wolverhampton will eventually assume responsibility for delivering services at Stafford and Cannock hospitals, and will require additional capacity and resources to manage any displacement from the Stafford site, where it is proposed that some services will be withdrawn.

We are aware that RCN members have responded to the consultation directly or through workplace meetings in their capacity as MSFT employees. Indeed, in some cases, those members have copied their responses to the RCN at our invitation. I have enclosed copies of the comments we have received from individual members at Appendix A. The names of these members have been omitted since we have made no assumptions about their willingness to be identified.

In addition, the RCN was represented on the national Nursing and Midwifery Advisory Group, which was established to support the clinical evaluation of the models for the future provision of services and the potential impact on recruitment and retention of relevant staff based on the information provided by the TSAs. The notes of the meeting of this advisory group on 4th June 2013, as published in Appendix 6 of Volume Two (Annexes to the main report) of the TSAs' draft report,[1] suggest, mistakenly, that the RCN was represented at local and regional levels in respect of clinical reference groups.

The consultation document states that 'the local clinical reference group assessed the proposed solution from their professional viewpoint for safety and whether it will be workable locally in the long term.' In the interests of accuracy, the RCN was not represented on this group.

1.0 Over-arching observations on the draft recommendations

1.1 Patient safety and access to services

Like other stakeholders, the RCN recognises the challenge of maintaining safe and clinically and financially sustainable services for people using Stafford and Cannock hospitals. We also acknowledge the national trend towards consolidating some services at larger specialist centres.

[1] Volume Two (Annexes to the main report) of the TSAs' draft report (ref page 107)

Clinically safe and sustainable services are paramount but it is clear that for many people in the Stafford area, in particular, it is the very availability of acute and urgent services at the hospital nearest to them that has helped to instil their sense of safety and reassurance. For many people, this confidence has been strengthened by their experience of using the hospital, which is widely regarded to be delivering safer and better quality services than during its troubled past.

It is entirely understandable, therefore, if some people believe that those services proposed to be withdrawn from or downgraded at Stafford Hospital would be less safe if patients had to travel further, and for longer, to access them. The plans for the future structure of services, and the implementation of any changes, must recognise and address those concerns honestly and thoroughly.

In addition, the RCN is concerned that the desire of the Clinical Commissioning Groups, expressed in the consultation document, to reduce the number of patients admitted to hospital unnecessarily and enable more patients to be treated closer to home remains an aspiration which has yet to be truly realised. In these circumstances, we believe it is imperative not only that sufficient capacity is created within community health care services to enable these commissioning intentions to be achieved as punctually as safely possible, but also that the effectiveness and efficiency of these alternative services is demonstrably proven before any change is made to the status quo in relation to hospital services provided at Stafford.

1.2 Care quality

Setting aside financial imperatives for change, the Care Quality Commission's most recent inspection report of Stafford Hospital (published on 6 March 2013[2]) found that the service at the hospital during an unannounced inspection was meeting the five standards reviewed, and that the government says the public have a right to expect, namely:

- Standards of treating people with respect and involving them in their care
- Standards of providing care, treatment and support that meets people's needs
- Standards of caring for people safely and protecting them from harm
- Standards of staffing
- Standards of quality and suitability of management

The RCN believes that, in the interests of patients and the public, any re-structuring of services must not jeopardise the positive performance in respect of the quality of care currently delivered at Stafford Hospital. This principle must also apply to any transitional arrangements put in place prior to any reorganised model of service delivery being fully implemented.

[2] Care Quality Commission Inspection Report, Stafford Hospital, March 2013
http://www.cqc.org.uk/sites/default/files/media/reports/RJD_Mid_Staffordshire_NHS_Foundation_Trust_RJD01_Stafford_Hospital_20130306.pdf

3

1.3 Staffing

Ensuring safe staffing levels and skill mix ratios across the health service was a key recommendation of the recent Francis report into the past failures at MSFT. The RCN believes that safe staffing levels are a pre-requisite to delivering high-quality patient care as well as guarding against the risk of poor care standards.

There is a wealth of research[3] across health systems worldwide showing the direct correlation between higher levels of nurse staffing and

- improved clinical outcomes for patients
- improved recruitment and retention of nursing staff and
- economic benefits to employers and communities

Furthermore, in September 2013 the Health Committee of MPs of the UK Parliament, in its report *After Francis: Making a Difference,*[4] concluded that health care commissioners should require NHS care providers to provide data on staffing levels at ward level on a daily basis and publish it immediately in a standard format designed to allow easy comparison against benchmarks.

The RCN believes that it must be a mandatory, legislated requirement that health care providers ensure staffing levels and skill mix never fall below levels determined to be safe. Safe staffing levels should be determined through the mandatory use of evidence-based, nationally-validated workforce tools. This must take place within a national framework of evidence-based standards and guidance, with flexibility that allows nurses to exercise their professional judgement to adjust local staffing in response to changing patient needs. Achieving safe staffing will require long-term national approaches to nursing workforce planning, with investment to ward off impending nursing shortages and an end to a history of boom and bust in the supply of registered nurses.

For all health care services and specialities one of the single most important issues is the workforce model. Clearly, nurses and midwives have clinical and managerial roles but they also are responsible for the maintenance of a safe caring environment and for leading teams and services. They have a wide range of accountabilities. It is, therefore, essential that the diverse roles and responsibilities of nursing staff within the modern acute sector is fully recognised.

1.4 Upholding the Principles of Nursing Practice

The RCN believes that any reorganisation of services must allow the nursing profession to deliver care in accordance with the RCN's Principles of Nursing Practice[5]. The Principles

[3] Mandatory Nurse Staffing Levels, Royal College of Nursing Policy Briefing, March 2012 http://www.rcn.org.uk/__data/assets/pdf_file/0009/439578/03.12_Mandatory_nurse_staffing_levels_v2_FINAL_.pdf

[4] Health Committee of MPs – After Francis: Making a Difference http://www.publications.parliament.uk/pa/cm201314/cmselect/cmhealth/657/65702.htm

[5] The Principles of Nursing Practice http://www.rcn.org.uk/development/practice/principles

describe what everyone can expect from nursing practice, whether they are nurses, patients, their families or carers. The eight Principles were developed by the RCN in partnership with the Department of Health (England), the Nursing and Midwifery Council, and patient and service user organisations.

1.5 Ensuring equality and fairness in access to services

The Equality Act 2010 consolidates protection against discrimination on the grounds of age, disability, gender reassignment, pregnancy and maternity, race, religion or belief, sex and sexual orientation. It also put in place a new Public Sector Equality Duty (PSED), which gives public authorities a legal responsibility to provide this protection and make decisions which are fair and transparent.
The RCN expects the PSED to be discharged through a comprehensive equality impact assessment of any reorganised model of services, and trusts that the advice of the independent Health and Equality Impact Assessment Steering Group established by the TSAs will be taken into account.

The RCN believes that the implications of the draft recommendations being implemented must be assessed from a risk and health inequalities perspective in respect of a number of groups including but not limited to:

- women going into labour
- sick children requiring assessment and inpatient services
- people without access to their own vehicle and who rely on public transport
- people living in more remote areas of South Staffordshire

We commend to the TSAs and commissioning bodies reference to the RCN guidance 'Rights, risks and responsibilities in service redesign for vulnerable groups'[6].

1.6 Engagement with affected staff

The RCN expects staff to be consulted fully in the development and implementation of proposals for the future of services currently provided by MSFT. Engagement with staff and their trade unions is critical, and the RCN expects this engagement to go on throughout any reorganisation process. This is essential to minimise any adverse impact on the recruitment, retention, professional development and morale of staff.

1.7 Impact on the training of the future nursing workforce

The RCN notes the TSAs' assertion that 91% of patient visits to Stafford and Cannock hospitals would continue if the draft recommendations are implemented. With MSFT currently a facilitator of clinical placements for pre-registration nursing and midwifery students from Staffordshire University, the RCN would not want to see students unfairly disadvantaged or inconvenienced by a reduction in the availability of clinical placements at Stafford and Cannock hospitals. We would expect due consideration to be given to the

[6] Rights, risks and responsibilities in service redesign for vulnerable groups RCN guidance, published April 2103

implications of removing clinical services from Stafford on the overall training experience of nursing students.

2.0 Observations on the implications for acute services as a whole

The RCN believes that a whole system healthcare commissioning approach to acute services should be taken to ensure that the needs of the entire population being commissioned for are met. This should consider, and be driven by, what the population being commissioned for needs, as opposed to what components are available from an existing fragmented system.

We also believe the impact of reconfiguration needs to be considered not only locally at CCG level but also regionally by NHS England. Central to any changes should be an outcome-based risk assessment considering the population in question and their profile and needs, the geographical and transport impact, the specialist commissioning considerations and, not least, an appreciation of potential unintended consequences.

Surgical, critical care, imaging and emergency services should not be considered in isolation. We consider that there is insufficient detail as to the proposed regional surgical capacity and supporting critical care capacity to draw any conclusions at this time from the draft recommendations that affect the structure of these services.

While the reduction of physical beds is not an issue in itself, it becomes a significant problem if the bed equivalent services are not mobilised to the community. To be feasible in this environment it is recognised that UEC pathways should be designed and commissioned as whole system, population-focused services.

Whilst, in theory, the view of the commissioners that ambulatory rather than emergency care is required is not opposed, it is important to understand that some of the conditions within the ambulatory emergency care directory are beyond the remit of some minor injuries units and indeed urgent care centres.

In order to meet the aim of maintaining or improving the level of quality, experience and outcome it is recommended that the vision for the healthcare service is articulated more clearly and that those who 'own' all component parts agree this vision. Only when the entire networked service has been designed can it be risk assessed, planned from a workforce perspective, commissioned and integrated.

We believe strongly that local people should be represented in this process and that particular attention is paid to the marginalised and vulnerable within the community.

3.0 Observations on the specific draft recommendations

Recommendation 1 - Stafford Hospital should continue to have a consultant-led Accident and Emergency (A&E) department between the hours of 8am and 10pm daily

The RCN acknowledges that the draft recommendation represents no change to the current arrangements although it must be pointed out that there has never been a formal consultation on the principle of permanently reducing A&E opening times at Stafford from 24/7 to 8am-

10pm each day. Clearly, local people will require access to trauma care and specialist emergency pathways such as those for heart attack, stroke and burns.

The RCN believes it is important that the impact of retaining the current 8am to 10pm service – as opposed to the 24/7 model that existed prior to December 2011 – on the operational effectiveness and resource capacity of other providers in the wider health economy, including the ambulance service, other A&E departments and urgent care providers, is fully considered and kept under frequent review.

We would expect commissioners and providers to consider the reinstatement of 24/7 A&E provision in Stafford if demand increases or if the quality, capacity or accessibility of emergency care in the wider area is considered to be at risk as a result of the current arrangements continuing.

See earlier section 2.0 for additional relevant comments in respect of acute services.

Recommendation 2 - An inpatient service for adults with medical problems will continue to be provided at Stafford Hospital for those who need to be in hospital

The RCN notes that this draft recommendation represents no change to the current arrangements and is an enhancement of the previous proposals put forward by the Contingency Planning Team appointed by Monitor.

If, however, there is to be a reduction in the number of acute medical beds in lieu of services being delivered in the community in order to avoid patients being in hospital unnecessarily, this redistribution of resources must be carefully assessed, managed and monitored to avoid the risk of patients slipping through the net of services provided potentially by a number of different providers.

See earlier section 2.0 for additional relevant comments in respect of acute services.

Recommendation 3 - As well as retaining the present inpatient service, a 14/7 Frail Elderly Assessment service is created to provide a one-stop assessment for older people and to take referrals from a wide range of sources

The RCN recognises that this is an important development in the service for older people. However, we would question why, if the inpatient service for adults with medical problems is available 24/7 – and the A&E service at Stafford may, in operational reality, still be assessing or treating patients beyond the 10pm closure time - this new assessment service is proposed to open only 14/7.

See earlier section 2.0 for additional relevant comments in respect of acute services.

Recommendation 4 - Beds should be available at Stafford Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home

The RCN supports the principle of patients being cared for and rehabilitated at a specialist hospital as close to home as possible, which this 'step down' service is designed to achieve.

Recommendation 5 - No babies should be born at Stafford Hospital's consultant-led delivery unit as soon as other local hospitals have the capacity to deliver a service for more pregnant women... Consultant-led pre and post-natal care should be delivered in partnership with University Hospital of North Staffordshire (UHNS) so that local patients can still attend routine appointments at Stafford. Women will have the choice to go elsewhere if they prefer.

The provision of maternity services needs to be balanced with the geographical as well as socio-economic footprint of the area. Risk assessment of the proposals will need to take account of other local reconfigurations, and how these will impact on the overall provision of maternity services across the county and bordering areas.

It may be evidentially unclear at present as to how closure or reconfiguration of health and social care services may impact on maternity. Nevertheless, change without due consideration of women's needs, expectations and the increasing birth rate/complexity of care, as well as expanding units beyond 6,000-8,000 births may not be in the best interests of women, or quality services, and may not be clinically sustainable or financially viable. This takes account of the call by the RCOG[7] (July 2011) for 24-hour consultant cover on labour wards to meet the increasing complexity. Equally units that have too few births may lack the ongoing expertise required for a safe effective service.

There are real concerns that providing a safe and effective birthing service requires comprehensive anaesthetic cover. Any changes to urgent and/or emergency care services, not only A&E, will need to take account of this.

The recent Birthplace in England Study[8] (NPEU 2011) compared the safety of planned births in four settings: home, freestanding midwifery units, alongside midwifery units, and obstetric units and demonstrated the value of the right care in the right place, including that midwife led care is safe and effective and leads to good outcomes. It also noted that this will require investment to provide the most appropriate services in the best locations that meet women's needs.

Significant changes to services may have an impact on safety and outcomes, especially where women may have to travel long distance in rural settings. If the recommendation is to centralise services, serious consideration should be given to having a local sustainable midwifery-led unit. If this is not viable then having local ante-natal and post-natal services, with good integration/networking with the wider services will be essential to support quality continuity of care.

The numbers of midwives available to provide safe, effective care across a range of appropriate settings, including midwifery-led care and high-risk care remains a persistent challenge. Midwives should be supported to be the lead professionals and coordinators of care which would have a greater impact on improving the continuity and experience of care.

[7] High Quality Women's Health Care: a proposal for change, Royal College of Obstetricians and Gynaecologists, July 2011 http://www.rcog.org.uk/files/rcog-corp/HighQualityWomensHealthcareProposalforChange.pdf

[8] Birthplace in England Research Programme, National Perinatal Epidemiology Unit https://www.npeu.ox.ac.uk/birthplace

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Consideration also needs to be given to the needs of the midwives, both practical considerations (such as travel) and professional (their ability to maintain skills and knowledge to remain on the NMC register).

Recommendation 6 - Children should no longer be admitted as inpatients to Stafford Hospital and the service should stop as soon as other local hospitals have the capacity to accept them safely. Patients should be transferred to larger specialist hospitals for appropriate inpatient care

Given the information available, we believe that it is in the best interests of patients not to offer inpatient, overnight paediatric services on the Stafford site.

Recommendation 7 - The Paediatric Assessment Unit should be led by specially trained nurses who will consult with paediatricians and emergency physicians as necessary. The PAU should only open between the hours of 8am to 10pm every day, to operate the same hours as A&E

The RCN believes the Short Stay Paediatric Assessment Unit model may work if appropriately staffed, located and operated. This requires available paediatric and emergency medicine cover and the operating hours should not exceed the availability of such cover.

Specialist nursing is required to operate such an ambulatory model, and paediatric nurse practitioners should be involved from the outset.

Appropriate, pre-arranged paediatric transport and retrieval services must be commissioned to allow for the transfer of an acutely ill child if and when required.

Recommendation 8 - Major emergency surgery should no longer be carried out at Stafford Hospital with the exception of minor surgical procedures which can be dealt with by A&E or where the patient can be stabilised by A&E and scheduled to return to Stafford Hospital for minor surgery... This means there will no longer be a surgical assessment unit on site

See earlier section 2.0 for relevant comments in respect of emergency surgery services.

Recommendation 9 - A small critical care area should be retained at Stafford Hospital so that very ill patients who come to A&E or inpatients who become very unwell can be kept stable prior to urgent transfer to a larger specialist hospital. Current staff on the critical care unit should work as part of a clinical network established with a neighbouring hospital. UHNS has proposed offering these services and the specialist staff to network with Stafford. An urgent transfer service should be established for very ill adults which is the same as the approach already used successfully across England to transfer sick children to regional centres

See earlier section 2.0 for relevant comments in respect of critical care services.

Recommendation 10 - Elective care and day cases should remain in Stafford. This would include orthopaedic surgery

The RCN notes that the arrangements proposed, aside from the transfer of elective orthopaedic surgery from Cannock to Stafford, reflect the status quo.

Recommendations 11-13 – Cannock Hospital

The RCN has no major comments or concerns in respect of the three draft recommendations that apply to Cannock Hospital.

Recommendation 14 – The dissolution of MSFT

The RCN notes the TSAs' view that, together, the proposals put forward by University Hospital of North Staffordshire NHS Trust (UHNS), which proposes running Stafford Hospital, and The Royal Wolverhampton NHS Trust (RWT), which proposes running Cannock Chase Hospital, offer the widest range of services to be delivered locally.

The RCN is very concerned about apparent failure in the NHS. This is because our members aspire to deliver safe, high-quality care. Sadly, there are still examples of where this does happen. Nurses and health care assistants report to us that they are struggling to do so because of a number of complex and inter-related factors which affect the NHS more generally, namely:

- Increasing demand as the population ages and increased patient expectations
- The drive for efficiency as the NHS budget is currently not keeping pace with the growth in demand

The RCN believes that the safety and quality of care, and the stability of hospital services, for the Stafford population must be protected and prioritised in the both the short and long terms. Patients will not cease requiring treatment and care while any re-structuring is taking place and their interests must continue to come first.

Thank you in anticipation of your consideration of our response to the consultation process. If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

Paul Vaughan

Paul Vaughan
Director
Royal College of Nursing West Midlands

Encl: Appendix 1 – comments forwarded on behalf of RCN members

Appendix 1

Comments received from RCN members

Received via email 14/08/13

The three 'heads' of departments, including myself, highlighted during last week's public meeting that we were not able to support the recommendations; as we were not provided the opportunity to meet with the TSA during the inspection of the proposals. One could argue that we are best placed to share information, with the ambition to get the proposals correct. The current proposals appear to be grossly in factual, mainly due to the TSA's misinterpretation of data; interestingly they appear to have under-estimated or under-recorded current activity.

We are now into a phase of trying to re-negotiate current proposals as we/I am not assured that the proposed model for Critical Care is safe for patients. I do not see any adequate and informed decision making resulting in a clear change of national practice resulting in the closure of Stafford's Critical Care. I do not think the public papers have clearly expressed that Critical Care will shut down. They imply a reduction in Critical Care, which is not true. All Critically ill patients will be transported 19 miles to UHNS and this is not a normative process for "non-clinical" transfers currently within the UK. I feel they have purposefully blurred the boundaries between what is current practice for clinically required transfers i.e. neurosurgical requirements in specialised hospitals versus the "normal" case load of ITU patients currently in DGHs.

Our outcome measures are excellent, our financial sheets are good and we have no predictions to fail sustainability in the future. Therefore we are state increasing the risk of these patients during transfer, which is a non-ideal care pathway, is not justifiable? We have not received assurance this is correct and safe. We need to continue to escalate an alternate view until we are assured the proposals are safe and not solely financially driven. We have met yesterday with a Director of Nursing from the nursing clinical advisory group and we/I remained unassured that these proposals are safe.

Received via email 23/08/13

I am a paediatric psychology nurse specialist and part of CAMHS. My manager (redacted) has asked as to contact you with any concerns we have about the TSA's plans to close Shugborough inpatient unit. The proposed plans are a great concern. Children who are suicidal or have taken an overdose currently get admitted to Shugborough Ward and sometimes have to remain for quite some time until a tier 4 CAMHS inpatient bed can be found. These children can be incredibly risky. My concern is that if other areas don't have the capacity to accommodate these children they will be forced to be contained within the community. This will pose an enormous risk. We know that young people do commit suicide as was currently indicated in the current media coverage.
Further to this I chair a paediatric user group which facilitates the views of young people and children. I've had a number of concerns from distressed young people and their families about the proposals. These children have developed trust with Shugborough Ward and their staff

and the prospect of travelling to other hospitals is causing an enormous amount of distress. Surely in this day and age of patient experience this should be taken into account? Several young people are encouraged to write to the TSA to express their views.

Received via email 27/08/13

The overall recommendations are not safe for the health and welfare for children in this locality. There is a high potential for sick children to either be referred or self refer. This will affect their mortality and morbidity outcomes.

Obvious disappointment that the TSA were provided with the wrong statistics for Paediatrics. Will they reassess now they are aware of the true figures?

A safe PAU cannot be staffed entirely by ANPs. Our gold-standard award-winning PAU is safe and effective due to trained Nurses and Doctors working in a cohesive timely fashion to APLS/Pemsoft protocol. Children do not come in labelled "well" or "ill". Children have the remarkable ability to physically compensate for illness until pre-terminal. Therefore a potentially ill child can walk in and without rapid assessment with immediate medical intervention can quickly deteriorate. Recognition of a sick and rapidly deteriorating child is the cornerstone of safe practice.

Practicality of arranging ambulance transfers for children who need an overnight bed and an escorting nurse to accompany them. Will there be a bed bureau system to locate free in-patient beds?

Stabilising and airway management for critically ill children require Paediatric Staff Grade/Registrar/Consultant Grade as well as paediatric trained Anaesthetists

Current emergency ambulances are not configured to transport critically ill infants and children eg physical position of monitors, paediatrics kit, infant seats, plug socket for transfusion pumps, seat for Mum etc.

Surgical cases automatically have shared care with Paediatrics eg for fluid management, pain control, recognition of deterioration. What provision will be in place under the new Recommendations?

The new Recommendations do not mention the provision for Paediatric trained Anaesthetists not just for planned surgery but for emergency intubation and ventilation on any child

Impact on allied services and the emergency provision for acute paediatric mental health needs, self harm, attempted suicide or Child Protection eg CAMHS, Police

Impact of the winter pressures due to seasonal variation

Impact on the needs of the children under "Open Access" rules

I fully agree that our services need to be evaluated especially the number of inpatient beds and the opening times of PAU but not to the determent of the child's health and welfare. Thank you

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Received via email 27/08/13

Stafford has had a hospital since the 1700s, originally Stafford General Hospital on Foregate Street. In the 1980s in order to fit the expanding population a bigger hospital was built to amalgamate all the outlying services into one and expand on existing services.

The population of Stafford has increased since then and will continue to in the coming years. There are 115 houses planned for Stafford at the moment, 85 new houses already being built in Gnosall (a local village 15mins drive from Stafford hospital, but 45mins from Stoke on Trent or Wolverhampton if no traffic issues). We are on the cusp of the largest baby boom for 40 years.

This is not the time to close Paediatric and maternity services.

Yes, our numbers have decreased recently as a direct result of constant negative media coverage, BUT we are now recovering from this and our services are now considered superior to others.

Reconfiguration of Stafford services should not close those areas essential for servicing our local population.

People should be considered, not just finances.

Please consider single parents who do not drive trying to visit a sick child 30 miles away, already probably struggling to make ends meet. A bus journey to Stoke on Trent or Wolverhampton could take an hour and a half each way. Visiting time would be limited if she had to get back for other children leaving school. Many of the children served by Stafford paediatrics have long term issues so this is a constant problem, not an isolated incident. What about the elderly relative trying to visit a loved one with no one to take them?

In support of retaining Maternity and neonatal services. Pre-term babies can stay in hospital for many months, how are the parents going to be able to visit on a daily basis without remortgaging their house? It is a government initiative to increase breastfeeding rates but evidence suggests that stress can reduce breast milk. What more stress can a new mother experience than going into pre-term labour, trying to get to a hospital at least 45mins away, then not being able to stay close to her baby at all times? On top of this she will be encouraged to provide breast milk, but how does she get it to the hospital on a regular basis if she cannot drive due to a caesarean section or pregnancy-related illness? Are we expecting her to sit on a bus for an hour and a half each way? A taxi would be out of the question, and the father would only get 4 weeks paternity leave. What happens after that?

The road system between Stafford, Stoke on Trent and Wolverhampton is the busiest stretch of motorway for many miles. It is constantly closed due to accidents and tail backs can reach many miles.

Consider the pregnant woman in labour trying to reach either of these hospitals on a Friday afternoon. Even ambulances cannot get through road blocks.

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Stafford is the county town, not Stoke on Trent or Wolverhampton. It should have a hospital fit to serve its expanding population, with local services for local people.

Stafford's local population should not have to bear the financial cost of travelling to other hospitals. Stafford should be used as a flagship example of how to improve services following bad publicity, not closed.

What happens to the 'whistle blowing policy' Are we now saying 'don't whistle blow or you risk your hospital being closed'? Surely that is not what the NHS wants. We need to be able to air views in order to improve.

Received via email 28/08/13

Some of my concerns are:

UHNS is so busy now, it is struggling getting patients into appropriate beds, patients are often moved around several times which isn't good for their wellbeing.

Wards are being run on skeleton staff so struggling to give good care which is a national problem but puts more pressure if more patients coming through.

The cost of ambulances back to Stafford!! Many patients struggle with transport and relatives struggle to visit. It is always complicated trying to transfer patients back.

The problems that occurred will not be solved by this, will lead to more complaints!

Received via email 28/08/13

I am an RMN at Brockington Mother and Baby Unit at Stafford and would like to make our team concerns known.

Our unit assesses and treats many women with mental illnesses in the pre and post-natal period. The infant remains with their mother throughout the admission and may at times require medical treatment out of our remit. These infants are usually sent to Shugborough unit for further medical attention at Stafford DGH. If this ward were to close, the babies may require transfer to North Staffs DGH for treatment, which will impact upon our patients who will have to experience additional stress and emotional turmoil regarding the well being of their infant.
The mother may not be well enough to attend the paediatric unit with their infant depending upon their presenting mental state and social circumstances. There are also implications for nursing staff in the event of the above occurring such as for staffing and making difficult decisions at times. We as a team strongly oppose the potential closure of maternity and paediatric units within the Stafford area. We cover a large demographic part of the country of which many partners and visitors travel to the unit to visit their loved one and infant. Further travelling to North Staffs DGH, if required, would be stressful for such individuals should their infant be transferred from Brockington.

Our team at the Brockington unit strongly oppose the potential maternity and paediatric unit closures. The negative impact that the closures will have on the patients, their families and staff is vast with potential serious consequences should there be a deterioration to the infant's condition during the transfer process with a delay to prompt medical treatment.

We hope that our concerns will be heard by those involved and considered during the decision making process.

Received via email 03/09/13

Thank you for giving me the opportunity to speak recently at the Staff Consultation meeting.

Having worked as a nurse for many years within critical care and also as someone who represents the Unit at network development meetings, I feel I am qualified to speak knowledgably on the proposals you have made with regards to the Critical Care Unit within Stafford hospital.

At the meeting you stated that in making your proposals you have been guided by the principles of making services that are both "safe" and "provided as near to patients' homes as possible". I believe that your proposals with regards to critical care Level 3 patients are neither safe nor close to home.

You have said in your proposals that "very unwell patients who need this type of care for more than a few hours would be stabilised and then transferred to a larger specialist hospital." Very few critically ill patients would be sufficiently stable within a few hours so placing them in the back of an ambulance would pose a great risk to their lives. The fact that Stafford has a well-run Critical Care Unit meeting the needs of general level 3 patients with positive outcomes means there is no justification to put them at risk and increase the possibility of a poor outcome. I agree that patients requiring specialist level 3 beds (neurology, cardio-thoracic, major trauma, major surgery) should be transferred as the benefit of receiving specialist interventions, which can only be delivered in a specialist centre, justifies the risk of transferring a critically ill patient in the back of an ambulance.

Furthermore, the suggestion to set up a retrieval system between UHNS and Stafford would not be financially viable. A retrieval team for critically ill adults, which was trialled a couple of years ago during the Swine Flu epidemic, requires a dedicated team of ambulance driver, anaesthetist and critical care nurse as a minimum, as well as a dedicated ambulance especially equipped for transfer of this group of patients, and would need to be staffed and available 24 hours a day, 7-days a week, with provision to access a backup team and ambulance should this team be out of region when an urgent transfer is needed. The nature of critical illness is that there are no specific trends of when these patients will need transferring and this may result in a team not being utilised at times which would be an expensive waste of specialist resources.

At present, there is a national shortage of Level 3 (ITU) beds. This is no different in our region where a working arrangement is in place, whereby when a unit is full, patients are transferred within the local network where possible. UHNS critical care beds are frequently full and it is known that at times level 3 patients are cared for in A&E and Theatre Recovery due to lack of capacity. If you remove the general level 3 patients from Stafford and transfer

them to UHNS – this will not only add to the burden of an overstretched critical care service at this hospital but it will also result in specialist beds being blocked with general patients. This will result in them having to travel significant distances to find another specialist care bed and some Stafford patients requiring general ITU support also having to be transferred to another hospital further away, at times even out of the region, due to the unavailability of beds.

All the research states that having family with you during critical illness reduces length of stay and improves the outcome. Having patients cared for away from home when there is no clinical justification will cause problems for family to be at the bedside and provide this support, this along with the suggestion of putting the patient in the back of an ambulance in the first place when they are critically ill, will significantly reduce these patients chances of survival – with an excellent service already in place at Stafford, there is no justification for this at all.

Another concern is that if general ITU patients take up specialist beds, access to these will be reduced. There has been some suggestion that the Level 3 bed capacity could be increased to accommodate an increase in numbers and this could be achieved by re-opening the old critical care area. UHNS have problems with recruitment and are not able to staff the beds that they have. Furthermore, if it was felt necessary to close this area and move to new accommodation there is no justification in re-opening it when there are perfectly good facilities at Stafford which have been upgraded with a continuous monitoring and recording system, new haemofiltration machines, new cardiac output monitoring equipment and an excellent training and development programme for nursing staff.

Your description of the proposals for Critical Care appears to be contradictory. You state that there will be a change in the need for critical care at Stafford as major emergency surgery would no longer be provided at Stafford. Over recent years most major emergency surgery has moved to UHNS such as AAA repairs, carotid endarterectomy, femoral bypass grafts, lower GI surgery to name but a few. However, this has not had an impact on the amount of patients that we are seeing on the Unit. A lot of our patients come through A&E, such as patients who are post-cardiac arrest, those with septicaemia, community acquired pneumonia and for whom we have the facilities and expertise to manage without risking their lives by transferring them to another hospital. Our patient outcomes and patient feedback will support this. In addition to this, we have acute medical admissions from the wards when their condition has deteriorated, along with some elective surgical patients who have had intra-operative or post-operative complications that have required Level 3 care. You support the continuation of A&E, acute medical admissions and elective surgery so a fully functioning Level 3 facility is required to support these patients.

It is widely recognised that in some circumstances care in the community to prevent hospital admissions or to support people at home with chronic problems is the way forward but it is also known that people are living longer with more co-morbidities which will increase the need for facilities for acute admissions and critical care input, not less. With further advances in medicine and surgery, the need for specialist critical care beds will also be increased and this is particularly so with UHNS since they have become a Trauma Centre for a large area of the country.

I refer to the consultation document again which states that "every patient is entitled to expect high quality and safe health services from the NHS". So I ask again why then would it be

suggested that critically ill patients` lives be put at risk by putting them in the back of an ambulance and travelling to another hospital unless it was because they needed to access specialist reasons? Where is the evidence that for general Level 3 patients their care would be superior to that which they already receive? There is no justification for such a transfer when a risk assessment is carried out.

I welcome the opportunity to work with another hospital. I think this will be an excellent development opportunity that will allow us to share knowledge and skills and develop working practices that ensure our patients receive the best care at all times. You have suggested in your draft proposals that you believe staff do not see enough cases to maintain and improve their skills, which I dispute strongly. However such a working partnership would mean that both sites are delivering the best evidence-based practice. National guidelines for critical care nursing have been developed over recent months which set standards for competencies and education that ensure that nurses in this area are trained to the same standard.

Another one of your concerns relates to the fact that Stafford hospital has found it difficult to attract and retain enough doctors and nurses, something that is not surprising considering the uncertainty of the hospital's future and the negative media campaign. However, only last week we received a large number of nursing applications for a clinical rotation and development programme which provides eight nurses the opportunity to rotate into critical care. Having been party to these interviews I can offer you reassurance that the calibre of candidates seen and recruited was exceptionally high and, although they wanted some clarification with regards to the proposals, they all believed that Stafford provided a positive learning environment due to the emphasis we place on training, education and development of staff. Furthermore, costs have been high at MSFT as during this period of uncertainty we have been employing Locum doctors at huge cost, one which should reduce significantly when a network is developed and the hospital's future is assured. On the Critical Care Unit at Stafford we rarely use Agency nurses and Bank nurse requirement is usually fulfilled with our own staff, this is not the case at UHNS where recruitment is a significant problem for them.

You have also stated in your report that "in the near future, it is likely that standards of care will slip compared to the wider NHS in England leaving local people worse off". I am not sure how you have reached this conclusion but feel the fact that the staff at Stafford hospital have shown hard work, dedication and a determination to deliver safe quality care for their patients is an approach that I have no reason to doubt will continue. Having gone through the experience that we have, I feel confident that staff will not allow any future management decisions to have a detrimental effect on patient care.

A further comment "there is a fixed budget for the whole NHS; patients elsewhere in the NHS lose out every time MSFT is bailed out" is a statement that could very well be applied to the majority of NHS hospitals around the country. It is recognised nationally that the NHS is facing huge financial problems and I believe that it is the way hospitals are currently funded that is the problem. I realise it is not within your remit to address this as it is a very complex problem, however, it should be recognised that MSFT is not the only hospital with financial difficulties, indeed UHNS are also experiencing significant ones. Furthermore, Stafford has seen a reduction in patients attending which has not been surprising given the relentless media campaign, often presenting inaccurate data and frightening potential patients of the experience they may have. Also the pressures that must have been felt by the PCT and

GPs to provide services elsewhere must have been huge given the criticism directed at them following the Francis Inquiry.

In making any decision in relation to a change in the provision of Level 3 beds within the region, it is essential that input is gained from the Critical Care Network who have access to current statistics and guidelines in relation to national and regional critical care.

In summary, I do not agree with the recommendation to remove Level 3 general beds from Stafford. I believe:

1. Level 3 facilities should remain at Stafford for general Level 3 patients.
2. All Level 3 patients who need specialist interventions should be transferred to UHNS or the next nearest available hospital with specialist facilities.
3. Stafford patients who have required specialist Level 3 care at UHNS and become a general Level 3 patient, i.e. one who requires weaning from a ventilator should be repatriated to Stafford Critical Care to free up a specialist critical care bed at UHNS.
4. Stafford and UHNS should build on the working relationship already in existence as described above, which will ensure clinical excellence for our patients and a development programme for nurses that ensures they maintain the appropriate skills and knowledge.

RCPCH
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Leading the way in Children's Health

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Joint Trust Special Administrators
Office of the Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
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30 September 2013

Dear Professor Mascie-Taylor, Mr Bloom and Mr Hudson

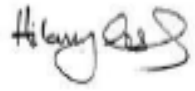
Consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals

Thank you for your letter of 13th August inviting RCPCH to consider the above proposals; although we would not usually comment on proposals for individual local areas I attach our formal response for information.

It is clearly important to ensure that the knowledge and skills of senior clinicians are fully utilised for sensitive and complex reviews such as this. Most of the Colleges now offer an Invited Reviews Service, with a trained pool of doctors who are experienced in assessing situations objectively and providing workable solutions based on professional standards that are achievable in practice. We work together through the Academy or individually with local trusts and commissioners and look forward to contributing where it would be helpful to the development of the TSA process.

Thank you again for inviting us to comment on the proposals and we look forward to hearing of developments in due course.

Yours sincerely



Dr Hilary Cass
President, RCPCH

RCPCH

Royal College of
Paediatrics and Child Health

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

RCPCH response - September 2013

RCPCH does not usually respond in detail to public consultations on redesign for specific local services, since that is the remit of our Invited Reviews programme[1] but we have provided below some general points relating to the principles and standards upon which reconfiguration proposals should be based. We note that Dr David Shortland, Vice President, Health Services at RCPCH, was nominated by RCPCH to be involved in the development of the recommendations through the CAG and support the process of clinical involvement in the development of the way forward for services.

The UK has some of the worst mortality and morbidity rates for children in Europe. Compared to other equivalent European countries, the UK fares worst for all cause childhood mortality for children between 0 and 14 years of age[2,3] and within the UK the *NHS Atlas of Variation in Healthcare for Children and Young People*[4] shows wide regional variation across a range of indicators. The RCPCH is committed to working with other royal colleges and stakeholders to make change happen and improve the health of our children.

The RCPCH strongly supports the principles of the case for change set out in the consultation document. A succession of Medical Royal College reports[5,6,7] have highlighted both the strong consensus amongst medical professionals and also the compelling evidence of the need to redesign services, concentrating specialist services into fewer centres and in providing care by senior clinicians (see RCPCH report on consultant delivered care[8]). In a number of areas across the UK, services are spread too thinly to ensure safe, sustainable, high quality care.

The modelling set out in the RCPCH's *Facing the Future*[9] publication, demonstrates that only by reducing the number of inpatient units will health outcomes for children and young people improve. The model sees fewer, larger inpatient units which are better equipped to provide safe and sustainable care, supported by short stay paediatric assessment units (SSPAUs) and networked services[10]. Fewer inpatient units must be supported by networked services with more care delivered closer to home through community children's nursing teams

and better paediatric provision in primary care. All children and young people must receive the right care, at the right time, in the right place, delivered by appropriately qualified and trained staff. This can be achieved by considering the whole pathway of care from first access to discharge planning and will apply to the range of services being provided at both hospitals and during transfer.

We are reassured that the recommendations in principle refer to the standards set out in the RCPCH's *Facing the Future* publication and that the recommendations for paediatric services are based on clinically sound rationale. There are other service standards which the College would recommend are taken into account when developing the clinical model for children and young people for planned and unplanned care, this includes:

- Intercollegiate Standards for Children and Young People in Emergency Care Settings (RCPCH 2012) covers staffing, training, facilities, communications and interfaces set out in a clear style and agreed by all professional colleges involved with urgent and emergency care. http://www.rcpch.ac.uk/system/files/protected/page/Intercollegiate%20Emegency%20Standards%202012%20FINAL%20WEB.pdf
- Short Stay Paediatric Assessment Units advice for commissioners and providers (RCPCH 2009) sets out models for provision of observation and assessment facilities to complement emergency care and reduce pressure on inpatient services. http://www.rcpch.ac.uk/sites/default/files/asset_library/Publications/S/SSPAUK.pdf
- The acutely or critically sick or injured child in the district general hospital – a team response (DH and intercollegiate 2006 – "Tanner report") details issues around anaesthesia and other services available. It has 42 clear service and competence recommendations and provides a clear checklist when reviewing urgent care services. http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Closedconsultations/DH_4124412
- Standards for Children's Surgery (Children's Surgical Forum, 2013) supersedes Surgery for Children: Delivering a First Class Service and provides fresh guidelines for children's surgical service provision, outlining clear procedures for all those involved in commissioning, planning and delivering services. http://www.rcseng.ac.uk/publications/docs/standards-in-childrens-surgery
- Service Standards for Hospitals Providing Neonatal Care 3rd edition (BAPM August 2010) defines medical and nursing staffing levels and links closely with the NICE and DH documents and Quality Standard and Toolkit. http://www.bapm.org/publications/documents/guidelines/BAPM_Standards_Final_Aug2010.pdf
- Safeguarding Children and Young people: roles and competences for health care staff (RCPCH, RCN, RCGP 2010). This document provides a competency framework for all groups (ranging from non-clinical staff to experts), information on education and training and role descriptions for named and designated professionals. This document will help all health

staff understand their responsibilities in recognising child maltreatment and how to take effective action.
http://www.rcpch.ac.uk/sites/default/files/asset_library/Health%20Services/Safeguarding%20Children%20and%20Young%20people%202010.pdf

- Improving the standard of care of children with kidney disease through paediatric nephrology networks, Royal College of Paediatrics and Child Health,
http://www.rcpch.ac.uk/system/files/protected/page/care%20of%20children%20with%20kidney%20disease.pdf

The College strongly support the involvement of children and young people and their parents/carers in service development and redesign and we can offer support to organisations in achieving this. The RCPCH believes patients and their families are not only beneficiaries of the NHS but also key stakeholders and therefore need to be involved in all areas of planning and service development[11] [12].

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[1] www.rcpch.ac.uk/invitedreviews

[2] Wolfe, I. et. al. (2011) Improving child health services in the UK: insights from Europe and their implications for the NHS reform. BMJ. 342:d1277.

[3] Wolfe, I. et al. (2013) Health Services for Children in Western Europe. The Lancet. 381;9875. 1224-1234.

[4] Right Care (2012) NHS Atlas of Variation in Healthcare for Children and Young People.
http://www.rightcare.nhs.uk/index.php/atlas/children-and-young-adults/

[5] Royal College of Physicians (2012) Hospitals on the edge? The time for action.
http://www.rcplondon.ac.uk/sites/default/files/documents/hospitals-on-the-edge-report.pdf

[6] Royal College of Obstetricians and Gynaecologists (2011) High Quality Women's Health Care: A proposal for change http://www.rcog.org.uk/files/rcog-corp/HighQualityWomensHealthcareProposalforChange.pdf

[7] Academy of Medical Royal Colleges, the NHS Confederation and National Voices (2013) Changing care, improving quality: reframing the debate on reconfiguration
http://www.nhsconfed.org/Publications/reports/Pages/Changing-care-improving-quality.aspx

[8] RCPCH (2012) Consultant Delivered Care - An evaluation of new ways of working in Paediatrics
http://www.rcpch.ac.uk/system/files/protected/page/CDC%20full%20report%2024%2004%2012%20V2.pdf

[9] RCPCH (2011) Facing the Future http://www.rcpch.ac.uk/facingthefuture

[10] RCPCH (2012) Bringing Networks to Life
http://www.rcpch.ac.uk/system/files/protected/page/Bringing%20Networks%20to%20Life%20for%20web_0.pdf

[11] RCPCH, NHS Confederation, Office for Public Management (2011) Involving children and young people in health services
http://www.rcpch.ac.uk/system/files/protected/page/Involving%20CAYP%20in%20Health%20Services.pdf

[12] RCPCH (2010) Not Just a Phase - a guide to the participation of children and young people in health services
http://www.rcpch.ac.uk/system/files/protected/page/RCPCH_Not_Just_a_Phase_0.pdf

The Royal College of Midwives
15 Mansfield Street, London, W1G 9NH

The Royal College of Midwives' response to the Trust Special Administrator consultation "Maintaining high quality, safe services for the future" on the future of services at Stafford and Cannock Chase hospitals.

The Royal College of Midwives (RCM) is the professional and trade union membership organisation that represents the vast majority of midwives working at Mid Staffordshire Hospitals NHS Foundation Trust.

The comments set out in this submission reflect the views of RCM members, representatives and officers and principally address the consultation proposals that relate to the provision of maternity services at Stafford Hospital.

The future of the obstetric unit at Stafford Hospital

The RCM acknowledges that at c1800 births a year, the current number of births at Stafford Hospital is insufficient to provide the necessary level of consultant cover. However, we believe that this figure understates the activity that the unit could achieve given projected increases in the size of the local population due to:

- The planned relocation of UK armed forces personnel to Ministry of Defence accommodation in the Stafford area, involving approximately 420 families.
- Plans to build an additional 3,000 houses in Stafford by 2018 and a total of 10,000 new houses by 2031.

The RCM is also concerned about the ability of neighbouring obstetric units to absorb the additional capacity that will result from the closure of the unit at Stafford. In particular, we note that University of North Staffordshire NHS Trust (UHNS), the likely recipient of the majority of women who currently birth in Stafford, already undertakes 5,800 births a year in an area which is also projected to experience a significant increase in the size of the local population. There is a strong possibility, therefore, that the level of activity at UHNS could approach or even exceed 8,000 births a year, at which point it would be necessary to employ a double rota of obstetricians. This would make the service more expensive to provide. In addition, we have concerns about the ability of units of this size to provide a personalised, responsive service

that is attractive for women and families and which midwives would wish to work in.

The RCM therefore recommends that the Clinical Advisory Group gives further consideration to the impact of projected increases in the size of the local population on the potential level of activity that could realistically be achieved at Stafford. Even if it is concluded that this increase is still not sufficient to maintain an obstetric service on the Stafford site, we strongly believe that the service should continue until it is established that other local hospitals have the capacity to deliver a service for more pregnancies.

The option on a Midwife-led Unit at Stafford

The RCM is disappointed that the option of establishing a Midwife-led Unit (MLU) on the Stafford Hospital site appears to have been ruled out. The stated reasons for not supporting this option are that:

- the MLU would see on average less than one birth a day;
- this rate of activity is insufficient for the midwives to keep their skills up to date and deliver babies safely; and
- the very small number of births makes this service too expensive to run.

The RCM is not persuaded by these arguments and we feel there is little in the way of evidence to support the assumptions on which they are based.

Number of women projected to use an MLU at Stafford

Whilst we would not disagree with the estimate that around 50% of births in Stafford would be suitable for midwife-led delivery, the analysis of the number of births at an MLU is flawed. The TSA draft report relies on HES maternity data for 2011/12 for the statement that only 10 to 12 per cent of mothers-to-be choose to use MLUs. This data is not reliable, because it does not clearly distinguish between births that take place in obstetric units and those that take place in midwife-led units (the HES categories are 'consultant ward', 'GP ward', 'consultant/midwife/GP ward' and 'midwife ward/other ward'). Furthermore, because of the somewhat confusing categories that HES uses, there is no way to determine the respective activity rates for MLUs that operate alongside obstetric units and standalone MLUs (of which Stafford would be one).

Evidence suggests in fact that MLUs which are established on previous obstetric sites can be both popular and viable. For example, the MLU in Blackburn delivers in the region of 1000 births a year, the MLU at Huddersfield has delivered 800 births in the last year and the MLU on the Maidstone Hospital site, which was established in the teeth of considerable opposition from local politicians and the media, has delivered approximately

600 women in the last 18 months. There are an increasing number of MLUs delivering in the region of 400-600 women a year; and we see no reason why an MLU at Stafford could not achieve a similar level of activity.

There is not a great deal of evidence available as to how many births an MLU would need to achieve in order to be financially sustainable. However, in 2007 the RCM commissioned Dr Suzanne Tyler to analyse the impact of Payment by Results on the financial viability of birth centres. Dr Tyler concluded that a birth centre would need to be delivering 300 women a year in order to generate sufficient activity to cover income. Dr Tyler's report is set out in appendix one of this paper. We see no reason why an MLU at Stafford could not be delivering at least 300 women a year, although it may take longer than a year to build up this level of activity.

Midwives maintaining their skills at the MLU

The RCM does not agree with the argument that the MLU would not undertake sufficient activity for midwives to maintain their skills or the statement (made at the National Clinical Advisory Group meeting of 25th May) that midwives working in MLUs need to be rotated due to the low number of births. The question of whether midwives need to rotate will depend not just on the number of births, but also on the number of midwives and the experience of those midwives. A midwife does not need to do lots of births to keep up her skills. The issue is how does she remain competent in dealing with emergencies, transfers etc. and this is addressed through mandatory training, which is most sensibly provided on site. In actual fact, where midwives do rotate it is normally in order to give hospital-based midwives experience in normality.

We would also question the statement, made at the meeting of the local Clinical Reference Group on 28th May, that MLUs face recruitment and retention problems because *"midwives choosing to rotate to a MLU are likely to deliver fewer babies"*. There is no evidence that MLUs have difficulty in recruiting and retaining midwives; in fact, MLUs are generally popular options for midwives because it enables them to practice midwifery in a way that is consistent with a philosophy of normality and woman-centred care.

Estimated cost of operating an MLU

The draft TSA report estimates that if the MLU delivered 200 births a year it would be projected to lose £225,000 a year. This is simplistic and in our view overstates the staffing costs and underestimates the income. It also based on projected births which, in our view, are at the low end of what the MLU could undertake:

- Most busy obstetric units only have between 9 and 12 delivery beds and we are not aware of any freestanding MLUs that have more than 5 beds (most have less than this).
- It is unclear how the staffing costs have been worked out, particularly in relation to the staffing ratio of 60:40 midwives: MSWs. This is a high ratio of MSWs to midwives and without having more information about the rationale for this ratio, it is difficult to determine whether this is appropriate. Furthermore, the number of midwives in an MLU should be based on projected births and not on number of beds. For MLUs, the Birthrate Plus workforce planning tool recommends a ratio of one midwife for every 35 births.
- The projected income excludes the antenatal and postnatal tariff payments that would also be due. So in addition to the £1477 for each of the 200 births, there should also be added (on the assumption that these are all low-risk women) £1076 for antenatal care and £241 for postnatal care. Therefore total income would be in the region of £560,000. However this probably understates income because the MLU would almost certainly provide antenatal and postnatal care to additional women than those giving birth at the MLU. In addition, if the MLU was to undertake 300 births a year then the income would be at least £840,000.
- It is of course inevitable that some women who present at the MLU will have to be transferred to an obstetric unit. Transfer rates from MLUs vary but, a transfer rate in the region of 20% to 25% would not be untypical. The birth tariff income would then go to the obstetric service provider: if this becomes the same provider as is responsible for the MLU in future (for example if UHNS provides the MLU at Stafford in addition to the obstetric unit at Stoke) then there is no loss of income to the trust. Obviously where a woman transfers to an obstetric unit that is managed by a different provider, then that income will be lost. This may be offset to some extent by any women from outside the MLU catchment area who transfer in to birth there.

The case for an MLU

The TSA report focuses on the perceived risks involved in establishing an MLU at Stafford. It is disappointing that no mention was made of the benefits for women and families that are associated with MLUs.

In particular, there is increasing evidence that midwife-led care is safe, effective and leads to good outcomes and experiences for women and families. The Birthplace in England study showed that for all low risk women, birth is as safe for babies in alongside and freestanding midwife units as it is in obstetric units, but with the added benefits of reduced interventions for the

mother[1]. A further study[2], which examines whether maternity services can be configured to provide 24/7 consultant care - for women who need it -, whilst also providing personalised care in smaller units, indicates that:

- Decreasing the number of women giving birth in an obstetric unit, by providing midwife-led alternatives for low risk women, results in a reduction in intervention rates.
- Although this reduces the size of obstetric units and the number of women needing obstetric care, the proportion of high risk women and of women needing obstetric care is increased, thereby centralising the work of consultants.
- Because the same population of women is cared for overall, the cost of 24/7 consultant presence is justifiable.

Furthermore, the establishment of an MLU on the Stafford site would enhance choice of and access to maternity care for women at low risk of developing complications. This is consistent with national policy:

- The NHS White Paper *Liberating the NHS* commits the current Government to extend maternity choice and *"help make safe, informed choices throughout pregnancy and childbirth a reality – recognising that not all choices will be appropriate or safe for all women – by developing new provider networks"*[3].

- The subsequent consultation document *Liberating the NHS: Greater choice and control* suggested that women and their families could be offered choice of:
  - Who provides antenatal care and where this takes place.
  - Where to receive antenatal education.
  - Where to plan to give birth i.e. at a hospital, in a midwifery unit or at home.
  - Where to access services for women who have additional needs.
  - Where to give birth when in labour.
  - Pain relief during labour.
  - Where to receive postnatal care.
  - A range of appropriate additional services i.e. breastfeeding support[4].

Taken together, policy and evidence emphasises the importance of ensuring that maternity services are organised in a way which:

[1] National Perinatal Epidemiology Unit (2012) *The Birthplace cohort study: key findings* https://www.npeu.ox.ac.uk/birthplace/results
[2] M Dodwell (2012) *The effect of different maternity service configurations on intervention rates (draft paper)*
[3] Department of Health (2010) *Equity and excellence: Liberating the NHS*NHS White Paper p.19
[4] Department of Health (2010) *Liberating the NHS: Greater choice and control* pp.15-16

- Leads to more women being offered an extension of choice of types of maternity care and place of birth.
- Gives due weight to a range of different, and sometimes competing, policy drivers such as safety, staffing, quality, accessibility and choice.
- Is based on evidence of the respective benefits – especially safety and quality - of different models of care.

Finally, having an MLU at Stafford will also help to alleviate the pressure on the obstetric units at Stoke and Wolverhampton, which as the TSA report makes clear, would not currently be able to absorb the additional workload were Stafford Hospital to stop birthing women.

However, an MLU on the Stafford site will only succeed if:

- The proposal commands the support of local commissioners, clinicians and other key decision makers;
- The MLU is vigorously marketed locally, with every effort made to engage with local women, their families and community and user groups; and
- The FMU is staffed in a way that facilitates integration with community midwifery services i.e. the core midwifery staff are supplemented by rotated midwives who will take responsibility for home births.

Alternative models

The RCM is aware that the Maternity Department at Stafford Hospital has developed a response to the Trust Special Administrators' report, which proposes entering into an alliance with a neighbouring provider in order to enable some continuation of obstetric care at the Stafford site. We recommend that this is assessed to see if it represents a viable alternative to either the closure of the obstetric unit or the establishment of an MLU.

Conclusion

The RCM has significant reservations about the proposals for maternity services set out in this consultation.

Whilst we accept that there may be a case for centralising obstetric services, we think further consideration is needed both of the potential for Stafford to undertake more births in future and of the impact of a closure at Stafford on the ability of neighbouring units to absorb additional capacity. We believe that at the very least, the obstetric unit at Stafford should remain open until these capacity issues have been satisfactorily resolved.

Whilst we recognise that considerable work would need to be undertaken to raise awareness of the MLU with the local population, we strongly

recommend that if the obstetric unit at Stafford Hospital closes then it should be replaced by a freestanding midwife-led unit.

The Royal College of Midwives
October 2013

FROM HERE, HEALTH

THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH

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

The Royal College of Surgeons Edinburgh (RCSEd) are pleased to provide comments and recommendations in relation to the Office of the Trust Special Administrator's consultation on the future of services for local people using Stafford and Cannock Chase hospitals.

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

In respect of this recommendation, the Royal College of Surgeons of Edinburgh has significant concerns about how patients will be transferred to surrounding hospitals if the A&E department is further down-graded and how the care of the acute medical take will be managed without level 3 critical care facilities. There is a potential for adverse impacts to patient safety if these issues are not properly addressed.

The College questions the safety of an A&E department that does not benefit from emergency and major trauma surgical cover without the ability to deal with stroke, cardiac disease, vascular surgery, obstetrics, gynaecology and having full paediatric support. The College believes that there needs to be a phased downgrading of the department to a minor injuries unit with a GP clinic facility.

RCSEd believe that a population of this size needs some form of immediate care, particularly for less serious injuries/conditions. The practicalities of staffing a 14/7 A&E department seem challenging and the College suspect that a minor injuries unit may be more appropriate. The impact on the local population and activity in adjacent trusts would, however, need to be assessed.

The College also is concerned about the undoubted increase in the requirement for additional ambulance transfers, as well as the undue pressure on paramedical staff in triaging patients to the appropriate A&E departments in surrounding hospitals.

In addition, the College also has concerns relating to the potential for significant equality and diversity breaches when patients over 70 years of age are denied rapid treatment for cardiovascular events and severe respiratory problems, by being taken to the Frail Elderly Assessment Service at Mid Stafford.

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

The Royal College of Surgeons of Edinburgh supports the recommendation around the inpatient service for adults with medical problems at Stafford Hospital.

The College believes that it is reasonable to have on-going medical care, but, there needs to be strict guidance on what should be transferred for a specialist medical and surgical opinion. Members of the College have experience of this model and have advised that, although at times it can be inconvenient, it is safe.

The College recommends that specialist outreach teams are developed to support care in the community by the Mid Stafford staff.

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

The Royal College of Surgeons of Edinburgh believe that a Frail Elderly Assessment service at Stafford Hospital seems appropriate.

In addition, the College believes that a Geriatric Unit led by Consultants is supported, but, there will need to be an on-call Consultant rota to provide adequate cover for the specialist nurses after 22:00. With the increased life expectancy of the population and the age of retirement being increased to 68, in coming years' admission to this unit may need to be reserved for patients over the age of at least 75 years old.

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

The Royal College of Surgeons of Edinburgh support the recommendation that beds should be available at Stafford Hospital for recovering patients.

The College believes that having step down beds available to enable transfer from specialist care centres is appropriate.

5. **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?**

The Royal College of Surgeons of Edinburgh consider the recommendations around inpatient services for adults at Stafford Hospital to be fair. Stafford Hospital is ideally placed to provide good quality step down services and rehabilitation.

Overall, the College believes that these suggestions seem viable and would offer the local community an acceptable option.

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

The Royal College of Surgeons of Edinburgh supports the recommendation around maternity services in Stafford, particularly in view of the limited paediatric cover.

The College has, however, concerns around the sustainability of rotas. The College believes that the withdrawal of maternity services is only viable if there is an appropriate alternative.

There are also concerns in relation to the on-going provision of obstetric services. The obstetric workload is considerable and, may be due to increase with the proposed re-siting of military services in the areas as well as a consistent and increasing new-build of houses. As such, there is not capacity in surrounding hospitals to manage the increased obstetric load.

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

The Royal College of Surgeons of Edinburgh supports the recommendation around the inpatient service for children at Stafford Hospital.

A number of members of the College believe that there should be no urgent or emergency children's assessments taking place at Stafford Hospital.

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

The Royal College of Surgeons of Edinburgh recommends that this proposal be reassessed. A facility to assess children with low risk medical problems at Paediatric Assessment Units (PAU) could be accepted, however, there would need to be specific protocols for triaging such cases.

Some members of the College question whether this recommendation is workable. Further, satellite paediatric units are very difficult (and expensive) to staff at levels which permit high quality clinical care. Details of this proposed approach would need to be worked out with the University Hospital of North Staffordshire (UNHS), however, it may need to be sacrificed in the interests of a more efficient, high quality service, perhaps with a paediatric outpatient facility.

9. How far do you support or oppose the recommendation around major emergency surgery at Stafford Hospital?

Members of the Royal College of Surgeons of Edinburgh have conflicting views in relation to the recommendation around major emergency surgery at Stafford Hospital. There is a view from our membership that this recommendation would require a strong relationship to develop with the adjacent Trust, but that it is practical provided that UNHS have the infrastructure to cope with this. Four cases per day may seem low on the face of it, but, usually, these derive from 12 admissions. As a result, the amount of work should not be underestimated and UHNS will need to improve its infrastructure to cope with this.

There are other important points to consider. Some members of the College have concerns in relation to the proposal to continue an acute medical admissions unit, despite there being no resident surgical presence. These members advise that about a third of their acute work comes from physicians, and that many medical admissions can have surgical problems as the root cause of their admission. For example, the acute kidney injury secondary to an obstructed hernia is often overlooked by other non-surgical specialities. It is important to consider who will review these patients at Stafford Hospital.

Further, the consultation document claims that the standard of surgical care is better elsewhere, however, there is no evidence for this. Sub-specialisation is beneficial in a small number of situations, but for the vast majority of acute and elective procedures the outcome of surgery is not related to the volume of surgery undertaken. The consultation document also states that there are only four unplanned procedures performed in theatre at Stafford Hospital each day. These four surgeries could fill a full-day CEPOD list dependent upon the case mix. Consequently, by removing the surgical assessment unit on site, this would represent a significant additional workload for the neighbouring hospital. Some members of the College do not believe that the theatre staff are at risk of becoming deskilled with this volume of work.

Overall, in relation to this recommendation, the College is concerned about the transfer of patients from the A&E to adjacent hospitals.

10. How far do you support or oppose the recommendation around the critical care unit at Stafford Hospital?

The College has concerns about the critical care unit at Stafford Hospital, both in terms of its suitability for the services being provided and its sustainability. The transfer of patients from a small to a large hospital requires special care in transit. This needs to be considered.

The recommendation is supported in principle, however, it is believed that the primary aim should be a 'preparation and transfer unit' and that attempts to run a mini Intensive Therapy Unit (ITU) should be avoided. Some members of the College believe that these 'mini ITU's' do not work and that staff in such units are unable to maintain skills.

Some of our members have expressed a view that high dependency areas are not designed for ventilated patients and, therefore, the plan to use them for resuscitation of patients incorrectly triaged to Mid Stafford is suboptimal. RCSEd does, however, accept there has to be a mechanism for dealing with these eventualities. To minimise the risks to patients finding themselves in this situation, there should be regular simulations to ensure that the team members in High Dependency Units and the anaesthetic staff work in a co-ordinated fashion when dealing with these, hopefully, rare occurrences.

In relation to the recommendation that an urgent transfer service should be established, the College believes that the Trauma Review produced by Professor Keith Willet, recommending regional trauma systems, should be considered in the Stafford area. This review is already being established across other areas in the UK. Some of the College's membership would expect a policy whereby major trauma bypassed the Stafford Hospital and went to a Major Trauma Centre.

Through the Ambulance Services, 'Medical Emergency Response Incident Teams' (MERIT) have been established across England. In the West Midlands, MERIT is available 24 hours a day, seven days a week. During the day, MERIT is operated by doctors on the air ambulance. In the evenings and out-of-hours, MERIT is run by a doctor and a critical care paramedic and they are mobilised by an ambulance. This service runs from roughly the junction of the M5 and M6 and covers the wider West Midlands. With appropriate tasking, MERIT will provide ED to MTC patient transfers and has indeed delivered intra-hospital transfers since inception in March 2010. The College advises that this service (unless committed elsewhere) would undoubtedly be available to move trauma patients from Stafford A&E to Stoke. Currently, the service is fundamentally funded for trauma and, consequently, it does not support medical transfers.

The College is aware of other hospitals with similar problems. The Royal Derby Hospital has advised that they have similar problems with two hospitals in their area. Their solution has been that the respective nominated receiving hospitals provide an ICU retrieval service for the Level 2 (HDU) and Level 3 (ICU) patients, staffed predominantly by Consultants with some input by trained Specialty Doctors (SAS grade), utilising the East Midlands Ambulance Service and using a non-paramedic crew. The transfer staff 'should' have undergone the MTCCN Transfer Course, which is a one-day specific course teaching the use of the MTCCN transfer trolley with standardised equipment (Oxylog 3000, Propaq monitoring, Laerdal Suction pump, Ferno Vacuum mattress etc). Some of our membership believe that, in principle, ICU patients and HDU patients who are at Stafford Hospital should fall into the responsibility of the receiving ICU/HDUs and be retrieved by them, unless Stafford Hospital has got suitably trained senior staff (Medical and Nursing) reliably available around the clock.

The College has a new qualification, the 'Diploma of Transfer & Retrieval Medicine' RCS Ed. It is a very important qualification, which evidences knowledge of the subject matter and knowledge and competency in the principles of this specialist practice field. This is a suitable qualification that would be useful for those involved in the transfer of patients from Stafford Hospital and to the surrounding areas.

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

The Royal College of Surgeons of Edinburgh supports the recommendation around elective care and day cases at Stafford Hospital and believes that this recommendation seems appropriate.

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

The Royal College of Surgeons of Edinburgh supports the recommendation that beds should be available at Cannock Chase Hospital for recovering patients.

13. How far do you support or oppose the recommendation around the elective inpatient surgery at Cannock Chase Hospital?

The Royal College of Surgeons of Edinburgh supports this recommendation, but, only if demand and throughput were sufficient to maintain skills. At its current state, there is a view from our membership that expanding services at Cannock Chase seems inappropriate and unnecessarily expensive.

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

The membership of the Royal College of Surgeons of Edinburgh have conflicting views in relation to this recommendation. Some members of the College believe that this recommendation is very vague, while other members are in full support. Some members of the College believe that it is unlikely that Cannock Chase can support the increase in procedures made available to the local population.

15. How far do you support or oppose the recommendation for MSFT to be dissolved with the services at Stafford and Cannock Chase hospitals managed and delivered by another organisation or organisations in the future?

The Royal College of Surgeons of Edinburgh believe that the economies of scale make this a reasonable recommendation and agree that this recommendation is an important and obvious step. There is a need for these hospitals to be rebranded and re-invented and some members of the College believe that any proposal to improve them will be hampered unless there is a major change. The College is also aware that many local people would prefer a fresh start.

There may also be an under-utilisation of good facilities in both Cannock Chase and Stafford Hospital unless there is a re-distribution of elective surgical services.

General Comments

RCSEd are aware that the clinicians in Stafford Hospital face a difficult situation, with many factors to consider. Some of these factors may not have been taken into account in providing solutions of the re-organisation of services in Staffordshire. Whilst the College in general supports the Terms of Reference (ToRs) for the Clinical Advisory Group, it is noted that these did not include services not already in existence and that there was no reference to finance, the Berwick Report or patient safety within them.

In considering the various models proposed by TSA, it should be recognised that these are contingent on new providers suggesting appropriate new models and the proposals for other adjacent trusts, for example expanding Cannock Chase Hospital. It is also important to recognise that the sustainability of these new services will be dependent on accurate financial modelling.

There is a strong feeling, amongst some of the College's membership, that the consultation by the TSA has not been as thorough and detailed as it could have been, and that this is manifested in the questions about the quality of the data used, and questions about sustainability of services under the three plans that have been drawn up. The data that was documented in the consultation by the TSAs and CAG may not have been validated (CEPOD data) and this may have led to the downplaying of the complexity of their services. As a result, this may have implications for patients.

There is some concern that there is a financial imperative under-pinning many of the arrangements within the report, which is to do with affordability in the context of £20 million annual overspend under the current arrangements, and the increasing difficulty with staffing the services. Some members of the College felt that this consultation document did not acknowledge the impact these changes will have on the large (300,000) population these hospitals serve, particularly given the geographical location of Stafford Hospital and the demographic composition of the area.

Some of the College's members would like to have seen a report that was more focussed on addressing the damage suffered by the local population. Another view expressed has been that Stafford Hospital has been left in a compromised position from which it cannot return without major reinvention and rebranding. As such, it may be necessary for a massive investment to restore public confidence in these hospitals and compensate for the damage suffered by the local population.

A number of our members have expressed a view that it is sensible that the two hospitals are split and managed by two completely different Trusts (as proposed). It has been suggested that, if these hospitals are to succeed, even under the proposed management by two adjacent Trusts, there should be significant investment to ensure they succeed and careful on-going monitoring and support to make sure they get it right.

There is a concern that there is not sufficient recognition that a safe clinical model may prove expensive, calling in to question long term viability. A proposal put forward by some of our members is that there should be 'a clean financial sheet', and that sufficient investment should be provided to address the underlying problems in infrastructure and buildings. This is felt to be an important part of 'rebranding' and is necessary to attract permanent staff and restore confidence.

The Royal College of Surgeons Edinburgh hopes that these recommendations and comments provided will assist in addressing some of the problems identified by Office of the Trust Special Administrators' of MSFT. The proposals seem reasonable but there is still a lot of thought and work that needs to go into making sure that Stafford and Cannock Hospitals maintain high quality and safe services for the future.

The Royal College of Surgeons of Edinburgh has a global membership of over 20,000 surgeons and dental surgeons across 100 countries, and is the longest-established of the UK Surgical Royal Colleges.

The primary purpose of the College is the pursuit of the highest standards of surgical practice and patient care, achieved through its work in surgical education and training, assessment, professional development and patient safety.

With half of its 20,000 Fellows and Members residing within the UK, principally within England, the College represents a significant voice within the UK surgical workforce.

7

Faculty of Public Health

Of the Royal Colleges of Physicians of the United Kingdom

Working to improve the public's health

UK Faculty of Public Health Response to the Mid Staffordshire NHS Foundation Trust Office of the Trust Special Administrator consultation on Maintaining high quality, safe services for the future

About the UK Faculty of Public Health

The Faculty of Public Health (FPH) is the standard setting body for specialists in public health in the UK. FPH is the professional home for more than 3,200 professionals working in public health. Our members come from a range of professional backgrounds (including clinical, academic and policy) and are employed in a variety of settings, usually working at a strategic or specialist level.

FPH is a joint faculty of the three Royal Colleges of Public Health Physicians of the United Kingdom (London, Edinburgh and Glasgow). In addition, FPH advocates on key public health issues and provides practical information and guidance for public health professionals, aiming to advance the health of the population through three key areas of work: health promotion, health protection and healthcare improvement.

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 select one answer only

- ...1 Strongly support
- ...2 Tend to support
- ...3 No views either way
- ...4 Tend to oppose
- ...5 Strongly oppose
- ...6 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 type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly

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stating which question your comments refer to.

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

The UK Faculty of Public Health sees no reason to oppose this recommendation although the ambulance services and local population in particular may find it difficult to behave in such a way that patients with serious life threatening situations suddenly remember not to take themselves to this hospital between 10pm and 8am as there may not be any one of any senior enough experience to deal with them.

There would have to be a senior and experienced A&E staff to deal with the more difficult situations in this time period and have adequate guidance on moving patients safely to to the major centre. There should be very careful monitoring and audit of this service arrangement. Staff recruitment and retention to this reduced level service may be an issue even with staff rotation.

Overall it is not clear that there is sufficient evidence to demonstrate the impact of the proposed A&E changes on the surrounding hospitals. A number of A&Es are reported to be struggling with capacity problems and possibly adding to the reported problems of nearby A&E units by the overnight closure of the Stafford A&E may make the situation worse.

It is not clear that there has been an adequate risk assessment of the impact of the proposed A&E changes on the behaviour of the local population. Will there be numbers of patients who do not call ambulances for emergencies or injuries of moderate severity and who decide not to travel the longer distance to other A&Es?

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 select one answer only

- ○ 1 Strongly support
- ◉ 2 Tend to support
- ○ 3 No views either way
- ○ 4 Tend to oppose
- ○ 5 Strongly oppose
- ○ 6 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 select one answer only

- ○ 1 Strongly support
- ◉ 2 Tend to support

- ○ 3 No views either way
- ○ 4 Tend to oppose
- ○ 5 Strongly oppose
- ○ 6 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 select one answer only

- ○ 1 Strongly support
- ◉ 2 Tend to support
- ○ 3 No views either way
- ○ 4 Tend to oppose
- ○ 5 Strongly oppose
- ○ 6 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 select one answer only

- ○ 1 Strongly support
- ◉ 2 Tend to support
- ○ 3 No views either way
- ○ 4 Tend to oppose
- ○ 5 Strongly oppose
- ○ 6 Not sure / Don't know

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

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to these recommendations.

Please type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly stating which question your comments refer to.

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

Whilst such a service is welcome and necessary especially for some groups of elderly patients there needs to be clear guidance to ensure those patients in need of more specialized and / or intensive care have their needs recognized quickly, have access to the clinical expertise or are moved urgently and safely to a site with such expertise. It will be incumbent upon the larger organization that clinical staff are rotated around the different sites to ensure that staff morale, knowledge and skills are maintained to support CPD and revalidation.

There are many interdependencies between different clinical services. It is not clear how taking forward these proposals on general medical services will be affected if some of the other clinical services are transferred to tertiary hospitals.

The proposed changes to support the frail elderly patients should be important as these can be complex patients who with a lack of appropriate and holistic care can spend unnecessarily long times in hospital beds. This can be to the detriment of the patients and not helpful for the NHS. However, it is not clear that the commissioning intentions of the CCG will translate into appropriate support for this model particularly when there are a number of financial challenges around that will make establishing new services more difficult.

A wider point is that with people living longer there are many older people needing treatment through the NHS. A lot of these patients will not necessarily be seen as frail elderly but may have co-morbidities that need management in additional to the more immediate medical problem being treated. For example, patients undergoing acute surgery but with some other problem(s). Will the services be established to support these patients in a holistic manner as well?

Recommendation 5: Maternity services in Stafford

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

Please select one answer only

- ○ _1 Strongly support
- ○ _2 Tend to support
- ○ _3 No views either way
- ○ _4 Tend to oppose
- ○ _5 Strongly oppose
- ○ _6 Not sure / Don't know

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 type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly stating which question your comments refer to.

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

The UK Faculty of Public Health recognizes the financial issues and provided there is a real choice that is not burdensome from an access perspective the recommendations could be supported. Economic support for poorer families without their own transport to enable access to more remote units will be an important consideration.

If the Stafford unit is judged to be too small to be viable for the number of deliveries then the alternative plans need to be clearly better than the current service. There is limited evidence about the ability of the surrounding units to be able to meet the increased need if Stafford's maternity unit is to close and it would be useful to have more detail and more confidence that other units will not be overloaded. This area and the likely fluctuations in demand need careful risk assessment to ensure that any changed service is not of more risk than the current one.

Recommendation 6

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

Please select one answer only

- ○ 1 Strongly support
- ◉ 2 Tend to support
- ○ 3 No views either way
- ○ 4 Tend to oppose
- ○ 5 Strongly oppose
- ○ 6 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 select one answer only

- ○ 1 Strongly support
- ◉ 2 Tend to support

- ○ 3 No views either way
- ○ 4 Tend to oppose
- ○ 5 Strongly oppose
- ○ 6 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 select one answer only

- ○ 1 Strongly support
- ● 2 Tend to support
- ○ 3 No views either way
- ○ 4 Tend to oppose
- ○ 5 Strongly oppose
- ○ 6 Not sure / Don't know

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 type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly stating which question your comments refer to.

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

The UK Faculty of Public Health recognizes the staffing and workload challenges for in-patient paediatrics in Stafford. However, economic support for poorer families especially with a number of small children with distant unit and child care where there are other children when prolonged and repeat visits to the distant unit are necessary.

There has been a higher than expected admission rate to the Stafford paediatrics unit and the reasons for this need to be further explored. For example, one argument is that a lack of GP support for certain patients has led to more admissions.

Recommendation 8: Major emergency surgery at Stafford Hospital

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Q14
How far do you support or oppose the recommendation around major emergency surgery at Stafford Hospital?

Please select one answer only

- ○ _1 Strongly support
- ◉ _2 Tend to support
- ○ _3 No views either way
- ○ _4 Tend to oppose
- ○ _5 Strongly oppose
- ○ _6 Not sure / Don't know

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 type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly stating which question your comments refer to.

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

The UK Faculty of Public Health recognizes that there is a general move to focus surgery on fewer and more central sites for major surgical procedures. Whilst we support this in principle we would want the TSA to be mindful of access for families and carers of patients admitted for longer periods. We would also seek reassurance that acute surgical cases are readily recognized and transferred quickly and safely outside of the A&E consultant led service window.

As with many of the other proposed changes there needs to be sufficient capacity at the distant hospital for problems not to occur. Given some of the current access issues at units with reduced capacity in new units then the need to develop additional capacity may be challenging and should be properly risk assessed.

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 select one answer only

- ○ _1 Strongly support
- ○ _2 Tend to support
- ○ _3 No views either way

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- ...4 Tend to oppose
- ...5 Strongly oppose
- ...6 Not sure / Don't know

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 type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly stating which question your comments refer to.

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

If the UK Faculty of Public Health were to support this initiative it would want reassurance that the staff at Stafford are suitably skilled and expert at dealing with these types of patients and that those patients in need of this level of support are readily identified.

There is also an underlying issue with a unit such as this having a critical mass of skilled staff and sufficient beds to deal with appropriate cases. This would need to link carefully with other plans for the care of older patients. Overall this area is likely to need more in-depth evaluation to understand the linkages and interdependencies with other clinical services.

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 select one answer only

- ...1 Strongly support
- ...2 Tend to support
- ...3 No views either way
- ...4 Tend to oppose
- ...5 Strongly oppose
- ...6 Not sure / Don't know

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 type in your answer below and if you are commenting on specific elements, please

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indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly stating which question your comments refer to.

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

This seems a reasonable service to support at Stafford.

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 select one answer only

- ○ _1 Strongly support
- ◉ _2 Tend to support
- ○ _3 No views either way
- ○ _4 Tend to oppose
- ○ _5 Strongly oppose
- ○ _6 Not sure / Don't know

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 type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly stating which question your comments refer to.

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

If anything this is a development of existing 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 select one answer only

- ○ _1 Strongly support
- ◉ _2 Tend to support

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- ○ 3 No views either way
- ○ 4 Tend to oppose
- ○ 5 Strongly oppose
- ○ 6 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 type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly stating which question your comments refer to.

Please do not include details that could be used to identify any individuals.
If anything this is a development of existing services at Cannock.

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 select one answer only

- ○ 1 Strongly support
- ◉ 2 Tend to support
- ○ 3 No views either way
- ○ 4 Tend to oppose
- ○ 5 Strongly oppose
- ○ 6 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 type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly stating which question your comments refer to.

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

If anything this is a development of existing services at Cannock.

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 select one answer only

- ○ 1 Strongly support
- ◉ 2 Tend to support
- ○ 3 No views either way
- ○ 4 Tend to oppose
- ○ 5 Strongly oppose
- ○ 6 Not sure / Don't know

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 type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment please use the box provided for question 28, clearly stating which question your comments refer to.

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

The model is of tertiary hospitals taking over key services and establishing clinical networks to support better quality services back in Stafford is a useful one. However it will need a lot of commitment to make that it works both from managers and clinicians and that the smaller hospital is not overwhelmed by the larger one.

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 type in your answer below and if you are commenting on specific elements, please indicate which ones.

If you want to provide a longer comment, additional answer boxes will be provided below. If you still need more room after typing in the answer boxes, please send an email to TSAconsultation@midstaffs.nhs.uk, clearly stating your ID number and which question your responses refer to.

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

Whilst the UK Faculty of Public Health accepts that there is a national trend for centralizing some services at larger specialist centres any changes need to put patient safety at the forefront whilst accepting that the healthcare provision has to be sustained within economically constrained limits. We make the following observations in response to the MSFT consultation.

We agree that NHS patients will only get the services they need if money is not wasted through inefficiency. Whilst inefficiency may come about through the way hospital structures are organized and staff deployed it can also come about through poor clinical decisions concerning the management of patients at various stages of their clinical pathway and at the end of life. Whilst the centralization of more acute services may deliver some efficiencies it does not necessarily address the quality of clinical decisions and appropriateness of the subsequent diagnostic investigations and treatments. More will be required of the new structure to ensure that clinical decisions concerning resource use are also addressed.

It is not clear how well the units that would take over some of the Stafford services will cope even with a 2-3 year lead in. If the changes were to go through then it is possible that Stafford Hospital will suffer some planning blight and a worsening of the current problems such as the difficulty in attracting good quality staff so that Stafford residents will have to endure a further difficult period whilst the DGH services struggle to maintain standards. Of course patients need to travel for the technical specialist services that are only delivered in small numbers of centres but this does not mean that all clinical services will benefit from centralisation.

The Faculty would support the concept of structured clinical networking but this needs piloting and evaluation as in the past big hospitals have been seen as taking over smaller ones and neglecting the latter's role. This is both at a management level and a clinical level.

Overall, the Faculty is concerned about a lack of sufficient evidence of what model(s) might work. This is in the face of the proposed changes that would entail considerable managerial and financial complexity, and also of multiple interdependencies between key clinical specialities. This is particularly true in terms of tertiary hospital / DGH networking and the lack of detailed risk assessments in the proposals means that there may be considerable unintended consequences.

Any model that might work well for Stafford and the surrounding hospitals could apply to other DGHs in comparable situations in terms of size and future difficulties in squaring finances and appropriate clinical services. It might be reasonable for any such model to be developed as a pilot rather than being a response to financial pressures.

Given the reservations expressed above, we are concerned the best solution population for the population is yet to emerge, and that there appears to be insufficient specialist public health input, which we believe our members would be able to assist with, if appropriately resourced and co-ordinated with the local public health team.

FPH and the Association of Directors of Public Health (ADPH) work closely together, and are committed to ensuring that patient safety, through provision of the highest possible standard and quality of care, is the priority focus of NHS and public health service delivery. Individual public health consultants specialising in health service public health can always be identified through the relevant local director of public health.

Public health specialists in this aspect of public health practice bring vital expertise to the commissioning and delivery of clinically effective, cost-effective and high quality NHS services, including acute hospital services, for the communities they serve. Health services public health

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consultants are employed within NHS hospitals, and specialists in this area of public health practice deliver real gains to the population through core functions that include:

- Identifying and highlighting areas of greatest potential gain in outcome, quality or safety
- Identifying inequity and ensuring fair access to treatments for all members of the community;
- Getting best value through identifying and prioritising effective and cost-effective treatments and organisational arrangements,
- Building integrated systems of prevention, treatment and care.
- Supporting continuous service improvements according to agreed priorities through innovation, developing monitoring systems, and providing critical analysis and interpretation
- FPH and ADPH members are active in commissioning and delivering the highest possible standard of care for the communities they serve and bring key knowledge and analytical skills.

We would strongly urge you to seek further dialogue with local public health leaders, with a view to securing further appropriately resourced specialist public health input.

If insufficient capacity is available locally, the provider trusts should consider appointing or seconding a consultant in public health to help oversee any new configuration of services around Mid Staffordshire hospitals and the surrounding hospitals. Such a post would provide an oversight of the impact on health care quality and population health including access to services with evaluation as a key focus. Given the lack of evidence about outcomes following restructuring of clinical services, professional support of this kind is essential. The Faculty could assist in the development of this proposal if required.

Background Information

Q29
Are you:

Please select one answer only

○ 1 Providing your own response or responding on behalf of another individual?

◉ 2 Submitting your response on behalf of an organisation or group?

About the UK Faculty of Public Health

The Faculty of Public Health (FPH) is the standard setting body for specialists in public health in the UK. FPH is the professional home for more than 3,200 professionals working in public health. Our members come from a range of professional backgrounds (including clinical, academic and policy) and are employed in a variety of settings, usually working at a strategic or specialist level.

FPH is a joint faculty of the three Royal Colleges of Public Health Physicians of the United Kingdom (London, Edinburgh and Glasgow). In addition, FPH advocates on key public health issues and provides practical information and guidance for public health professionals, aiming to advance the health of the population through three key areas of work: health promotion, health protection and healthcare improvement.

Q42
What category of organisation or group are you representing?

Please select all answers that apply

☑ 1 A professional body (e.g. a Royal College)

☐ 2 An NHS trust (provider of services)

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- [ ] 3 Charity / voluntary sector group
- [ ] 4 National patient group
- [ ] 5 Local patient group
- [ ] 6 Local Authority
- [ ] 7 Trade union
- [ ] 8 Trade body
- [ ] 9 Academic organisation
- [ ] 10 Political party / Political group
- [ ] 11 Clinical Commissioning Group
- [ ] 12 Other NHS body
- [ ] 13 Regulatory body
- [ ] 14 Other
- [ ] 15 Don't know

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

3,300

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

Please type in your answer below

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Mr Charlie McLaughlan

Director of Professional Standards

The Royal College of Anaesthetists

Q2

There was some disagreement on members about this. Some felt that the current system is not working and that closing the A&E department and centralising this service would be a better and more viable option, both in terms of finance and staffing.

Other members however felt that A&E services at Stafford Hospital should be retained, but they would prefer to see a 24 hours service.

Q7

Question:

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

Our clinical members generally support this recommendation, but have expressed concern that inpatients deteriorating can put pressure on surgery, ICU and emergency departments.

Our lay members fully support this recommendation and have made the following comments:

- We fully support these steps, provided that the quality of services and care are maintained at Stafford Hospital, in particular those area that were so neglected before (e.g. hydration, nutrition) and infection risks.
- Maintaining a wide range of services in the hospital should also help to attract and keep good staff.

Question:

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

Both our lay and clinical members fully support this recommendation. Our clinical members commented that we are caring for an increasingly elderly population who require specific services and appropriate multi-disciplinary input to care for them. Geriatricians are best-placed to guide and

co-ordinate this care. However, development of this service will require heavy input from other medical professionals such as physiotherapists, occupational therapists, dieticians etc. Recruitment of such individuals will obviously have financial implications.

Question:

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

Both clinical and lay members fully support this recommendation. Our lay members have offered the following comments:

- As regards the provision for recovering patients, this proposal seems to make sense to us provided that there is a smooth transition for the patient when stepped down from the specialist centre to the local hospital, and patients are not hurried too quickly out of beds. We presume these steps will tie up with the recently introduced Enhanced Recovery Programme (ERP) to get patients better quicker. We would also ask however, what is the transfer provision in the event of deterioration of a patient?

- As regards the frail and elderly, we recommend closer working relationships with social care services that need to be carefully worked out and monitored, not left to chance. Further, the emphasis seems to be on the elderly actually accessing and using the hospital, but there should be provision to ensure identification through other means. In addition, the huge reduction in availability of accessible and public transport could mean that the elderly and frail might not have equality of access.

- Whilst elderly patients may prefer to be treated closer to home, they may be quite nervous at the step down in levels of care that are provided in specialist centres.

Q9

Both our clinical and lay members support this recommendation. From a patient point of view, this decision may not be immediately popular, but would offer more choice to mothers to be in the long term. It is good to see that antenatal services will continue to be provided at Stafford and it is hoped that the changes will be communicated effectively to service users at Stafford Hospital.

Q13

Question:

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

This may not be a popular decision at local level, but our members support this recommendation, since there is already an increase in centralisation of inpatient paediatric services at national level. Stafford Hospital and relevant agencies will need to communicate the changes appropriately to service users.

Question:

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

There was a split of opinions on this recommendation. Generally the clinical members were not supportive. Although some lay members were supportive, many were not. Of particular concern to both clinical and lay members is the suggestion that the PAU should operate only between 8.00am and 10.00pm. Our members, both lay and clinical, feel that the PAU should operate a 24 hours service. Concern was also expressed that there is a need for local paediatric services and it would be difficult for parents to know where the new services would be located.

Question:

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

Our clinical members have some reservations on this proposal; it would seem that the planned withdrawal of inpatient paediatrics would result in no paediatricians on site. This potentially leaves the anaesthetists (and ED doctors) to take the brunt of managing the small but definite number of critically ill children who will be brought to the nurse-led PAU without the on site support of paediatric specialists.

Q15

There was a split of opinions for this recommendation, and at the same time some concern was expressed about the system being confusing. The 'most' in the sentence "Most major emergency surgery would instead be provided by a local larger hospital such as UHNS or The Royal Wolverhampton Hospitals NHS Trust" indicates vagueness on how exactly this is going to work in practice. What about the rest of the major emergency surgery coming into Stafford and what exactly classifies as emergency surgery? The consultation document focuses on general surgical and trauma but there are other major emergencies in other surgical specialities that need to be considered here (e.g. acute airway obstruction requiring ENT expertise to provide a surgical airway). One clinical member suggested that all emergency surgery should be transferred elsewhere. Moreover A&E staff must still be able to assess quickly a patient's condition.

Q17

There is strong opposition from clinical members to this recommendation. The concern is that there will not be suitably equipped and staffed ICUs in case a patient admitted to A&E deteriorated rapidly. The proposed 'small critical care area' would inevitably need to service the needs of inpatients who have collapsed and need initiation of intensive care as well as those arriving via ED. This would have implications for the size of the facility and the resources (nursing, medical and otherwise) required.

There is also concern on how the rotation and networking of staff would work in practice in terms of transport links for staff and how trainees might be affected if they are to spend a period of weeks in a level 2 ICU, i.e. not gaining enough experience in a level 3 ICU.

These views are also echoed by the Faculty of Intensive Care Medicine of the Royal College of Anaesthetists, who has responded separately to the consultation expressing their concern in detail in a letter to Mr Mascie-Taylor, Mr Bloom and Mr Hudson, specifically on this recommendation.

Q19

This recommendation was well supported by both clinical and lay members of College, with the caveat that adequate preoperative assessment is provided so that high risk cases are promptly identified and transferred to larger hospitals, for example revision arthroplasty surgery in particular would require careful risk assessment.

Q21

It was generally felt that this is a possible solution, providing that adequate resources are available.

Our lay members point out that, Cannock Chase, may not be a suitable location for all patients (and their relatives), if some patients are perhaps located closer to Stafford Hospital.

Q23

Both our lay and clinical members think that this is a reasonable proposal. Not enough detail is given on which new surgical specialities will be introduced to Cannock Chase, but our lay members advise that the surgical team must be able to maintain their skills with a wide range of cases.

Our clinical members warn that Development of increased surgical specialties at Cannock Chase Hospital would need to consider whether ICM/HDU support and on call anaesthesia services were required.

Q27

There is general support from members for this recommendation and the evidence in the consultation document would indicate that this is the most likely and viable option. Members agree that 'a new name over the door' would help change the perception of the hospitals and boost patient confidence in the new services. Our lay members have expressed the hope that the hospitals will be run by NHS partnerships, rather than private organisations.

Q28

This response is from clinical and lay members of the Royal College of Anaesthetists.

Dr A G Prentice

President

Royal College of Pathologists

Q28

I am responding to this consultation as the President of the Royal College of Pathologists. It is impossible to determine whether any of the TSA's recommendations for the future of clinical services is viable since there is no description of the current state of clinical pathology departments and services necessary to support clinical practice now or any changes needed to support them in future. Implementation of any of these recommendations for the reconfiguration of clinical services without any analysis of the demand they will create, or the capacity of the clinical pathology departments' capacity to meet that demand, could increase risk to patients and the community.

It must be made clear that the involvement of the College's representative on the TSA's CAG does not mean that this College supports the proposed reconfiguration of services since that representative was not given the opportunity to comment on the issues decribed above.

Dr A G Prentice

3. NHS Commissioners

NHS
Stafford and Surrounds
Clinical Commissioning Group

30 September 2013

Greyfriars Therapy Centre
Unit 12 Greyfriars Business Park
Greyfriars
Stafford
ST16 2ST

Telephone: 01785 221051

Alan Bloom,
Trust Special Administrator
Mid Staffordshire Hospitals Trust

Dear Alan

RE: Stafford and Surrounds CCG Response to the TSA Draft Report on the future of Mid Staffordshire Hospitals Foundation Trust

I am writing on behalf of the Stafford and Surrounds Clinical Commissioning Group to set out the CCGs views on the recent consultation carried out by the Trust Special Administrators on the future of Mid Staffordshire Hospitals Foundation Trust.

For ease the CCG comments are broken down into three sections:

- Comments on the process and the draft report
- Comments on the proposals
- Comments on the clinical and financial sustainability question

Comments on the process and the draft report

As you will be aware the CCG Chairs and Chief Officer have been meeting regularly with the members of your team since the TSA was asked to take responsibility for the Trust in April 2013. This meeting pattern has continued throughout the consultation process.

It is worth making the point that the CCG accepts that the TSA has had an unenviable task and was working within a defined set of parameters that are governed by statute. The CCG has always been clear that the TSA draft report was a 'fair reflection' of the discussions between the two parties. However, this could never be considered as an agreement by the membership that they support the draft report in its entirety.

The TSA has advised the CCG that its task is limited by statute. The TSA have not produced a solution that delivers clinical and financial sustainability for the Mid Staffordshire Health Economy. However the TSA did not have the remit to look more widely across the health system and other organisations.

The CCG accepts that the TSA proposals have been researched to the extent that was allowed in the limited time available but are concerned that risk assessment, quality impact assessment and options appraisal have not been performed to the level that would satisfy the CCG to allow them to make long term commissioning decisions for the local population.

The CCG understands that financial sustainability of services has been calculated using price (tariff) x activity and that no consideration was given to different costing methodologies. The fact is that services could be commissioned, provided and costed differently, underpinned by the drive to integrate services. The CCG believes this different approach could deliver a more financially sustainable solution.

As CCGs understand it the TSA final report will be submitted to Monitor, who will confirm whether the TSA have completed the programme of work. If this is confirmed then the report will be submitted to the Secretary of State for Health. As the CCG understands the legislation the only decision for the Secretary of State is whether the Trust should be dissolved or not, this would be alongside any agreement to transitional funding.

In our view the TSA has completed the programme of work as set out in statute in recommending the dissolution of the Trust. However, the CCG doesn't think the work as outlined above has gone far enough. The CCG accepts that an extension of the work was not in their remit.

Comments on the Proposals and the Draft Report

The CCG membership have reviewed the report and its proposals and would agree that many of the ideas put forward are in line with commissioner aspirations for the future. However, commissioners would wish to validate and test these assumptions using different costing models which promote service integration between and across providers where appropriate. The CCG, as the commissioner, views this as an opportunity to develop new incentive and risk sharing arrangements. This approach would allow the CCG to work with local clinicians and the public to outline what could be provided, the choices available for different service provision in terms of style, location and cost.

The member practices within the CCG have also made it clear that of paramount importance is the quality and safety of care to patients through their responsibility as the commissioner. The practices are aware there will be difficult decisions to be made but they are determined to come to conclusions with the population served. In conjunction with other CCGs in Staffordshire they will also continue to lobby central government about funding for South Staffordshire. The CCG Membership perceive this as part of the problem to be resolved.

The CCG does not, at this stage; wish to give a view on each of the service proposals without working through them locally outlining risk, rewards and the opportunity costs of providing one service locally and what that means for other services. The TSA work to date has been helpful in aiding what may be possible but the focus has been on the acute sector. What the CCG wishes to do is to ensure that acute services should be seen in the round alongside community based provision.

The proposals meet or exceed the requirements set out in the CCGs Location Specific Services agreed on 26th April 2013.

Comments on the Clinical and Financial Sustainability Question

Throughout the discussions with TSA and, prior to the TSA, through the CPT the CCG as the commissioner has been clear on two things:

- That the CCG would not pay a premium for services i.e. tariff plus
- That the CCG would not be responsible for a deficit position in any plans produced by the TSA

The CCG supported the TSA to commence consultation, as they had been informed by the TSA that in parallel to the consultation process it was working to reduce the deficit position in its model. As we are near the end of the consultation period the CCG notes that we have not received assurance that the deficit gap has been closed.

The CCG also understands that the TSA views financial sustainability from an affordability perspective and that their proposals, still have a deficit at the end of year three. This deficit position is

unacceptable to the CCG if the view is that the CCG is responsible for that debt at the end of the transitional period.

The CCG as the responsible commissioner would wish to commission and procure services which are financially affordable through working differently with providers on costing and risk sharing which is reflected in contracts with those providers. The option appraisal work which defines the procurement strategy is underway.

The CCG cannot sign up to the TSA report because it does not propose a solution that would both enable the commissioner and providers to discharge their statutory duties to achieve financial balance. The CCG believes that are alternative ways of commissioning services to create better alignment between services provided and funds available.

At the time of the consultation the TSA presented a proposed solution that has a smaller deficit than the Location Specific Services (LSS). The work undertaken to define LSS previously protected services was undertaken without view on the financial implications of LSS. Given that we supported the TSA model that maximised the service offering locally and have given them the opportunity to reduce the financial gap we have not had the opportunity or time to test the affordability of LSS.

The CCG is of the view that with a different approach to pricing, an extension of the timescale for financial sustainability to five years and with appropriate transitional support to build community based services that it may be possible to reduce the present financial gap however the CCG would still have concerns about achieving financial stability without significant financial support over the transitional period. Furthermore the CCGs proposed procurement process for services will also commission further efficiencies which drive out unnecessary costs.

The CCG therefore proposes that:-

- A five year transitional timescale is agreed rather than the present three years
- Revenue to support commissioners to aid double running whilst transforming services is agreed

Finally, the CCG is absolutely clear that it is the body responsible for commissioning and therefore will be the organisation charged with commissioning services differently from 2014.

In conclusion the CCG confirms the following:

1. The CCG believes the TSA has delivered its functions under the act and the Mid Staffordshire Hospitals Foundation Trust should be dissolved at a point when it is clear who will provide the future services.

2. The CCG proposes a five year transitional timescale

3. The CCG notes the clinical model for future reference but further work through local commissioners now needs to take place.

4. The CCG believes a potentially larger piece of work with a wider remit is undertaken to ensure clinical and financial sustainability can be delivered.

5. The CCG wishes to see specific transitional costs allocated to commissioners for transition

6. The CCG notes the three models and the deficit outlined in each. The CCG confirms that it will not be responsible for any outstanding debts at the end of the transitional period.

I trust this is helpful and please be assured that the CCG appreciates and acknowledges the work of the TSA.

Yours sincerely

Dr Anne Marie Houlder
Chair

Andrew Donald
Chief Officer

CC Alan Hudson
Professor Hugo Mascie-Taylor

NHS
Cannock Chase
Clinical Commissioning Group

30 September 2013

Alan Bloom
Trust Special Administrator
Mid Staffordshire Hospitals Trust

Greyfriars Therapy Centre
Unit 12 Greyfriars Business Park
Greyfriars
Stafford
ST16 2ST

Telephone: 01785 221051

Dear Alan

RE: Cannock Chase CCG Response to the TSA Draft Report on the future of Mid Staffordshire Hospitals Foundation Trust

We are writing on behalf of the Cannock Chase Clinical Commissioning Group to set out the CCGs views on the recent consultation carried out by the Trust Special Administrators on the future of Mid Staffordshire Hospitals Foundation Trust.

For ease the CCG comments are broken down into three sections:

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The CCG understands that financial sustainability of services has been calculated using price (tariff) x activity and that no consideration was given to different costing methodologies. The fact is that services could be commissioned, provided and costed differently, underpinned by the drive to integrate services. The CCG believes this different approach could deliver a more financially sustainable solution.

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The proposals meet or exceed the requirements set out in the CCGs Location Specific Services agreed on 26th April 2013.

Comments on the Clinical and Financial Sustainability Question

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I trust this is helpful and please be assured that the CCG appreciates and acknowledges the work of the TSA.

Yours sincerely

Dr Johnny McMahon
Chair

Andrew Donald
Chief Officer

CC Alan Hudson
Professor Hugo Mascie-Taylor

NHS
North Staffordshire
Clinical Commissioning Group

Ref DH/LE

28th August 2013

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Dear Colleague

I am GP clinical accountable officer for North Staffordshire Clinical Commissioning Group and have today been pulling together a paper for our next CCG Governing Board meeting on the 4th September, TSA draft report and potential implications for North Staffordshire. I note that there are arrangements in place to run 8 public meetings in the South of the county but not for a meeting to cover North Staffordshire and Stoke.

On reflection I believe there will be some concerns from the public with regard to how additional pressure on UHNS may impact on care for North Staffordshire residents. Whilst I recognise time is tight I believe it may be useful to hold a meeting in the North of the county and I would be grateful for your thoughts on this .

I am happy to liaise with you probably jointly with our CCG colleagues in Stoke regarding our input into any such meeting.

Yours sincerely

David Hughes
Clinical Accountable Officer

Subject: Gnosall surgery response

Dear sirs,

Two partners and our practice manager attended the scheduled meeting with the TSA at Greyfriers last night.

Following a lunchtime practice meeting we have some genuine concerns about the draft recommendations. I was asked to convey these to you for documentation.

Firstly the reason that the trust is in administration is because the Mid Staffs hospital was that it was deemed to be neither financially or clinically viable. We have read your report and all the appendices and concluded that the trust will remain financially unviable even after implementation of this plan.

Your financial report makes grim reading. Even if everything you hope comes to fruition then you predict in 3-4 years time a continued loss of £8.5 million. We believe that these losses can not be carried forward on the hospital provider accounts.
We are very concerned that the in year and recuurent debts set out in your plan will be a health economy and CCG liability. We believe that we will be liable for the big debts in 2013/4 whilst this is all sorted at the secretary of state level. You state that the plan is to make financial efficiencies in 2014-6 and inject £29.1 million. We are concerned that this will be distributed to the acute trusts and we will still be left with accumulated debt. There are a lot of presumptions about the £40 million savings and we have examined the detail in the appendices. What happens if they don't happen? Are we the membership board of the CCG ulitimately responsible here? We are used to creative accounting and set little store by predictive accounts and have a lot of experience in health care budgets and spreadsheets.

Secondly we understand that as a CCG we pay a lot but not all of our activity at PBR for acute service provision. So whatever the activity and where ever it is done we are responsible. The present position is that we as a health economy are over performing against plan (£6 million plus deficit and growing) as we have little control over the acute sector spend. Our financial position at year end will be the over performance and the additional hospital losses. We presume that if the reconfiguration of services goes to UHNS , Wolves or Walsall - this just changes the source of the invoices not the amount - so the financial consequences will remain with us. This is a demoralising and difficult position to be in and will inevitably impact on implicit and explicit rationing and other areas of the health economy. Such debts are not sustainable and will impact on the performance and stability of provider units like ourselves that at present are standing firm to meet the needs of our patients.

It was against our concern about the financial position that we considered the following.

1. The CSIP process gave clarity about what could be done with integration. This work is done and involved a lot of commitment from all healthcare stakeholders. The block to enacting this was that the resources to fund the workload shift were not available. If there is transition funding will this be spent on infrastructure or the necessary pump priming to enact CSIP and rebalance the health economy?
2. Before the TSA was appointed there was considerable debate championed by local MPs about the capital repayment system for the hospital property. There was a suggestion that the mortgage debt could be written off and the property returned to the control of the public through the local authority. This had two benefits. It immediately reduced the hospital expenditure and therefore the deficit. Aaron Cummings suggested this would have an enormous impact. It also transferred the responsibility of the hospital footprint to the people and made it their problem. They would be responsible for maintenance and for revenue streams for the use of the footprint excess after that required by the NHS. Is this still on the cards?
3. The fair funding deficit is well known and understood but the expenditure tariff is set at a national average. The health economy will run into recurrent debt because of this. The health activity for the locality is no different from elsewhere - our patients are just as sick as other areas. The acute sector activity is the main cause of over performance against plan. All other areas of the health economy are doing better for less. The TSA service plans are designed to make the acute sector stable and are based on tariff that adds to and do not resolve this deficit. Has the TSA considered the right of the commissioners to look at an integrated service specification that does not require a tariff payment. For example a frail elderly service as described by the TSA would cost the commissioners £300 per activity. The same consultant and therefore expertise employed in the community would cost £300 per session to see six patients. The same logic would apply to other areas of service reduction. We as commissioners might be able to secure, afford and run a consultant led obstetric unit if this was based on an integrated community model rather than the hospital tariff.
4. Has the TSA considered the impact of patient choice when building their financial model? The competitors certainly have. The same consultant personnel acting through another management system are prepared to look at service redesign to provide services closer to home. What would be the impact of reduced market share for elective work?
5. The plans for reduced length of stay require a commitment from other players in the health economy. The announced reduced financial plans of the local authorities will certainly impact on state social care. The nursing home and residential home capacity is finite (605 NH beds and 187 RH beds). So has he considered the impact of discharge on the other health providers ?
6. The plan seems to be to get UHNS, RWT and WHT to do the same work but under different management. We could not see a plan where there has been a consideration of total service redesign for the Stafford or Cannock branch. For example the opportunity to free hospital footprint by moving outpatient services into the community and provide extra day case elective work recruiting patients from the larger catchment areas. The problem is that without this innovative thinking the presented financial plans do not seem to make sense. If all you do is what you do etc.

The Stafford doctors have endured several years of scrutiny, turmoil and criticism and yet continue to try to engage to make the service better. I hope that the TSA and team respect and acknowledge the experience, skills and expertise that comes with being battle hardened. We understand and are used to political process and accountability. However, we have also learnt to stand up to defend the rights and expectations of our patients and our own integrity. We are not yet convinced that the draft plan meets its brief. We have already experienced with Francis, McKinsey and others that will be the ones left with this after you have all gone.

Yours faithfully,

Ian Greaves MBChB, BDS, BMSc, FRCGP.

NHS
North Staffordshire
Clinical Commissioning Group

Ref: DH13-46

Date: 1st October 2013

Private & Confidential
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Dear Colleague

NHS North Staffordshire Clinical Commissioning Group has considered the TSA draft recommendation on the future services for local people using Stafford and Cannock Chase hospitals. Our focus has been on the potential impact that these recommendations will have on the population we serve and the local health care services we commission.

We have been involved with the work of the TSA and recognise that MSFT is not clinically or financially sustainable and that there is a need for services reconfiguration. However, we have a constitutional duty to ensure that our responsible population has timely access to high quality and safe services and it is in this context that we have considered the recommendations:

Recommendation	North Staffordshire CCG Response
(1) Stafford Hospital should continue to have a consultant-led Accident and Emergency (A&E) department between the hours of 8am and 10pm daily	Support with comments. Conditional support that UHNS being able to achieve the right capacity and capability mix to ensure that there will be no negative impact on quality, safety and service provision.
(2) An inpatient service for adults with medical problems will continue to be provided at Stafford Hospital for those who need to be in hospital.	Support

North Staffordshire Clinical Commissioning Group
Commissioning NHS services for the people of North Staffordshire on behalf of NHS North Staffordshire

(3) As well as retaining the present inpatient service, a 14/7 Frail Elderly Assessment Service is created to provide a one-stop assessment for older people and to take referrals from a wide range of sources. The unit should be staffed by geriatricians to ensure greater links with the community. The Frail Elderly Assessment Service should have clear referral systems in place so older people get the most appropriate care.	**Support with comments.** The community step down services / infrastructures in South Staffordshire are such to enable Stafford patients to be discharged from UNHS in a safe and timely manner to support flow of patients through acute beds and assist with the delivery of planned productivity gains in UHNS.
(4) Beds should be available at Stafford Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer home.	
(5) No babies should be born at Stafford Hospital's consultant-led delivery unit as soon as other local hospitals have the capacity to deliver a service for more pregnant women. The TSA's plan is designed to ensure there is sufficient capacity at neighbouring hospitals so that mothers-to-be have a choice of where they have their baby. Consultant led pre and post-natal care should be delivered in partnership with UHNS so that local patients can still attend routine appointments at Stafford. Women will have the choice to go elsewhere if they prefer.	**Support with comments.** Dependent upon UHNS being able to deliver this ambition and that there is the right capacity and capability mix to ensure that there will be no negative impact on quality, safety and service provision.
(6) Children should no longer be admitted as inpatients to Stafford Hospital, and the service should stop as soon as other local hospitals have the capacity to accept them safely. Patients should be transferred to larger specialist hospitals for appropriate inpatient care.	Support
(7) Children will continue to be assessed at Stafford Hospital's existing Paediatric Assessment Unit (PAU) during its present opening hours of 8am to 10pm every day. The PAU will be led by specially trained nurses who will consult with paediatricians from UHNS. Referrals will either be through A&E, GPs or other health care professionals as they are now.	Support

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(8) Major emergency surgery should no longer be carried out at Stafford Hospital with the exception of minor surgical procedures which can be dealt with by A&E or where the patient can be stabilised by A&E and scheduled to return to Stafford Hospital for minor surgery. Most major emergency surgery would instead be provided by a local larger hospital such as UHNS or The Royal Wolverhampton Hospitals NHS Trust.	Support
(9) A small critical care area should be retained at Stafford Hospital so that very ill patients who come to A&E or inpatients who become very unwell can be kept stable prior to urgent transfer to a larger specialist hospital. Current staff on the critical care unit should work as part of a clinical network established with a neighbouring hospital. UHNS has proposed offering these services and the specialist staff to network with Stafford. An urgent transfer service should be established for very ill adults, which is the same as the approach already used successfully across England to transfer sick children to regional centres.	Support
(10) Elective care and day cases should remain in Stafford. This would include orthopaedic surgery.	Support
(11) Bed should be available at Cannock Chase Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.	**Support with comments.** The community step down services / infrastructures in South Staffordshire are such to enable Stafford patients to be discharged from UNHS in a safe and timely manner to support flow of patients through acute beds and assist with the delivery of planned productivity gains in UHNS.

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Commissioning NHS services for the people of North Staffordshire on behalf of NHS North Staffordshire

(12) Elective Surgery is retained at Cannock Chase Hospital. There should be new surgical specialties introduced, enhancing the current range of elective inpatient services for Cannock patients. This recommendation assumes that the ongoing discussions with the National CAGs regarding safe overnight staff cover can be successfully resolved.	**CANNOT SUPPORT.** The plans for Cannock Chase Hospital need to be considered alongside UHNS plans for Stafford to ensure that there are no unintended consequences. The potential loss of anticipated elective care provision and the increase in bias towards non-elective activity could have a negative impact on the financial modelling and sustainability of UHNS. Geography being such that there is not a clear need to deliver elective surgery at Cannock.
(13) The current range of day case procedures (surgical and medical), including rheumatology services, should continue at Cannock Chase Hospital and the range be increased where possible.	
(14) To allow for the TSAs' draft recommendations to work in a way that does not negatively impact the safety at other hospitals or their financial position, it is recommended that MSFT as an organisation be dissolved.	**Support with comments.** The CCG seeks to be assured that patients in North Staffordshire will still able to access the full range of services from UHNS and not have to travel to Stafford unless they choose to. UHNS has an underlying financial deficit and the CCG would like assurances that the financial position at Stafford will not have further negative impact on this.

Financial Concerns

The terms of reference for the TSA are such that any solution must be both clinically and financially sustainable. However, the CCG is not satisfied we have seen anywhere near enough detail to be able to assure ourselves that under the proposals this represents a financially viable solution for the residual services at the Stafford site or indeed its direct impact on UHNS, who are clearly most affected by the proposals.

Further clarity is required around the under-pinning assumptions in terms of the productivity gains at UHNS to establish if there are in fact viable and sustainable solutions, or whether this places a further burden on the North Staffs Local Health System to resolve. It is important to recognise that North Staffordshire CCG and Stoke CCGs now commission less than 50% of services at UHNS given the fragmented nature of commissioning.

We would like to seek clarity on what funding streams have been assumed during the transition. Many of the productivity gains, such as reduced lengths of stay will require infrastructure to come on stream in/around Stafford in order to realise these gains. Does this place an even further financial burden on UHNS in the short/medium term and what assumptions have been made as to who picks up these dual running costs?

North Staffordshire Clinical Commissioning Group
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We understand that capital monies have been secured for the Stoke site but that is not yet the case for the Stafford site. How will this be resolved? The centre needs to explore ALL technical measures to fund this such that there should be no ongoing revenue legacy impact of putting this right.

We need to be very clear that as a CCG we will continue to fund services at UHNS at tariff and in accordance with the national business rules, and we should not be expected to pay at 'tariff plus' for services at UHNS.

Protecting Patient Services through the Transition

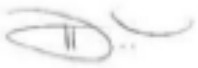
The TSA describes a planned solution that involves the dissolution of MSFT and the transfer of a significant volume of patient care to other providers.

As a CCG responsible for the commissioning of health services to our local patient population we are concerned that through a transition period of uncertain duration there exists risk to this care in terms of both access and quality. The accountability for MSFT services through this period lies with the TSA, whose responsibility is formally limited to the health services of those who use Stafford and Cannock Chase hospitals. The remit does not extend to North Staffordshire and Stoke residents.

However, as a CCG we require assurance that through an effective Transition Board the commissioners and providers (acute/ community/social care) will have real grip on this transition. It is clear that such a Board will need to ensure that patient flows, provider capacity and financial shifts are in step.

On behalf of the CCG, I hope that these comments are helpful in supporting the delivery of safe and sustainable services to the people of Stafford, Cannock and the surrounding areas and in ensuring as a result, that the people of Northern Staffordshire experience no denudation of the services they currently enjoy. We are a health and social care system under significant pressure and clearly have an interest in the draft recommendations of your report.

Yours sincerely



David Hughes
Clinical Accountable Officer

North Staffordshire Clinical Commissioning Group
Commissioning NHS services for the people of North Staffordshire on behalf of NHS North Staffordshire

NHS

East Staffordshire Clinical Commissioning Group

Edwin House
2nd Avenue
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DE14 2WF.

30.9.13.

The Office of Trust Special Administrator.

Dear Sirs,

As Chairman on the East Staffs CCG I am writing in response to your draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals. This is supplementary to an on line submission ref. 2112384134. My response takes in to account views obtained from canvassing members of the Governing Body and the General Practitioners who are members of our CCG. I have also obtained a view from the CEO of Queens hospital Burton.

The East Staffordshire CCG is in agreement with the dissolution of the Mid Staffordshire NHS Foundation Trust.

We are in broad agreement with the draft recommendations proposed for changes to services provided from the two hospitals in question.

However, we note the remaining deficit within the recommendations and cannot support the plans whilst any deficit remains.

We have concerns as to the capital cost implications for Queens's hospital to build capacity for additional in-patients, and maternity cases. We would seek assurance that the current breast-screening programme would not be adversely affected by the move of breast surgery to UHNS.

Thank you for the opportunity to respond to your recommendations.

Yours sincerely

Dr Charles Pidsley (Clinical Chairman)

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Telford and Wrekin
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Mr Alan Bloom
Office of the Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Date: 20th September 2013

Dear Mr Bloom,

Re: Response to consultation on the Trust Special Administrators' draft recommendations on the future of services for local people using Stafford and Cannock Chase hospitals.

I should like to thank you for giving NHS Telford and Wrekin Clinical Commissioning Group (CCG) the opportunity to consider the draft recommendations and to make a response as part of this consultation process.

The CCG has reviewed the consultation document and would like to make the following points:

- The CCG believes that the landscape of service provision for any population should be predicated on the principle of delivering the highest quality service possible. The aim should be to achieve that as close to home as those requirements for high quality allow. Cost is a necessary factor, but it should not override quality.
- Given that view, the CCG believes that the proposals strike the right balance between continuing to provide local services to the population and the need to ensure these services are both of a high standard and sustainable.
- Although the current number of Telford and Wrekin patients accessing Stafford and Cannock Chase hospitals is small, it is likely that patients from Telford and Wrekin, who were previously using the services at Stafford and Cannock Chase hospital that will be downgraded, will now choose to attend Shrewsbury and Telford Hospital NHS Trust instead.

- Because the number is likely to be small and contracts are held with all the providers in the proposed reconfiguration, the CCG does not currently believe that the reconfiguration presents a problem to it, as a neighbouring commissioner.
- The CCG is committed to working with the Trust to understand the numbers in detail as the programme develops.
- Finally, the CCG is interested to know what requirement there is for the TSA or local commissioners to manage the changes through a tendering process rather than simply by reallocation of patient flows.

Yours sincerely

Dr Mike Innes

Clinical Chair, NHS Telford and Wrekin Clinical Commissioning Group

Phil Griffin Strategy Lead

Tony Gallagher Chief Financial Officer

Walsall CCG

Q2

We strongly support because provsion of local A & E access is essential during the hours specified, thus enabling the better management of A & E attendances across the stafford area and neighbouring health economies.Neighnbouring health econimies are already experiencing increased levels of demand for A & E aceess so retaining this level of access in Satford is essential.

Q9

We tend to support the recommndation as patinets living locally can still attend routine appointments at Stafford to cover the pre and post natal care elements of the pathway

Q13

We strongly support this service model for the reasons set out in the consultation document

Q15

The consulation document sets out the strenths of the proposal to undretake major emergency surgery at larger local hospitals and the rationale set out is fully accepted

Q17

We aceept the rationale for this which is influenced by the transfer of major emergency surgery and note a small critical care service will be retained at Stafford Hospital for very ill patinets attending A & E

Q19

We support the principal that as far as possible the provision of elective and day case procedures should be retained locally

Q21

We endorse the proposal to rehabilitate patients closer to home which will enable more effective management of this phase of treatment

Q23

we strongly support because it enables more local and accessible provision

Q25

we strongly support as this improves local access and provision

we support this as we understand that the provsion of services will be through a combination of local expert providers making the continuation of the FT unnecessary

Dr Helen M Hibbs BM.BS. MRCGP

Chief Officer

Wolverhampton Clinical Commissioning Group

Q2

Closing the A and E department at Stafford Hospital would put too great a pressure on neighboring services which are already stretched. Wolverhampton CCG support the proposal to keep the A and E services open during the daytime for those patients who have conditions suitable for treatment there, at least until more capacity is available at neighboring hospitals .

Q7

Wolverhampton CCG support the provision of services for the frail elderly and the provision of step down facilities in Stafford.

Neighboring hospitals are already under extreme pressures and one of the problems is with regard to providing suitable facilities for assessment and especially discharge of frail elderly patients. These patients need to be treated as close to their home as possible and a whole series of potential problems could ensue if people spend too long in hospitals away from their home . Cross boundary discharge can be challenging and this would assist patient flow when patients have had to go to other hospitals such as New Cross Hospital in Wolverhampton due to the nature of their presentation.Provision as described will help patient flow ,capacity in surrounding hospitals and above all provide a quality care pathway for patients

Q9

We support high quality and safe maternity services for all residents . It is vital to ensure that sufficient capacity and sufficient numbers of trained staff are recruited and available in maternity units which would need to take the extra patients .At no time would we wish to see a fall in the highest quality of service that we expect for all our residents.

Q13

Although this is in relation to Stafford hospital and UHNS we would again like to reiterate the comment that we would not like to see any reduction in service for Wolverhampton residents as a result of changing patient flows

Q21

The CCG commissioning intentions include a simplification of urgent care ,improved and simplified pathways of care and provision of care in the community when possible.The recommendations are in line with this.The CCG supports the recommendations especially for rehabilitation of patients near to their homes for patients from the Cannock and Stafford area .They wish to commission services for Wolverhampton residents which are in Wolverhampton. They would not wish to see any reduction in provision for Wolverhampton residents

Q23

The CCG wishes to support the provision of suitable surgery at Cannock as long as patient safety is exemplary and the question of overnight cover is suitably resolved . There should be choice for patients and no Wolverhampton patient should be denied choice of site as a result of this development.

However the increased theatre provision should be welcomed as a way to reduce waiting times and improve patient satisfaction.

Q25

Views very much as in last answer .The CCG tends to support the proposal as long as patient choice and quality of service provision is retained .

Q27

ThG CCG wish to see sustainable health services for patients of Wolverhampton and all surrounding areas for years to come. They support the financial solution suggested by the TSA however believe that adequate resource must be available to the health economy locally to allow for development of premises to enable highest quality modern services to be delivered.

99997

Dr Charles Pidsley

Clinical Chairman of NHS East Staffordshire CCG

Q2

We believe it vital that a clear and effective strategy is drawn up to encourage retention and recruitment of high quality medical and nursing staff to the A/E department. Other than General practitioners it would seem sensible to ensure that all doctors and possibly senior nurses are regularly rotated through the UHNS emergency care department to ensure they do not become deskilled and that the posts are attractive to applicants who may seek a career in a/e as well as those who are working as part of vocational training for general practice.

Q7

What is proposed would appear to be the most comprehensive service provision that is feasible in the circumstances. The residual deficit of £8m is noted.

A concern is that the proposed changes would leave the Stafford hospital even more vulnerable to the loss of income effects of transition of more care in to the community of people with LTC, ACS conditions and the Frail elderly.

Q9

As commissioners for Queens hospital Burton, we would be concerned about the effect of significant rise in maternity bookings from Rugley which may impact on the threshold for consultant provision at Burton.

Q28

A concern lies with the effects of the proposed changes on breast screening in South Staffordshire in the event of services in Stafford being taken over by UHNS. It is noted that the breast screening programmes would continue at both Cannock and Stafford but the impact on Queens Hospital Burton Screening programme which has input from a consultant at Stafford needs to be considered. It is not clear at this point what if any changes this may lead to.

4. NHS Providers

The Royal Wolverhampton NHS
NHS Trust

New Cross Hospital
Wolverhampton
West Midlands
WV10 0QP

Tel: 01902 307999

25 September 2013

Office of the Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Dear Sirs

RE: Response from The Board of Directors of The Royal Wolverhampton NHS Trust to the draft recommendations on the future of services for local people using Stafford and Cannock Chase Hospitals

Over the past few months The Royal Wolverhampton NHS Trust (RWT) has welcomed the opportunity to work closely with the Trust Special Administrator (TSA) in order to develop proposals for the future configuration of services currently delivered by the Mid Staffordshire NHS Foundation Trust (MSFT).

The TSA's draft recommendations for the Cannock Chase Hospital are fully aligned to the proposals developed and submitted by RWT to the TSA. The Board believes that these present a clear opportunity to better utilise the site, enhance clinical pathways and increase the range of services to local people. Although there is further detail to work through following the current period of consultation we are in support of the proposals for the Cannock Chase Hospital contained within the document.

The Trust has also modelled the way in which it could accommodate the potential of increased activity transferring from Stafford Hospital to New Cross in particular Maternity, Paediatrics and Emergency Care. We are undertaking further work to ensure that this will be a clinically sustainable solution.

The Board's has taken time to consider the specific questions within the consultation document and responds as follows:

1. **Provision of A&E services at Stafford Hospital**: the Trust will continue to support A&E service provision by receiving appropriate patients both in and out of hours as it does at present. The Board anticipates being involved in discussions moving forward about the sustainability of service provision on the Stafford site.

2. **Provision of inpatient services for adults with medical problems:** the Board is supportive of this recommendation within clear clinical guidelines and anticipates that the Trust will have a role in the management of some specialist care as well as non elective care.
3. **Development of a Frail Elderly Assessment service:** the Board is supportive of this recommendation but would encourage consideration of integration with community services to ensure that there is a seamless pathway and single point of contact for this patient group to support reduction in unnecessary admissions to hospital.
4. **Development of a rehabilitation service at Stafford Hospital:** the Board is supportive of this recommendation as it generally supports more effective recovery but would encourage consideration of integration with community services to ensure that there is a seamless pathway.
5. **Proposal to cease delivery of babies at Stafford Hospital:** there is a clinical evidence base that supports larger maternity units as offering the safest clinical model due to the range of specialist expertise available. Within our modelling we have made provision for the transfer of activity as indicated within the TSA modelling. As such the Board is supportive of this recommendation.
6. **Proposal to stop inpatient admissions for children at Stafford Hospital:** there is a clinical evidence base that supports larger paediatric units as offering the safest clinical model due to the range of specialist expertise available. As such the Board is supportive of this recommendation.
7. **Proposal to continue with a Paediatric Assessment Unit at Stafford Hospital:** the Board is supportive of this recommendation within clear clinical guidelines and anticipates that the Trust will have a role in the management of some children based on geographical location.
8. **Proposal to cease emergency surgery at Stafford Hospital:** there is a clinical evidence base that supports emergency surgery being undertaken in units where there is access to a comprehensive range of support services as offering the safest clinical model. As such the Board is supportive of this recommendation.
9. **Proposal to provide critical care level area to stabilise patients prior to transfer:** the Board is supportive of this recommendation within clear clinical guidelines and anticipates that the Trust will have a role in the management of some patients based on geographical location.
10. **Proposal to retain elective care and day cases at Stafford Hospital:** the Board is supportive of this recommendation within clear clinical guidelines for patient selection.
11. **Development of a rehabilitation service at Cannock Chase Hospital:** the Board is supportive of this recommendation as it generally supports more effective recovery but would encourage consideration of integration between acute providers and community services to ensure that there is a seamless pathway.
12. **Proposal to enhance the range of elective inpatient services at Cannock Chase Hospital:** the Board is supportive of this recommendation. It believes that this offers a significantly enhanced service for local people and will support greater certainty for patients in planning for their treatment. The Trust is committed to delivering the best possible service for patients under its clinical model and is pleased that this has now been approved by the Clinical Advisory Group.
13. **Proposal to enhance the range of day case procedures performed at Cannock Chase Hospital:** the Board is supportive of this recommendation. It believes that this offers a significantly enhanced service for local people and will support greater certainty for patients in planning for their treatment.
14. **Proposal to dissolve MSFT with service being delivered by other organisations:** there is substantial evidence that MSFT is not viable either clinically or financially. As such the Board is supportive of the proposal to dissolve MSFT.

The Board and members of the senior team are will continue to work with the TSA over the coming months to reach the final solution for services and an agreed implementation plan.

For and on behalf of the Board of Directors

Richard Harris
Chairman

David Loughton CBE
Chief Executive

Chairman: Richard Harris
Chief Executive: David Loughton CBE
Preventing Infection - Protecting Patients

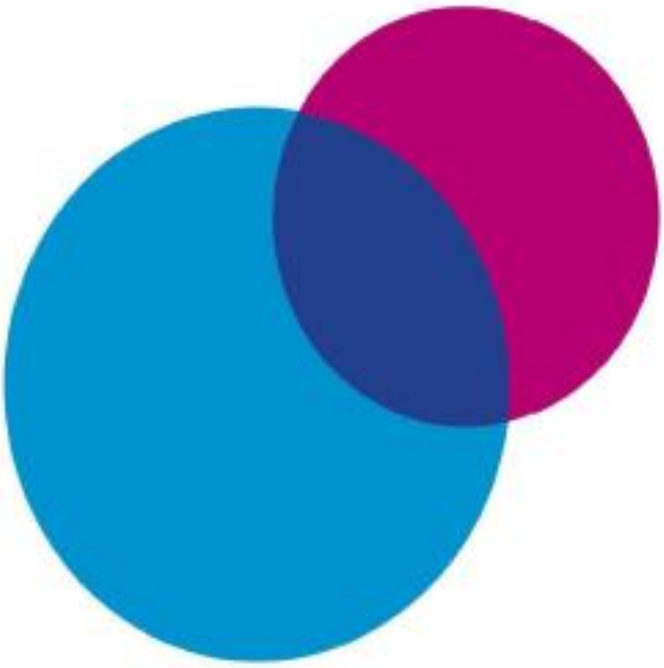
A Teaching Trust of the University of Birmingham

Better Together

Staffordshire and Stoke on Trent Partnership NHS Trust

Response to Public Consultation

Mid Staffordshire Foundation NHS Trust



Introduction

Staffordshire and Stoke on Trent Partnership NHS Trust (SSOTP) is welcomes the opportunity to comment on the public consultation phase of *Maintaining high quality, safe services for the future* surrounding the future service provision in the Mid Staffordshire economy. SSOTP has had a number of opportunities to discuss the options and potential solutions with the Trust Special Administrators (TSA) and submitted an initial response on 14th May to the TSA's *Memorandum for Market Engagement Exercise*.

Clearly, and appropriately, most of the TSA's work has looked at the services currently provided by Mid Staffordshire NHS Foundation Trust (MSFT) and potentially future delivery models. However, SSOTP continue to believe that the future model for service delivery should be developed around more proactive and personalised care for individual service users, with the majority of care provided in their usual place of residence by a community based team that includes all specialists required to deliver a package of care, whether from the statutory or voluntary sector. Such a service model is consistent with multiple public consultations undertaken both locally and nationally over the last 5 years and reserves more specialist hospital care for those who require that degree of specialist or technological support at the moments of condition exacerbation or sudden crisis.

SSOTP has discussed a more integrated model with both the Cannock and Stafford CCGs and the North Staffordshire CCGs. There was significant interest in this model, as it offers the greatest potential to reduce urgent care admissions for those patients who are able to be cared for in their usual place of residence. This offers a higher quality care package than the current arrangements and has significant potential to reduce costs in the system

Specific Consultation Questions

In terms of the questions asked in the consultation document, SSOTP would wish to make the following observations:

Recommendation	Response
1. How far do you support or oppose the recommendation around the Accident and Emergency (A&E) department at Stafford Hospital?	Since the change to a 14 hour A&E took place at Stafford there has been a noticeable shift in the number of complex cases admitted to surrounding Trusts. This has not just occurred in the hours the A&E is closed but has been increasing across the 24 hour period.

	As commissioned services have not changed to reflect this, there are significant delays repatriating patients back to their own neighbourhood. Some of this has been mitigated by short term appointments, but if this is to become the long term model, there needs to be a review of the capacity in the discharge and assessment teams at UHNS, Royal Wolverhampton and Walsall Hospital As the provider of the Minor Injuries Unit at Cannock, it would be helpful to understand the assumptions around the MIU as part of the urgent care delivery model Although by necessity the consultation has focussed on the acute elements of the pathway, it would be helpful to demonstrate by case study how a closer whole system response would improve patient care and outcomes. SSOTP's initial response document demonstrated some of the improved pathways that could be gained from this approach to the delivery of care.
2. How far do you support or oppose the recommendation around the inpatient service for adults with medical problems at Stafford Hospital?	It is unclear how the impact of an enhanced and proactive community model has been assessed in determining the need for a Stafford capacity. Many of the current shorter admissions could be safely managed in the community with the right services. The last few years has seen the development of more integrated health and social care, with fully integrated teams coming into place since 1st July 2013. These teams are already demonstrating the ability to avoid unnecessary hospitalisation of complex service users, which has benefits both for their immediate care needs and increases the likelihood of rehabilitation to their usual level of independence that can often be eroded by sustained periods of care in an acute setting. The model underpinning this development was

	contained in the 14th May submission. Whilst there are references to the potential for this community based model underpinning the consultation, there is little to quantify the impact of this approach in the proposed solutions and therefore the commentary does not suggest that there has been a significant activity shift away from the more reactive care currently delivered by MSFT to a more proactive community based model. It is the belief of SSOTP that this could significantly change the bed based requirement for services in the future and change the need for community accessed diagnostics and local specialist opinion which would enable more care to be delivered locally for the population of Stafford and Cannock. In considering the estates options for the future, there also needs to be consideration of the potential for community intermediate care teams to be located closer to any bed based services to make the transitions of care easier and quicker. The co-location of these services also leads to a closer informal dialogue between teams which enhances the education of all staff on the potential options and leads to a more informed choice on future care options. In order to model the impact of the recommendation it would be helpful to understand • the demand management assumptions, • the number of direct admissions to Stafford • the number of repatriations to Stafford who cannot be discharged to their usual place of residence from the presenting hospital There is also an opportunity as part of the consultation response to look at some of the underlying issues in the MSFT economy that has resulted in high levels of hospitalisation for service users. It is recognised by the Clinical Commissioning

	Groups (CCGs) that there are capacity issues in non-hospital services that has resulted in the high levels of admission and there is an opportunity as part of the option appraisal to demonstrate how this could be addressed. Community nursing levels in Stafford are 9% below the national average (based on the current commissioner figures) which is preventing the more proactive model being developed. Early iterations of the MSFT options identified the potential for significant change in activity flows if this was to be addressed. The same model has recently been commended in North West London, upon which the local work was modelled. It is recognised that there is a need to invest £1m into baseline district nursing to deliver the current model of care on a consistent basis. Indications from North Staffordshire suggest a similar investment again would be required to deliver a model of proactive case managed care, which has been supported in public consultations locally There is also a need to consider the impact on Local Authorities in terms of the changes proposed. In order to deliver the change in outcomes there are impacts particularly on social care, both in terms of volume and change in acute threshold, but also in terms of assessment capacity as the consultation proposes changes in location for the most complex medical and surgical cases with Stafford and Cannock patients likely to be admitted to neighbouring Trusts. Without addressing this assessment capacity in those Trusts, it is likely that patients will be repatriated back to step down beds in Stafford and Cannock hospitals for assessment, rather than more appropriately being supported to return to their usual place of residence. It is widely recognised that this adds considerably to the combined hospital length of stay, and for the elderly increases the likelihood of them being admitted into a less independent long term package.

	In delivering this integrated model for service users it will be important to look at the inter-provider model that underpins the delivery of care. Whilst again this is technically out of scope for the TSA, the success of any recommended model is significantly dependent on all services in the patient pathway being co-ordinated and the service being supported at all stages of their decision to be able to make informed choices on their care. For this to happen the co-ordination needs to be separated from the bed based resource and a personalised plan developed to maintain independence for as long as possible with bed based care, including acute hospitals, being a last resort for those who really need such specialist care. There is strong international and UK evidence (Kaiser Permanente and North West London as two examples) that a community based lead that focuses attention on maintaining the individual at their usual place of residence and which then subcontracts acute placements when necessary is more likely to lead to a care package that maintains independence and where the providers are incentivised to maintain care at home rather than defaulting to a supported bed based model. The additional integration of social care (as happens in Cannock and Stafford) to this community model also factors in domiciliary care and long term assessment rather than the shorter term objectives of relieving pressures on the acute bed stock
3. How far do you support or oppose the recommendation around a Frail Elderly Assessment service at Stafford Hospital?	SSOTP is fully supportive of the concept of a Frail Elderly Service and is in active discussions with GP First, the local GP collaborative, on how an enhanced community service could interface with the acute elements to provide a seamless step up and step down model for the most complex service users. The recent implementation of health and social care teams in the community is specifically targeted at supporting this care group

	In developing the future staffing model, consideration should also be given to the opportunities for staff to cross organisational boundaries to deliver better care to patients. There is discussion in the consultation on the development of a community geriatrician model to support a Frail Elderly service. However this model of care needs to be extended to look at all needs for the service user with the community teams and geriatricians working in partnership. SSOTP is developing a community element to this model with GP First, the local GP collaborative, and would wish this to be part of the service vision for this client group.
4. How far do you support or oppose the recommendation that beds should be available at Stafford Hospital for recovering patients?	The availability of step down beds in Stafford and Cannock has been an issue for many years and provision is welcomed. However, for patients who have first been admitted to another hospital it is important that they have been appropriately assessed to determine if they can return straight to their usual place of residence rather than to another bed based service. Transfer between wards/hospitals is recognised to add days to the overall length of stay in hospital and has the potential to reduce long term independence. The current service in Mid Staffordshire is recognised as having a high number of patients who remain in hospital due to a shortage of community capacity. It is unclear whether the proposals have addressed this issue which could have a significant impact on the bed modelling Although the number of patients whose care is potentially being transferred to other hospitals may be small in percentage terms, it is inevitable that these will be the most complex cases both from an acute and consequently long term community consequences. Experience of the last few years has indicated that the assessment and repatriation services attached to these external acute sites needs to be strengthened otherwise patient

	outcomes deteriorate through extended length of stay and greater loss of independence. This can often result in long term dependence on nursing home and residential home placement rather than rehabilitation at their usual place of residence with strong long term independence
5. How far do you support or oppose the recommendation around maternity services?	No specific comment
6. How far do you support or oppose the recommendation around the inpatient service for children at Stafford Hospital? 7. How far do you support or oppose the recommendation around the Paediatric Assessment Unit (PAU) at Stafford Hospital?	The proposal to develop a paediatric Hospital at Home service is welcomed. There is some concern about children's assessment out of hours as there is the potential for children to be taken to surrounding hospitals in the evening as there is no back up of 24 hour children's services at Stafford Hospital. This could make it more difficult to arrange community alternatives if children are split into multiple emergency streams in different towns and cities
8. How far do you support or oppose the recommendation around major emergency surgery at Stafford Hospital?	The issues surrounding long term assessment and repatriation are similar for surgery as for medicine
9. How far do you support or oppose the recommendation around the critical care unit at Stafford Hospital?	No specific comment
10. How far do you support or oppose the recommendation around elective care and day cases at Stafford Hospital?	No specific comment
11. How far do you support or oppose the recommendation that beds should be available at Cannock Chase Hospital for recovering patients?	In looking at the future of Cannock Hospital there is significant potential for the building to be the focus of a community capacity Hub to co-ordinate care in the future. SSOTP would like to see a greater emphasis on the facilities being used to support the extension of community services as both a step up and step down support. This will offer a better service for the population of Cannock than a focus on an elective centre
12. How far do you support or oppose	The indications from the consultation are that there

the recommendation around elective inpatient surgery at Cannock Chase Hospital?	will be a weaker economic argument for a full range of services at Cannock Hospital. To mitigate this it appears likely that the elective catchment of Cannock is likely to be higher than the current activity. This may limit the potential for the joining up of services locally
13. How far do you support or oppose the recommendation around day case procedures at Cannock Chase Hospital	See response to recommendation 11
14. How far do you support or oppose the recommendation for MSFT to be dissolved, with the services for Cannock and Stafford managed and delivered by another organisation or organisations in the future?	SSOTP is happy to work with any future organisation(s) to deliver seamless care for the populations of Cannock and Stafford. We already have excellent working relationships with most surrounding Trusts and existing patient pathways that could be replicated across the revised health economy.

Additional Services

As outlined in our initial response on 14th May to the TSA's *Memorandum for Market Engagement Exercise* there are a number of services where SSOTP has considerable expertise in providing services currently delivered by MSFT. If the preferred model is agreed as the dissolution of MSFT then a number of services would be more appropriately based in SSOTP rather than the other acute options proposed in the consultation document. This is particularly true of services such as Rheumatology and GUM which are not currently provided by UHNS

- **Rheumatology** - SSOTP run a nationally recognised rheumatology service, providing inpatient, outpatient and day-case services from a Community Hospital Hub. These services are Consultant-led, supported by Senior Specialist Nurse input and include investigation, diagnosis and management. Treatments include the prescribing and monitoring of anti-TNF biologics, and are supported through joint research work with Keele University.

  Our Rheumatology centre at the Haywood Hospital currently welcomes patients from North Staffordshire, Derbyshire and Cheshire; the catchment area has a population of over 500,000 patients.

  The centre deals with the investigation, diagnosis, management and treatment of patients with arthritis and other musculoskeletal conditions many of which are chronic conditions which require lifelong treatment.

The Hospital is pioneering in many different aspects of rheumatology, the first Community Rheumatologist was appointed here and the first development of a computerised drug monitoring system was also at the Haywood Hospital.

The Centre also has an active research team known nationally and internationally for its work.

Our Services also extend to the provision of a community based orthopaedic and rheumatology triage service which involves extended Scope Physiotherapist Practitioners and Podiatrists providing assessment and advice for patients with orthopaedic and rheumatoid conditions.

- **Dermatology** – Provision of Consultant, Nurse and General Practitioner with Specialist Interest (GPSI) clinics to assess, diagnose and treat a range of skin conditions in the community.

  SSOTP currently provides a Community Dermatology Service, utilising the skills of specialist nurses, GPSIs and Consultant Dermatologists. This service provides face to face assessment, diagnosis and treatment of skin conditions, in addition to telephone support to primary care to advise on the treatment of presenting patients and appropriate referral pathway

- **Respiratory** – SSOTP is experienced in the delivery of community based specialist respiratory services to both prevent and manage acute exacerbations. Services are delivered by specialist nursing teams, in partnership with Consultant input in Northern Staffordshire.

  SSOTP provides specialist nursing teams across Staffordshire to manage patients in the community to prevent exacerbation and to promote 'self-management' of their condition. These Teams include the input of Consultants and respiratory physiologists to enable the management of more complex cases.

- **Genito-Urinary Medicine (GUM)** – Experience in the delivery of acute and integrated GUM and sexual health services. Our workforce will include Clinical Director, Consultants, Associate Specialists, Nursing and qualified sexual health workers.

  Our organisation delivers Integrated Sexual Health and GUM Services in Staffordshire. This service will be led by a Clinical Director and supported through a range of medical and nursing professionals to provide Contraception and Sexual Health (CASH), Human Immunodeficiency Virus (HIV) counselling, psychosexual and broader promotional activities. This Service offers full screening, diagnosis and treatment of sexually transmitted diseases including HIV

- **Stroke Care** – Provision of bed-based and community rehabilitation services with medical, nursing and therapy input in the delivery or successful rehabilitation outcomes for patients.

  Our Stroke Rehabilitation Service at the Haywood includes bed based rehabilitation plus an effective Early Supported Discharge Team which provides on-going specialist

rehabilitation immediately after discharge in the patients' place of residence. Services are provided by a multi-disciplinary team, including Consultants in Rehabilitation Medicine, Specialist Nursing and Allied Health Professionals (AHPs). SSOTP also manages a 25 bed rehabilitation ward for adult patients requiring neurological rehabilitation. Patients present with a variety of neurological diagnoses including stroke, Multiple Sclerosis, traumatic brain injury, brain tumours and spinal problems.

- **Elderly Care** – Delivery of both inpatient and outpatient services from an experienced team of medical and nursing clinicians. These services include the assessment and management of complex needs for older people.

  SSOTP currently manage 5 community hospitals in North Staffordshire, delivering a comprehensive range of bed-based and outpatient services to adults and older people. Our Teams include the services of Consultant Geriatricians in delivering complex assessment, rehabilitation and intermediate care services. The innovative approach to maximising bed capacity and linking to the community teams has already been described in the model of care

- **Physiotherapy** – Delivery of a comprehensive community physiotherapy service, in addition to a workforce with enhanced skills including Musculo-Skeletal (MSK), chronic pain management and respiratory care. Our workforce includes Consultants, Specialist Doctors, Pharmacists, Consultant Physiotherapists, Extended Scope Practitioners, Physiotherapists and Assistants.

- **Occupational Therapy** – Provide Occupational Therapy services as part of multi-disciplinary teams and across the community. Our Occupational Therapy Teams are experienced providers of both community and hospital based services, operating as part of multi-disciplinary teams in the delivery of comprehensive rehabilitation packages. These teams provide support to both children and adults, and again are supported through our Professional leadership structures. The integration of health and social care Occupational Therapists will have a significant benefit in reducing duplication and facilitating faster hospital discharge

- **Dietetics** – Deliver a range of services including weight management, lifestyles, children and adults in both a community and in-patient setting. SSOTP employs registered dieticians working as part of a multi-disciplinary team to maintain, improve and promote the nutritional health and wellbeing of people of all ages by enabling and supporting individuals, groups and populations to make informed choices about food and lifestyle.

  Our Dieticians work at various levels of specialism (e.g.: nutritional support and enteral feeding, paediatrics, learning disabilities, obesity, diabetes, eating disorders, renal etc) supported by Dietetic Assistants and Assistant Practitioners. The Service is available to all age groups, from birth onwards, and is provided in a variety of settings including community clinics, outpatients and inpatient wards

- **Diabetes / Endocrinology**—Provision of Consultant and Specialist Nurse Led Clinics in a community setting. It would significantly improve continuity of care to transfer the nurses employed at MSFT to work with the SSOTP Consultant
- **Bone Densitometry**—Operate an open access bone densitometry (DEXA) service for primary and acute care physicians, and as part of diagnostic pathways in our inpatient and outpatient services at Haywood Hospital. The DEXA service is complimented by a Consultant-led Osteoperosis clinic for specialist investigation and therapeutic interventions. Our services also include the provision of Falls Clinics and Fracture Liaison services.

SSOTP will be delighted to continue its ongoing discussions with the TSA throughout the next phase of the work. Our response indicates a number of areas where SSOTP would add value to the proposals regardless of the main acute provider(s). It would also be helpful to understand more of the detail behind the planning assumptions and bed modelling to ensure that any community assumptions being made are compatible with the final model, accepting that the detail of these community assumptions fall outside of the scope of the MSFT recommendations.

Burton Hospitals NHS
NHS Foundation Trust

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Our Ref: HA/ELS

30 September 2013

SENT VIA EMAIL : ***TSAconsultation@midstaffs.nhs.uk***

Mr Alan Bloom
Trust Special Administrator
Mid Staffordshire NHS Foundation Trust

Dear Alan

RE: Burton Hospitals NHS Foundation Trust Response to the TSA Draft Report on the future of Mid Staffordshire Hospitals NHS Foundation Trust

I am writing on behalf of the Board of Burton Hospitals NHS Foundation Trust in response to your consultation for the future of services for local people using Stafford and Cannock Hospitals.

As a key stakeholder, and the only other Acute services provider geographically based in South Staffordshire, we would like to take this opportunity to share with you our concerns in respect of the impact of any proposed reconfigurations on :-

- Inpatient capacity
- Services currently provided by the by Mid Staffs to the Trust

I would like to start by stating our disappointment that, despite our contribution and engagement with the Contingency Planning Team, the Trust has not been included in local meetings since the appointment of the Special Administrator. That has made responding to the consultation more challenging as we have not been an active participant in discussions and have therefore been left to make assumptions for ourselves on what any changes may mean.

That said we have, as a Board and Executive Team reviewed how we would respond as an organisation to the proposed reconfiguration of services at Stafford and Cannock, details of which are set out below.

When considering the consultation the Trust considers that 2 main service areas would be impacted upon :-

1. **Adult Inpatients capacity**
   There has previously been a clear and demonstrable impact on the Trust of the overnight closure of ED at Stafford since December 2011, which has in the past been a contributory cause of pressure on our capacity. Given that initial estimates of impact from the ED closures were low – the Trust is concerned about the impact that

any further changes could have, and implications on the Trusts inpatient capacity, especially if estimates turn out to be understated. For planning purposes and based on the activity modelling that your team has undertaken, we believe the additional requirement to be somewhere in the region of 18 to 34 beds. Should the proposals be enacted the Trust estimates that it will require up to 1 additional inpatient ward with an associated **capital cost of £1.25m**.

2. **Obstetrics**

As a Trust we are concerned about the impact that the lack of an obstetric service in Stafford will have on the number of births here in Burton. Given the significant degree of patient choice it is difficult to model the exact impact on our capacity, but given the pressure on our existing facilities any additional births would require the creation of further capacity on the Queens Hospital site. The Trust would, in all likelihood, look to create further delivery rooms in order to respond to any additional demand. **The cost of the additional facilities would be £0.75m.**

All of that said it is the view of the Trust that there should be provision of maternity services in the Stafford area with, as a minimum, a midwife- led facility in the Stafford area, in order to support the needs of the local population.

The Trust has experience of running such services in Lichfield, at Samuel Johnson Community Hospital and would be keen to explore doing the same within the Stafford locality should Commissioners wish to explore this option.

Other implications

Breast Imaging and Screening Services

Currently all of the Trusts breasts imaging services (with the small exception of breast MRI reporting) are provided by Mid Staffordshire NHS Foundation Trust under an SLA. The dissolution of Mid Staffs could fundamentally jeopardise the breast imaging provision for the Trusts symptomatic breast service.

In addition the local breast screening service is provided by the South Staffordshire Breast Screening Service under the National Breast Screening Programme now delivered by Public Health England. The area is defined geographically and has delivered screening and generated patient/cases related data since 1987. The service is currently hosted by Mid Staffs, which, given the dissolution of the Trust could see the service either hosted in its current form by another organisation or broken up and appended to other existing breast screening areas.

As a minimum the Trust would wish to see a clear direction of travel for both of these services, though our preference would be to take over the running of both services prior to any dissolution of the Trust.

Step – Down / Rehabilitation Inpatient Services

As a provider of Community Hospital Services, the Trust currently provides step-down rehabilitation beds to inpatients who have undergone an acute episode of care at Stafford Hospital. The consultation document refers to the development of similar services in Stafford and Cannock, though as far as we are aware very little modelling has been

undertaken on the potential impact that any provision of services could have on the demand for inpatient beds in Lichfield, where the Trust runs its Community Hospital. We would therefore hope and expect that further modelling would be undertaken, and the implications for other services considered before any new services are put in place.

I trust that our comments have been helpful in planning not only for future service provision of services at Stafford and Cannock, but also the impact upon ourselves as a neighbouring organisation.

Yours sincerely

Helen Ashley
Chief Executive

C.C: Mr Alan Hudson
Professor Hugo Mascie-Taylor

University Hospital of North Staffordshire NHS
NHS Trust

Response to consultation

on the

draft recommendations of the

Trust Special Administrators for Mid Staffordshire NHS Foundation Trust

on the future of services for local people using Stafford and Cannock Chase Hospitals

Response of the Trust Board

Discussed in Public

30th September 2013

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1. Introduction

In April 2013, the Trust Special Administrators (TSAs) for Mid Staffordshire NHS Foundation Trust (MSFT) undertook a 'Market Engagement Exercise' to assess the extent to which neighbouring NHS Trusts and others would be interested in providing services currently delivered by MSFT. University Hospital of North Staffordshire NHS Trust (UHNS) responded with an expression of interest and has worked closely in recent months with the TSAs to develop a model of care that supported the retention of a local hospital in Stafford and placed patients at the heart of the proposals to build a healthier future for the people of Staffordshire.

Our expression of interest was based on extensive engagement with our clinicians on ways in which we could make services more sustainable and improve the quality of care at Stafford and Stoke-on-Trent through greater integration across both sites. As the service models have been developed, we have also engaged throughout the public consultation period with our staff, Shadow Council of Governors, clinical commissioning groups and local stakeholders including our staff whose families rely on local health services and the public whom we serve to seek their views on these proposals.

The Trust Board has been fully involved in the development of our response to the TSA, through setting clear objectives at the beginning of the process, ensuring appropriate governance arrangements for the scrutiny of proposals as they were developed, and by subjecting the final proposals to a set of 'assurance tests'.

Profile of our Trust

UHNS is a large acute university teaching hospital on the border of Stoke-on-Trent and Newcastle-under-Lyme in Staffordshire. We are one of the largest hospitals in the West Midlands and have one of the busiest emergency departments in the country. Our clinical services are based at the City General Hospital site. Our new, state-of-the-art hospital building is now fully operational and has 1,150 inpatient beds.

We provide a full range of general acute hospital services for approximately half a million people living in and around North Staffordshire. We also provide a range of specialised services for three million people in a wider area, including neighbouring counties and North Wales. These services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care and paediatric intensive care. We are recognised for our particular expertise in trauma, respiratory conditions, spinal surgery, upper gastrointestinal surgery, complex orthopaedic surgery, laparoscopic surgery and the management of liver conditions. We have achieved Level 2 in the Clinical Negligence Scheme for Trusts (CNST), which is a measure of the utmost importance we place on safe, high quality care for our patients.

We continue to develop the City General site with continued building works and alterations to our estate following our move from three sites into our new purpose built hospital at City General Hospital. Recent PLACE[1] surveys in our facilities give the Trust high scores for cleanliness and for patient experience of privacy and dignity. Current works on the site will be completed in August 2014 and will include the demolition of old clinical buildings to make way for 300 extra car parking places, 200 of which would be earmarked to accommodate additional patients from Stafford, should the TSAs' proposals for the provision of services at Stafford Hospital be taken forward.

Statement of our mission

We will be a leading centre in healthcare, driven by excellence in patient experience, research, teaching and education. We are here for our patients, their carers and families. We will strive continually to improve patient experience and the safety and effectiveness of our services. We will support both current and future generations of healthcare professionals by instilling a culture of clinical innovation, research, teaching and education. We will work with other health and social care organisations to provide continuity of care from hospital to home.

2. Our overall response to the proposed clinical model for Stafford Hospital

We are committed to playing our part in the creation of a sustainable model of acute hospital services for the population served by Stafford Hospital. We see our future as being inextricably linked to that of Stafford Hospital in that any significant changes in services in Stafford inevitably impact our Trust. In recent years, we have seen at first hand the way in which planned changes in services between UHNS and Stafford Hospital can achieve benefits for the populations served by both hospitals. For example, the creation of a vascular surgery network has given us a service which covers a population sufficient to support safe rotas and to maintain expertise. In all, 15 services are currently provided in an integrated model between our two trusts. Any proposal which caused these services to be divided or separated would be difficult to implement. Currently integrated services are as follows:

1. Major Trauma - UHNS is the Major Trauma Centre for the North Midlands Network within which Stafford sits.
2. Vascular Surgery - UHNS is the vascular hub for Stafford and Leighton Hospitals and also the provider of vascular screening services for the Network.
3. Stroke Services - UHNS is the sub-regional hyper-acute stroke centre and supports local units via advanced telemedicine.
4. Specialist Surgery - ENT, oral surgery, maxillofacial and plastic surgery services at MSFT are all provided by UHNS.
5. All UHNS tertiary services support MSFT. Cardiac surgeons and neurosurgeons carry out clinics at Stafford.
6. Cardiology - an MSFT consultant carries out elective work in UHNS facilities.
7. Emergency Surgery and Urology - plans are at an advanced stage to reconfigure all emergency activity, and elective activity requiring overnight stays, onto the UHNS site.
8. Upper and Lower GI Surgery - UHNS consultants operate at Stafford and support consultant rotas.
9. Obstetrics - high risk births from Stafford are transferred to UHNS.
10. Paediatrics - patients from Stafford are referred for specialist care including paediatric intensive care (PICU) and a UHNS neonatologist supports Stafford Special Care Baby Unit (SCBU).
11. Nuclear Medicine - UHNS provides consultant staff to deliver the Stafford service.
12. Cancer Services - a number of UHNS clinicians attend Stafford multi-disciplinary team (MDT) meetings.

13. A Pathology Alliance is currently strengthening links between the departments.

14. Renal Dialysis – UHNS manages a satellite unit in Stafford.

15. Supplies and Procurement services.

However, where change has been unplanned the impact has been felt in both the north and south of the county. The drift of Accident and Emergency (A&E) attendances and emergency admissions from the Stafford area to UHNS over the past few years has contributed to a 10% increase in A&E attendances and a 7% increase in emergency admissions over the past year when there was little scope to extend capacity without recourse to expensive short-term measures.

Based on this experience, our Trust Board supports the case for change made by the TSAs to MSFT. Planned change is required in the services currently delivered by MSFT in order to maintain the quality and safety of services in the future, achieve financial balance, improve recruitment and retention of high-quality clinicians and meet the changing needs of an ageing population. The status quo is not an option and our view is that the risks to services at Stafford, Cannock and, through the knock-on effect, neighbouring Trusts such as UHNS will increase unless change is planned and properly managed. For far too long patients and health professionals have been subject to uncertainty, which has prevented service change to improve services and attract the best people to Staffordshire.

Furthermore, our Board believes that there is a compelling public interest in UHNS providing services at Stafford Hospital in order to improve patient care through greater integration of service provision between the two hospitals. This would allow us to centralise services where necessary for safety and quality and to support more local access to services at Stafford Hospital than could be achieved by a standalone provider of services at Stafford.

3. Our Vision

Greater integration of services would benefit the residents of both North Staffordshire and South Staffordshire who receive our services. A single trust operating across two sites would help us to attract the best people to come and work, learn and research at an integrated university hospital providing services that:

- are sufficiently large in scale to deliver high quality outcomes for patients.
- centred around patients' recovery, locally where necessary and at a distance when required, with staff who are skilled, available and competent to deliver care - "right place, right care, right staff and right time for care" being our goals.
- supported by excellent facilities that meet the expectations required by the public and policy makers of a modern 21st century healthcare provider.

- focused around the delivery of seven day consultant-delivered emergency care and a flexible, responsive elective care service that is fully digitalised, local and of sufficient capacity to meet the demands placed on it.
- provide, in collaboration with our university partners, Keele Medical School and Staffordshire University:
    - world-class training and education for healthcare professionals, which benefits staff and attracts talented professionals from a national pool.
    - services on a scale that will enable us to develop new and existing partnerships to attract academic medicine, nursing and other allied professionals to Staffordshire.

Our vision is to develop one organisation across two equally important hospital sites with the City General Hospital becoming more focused on emergency and tertiary services while the Stafford Hospital site would provide excellent local emergency and elective services to local people in the borough of Stafford and beyond. These services would be integrated between the two hospitals, working seamlessly and in tandem with community services to ensure that patients receive co-ordinated care for their condition on discharge from hospital, supported by hospital and community services organised by the trust. By working closely with our commissioners and public we would be able to deliver on the expectations of our patients and taxpayers.

Greater integration of services would also benefit the residents of both North Staffordshire and South Staffordshire who receive our services in other ways:

- enabling more services to be supported at Stafford Hospital than would be possible for a standalone provider at Stafford. A networked model of service with rotation of key clinical staff between Stoke-on-Trent and Stafford is the best solution to the difficulty Stafford Hospital faces in recruiting and retaining key clinical staff.
- providing services at Stafford Hospital reduces the drift of activity to UHNS and lessens pressure on capacity at UHNS.
- a planned transition process is the best means of securing benefits for patients and managing risks. A planned transition with support for transitional costs would underpin the development of the changes to capacity (buildings and people) that will be needed at UHNS and Stafford to provide the new service models, should the Secretary of State approve the TSAs' recommendations. Our close clinical links with Stafford Hospital and experience in working on service change with MSFT put us in a good position to be a key partner in this transition.
- greater efficiencies can be achieved from the merger of support services, e.g. pathology.
- a bigger catchment population enables us to secure specialist services such as cardiac surgery in north Staffordshire for the benefit of patients throughout the county.
- creating opportunities to develop our teaching, education and research base, thereby ensuring a vibrant and innovative Staffordshire provider of acute services for the future.

- developing our reputation and making this area an attractive place to work for the best clinicians. For example, we know that Keele Medical School and UHNS are well-regarded by medical students as providing a good medical education, but we currently retain too few of the doctors who train here as they progress through their careers. This point is endorsed by the Dean of the Medical School, who has raised concerns with us on the attractiveness of medical rotation placements at Stafford.

Our Board is also concerned to ensure that any changes made to services at Stafford are clinically and financially sustainable beyond the transitional period not only for the benefit of current Stafford services, but also for UHNS as the 'receiving' Trust.

Perhaps most importantly, our vision for these services is not just about ensuring clinical and financial sustainability but is grounded in a commitment to improve the quality of services we provide. We will do this in a number of ways, including:

- increasing the scale of some services will support improved quality standards to the benefit of all patients. For example, increasing the population covered by emergency surgical rotas supports greater specialisation on those rotas. Increasing the number of births at UHNS allows us to support a greater level of consultant cover of labour wards and improve the ratio of midwives to patients.
- increasing the scale of some services allows us to move further towards a model of consultant-delivered services and higher levels of consultant cover out-of-hours and at weekends.
- Rotating staff between the specialist centre at UHNS and Stafford improves staff training and the robustness of staff cover arrangements.
- Planning capacity across two hospitals and commissioning community 'step down' care we can better ensure patients are in the right place for their needs and reduce occupancy levels at the City General site.
- Planning the required development of the facilities at Stafford Hospital site to improve patient experience, privacy and dignity to meet modern standards, regulatory requirements and the lessons of the recent Keogh and CQC reviews of hospitals.

Summary

Our Board supports the overall draft clinical model set out by the TSAs for Stafford Hospital. However, we demonstrate later in this response that the current proposals will not be affordable to the Trust on national tariff payments. Our support for the final plan will depend on the outcome of due diligence and the agreement of the financial, operational and governance arrangements both for the transition programme and in the longer term.

4. Response to consultation recommendations

EMERGENCY AND URGENT CARE

Recommendation 1: Stafford Hospital should continue to have a consultant-led Accident and Emergency department between the hours of 8am and 10pm daily.

Clinical rationale and sustainability

We believe that the continued operation of a consultant-led Accident and Emergency (A&E) department at Stafford Hospital, operating between the hours of 8am and 10pm, represents an appropriate clinical model. Our support for this model is contingent on the service at Stafford being provided by UHNS as part of a network with the A&E department and Major Trauma Centre at City General Hospital in Stoke-on-Trent. We would not support the continuation of the current arrangements for a standalone A&E department at Stafford as the department is not of a size that would enable it to recruit and retain senior clinical staff in the longer term. Any interim arrangements to support the department with staff from outside the Trust would be unlikely to be sustainable in the longer term.

We support the clinical argument for providing a full A&E department at Stafford rather than a GP-led Urgent Care Centre or some other form of urgent care service. Without a full A&E department, many of the patients currently seen in Stafford would have to go elsewhere and we estimate that only approximately half of the current A&E attendances would remain at Stafford. In addition, A&E has strong interconnections with services in the rest of the hospital and our view is that a consultant-led A&E department is necessary in order to maintain acute medicine and critical care services in the hospital for the benefit of local people.

We agree with the TSAs' view that if the A&E department were to be reduced at Stafford, there would be a major impact on those A&E services provided at surrounding hospitals which are already under strain from recent increases in demand. We have examined the option to extend the opening hours for A&E at Stafford and concluded that it would be financially unsustainable. It would also be very difficult to staff the department overnight with trained A&E clinicians. However, we would wish to examine with commissioners the option of providing a primary care-led urgent care service from A&E between the hours of 10pm and 8am, to be run by a GP Out-of-Hours (OOH) provider. With ambulances diverted elsewhere, this service would meet the needs of approximately half the patients arriving out of hours and would arrange urgent transport to a neighbouring hospital for those patients who needed it. In this way local people could benefit from the provision of high quality out-of-hours primary care with access to diagnostic facilities at the hospital, enabling better patient care.

We agree that existing arrangements should continue for patients with major trauma, stroke and certain cardiac problems who are transferred to City General Hospital by the West Midlands Ambulance Service. Ambulances transporting these patients currently bypass Stafford Hospital and proceed to a larger neighbouring hospital, ensuring that patients receive the right care at the right time and in the right place. We would propose that these arrangements should be extended under a networked model for A&E.

In a networked model, most medically-ill patients who arrive at Stafford A&E would continue to be admitted to Stafford Hospital. If Stafford were no longer able to provide the service needed by these patients, ambulances would bypass the hospital and proceed to the nearest hospital providing emergency surgical services. These changes should be planned with neighbouring providers and West Midlands Ambulance Service.

We believe that an A&E department working to this model could be staffed sustainably. Our proposed staffing model would involve a rota combining consultant leadership and a supervised middle tier of doctors with junior doctors and enhanced nurse practitioners. The service would manage both major and minor emergencies and would provide dedicated services to assess the needs of frail elderly patients and children. The service would work closely with the Acute Medical Unit, which would open between 8am and 10pm, and would be staffed until midnight. This would enable elderly people, children and adults of working age to be seen, assessed, treated and admitted to the right place at Stafford Hospital or where the complexity of their condition demands it, to be transferred to City General Hospital.

Our A&E clinical leaders believe that a networked arrangement would enable UHNS to provide a consultant presence at Stafford Hospital on a rota system that would ensure a safe and effective A&E service. We would increase the size of the consultant workforce (from 15 to 20) and some of these consultants would work at Stafford on a rotational basis. As a Major Trauma Centre, UHNS has been able both to attract and retain consultant staff in A&E.

Although Stafford Hospital currently has a relatively stable rota of middle grade doctors, there is nonetheless a national shortage of middle grade A&E doctors, which is likely to continue into the foreseeable future. As a result, all trusts will eventually need to change their A&E workforce model to ensure sustainable services in the longer term. We believe that being part of a larger, networked service would place both City General Hospital and Stafford Hospital in a stronger position to face those challenges as they arise.

Our view on the A&E infrastructure at Stafford is that the service requires a significant degree of refurbishment and reconfiguration in order to support modern A&E care and provide a dedicated area for children's assessment and treatment. We would expect these developments to be funded as part of a future transition programme.

In summary, we believe there is a strong clinical rationale for providing a consultant-led A&E department at Stafford Hospital as part of a network with the A&E department at the City General Hospital in Stoke-on-Trent. This change would make the service more clinically sustainable.

Financial consequences

The Contingency Planning Team report that preceded the appointment of the TSAs highlighted the fact that the cost of the A&E department at Stafford Hospital was in excess of the income received under tariff arrangements. Indeed, the service made the largest deficit, at approximately £4m, of any of the Trust's services in the year to March 2012 although it should be noted that the service operated 24 hours per day during that period.

There is some scope to mitigate this loss by recruiting to posts that have been covered by expensive locum and temporary staff. However, the proposed operating model would see UHNS operating a full A&E department with rotas staffed to recommended standards for levels of activity that would be approximately 30% lower than current volumes (Stafford A&E is already among the smallest Type 1 A&E services in the country). Overall, we believe that the service will continue to make a deficit if funded on the basis of current national tariffs.

In summary, it is our view that this service is clinically sustainable but not financially sustainable.

INPATIENT SERVICES FOR ADULTS

Recommendation 2: An inpatient service for adults with medical problems will continue to be provided at Stafford Hospital for those who need to be in hospital.

Recommendation 3: As well as retaining the present inpatient service, a 14/7 Frail Elderly Assessment service is created to provide a one-stop assessment for older people and to take referrals from a wide range of sources. The unit should be staffed by geriatricians to ensure greater links with the community. The Frail Elderly Assessment service should have clear referral systems in place so older people get the most appropriate care.

Recommendation 4: Beds should be available at Stafford Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.

Clinical rationale and sustainability

On Recommendation 2, we support the view that Stafford Hospital should continue to provide an inpatient service for adults with medical problems who need to be in hospital. Our support for this model is contingent on the service being provided by UHNS as part of a network with the acute medical service at the City General Hospital in Stoke-on-Trent.

Under this model, most of the patients with medical problems who arrive at Stafford Hospital could be seen and treated there. The care of some patients may be undertaken on an ambulatory basis (i.e. no overnight stay needed) in what is termed 'hot clinic' settings. Other patients may require medical assessment and a relatively short stay in hospital.

Acute medicine is predominantly a service for older people. Older patients who are seen in hospitals are frequently frail, have a complex pattern of illness (including dementia) and a wide range of associated conditions and care needs. The acute medical service specialises in the holistic assessment of a patient's clinical, care and support needs and ensures that these patients receive the right services either inside or outside hospital. For these reasons, the acute medical service cannot be seen in isolation from the A&E department, critical care, 'step up' hospital services and the services available in the community.

On Recommendation 3, we support the view that a Frail Elderly Assessment service, supported by geriatricians who specialise in the care of elderly people, would be essential in Stafford for patients with complex needs, particularly as the age profile of our population increases in line with national trends. We operate a similar service successfully in Stoke-on-Trent, enabling GPs and others to refer patients directly to the service. In doing so, they are able to prevent most elderly medical patients from needing to be seen in A&E, which can be a source of anxiety at any age. However, we do not see this as a unit which is separate and distinct from the acute medicine but is instead an integral part of the acute medical assessment process.

On Recommendation 4, we agree with this proposal with the requirement that rehabilitation or 'step down' beds are managed by UHNS in order to ensure a seamless transition from a hospital stay to

rehabilitation. In this way we would be better able to organise care around patient needs and work with GPs, mental health and community services to deliver the best services. In addition to providing an appropriate setting that supports rehabilitation and reablement for these patients, this proposal would also reduce pressure on beds at City General Hospital from the Stafford area.

In our view, the success of the proposed model of care for adult inpatients at Stafford Hospital would depend on two further building blocks being in place:

- The Stafford site requires significant refurbishment and reorganisation to support an adult acute medical inpatient service that meets modern standards on infection control, single-sex accommodation, basic privacy and dignity and enables inter-dependent clinical services to be located close together in the best interest of patients. The current positioning of the acute medical unit and wards at Stafford Hospital would not support the proposed model. We would expect these developments to be funded as part of a future transition programme, alongside funding of the necessary development at City General Hospital to accommodate the additional patients who would be admitted in Stoke-on-Trent. Expert assessments have shown more than £40m of capital investment in the current structure at Stafford Hospital would be needed to meet these standards, which are becoming ever more urgent and must be provided in the next three to five years.
- The effectiveness of the adult inpatient service would depend on the availability of effective community and mental health services for frail elderly patients with complex needs. Such services prevent unnecessary hospital admissions for patients who do not need care in an acute setting, sparing them the trauma often associated with being in hospital. Good community and mental health services would also enable patients to leave hospital when their condition meant they no longer needed a hospital bed and would benefit from being cared for in the community or at home. Without these community 'step down' services, operating seven days a week, Stafford Hospital would struggle to discharge patients, resulting in a reduced capacity for new patients.

It is outside of the scope of the TSAs' terms of reference to make specific recommendations about the models of community service needed in South Staffordshire. However, we would expect a clear commitment from commissioners to develop existing community services as a part of the transition programme for changes at Stafford Hospital. We are currently discussing a proposal with healthcare commissioners in Stafford to implement arrangements for 'prime providers' of 'step down' community services in order to facilitate discharge from hospital should UHNS take over responsibility for acute medical services at Stafford Hospital. Under these arrangements, UHNS would be given the budget for 'step down' community services and would buy 'packages of care' from providers who were best able to meet the needs of patients and facilitate prompt discharge. This innovative approach, which has received considerable support from the public, patients, and local stakeholders, would enable us to deliver a better service to both to patients and taxpayers.

We believe that the acute medical service could be staffed on a sustainable basis by appropriately qualified and experienced medical and nursing staff who would enable rapid diagnosis and treatment of patients. In our view, the service should operate on a 24/7 basis and be open to GP and A&E

referrals from 8am to 10pm. It should be staffed by three tiers of doctors (consultants, middle and junior grade doctors) in addition to an advanced nurse practitioner who would provide cover at night to support general medicine, 'step down' and rehabilitation services, supported by the three tier acute medicine rota. The acute medical service would be supported by critical care and retrieval of patients would be undertaken in hours by the Major Trauma team. A trust grade doctor would provide out of hours cover at Stafford Hospital with an on call consultant providing support at Stafford Hospital.

In summary, there is a strong clinical rationale for providing an acute medical service at Stafford Hospital, which delivers a rapid assessment and treatment service to a mainly frail and elderly group of patients. The service should have access to beds in Stafford Hospital to support 'step up' and 'step down' care and be supported by effective community services to prevent unnecessary admission to hospital and support prompt discharge. We propose that innovative 'prime provider' arrangements are introduced as part of the implementation of the new service model to support UHNS in commissioning the discharge support services needed to make the systems work.

Financial consequences

The proposed operating model would see UHNS operating a full acute medical rota to recommended standards with supporting hospital-at-night cover in addition to cover for the 'retrieval' of sick patients to a specialist centre. However, the level of admission would be approximately 30% lower than current volumes. Overall, we believe that the service would continue to make a deficit if funded on a current national tariff basis.

In summary, we believe that this service is clinically sustainable but not financially sustainable.

MATERNITY SERVICES

Recommendation 5: No babies should be born at Stafford Hospital's consultant-led delivery unit as soon as other local hospitals have the capacity to deliver a service for more pregnant women. The TSAs' plan is designed to ensure there is sufficient capacity at neighbouring hospitals so that mothers-to-be have a choice of where they have their baby. Consultant-led pre- and post-natal care should be delivered in partnership with UHNS so that local patients can still attend routine appointments at Stafford. Women will have the choice to go elsewhere if they prefer.

Clinical rationale and sustainability

The Trust Board recognises the sensitivity of this recommendation and the understandable view of many people in Stafford and the surrounding area that they should be able to choose to have their children at their local hospital.

Depending on the responses received during consultation from commissioners and, there may be a requirement for further detailed discussion on the plans for maternity services both in the short term and longer term. UHNS would welcome the opportunity to remain part of these discussions and our stance would be dictated by three guiding principles:

- Is the service model safe?
- Is the service model affordable on the income we receive from commissioners?
- Can the service model be delivered operationally?

Our current view is based on a detailed examination of the issue, informed by discussions with our local clinicians, national advisers and commissioners. We agree with the clinical advice given to the TSAs that the small number of births at Stafford would make a consultant-led maternity unit unsustainable on both clinical and financial grounds. We also agree with advice on the feasibility of a midwife-led unit at Stafford. The number of women who choose to give birth at a midwife-led unit is likely to be much lower than the current numbers at Stafford, and some of those who choose Stafford would be transferred if they needed the services of a consultant-led unit. We believe that this would make the model financially unsustainable and make it difficult to maintain standards at such a small unit.

Under the TSAs' proposals, mothers-to-be would no longer have their babies at Stafford Hospital but the hospital would provide a full range of antenatal clinics, scanning facilities, and an early pregnancy assessment unit. We believe that we would be able to provide these services in a clinically sustainable way at Stafford.

We estimate that these proposals would result in approximately 600 additional deliveries a year (two to three per day) in our Maternity Centre on the City General Hospital site. All these births would be

to mothers-to-be from the Stafford area who had been assessed as being at low risk. All mothers-to-be assessed as potentially high risk deliveries are already transferred to the City General Maternity Centre and other neighbouring units. No capital expenditure would be needed to accommodate additional deliveries in the Maternity Centre. The public will understandably want to be assured that the City General will be able to cope with the additional deliveries. We would like to state here that there have been no closures in our Maternity Centre or Midwife-Led Unit at the City General Site for more than two years. Past closures were caused by staff shortages, not lack of physical space.

We believe the clinical model can be staffed sustainably and would improve consultant and midwife cover. We would require consultants and midwives to cover daily planned caesarean lists and also an increased consultant presence on the labour ward. By early 2014 we would plan to have 84.5 hours of consultant presence on our labour ward, which would rise to 112 hours per week with the larger consultant workforce. This will ensure a consultant presence for mothers and their babies from 8am to 12 midnight, seven days per week.

In the tables below we set out some examples of how the new model would work.

Example 1 Stafford mother-to-be screened in local antenatal clinic as being low risk	
What happens now?	What would happen under these proposals?
All antenatal care, scans and screening tests carried out at Stafford Hospital in a midwifery-led or consultant-led clinic. Delivers baby at Stafford Hospital	All antenatal care, scans and screening tests carried out at Stafford Hospital in a midwifery-led or consultant-led clinic. At the start of labour mother-to-be travels to MLU at City General Hospital Delivers normally in MLU and returns home

Example 2 Stafford mother-to-be assessed in local antenatal clinic as being low risk develops unexpected complications during first or second stages of labour	
What happens now?	What would happen under these proposals?
All antenatal care, scans and screening tests carried out at Stafford Hospital in a midwifery-led or consultant-led clinic Mother-to-be delivers baby at Stafford Hospital (Mothers-to-be with severe complications are transferred to CLU at City General Hospital)	All antenatal care, scans and screening tests carried out at Stafford Hospital in a midwifery-led or consultant-led clinic At the start of labour patient travels to MLU at City General Hospital Mother-to-be develops unexpected complication and has immediate access to medical care if necessary, including: • consultant *present* for her care 112 hours per week (and on call for the other 56 hours) • highly skilled neonatal resuscitation for her baby • immediate access to subsequent, highly skilled neonatal care • interventional radiology- if needed, this could save her womb or even her life Mother-to-be has an assisted or operative delivery and returns home Access to skilled care in High Dependency Unit, if required

Example 3 Stafford mother-to-be assessed as being high risk owing to medical problems or previous complicated childbirth history	
What happens now?	**What would happen under these proposals?**
Mother-to-be may choose to have her antenatal care at Stafford or City General Hospital or may require transfer of care to City General Hospital antenatal clinic Many mothers-to-be deliver their baby in CLU at City General Hospital	Mother-to-be may choose to have her antenatal care at Stafford or City General Hospital or may require transfer of care to City General Hospital antenatal clinic Baby delivered in CLU at City General Hospital, which gives immediate access to medical care if necessary, including: • consultant *present* for her care 112 hours per week (and on call for the other 56 hours) • highly skilled neonatal resuscitation for her baby • immediate access to subsequent highly skilled subsequent neonatal care not requiring transfer • interventional radiology, which, if needed, could save mother's womb or even her life Mother-to-be has an assisted delivery and returns home

Caring for very sick babies - and their anxious parents

Poppy Coysh was born in our Maternity Centre earlier this year and subsequently needed treatment in our Neonatal Intensive Care Unit. Mother Vanessa recalls the patience and understanding of nurses caring for her child: "The nurses here are lovely, you can ask them anything. They will sit and describe things for you. Poppy had a problem with her heart. We didn't understand what they were telling us so the doctors sat us down and drew it out for us, they explained what was going on and how they were going to fix it. This made things a little bit easier.

"There is a kitchen area where all the parents can go. You can chat to other parents which makes you feel like you are not the only one going through it, and you make new friends. The bedrooms make it easier when your baby is in intensive care because you can stay with them and go in and out to see them whenever you can."

SERVICE FOR CHILDREN

Recommendation 6: Children should no longer be admitted as inpatients to Stafford Hospital and the service should stop as soon as other local hospitals have the capacity to accept them safely. Patients should be transferred to larger specialist hospitals for appropriate inpatient care.

Recommendation 7: Children will continue to be assessed at Stafford Hospital's existing Paediatric Assessment Unit (PAU) during its present opening hours of 8am to 10pm every day. The PAU will be led by specially trained nurses who will consult with paediatricians from UHNS. Referrals will either be through A&E, GPs or other health care professionals as they are now.

Clinical rationale and sustainability

We agree with the view that children should no longer be admitted to Stafford Hospital once other local hospitals have the capacity to take them. When children are so unwell that they need to be admitted to hospital, they should receive the standards of care that their families expect and deserve. Two key standards recommended by the Royal College of Paediatricians for these children are:

- they are seen by a paediatrician on middle or consultant grade rotas within four hours of admission
- they are seen by a consultant paediatrician (or equivalent) within the first 24 hours.

The delivery of these standards, both in and out of hours, requires a paediatric rota that Stafford Hospital would be unable to maintain. Even if the rotas could be filled, the volume of work would not be sufficient to maintain and develop the skills of doctors and nurses. It will be increasingly difficult for all small paediatric departments like that at Stafford Hospital to recruit to sustainable paediatric rotas in the future. Bigger trusts such as UHNS are able to operate a rota that is large enough to achieve the required standards.

We would propose to offer paediatric assessment and Hospital@Home services from Stafford Hospital. In this way, we believe we would be able to reduce the number of hospital admissions of children and ensure that they were only admitted to UHNS when absolutely necessary.

We would not propose the provision of a distinct Paediatric Assessment Unit as the predicted number of children (approximately 8-10 per day) would be too low to make this feasible. Instead, we would propose a paediatric assessment process in A&E in a dedicated children's area. Paediatric trained medical and nursing staff would be available on every shift for A&E. In addition, children's outpatient clinics would operate on a daily basis and urgent 'next day' appointment slots would be available to GPs requiring urgent advice or assessment.

Our view is that the A&E department at Stafford Hospital would require a significant degree of refurbishment and reconfiguration in order to support care for children. We would expect these developments to be funded as part of a future transition programme alongside the development of

the Children's Centre at City General Hospital, which would be required to accommodate an increase in child admissions. We also recognise that we would need to review the availability of accommodation for parents who would want to stay overnight at the hospital to be close to their child.

UHNS does not provide paediatric outreach services. In North Staffordshire, these are operated by the Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) for babies and children from 0 to 19 years old. The service is highly integrated with the hospital service and team members work seamlessly with our matrons and the on-call consultant paediatrician. They also work closely with the GP Out-of-Hours (OOH) service and there is a plan for the service to be located in the same place as the GP OOH service. The current Hospital@Home service in Stafford is provided by the Shropshire and Staffordshire Healthcare NHS Foundation Trust. It is not clear to us how this service differs from the SSOTP service in terms of the operating model and the capacity that is commissioned by Staffordshire and Surrounds CCG for the Stafford population. We would wish to seek clarification from the CCG on these specific points and we would naturally be keen to understand and learn from current best practice in Stafford.

The proposed model is underpinned by a full integration of clinical services between Stoke and Stafford. We would suggest that, over time, there should be a single integrated provider of Hospital@Home services operating in Stoke, North Staffordshire and Stafford. There is also a need to examine the case for further integration of children's services in the County across community and acute services where this can be shown to benefit patients.

There are two key elements to the Hospital@Home service provided to UHNS, which we believe works well and we would seek to ensure that the same level of service was put in place in Stafford:

- admission avoidance - GPs may refer directly into the service for home-based support as an alternative to hospital assessment or admission
- early discharge - a representative of the Hospital@Home service attends the daily bed meetings at UHNS and arranges home support to facilitate early patient discharge, eg by providing IV antibiotics, respiratory or gastro support etc. The service is also able to support orthopaedic patients for a period of 'home leave'.

To support understanding, we set out below a number of different scenarios to show the way in which children would be cared for under these proposals.

- A seriously injured or seriously unwell patient in Stafford referred by a GP or the ambulance service would be taken directly to UHNS by ambulance, which happens regularly now.
- A patient who is not seriously injured or unwell would be seen in the Emergency Department (ED) at Stafford and assessed by a team led by an ED consultant with experience in assessing and treating children, and paediatric trained nurses:
    - a patient with minor illness or injury would be assessed, treated and discharged

- some patients may need observation for a period of time and would then be discharged home after completion of their treatment or to the Hospital@Home team to have their treatment completed at home.

- If hospital admission is likely to be needed, the patient would be transferred to the inpatient facility at UHNS.
- Patients admitted to City General Hospital would be discharged home after completion of their course of treatment or to the Hospital@Home team to have their treatment completed at home.
- If an extremely ill or injured patient presented unexpectedly to Stafford ED and required resuscitation, this would be undertaken by the team in Stafford ED. The patient would then be transported to an appropriate intensive care unit by the specialised 'retrieval' service, which is already well established.

In addition, GPs would have access to urgent next day and routine consultant paediatric clinic appointments for patients who did not fit any of the above categories.

Patients who may currently be travelling to Birmingham for certain types of specialist treatment such as gastroenterology, respiratory medicine, specialist allergy, epilepsy, echocardiogram or endocrinology would be offered the opportunity to attend specialist clinics at UHNS, which will help local services in the county.

MAJOR EMERGENCY SURGERY

Recommendation 8: Major emergency surgery should no longer be carried out at Stafford Hospital with the exception of minor surgical procedures which can be dealt with by A&E or where the patient can be stabilised by A&E and scheduled to return to Stafford Hospital for minor surgery. Most major emergency surgery would instead be provided by a local larger hospital such as UHNS or The Royal Wolverhampton Hospitals NHS Trust. The TSAs have already had initial positive discussions with UHNS about this. This means there will no longer be a surgical assessment unit on-site. A&E consultants at Stafford Hospital will be able to consult surgeons remotely at larger hospitals about patients' surgical needs. Patients would then be transferred to another hospital for surgery where required.

Clinical rationale and sustainability

The volume of major emergency surgery currently being performed at Stafford Hospital is relatively small as vascular surgery and major trauma have already been centralised at City General Hospital and plans to centralise urology are underway.

We agree that the levels of major emergency surgery remaining at Stafford Hospital are not clinically or financially sustainable and that, where possible, these procedures should be undertaken at hospitals that can support a robust emergency surgical rota. A greater concentration of gastrointestinal surgery will make surgical rotas at City General Hospital more specialised and more sustainable for the benefit of patient outcomes.

We support the proposal that some minor trauma and other minor surgical procedures can continue to be provided at Stafford.

CRITICAL CARE

Recommendation 9: A small critical care area should be retained at Stafford Hospital so that very ill patients who come to A&E or inpatients who become very unwell can be kept stable prior to urgent transfer to a larger specialist hospital. Current staff on the critical care unit should work as part of a clinical network established with a neighbouring hospital. UHNS has proposed offering these services and the specialist staff to network with Stafford. An urgent transfer service should be established for very ill adults which is the same as the approach already used successfully across England to transfer sick children to regional centres.

Clinical rationale and sustainability

The TSAs' recommendations envisage the need for critical care to reduce at Stafford Hospital as a result of the removal of major emergency surgery. However, as a hospital providing acute medical services Stafford will require a smaller scale critical care capability to support medical patients whose condition deteriorated. As noted in the TSAs' recommendations, this would cover the stabilisation of patients prior to the transfer to more appropriate settings.

We support the recommendation to provide a small critical care area at Stafford Hospital if this is provided as part of a networked approach with UHNS in which key staff rotate between Stafford Hospital and the large critical care unit at City General Hospital in order to maintain their skills and ensure consistency of standards.

We would propose that the unit is equipped and staffed to treat Level 2 (high dependency) patients, but that patients requiring Level 3 care are stabilised and transferred to the Critical Care Unit at the City General Hospital. This will include patients requiring advanced respiratory support, or basic respiratory support together with support of other organ systems, and patients requiring support for multi-organ failure.

We believe that this unit could be staffed sustainably. Medical care would be provided by trust grade doctors covering the unit and providing support to the rest of hospital, i.e. A&E, recovery, theatre lists, and intubation and stabilisation. Consultant cover would be provided by critical care consultants at City General Hospital and Stafford Hospital's on call consultant anaesthetic rota. The additional staff would enable the provision of two 1-in-6 rotas at City General Hospital, as recommended by the professional bodies. The 'retrieval' process would be operated by the Major Trauma team from 8am to 8pm and out-of-hours by the trust grade doctor at Stafford Hospital, backed by the consultant on call supporting at Stafford Hospital or vice versa. Our views are conditional on understanding more fully the TSAs' proposals, agreed with West Midlands Ambulance Service, on the retrieval specification for such a service.

Our view is that the Critical Care Unit at Stafford Hospital would require a significant degree of refurbishment and reconfiguration in order to support modern critical care. We would expect these developments to be funded as part of a future transition programme alongside the funding of the

expansion of critical care capacity on the City General Hospital site, which would be required to accommodate an increase in patients. Our initial views on the capacity and configuration of critical care will be further refined when we are able to undertake more detailed clinical analysis on the critical care data for Stafford patients.

Financial consequences

Providing safe rota arrangements in a very small unit, combined with the requirements for anaesthetic cover for intubation and stabilisation of deteriorating patients, is not a typical model of critical care on which national pricing assumptions are based. In our view it would not be possible to provide this service within existing national tariff arrangements.

ELECTIVE CARE AND DAY CASES

Recommendation 10: Elective care and day cases should remain in Stafford. This would include orthopaedic surgery.

Clinical rationale and sustainability

We support the recommendation to continue to provide elective (planned) care at Stafford Hospital if this is provided as part of a networked approach with UHNS.

In our view, the focus should be on providing non-complex, short stay elective cases from Stafford Hospital and more complex procedures should carried out at City General Hospital. We believe that it would be possible to increase the number of elective cases undertaken at Stafford but this would depend on patients choosing to have their surgery there. In recent years many local residents have chosen to have their surgery at other hospitals including City General Hospital, but as confidence in Stafford Hospital is re-established, we believe this trend can be reversed.

We note that the TSAs propose a major expansion of surgical capacity at Cannock Chase Hospital linked to the service at New Cross Hospital in Wolverhampton. This could result in many patients from South Staffordshire choosing to go to Cannock whereas previously they would have elected to have their surgery at Stafford Hospital. The expansion of elective capacity at Cannock Hospital would reduce the catchment population for Stafford Hospital and would mean that we would not be able to make the most effective use of the elective capacity at Stafford. Given their close proximity and the availability of other providers, it is unlikely that both Stafford and Cannock Hospitals should provide elective surgery sustainably. Our view is that there needs to be a careful consideration of the options for elective surgical, out-patient and diagnostic services to the population served by the Cannock CCG, given the choices available at Walsall, Wolverhampton, Stafford and Telford.

Our view is that the theatres, day case and outpatient areas at Stafford Hospital would require a significant degree of redevelopment and reconfiguration in order to support modern elective care. We would expect these developments to be funded as part of a future transition programme.

In our view elective surgery at City General Hospital can be staffed sustainably. Surgeons would rotate from City General Hospital to Stafford Hospital for theatre sessions and outpatient clinics for those patients having their operations at Stafford. Surgery for children would be undertaken in line with guidelines from the Royal College of Surgeons, which stipulate that children must be cared for by a paediatric nurse in a designated area. Robust plans for the transfer of children to the neighbouring Inpatient Paediatric Unit at City General Hospital would need to be in place in the rare event that this was needed.

CANNOCK HOSPITAL

Recommendation 11: Beds should be available at Cannock Chase Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.

Recommendation 12: Elective surgery is retained at Cannock Chase Hospital. There should be new surgical specialties introduced, enhancing the current range of elective inpatient services for Cannock patients. This recommendation assumes that the ongoing discussions with the National CAGs regarding safe overnight staff cover can be successfully resolved.

Recommendation 13: The current range of day case procedures (surgical and medical), including rheumatology services, should continue at Cannock Chase Hospital and the range be increased where possible.

Clinical rationale and sustainability

On Recommendation 11, we would support the provision of rehabilitation services at Cannock Hospital alongside a range of other community services, which would provide care close to home for the population of Cannock. We believe that the services operated at Cannock should be closely integrated with primary care provision and other community services provided in the area.

On Recommendation 12, we would support the retention of the current levels of elective surgery at Stafford Hospital but could not support elective surgery at Cannock Hospital as this would have a direct impact on the viability of elective surgery at Stafford Hospital. In addition, it is likely that the creation of new capacity in the local health economy would drive an increase in access rates for elective surgery and would impact on the affordability of acute services for commissioners. Further, the catchment population for the elective surgical service at Cannock is not set out in the consultation document. If the catchment population is just Cannock and surrounding areas of South Staffordshire, then this would fall well below the Royal College of Surgeons recommended catchment population of 450,000 to 500,000 for an elective surgical service. If the catchment population is wider than this, then the potential impact of surrounding units should be made clear. Any changes which impact on surgical flows for populations beyond the Stafford and Cannock catchments should be subject to public consultation in their own right. We would suggest that the CCGs examine potential alternatives and innovative options for these services which maintain the ethos of Cannock Hospital as a local hospital serving the community of Cannock.

On Recommendation 13, we are unable to support the retention or expansion of surgical and medical day case procedures at Cannock Hospital as it would have a detrimental impact on the viability of elective surgery at Stafford Hospital. In addition, introducing new capacity into the local health economy would be likely to drive an increase in access rates for elective surgery and would have a negative impact on the affordability of acute services for commissioners. We would want rheumatology services for Stafford CCG patients to be delivered in Stafford by UHNS.

Recommendation 14: To allow for the TSAs' draft recommendations to work in a way that does not negatively impact the safety at other hospitals or their financial position, it is recommended that MSFT as an organisation be dissolved.

Rationale for our response

We agree with the view that the future clinical sustainability of the hospitals in Stafford and Cannock would be improved by greater integration with larger hospitals. In implementing these changes, organisational change would be needed to bring services together across hospitals.

Under the TSAs' recommendations, all of the services currently provided by MSFT would move to new trusts, so it would appear inevitable that MSFT as an organisation will be dissolved at some point in the future. The timing of this change would need to be planned as part of the overall transition programme, which would be agreed once plans for the future of MSFT are agreed. The move to new organisational arrangements should be handled with care to ensure that quality and safety is maintained during the transition period. Should the financial affordability issues be resolved, and following an appropriate period for due diligence work to be undertaken, we believe that Stafford Hospital should be brought under the management control of UHNS. We would support similar arrangements for Cannock Hospital when there is an agreed and viable plan for the future of that hospital.

However, as explained in below in the section on financial considerations, as they stand the TSAs' proposals would still have a detrimental impact on the viability of UHNS, even if MSFT is dissolved.

5. Financial considerations

In considering the financial implications of the TSAs' recommendations, we have taken the proposed clinical model and worked through the detail of the way in which we would run these services, what it would cost to deliver them and the income we would receive from commissioners. We have considered how we would staff the services to safe levels, the cost of drugs, consumables, and other non-pay costs. We have made assumptions about delivering more efficient services and the productivity improvements we could make by looking at 'best practice' benchmark data from other hospitals.

This analysis demonstrates that there would be significant financial disincentives to running an A&E department and acute medical services on the scale of those at Stafford Hospital for the relatively small number of patients who would use the hospital under the TSAs' proposals. These services have fixed costs associated, for example, with the requirements of running a medical rota. Compensation for these costs would be inadequate in the light of the low levels of activity, and therefore low levels of income, that these services would attract.

Furthermore, the TSAs make clear in their public consultation document that they have been unable to "balance the books". They identify a residual overspend in 2017/8 for all MSFT's current services of £8.5m per annum after assuming a year-on-year savings programme of 8.5%. Our cost estimates currently show a deficit against assumed tariff income that is greater than the TSAs' estimates. Our cost model builds in challenging productivity improvements, but we consider the TSAs' identified savings target of 8.5% each year for three years to be unachievable.

Our cost estimates build in quality improvements and include investing an estimated £67m in improving buildings and equipment at Stafford Hospital to bring the facilities up to current standards. This figure should be seen in the context of an estimated current 'backlog maintenance' cost for Stafford of c.£40m. In addition, we estimate that we would need to invest a further £58m in expanding capacity on the City General Hospital site to accommodate the more acutely-ill patients who would in future come north. In summary, our costs include bringing the physical environment and medical and other clinical staffing levels at Stafford Hospital up to current standards and fulfilling our vision for the integrated trust.

We remain committed to finding a way to deliver sustainable acute services for the populations of North and South Staffordshire, but clearly cannot put our current plans to achieve financial sustainability at UHNS at risk. We are therefore working on measures that can be taken to make the TSAs' clinical proposals financially sustainable. These include the following:

- mitigating the financial disincentives described above by maximising the amount of elective inpatient and day case work that would be carried out in new facilities at Stafford Hospital. We are concerned that the TSAs' proposals to expand elective facilities at Cannock will create more disincentives than exist in the present system and therefore cannot support the proposals.
- strengthening community health services in order to benefit patients who, evidence shows, recover more quickly at home, and reduce admissions to hospital and the time people need to be in hospital.
- undertaking a "due diligence" process, which would give us a more detailed picture of the current services at Stafford Hospital and provide more opportunities to make the most of synergies and productivity improvements across the two sites. However, we are also conscious that it may equally bring to light more risks that would need to be addressed.
- In order to minimise transitional costs, it is essential that decisions are taken quickly and the period of change is minimised. We have not as yet developed a detailed view of transitional costs but we recognise that this will need to be done as a matter of urgency once the outcome of the public consultation is known. We do not have the resources to meet transitional costs and would be seeking reimbursement for these.

Despite measures to improve financial sustainability at Stafford Hospital, many of the major services that the TSAs envisage being provided there do not relate directly to volume of activity. These include:

- the A&E department, which is open for a number of hours regardless of the number of attendances
- the Acute Medical Unit, which supports medical assessment and is essential to support A&E
- the Critical Care Unit, which is necessary to support the sickest patients.

If local CCGs support this model of care and commission these services, we will be seeking local pricing agreements that reflect the full cost of providing these and other services.

In conclusion, the TSAs' proposals for Stafford are clinically but not financially sustainable at present. The view of the UHNS Trust Board is that unless the Trust receives the level of funding required we will be unable to run safe, high-quality services at Stafford.

We will continue to work with the TSAs' and others to bridge the financial gap in the proposals.

6. Conclusion

Patients and local people have endured many years of uncertainty about the future of Stafford Hospital during which many staff have moved on and a number of key services have been adversely affected by the impact of unplanned change. For those staff who have remained, it has been a challenging period in which the ever-present spectre of adverse media coverage casts a shadow over their very real achievements and improvements achieved in recent years. During that time staff at UNHS have worked ever more closely with colleagues at Stafford Hospital to create more seamless care for patients. Our networking arrangements have brought common standards and processes across our two hospitals and delivered better services to patients in areas such as Vascular Surgery and Urology. We at UHNS are keen to build on these and other achievements, working together with our colleagues at Stafford Hospital to integrate key services and create one hospital across two sites.

The longer that a decision is delayed on the future plan for Stafford Hospital, and the longer the delay in implementing that plan, the greater the risk that services at Stafford Hospital become destabilised and the greater the risk that quality and safety will suffer. An early decision on the future of Stafford Hospital is crucial in order finally to put an end to the uncertainty and mark a new chapter not only in the history of Stafford Hospital but also that of UHNS.

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01 OCT 2013

West Midlands Ambulance Service NHS
NHS Foundation Trust

Our Ref : ACM/KB/KAF

Date : 24 September 2013

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Tel: 01384 215555
Website: www.wmas.nhs.uk

Mr Alan Bloom
Joint Trust Special Administrator
Office of the Trust Special Administrator
Mid Staffordshire NHS FT
Stafford Hospital
West Road
Stafford ST16 3SA

Dear Alan

Thank you for your letter of 6 August 2013 asking WMAS to provide a formal response on the draft recommendation. Please find attached comments set out in response to each of the recommendations in the consultation report. We have responded to each in as much as the recommendation affects the ambulance service and where appropriate, we have commented given our knowledge of the local health economy.

I would however like to stress that all the responses given are on the understanding that full and detailed consideration will be given to the resource requirements of West Midlands Ambulance Service. The proposals that have been put forward have significant implications from all providers in Staffordshire and the surrounding areas and potential implications for clinical quality, patient care and patient satisfaction. WMAS believes that it is the provider most likely to be impacted by the changes and wishes to work with the TSA to ensure patient safety throughout the period of change and beyond. However, this cannot be delivered without significant investment in the service to ensure that we have sufficient staff, training programmes, vehicles and support services to facilitate the safe transport of patients to alternative facilities. All positive responses and support given here are therefore subject to the West Midlands Ambulance Service being fully funded to effect the proposals in a way that preserves the integrity of the service, standards of patient care and customer satisfaction.

Best,

Dr Anthony C. Marsh SBStJ DSci (Hon) MBA MSc FASI
Chief Executive Officer

Trust us to care.

Recommendation	Response
Stafford Hospital should continue to have a consultant-led A&E department between 8am and 10pm daily. How far do you support or oppose the recommendation?	WMAS has worked with commissioners and the hospital to ensure patient safety on this basis for some time. Additional costs per annum as a result of the overnight closure are in the region of £1.6m. If the arrangement continues this value must be included in the baseline contract with Commissioners. We will support this recommendation if adequate funding is made available to ensure patient safety and on the understanding that appropriate medical cover is maintained. Maintaining an A&E function during the day in Stafford will ensure that patients are transported to A&E as quickly as possible and will not impact on the capacity of wither WMAS or surrounding A&E departments during the day time hours.
An inpatient service for adults with medical problems will continue to be provided at Stafford Hospital. How far do you support or oppose the recommendation.	WMAS supports this recommendation on the understanding that appropriate support services and networks were available to ensure clinical safety.
As well as retaining the present inpatient service a 14/7 Frail Elderly Assessment service is created to provide a one stop assessment for older people and to take referrals from a wide range of sources. The unit should be staffed by Geriatricians to ensure greater links with the community. The Frail Elderly Assessment Service should have clear referral systems in place so older people can get the most appropriate care.	WMAS would need to understand fully the inclusion and exclusion criteria for the service before being able to provide a full response.
Beds should be available at Stafford Hospital for recovering patients following a spell of inpatient treatment at a specialist hospital to rehabilitate nearer to home.	WMAS agrees with this in principle but will need to understand the numbers involved and the requirement for inter-hospital transfers to facilitate this arrangement. For example, WMAS would need to understand the clinical requirements of the patients requiring transport to this facility and whether the intention would be to commission for this through the current Emergency and Urgent contract or through existing arrangements with PTS providers.
No babies should be born at Stafford Hospital's consultant led delivery unit as soon as other hospitals have the capacity to deliver a service for more pregnant women. The TSA's plan is designed to ensure that there is sufficient capacity at neighbouring hospitals so that mothers have a choice of where they have their baby. Consultant led	WMAS agrees with this in principle and will need to understand the trajectory for increasing capacity at other units and therefore the expected changes in patient flow over the period of change to ensure sufficient resource is available. Without adequate resource at UHNS for maternity cases it is likely that cases will need to be

pre and post natal care should be delivered in partnership with UHNS so that local patients can still attend appointments at Stafford.	taken to Cheshire which will have a significant effect of job cycle times and resource deployment in Staffordshire. It should be noted that WMAS would not support the creation of a midwifery led unit as this is considered to increase clinical risk.
Children should no longer be admitted as inpatients to Stafford Hospital and the service should stop as soon as other local hospitals have the capacity to accept them safely. Patients should be transferred to larger specialist hospitals for appropriate inpatient care	WMAS would need to discuss this further and understand the staffing levels and skills of the staff based in the A&E unit and the Paediatric Assessment Unit at Mid Staffs.
Children will continue to be assessed at Stafford Hospital's existing Paediatric Assessment Unit during 8am and 10pm.	As above.
Major emergency surgery should no longer be carried out at Stafford Hospital with the exception of minor surgical procedures which can be dealt with by A&E and scheduled to return to Stafford Hospital. Most major emergency surgery would instead be provided by a local larger hospital such as UHNS or RWHT. This means there will no longer be a surgical assessment unit on site. A&E consultants at Stafford Hospital will be able to consult surgeons remotely at larger hospitals about patients' surgical needs. Patients would then be transferred to another hospital for surgery when required.	Whilst WMAS agrees with this in principle it will be necessary for the anticipated patient flows to be carefully considered and additional resource appropriately commissioned from WMAS.
A small critical care area should be retained at Stafford Hospital so that very ill patients who come to A&E or inpatients who become unwell can be kept stable prior to urgent transfer to a larger specialist hospital. Current staff on the critical care unit should work as part of a clinical network established with a neighbouring hospital. An urgent transfer service should be established for very ill adults which is the same approach already used successfully across England to transfer sick children to regional centres.	The urgent transfer service should be established in conjunction with WMAS and commissioned separately .
Elective care and day cases should remain in Stafford. This would include orthopaedic surgery	WMAS would support this on the understanding that appropriate support services are made available to avoid the need for any inter hospital transfers.
Beds should be available at Cannock Chase Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.	WMAS would need to understand whether a WMAS resource is anticipated as being required for patients being transferred to this facility
Elective Surgery is retained at Cannock hospital	WMAS does not anticipate any impact from this recommendation.
How far do you support or oppose the recommendation for MSFT to be dissolved.	WMAS has no view on this.

with the services at Stafford and Cannock Chase hospitals being managed and delivered by another organisation or organisations in the future.	

Debbie Vogler

Director of Business and Enterprise

Shrewsbury and Telford Hospital NHS Trust

Q2

We have not identified any concerns in relation to the potential impact of this model on our ability to continue to provide safe services to our population within Shropshire, Telford & Wrekin and mid Wales. Given the challenges faced by a DGH of its size and the need to move towards consultant delivered care, lessons learnt from the Stafford model will be of great interest to other DGHs across the country in addressing similar challenges to clinical sustainability.

Q7

We have not identified any concerns in relation to the potential impact of this model on our ability to continue to provide safe services to our population within Shropshire, Telford & Wrekin and mid Wales. Given the challenges faced by a DGH of its size and the need to move towards consultant delivered care, lessons learnt from the Stafford model will be of great interest to other DGHs across the country in addressing similar challenges to clinical sustainability. Of particular interest to other Trusts will be the approach to creating a better model of care for the frail older population, the model for providing adequate high dependency support locally for medical patients and the transfer protocols for the small number of patients requiring transfer to the specialist centres.

Q9

we recognise the challenge in delivering safe consultant led care with only 1800 births. Offering mothers choice of where to receive consultant or midwife led care once other providers are able to increase capacity is key. We know for instance that additional capacity will be available at our new Women and Children's unit at Telford opening in September 2014.

Q13

We have not identified any concerns in relation to the potential impact of this model for children on our ability to continue to provide safe services to our own population within Shropshire, Telford & Wrekin and mid Wales. Lessons learnt from the development of enhanced paediatric services in Stafford to reduce admissions and offer care closer to home, will be of interest to other DGHs across the country in addressing similar challenges.

Q15

We are keen to be involved in the continued development and assurance of agreed, safe, timely pathways of care with the ambulance service and the network of neighbouring hospitals for emergency surgical patients.

Q17

We would anticipate the continued development and assurance of sufficient critical care capacity across the network. NHS England will play a key role in ensuring the sustainability of a safe and adequate critical care network.

Q19

We have not identified any specific issues in relation to the potential impact of implementing this model in Stafford on the safety or viability of the services we provide to our population within Shropshire, Telford & Wrekin and mid Wales.

Q21

We have not identified any specific issues in relation to the potential impact of implementing this model in Cannock on the safety or viability of the services we provide to our population within Shropshire, Telford & Wrekin and mid Wales.

Q23

We have not identified any specific issues in relation to the potential impact of implementing this model in Cannock on the safety or viability of the services we provide to our population within Shropshire, Telford & Wrekin abd mid Wales.

Q25

We have not identified any specific issues in relation to the potential impact of implementing this model in Cannock on the safety or viability of the services we provide to our population within Shropshire, Telford & Wrekin and mid Wales.

Q27

We look forward to the further work necessary in order to address the remaining financial gap identified in this proposal, without adverse impact on the wider NHS. The development of these robust clinical and financial plans to address sustainability of smaller DGHs will be of interest to other Trusts facing similar challenges.

Q28

We look forward to this process of developing robust clinical and financial plans to address the challenges facing MSFT, being shared more widely across the NHS in order to address the challenges as set out in the Call to Action

Walsall Healthcare NHS
NHS Trust

Dear Mr Bloom

'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

Thank you for the opportunity to respond formally to the above consultation document. You will be aware that we have been involved in the process to date, and have also taken the opportunity to clarify directly with members of your team in recent weeks to ensure an effective response can be made.
We can confirm that we broadly support the model of care you propose subject, of course to its affordability to commissioners and to providersThis response concentrates on the issues of most direct relevance to this trust – the impact of proposed changes at Stafford on Walsall Manor Hospital and the proposals for the future of services in Cannock Chase Hospital.

We agree that it is essential that current services are sustained to provide services during the changes and are happy to be fully engaged in the Local Health Economy structure to support this.

1. Ensuring sufficient capacity for Staffordshire patients at Walsall Manor Hospital

The activity modelling that you have included in the document has influenced the level of capital investment required in the financial assessment. For the Manor Hospital we accept that our proposals regarding maternity capital have been directly used. However, the level of capital is related to an assumption that the main provider at Cannock Chase Hospital will receive the greater share of Cannock population non elective activity. We believe this assumption to be flawed. The application of as little as 10% sensitivity in the modelling increases the capital requirement for the Manor Hospital to above the capital

assumptions for one ward included in the document. We have already shared our modelling and sensitivity analysis with your team.

It remains our view therefore, that we require £14m capital to ensure we have sufficient capacity to continue to ensure safe, high quality services to the people of Walsall and Staffordshire. . We are clearly reassured by the Secretary of State's clear support with this view expressed in Parliament in response to a local member of Parliament "we will not make any changes that have knock-on effects on neighbouring trusts without proper assessment and making sure that provisions are in place so that they can cope with additional pressures" (Hansard 10th September 2013).

We have shared with you and your team the work we have done to arrive at our assessment that the capital requirement for the Manor Hospital remains £14m and we are of course happy to continue to work with you on the detail of this part of your planning.

2. Services at Cannock Chase Hospital

As you recognise in the consultation document we presented a credible proposal to make use of the majority of Cannock Chase Hospital for Cannock people. We wish to make three important points in this response with regard to Cannock

2.1 We remain keen to provide services to the people of Cannock and to work with your team, the Cannock commissioners, community and social care providers to develop these proposals further.

2.2. We welcome the fact that the consultation document and your draft report are both clear that you have not yet made a decision on the best provider of services for Cannock (para 514) and that the market engagement work you have done to date does not constitute a full procurement process. We believe that the people of Cannock will be best served by a full and fair process that gives all interested providers an equal opportunity to set out their plans in detail and includes local commissioners in order to reach a decision. We look forward to hearing what process will be put in place to deliver this (para 516)

2.3 As you know, we shared the reservations of the National Clinical Advisory Group about the level of clinical support that would be needed to provide safe inpatient elective care at Cannock. We did not include inpatient elective care in our proposal for Cannock and as far as we understand it, the NCAG concerns about the safety of this element of the model remain. Inpatient elective care should therefore only be part of the model at Cannock if these concerns can be adequately addressed and the clinical solution can be sustainable from a clinical workforce point of view and delivered from within the NHS standard tariff.

3. New models of care

We believe that the proposals you have outlined could place greater emphasis on the delivery of the commissioner's intentions for greater use of community and integrated models of care. We have continued to work with the Staffordshire and Stoke on Trent Partnership NHS Trust to identify how we can ensure that repatriation of Cannock patients appropriately and safely. Whatever the final solution, we expect that the care pathways should be commissioned with this community link as a key aspect.

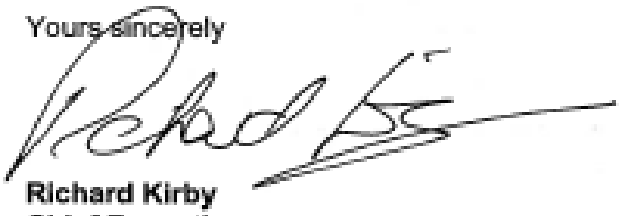
4. Anticipated levels of cost improvement and demand management

We feel that the level of savings and cost efficiency built into your assumptions is very ambitions over and above the year of year requirements of the NHS. We also note that it is assumed that the current historic growth in activity will be abated through demand management, which provides greater emphasis to community solutions potentially with primary care which are not outlines. Overall, including the additional 'tactical CIP' of 2% we believe there is approaching a 10% saving target. We have not been part of the more detailed work that we understand you have done on this with other providers and it would be helpful to see in more detail why you believe this to be deliverable

We have identified a number of specific issues regarding the costing and capital analysis which we have included in an Appendix to this letter.

Finally, I would like to reiterate the Trust's willingness to play its part to ensure that services to the people, primarily of Cannock are provided safely and effectively in the transitional period and following the new configuration. To do this however, we need to act in the near future to ensure that the capacity is available without any detriment to our existing core catchment and we need a clear and fair process for deciding the provider(s) who should provide services for Cannock.

Yours sincerely



Richard Kirby
Chief Executive

5. Independent Providers

People caring for people

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Professor Hugo Mascie-Taylor
Trust Special Administrator
Office of the TSA
Stafford Hospital
Weston Road
Stafford
ST16 3SA

30th September, 2013

Dear Professor Mascie-Taylor,

Re: Mid Staffordshire NHS Foundation Trust – TSA Report Response

Thank you for providing Ramsay Health Care with the opportunity to respond to the TSA report into the future of Mid Staffordshire NHS Foundation Trust.

We have read this with interest and are in broad agreement with the recommendations made. In particular, the focus on the use of clinical networks to help maintain services and skills in the local area appears to be a very sensible way forward. This, along with the intention to locate more specialist or complex services in larger centres of excellence, would appear to be an effective model for collaboration and sustainability.

We understand that following approval of the report by the Secretary of State, the implementation of the proposals would be delivered through CCG commissioning. Accordingly, our feedback relates to this next stage of the process rather than to the content of the report itself.

We feel it is important that commissioners remain open to the involvement of the private sector in supporting new integrated care models and potentially contributing to service delivery in both primary and secondary settings. With an existing hospital capability in Stafford, Ramsay believes that it can make a contribution towards improving health outcomes in the area, whether that be through involvement in clinical networks, the provision of specific services or indeed the management of additional facilities. As an organisation, we feel well placed to support a collaborative approach towards developing and delivering innovative service models.

Ramsay Health care was established in 1964 and has grown to become a global hospital group, operating over 120 hospitals and day surgery facilities across Australia, the United Kingdom, France and South East Asia. Ramsay is well respected in the healthcare industry for its excellent record in hospital management and patient care. We cater for a broad range of healthcare needs from day surgery procedures to highly complex surgery, as well as psychiatric care and rehabilitation. With over 11,000 beds, we employ more than 30,000 staff across four continents.

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In Australia, Ramsay Health Care is now the largest operator of private hospitals in the country with over 68 hospitals and day surgery units. We admit over one million patients per annum and are well respected as a leader in the private health care industry. In the UK, we have 36 sites and are one of the largest providers of independent hospital services in England. We have developed strong relationships with the NHS and deliver activity through the Standard Acute Contract in all of our Hospital's having also gained large scale contractual experience through the GC4 and EO5 contracts. We are now able to draw on the Global expertise available across the Ramsay Group.

Ramsay's facility in Stafford has benefitted from recent investment in a second operating theatre and ambulatory unit. It currently carries out approximately 20,000 outpatient visits a year as well as 4,000 theatre procedures. Around 70% of these involve the treatment of NHS funded patients. In addition to the potential to integrate more fully in local health service delivery, we also provide the opportunity for Consultants to utilise our facility to develop a private practice.

In summary, Ramsay Health Care welcomes the recommendations contained in the TSA report and very much looks forward to the opportunity for future dialogue with commissioners on how we might utilise our facilities, skills and experience to the benefit of the local health economy.

Yours sincerely

Jill Watts
Chief Executive Officer

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Our Ref: MR/lah/MSNFT

01 October 2013

FAO Alan Bloom & Alan Hudson of Ernst & Young LLP
The Trust Special Administrators
Office of the Trust Special Administrators for
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford ST16 3SA

Dear Sirs

CONSULATION RESPONSE – SPECIALIST PALLIATIVE CARE SERVICE IN MID STAFFS GENERAL HOSPITAL

We are writing in response to the TSA proposals for the future of Mid Staffs general hospital (MSGH) and the services to be provided in Mid Staffordshire.

We have no comment to make on the overall configurations which will retain most of the current services at MSGH. However we understand that the transfer of the more complex cases to UHNS will lead to a reduction in the average complexity of patients at MSGH. This will apply equally to patients who are in need of specialist palliative care and are approaching the end of life. Therefore there is likely to be a reduction in the number of complex cases that need to be seen by the specialist palliative care team at MSGH.

At the present time the single handed consultant in palliative care employed by MSFT works half of the time at MSGH and the other half of her time is contracted out to us. The post holder also participates in the specialist on call service based at the Douglas Macmillan hospice that covers Northern Staffordshire. We understand that there is a small support team of a specialist nurse(s) and therapeutic support. This team works in isolation of other specialist palliative teams in Staffordshire apart from the time which is contracted out to us. We believe that a much improved service could be delivered if this team was integrated into a bigger team which was able to give increased support, training, education and cover for absences.

We would therefore like to suggest that the specialist palliative care team working at MSGH should be transferred by TUPE to us. We would then contract back to the new MSGH whatever level of specialist palliative care service the hospital wished to purchase from us. This could be arranged on a flexible basis to cover varying levels of workload. We believe that this would give a much improved service to patients and give added flexibility to the hospital to balance supply and demand. It would also enable the staff to keep the practice up to date more easily by becoming part of a very much larger specialist palliative care team and provider.

This would have the advantage of improving patient care, adding flexibility to the specialist palliative care team, improving their access to education and training, enhancing opportunities for their development and matching the costs much more closely to the service needs.

We look forward to the opportunity of developing these proposals with you in due course.

Yours sincerely

Michelle Roberts
Chief Executive Officer

6. Members of Parliament

Joan Walley
Member of Parliament for Stoke-on-Trent North
House of Commons, London, SW1A 0AA
Tel: 020 7219 4524/6985 Fax: 020 7219 4397

The Rt Hon Jeremy Hunt MP
Secretary of State for Health
Department of Health
Richmond House
79 Whitehall
London
SW1A 2NS

13 August 2013

Dear Jeremy

I am writing further to the delayed publication of the Trust Special Administrators' draft recommendations for Mid Staffordshire Hospital NHS Foundation Trust.

I wish to state at the outset that there are questions about the timing of the delayed report and the lack of formal consultation in respect of North Staffordshire.

I have now had chance to consider the report and, as the consultation began on August 6th, I wish to point out that there is very limited scope to scrutinise the issues relating to North Staffordshire arising from the TSAs recommendations in the time available. It is also the case that there are similarly no clear guidelines for how North Staffordshire's needs will be considered in the post-consultation procedures.

I am aware that it is for the people of Stafford to respond to the TSAs' report and I have no intention of pre-empting their wishes. However, I do have questions relating to what the various options may be for the University Hospital of North Staffordshire NHS Trust (UHNS) and what this will mean for services in North Staffordshire and the changed management role of UHNS. I believe that we have an entitlement for this to be spelt out and consulted upon.

Please could you comment on the following issues arising from this?

1. I am concerned that any consultation process must be fully resourced and allow for detailed and planned input from all those involved in the National Health Services, to include the whole of North Staffordshire. I am aware that the planned public meetings are restricted to Stafford and Cannock and view the exclusion of North Staffordshire as a serious oversight. I have made a request to the TSAs to ensure that there is provision for meetings in North Staffordshire as part of the official process however this has been denied on legal grounds. Please can you therefore suggest who has responsibility for ensuring full consultation in North Staffordshire?

2. What authority do the TSAs have to make recommendations which require Trusts other than Mid Staffordshire NHS Foundation Trust (to which the TSAs have been appointed) to undertake the provision of services? If the TSAs recommendation that UHNS be responsible for Stafford Hospital goes ahead, who then has responsibility and oversight for the commensurate changes required of UHNS?

3. What talks are currently underway with the Government to give the TSAs assurances that there will be no unintended consequences for health care across Mid and North Staffordshire arising from the recommendations?

4. What assessment has the Government made of the existing mismatch between the Fit for the Future programme in North Staffordshire as originally envisaged compared to its current delivery? Will the proposed changes fully engage with all local community services, including the ambulance service and Local Authority, in order that there is no further strain on an already under-resourced system?

5. Who is responsible for ensuring that the capital investment required at UHNS and Stafford, arising from any changes to services, is in place prior to any agreement about the future configuration of services? How can there be due process and appraisal of the extra capital and revenue investment required if there has been no formal consultation? I understand that substantial sums are required to accommodate the proposed recommendations. Will there, then, be assurances from the Government that the increased capital and associated revenue costs will be met in full?

In summary, I very much regret the uncertainty surrounding future NHS services in Stafford and Cannock and believe it should be for the people in that area to have a say in future configuration of services before any alternative provider is appointed. I appreciate that UHNS has put forward a strong expression of interest and that this has been accepted as part of the TSAs' recommendations; however for UHNS to fulfil the recommended role there needs to be a full and detailed financial appraisal of its needs including, not just the additional capital and revenue commitments arising at both sites in Stoke and Stafford, but also a commitment to ensure that current debt levels are addressed.

Finally, it is essential that the Fit for the Future Programme continues to operate as intended before the commencement of any reconfiguration. To this effect, formal consultation in the North Staffordshire area is just as vital as that in the Mid Staffordshire area and indeed for those affected in the south of the county. Until the above considerations are addressed, it is difficult to see how there can be any smooth transition to a new management structure.

I would be grateful for clarification on the issues I have raised.

Yours sincerely

Joan Walley.

Joan Walley MP
Member of Parliament for Stoke-on-Trent North

Our ref:

RF/HT_BLOO29001

Dear Mr Bloom

I would like to add my concerns about the need for a public consultation in the Stoke on Trent and North Staffordshire area regarding the proposals surrounding Stafford Hospital.

I am particularly concerned by the recommendations put forward by the University Hospital of North Staffordshire to take responsibility for the provision of acute services either at Stafford Hospital or at UHNS in place of Stafford Hospital and how this will impact on current services for residents in this area.

It is important for the public to have the opportunity to question and scrutinise the proposals to obtain a clearer idea as to how the proposals may impact on the services they are currently receiving. Many of my constituents are concerned as to how these proposals will impact the local health economy as well as local health services and providers.

It is vitally important that proposals provide an improved health service to the residents of Stafford, whilst not impacting and reducing the quality of services in North Staffordshire.

Therefore I would like to see a series of public events in Stoke on Trent and North Staffordshire to reassure residents of the quality of healthcare services provided to them.

Yours sincerely

Rob Flello MP

Michael Fabricant MP

House of Commons
Westminster
London
SW1A 0AA

9 September, 2013

11 SEP 2013

Mr Alan Bloom
Joint Trust Special Administrator
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Dear Mr Bloom

CONSULTATION ON THE TRUST SPECIAL ADMINISTRATORS' DRAFT RECOMMENDATIONS ON THE FUTURE OF SERVICES FOR LOCAL PEOPLE USING STAFFORD AND CANNOCK CHASE HOSPITALS

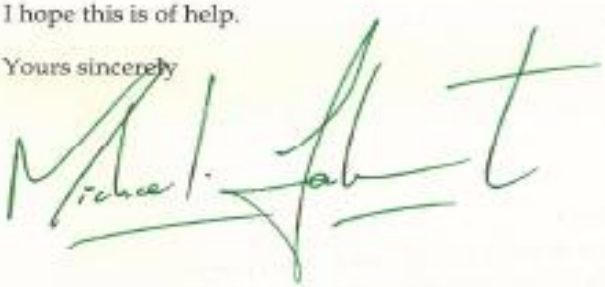
Thank you for your letter of 6th August regarding the above consultation.

I do recognise that some services cannot continue to be provided at Stafford Hospital and that this may be the best way forward in order to maintain services of a high standard. I am pleased that some new or enhanced services may be provided at both hospitals.

I have not received any comments from constituents in connection with the future of services. If concerns are raised as a result of the consultation, I will forward them to you.

I hope this is of help.

Yours sincerely



from the Member of Parliament for the Constituency of Lichfield

the Parliamentary constituency of Lichfield includes the City of Lichfield, Abbots Bromley, Alrewas, Armitage, Barton under Needwood, Burntwood, Chase Terrace, Chasetown, Colton, Fradley, Hammerwich, Handsacre, Kings Bromley, Kingstone, Longdon, the Ridwares, Streethay, Tamhill, Whittington, Yoxall and surrounding Staffordshire villages.
website and email form: www.michael.fabricant.mp.co.uk

House of Commons
London SW1A 0AA
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Valerie Vaz MP

Mr Alan Bloom
Trust Special Administrator
Mid-Staffordshire NHS Foundation Trust
MSFT-TSA Consultation,
Ipsos MORI, Research Services House,
Elmgrove Road,
Harrow, HA1 2QG

Our Ref: p/ci/w-Manor Hosp

BY EMAIL: TSAconsultation@midstaffs.nhs.uk

27 September 2013

Dear Mr Bloom

Re: Public Consultation on Services for People Using Stafford and Cannock Chase Hospitals

I refer to the proposals for the future of Stafford and Cannock Chase Hospitals set out in your recent public consultation document.

I understand that the proposals for the future of Stafford Hospital will result in more patients from Staffordshire will be treated at the Manor Hospital. I am informed by the Trust that this will require a capital investment in additional facilities totaling £14m together with full revenue funding under the NHS tariff.

The Manor Hospital has already seen a significant increase in activity from Staffordshire residents as a result of recent events at Mid-Staffordshire NHS Trust which led to the closure of the Accident and Emergency Department. Emergency admissions at the Manor Hospital for Staffordshire residents have risen by approximately 40% over the last 12 months.

The Secretary of State for Health said in the House of Commons in response to a question about the impact of changes in Stafford on neighbouring hospitals, that the Government "will not make any changes that have knock-on effects on neighbouring trusts without proper assessment and making sure that provisions are in place so that they can cope with any additional pressures."

I would be grateful if you could ensure that your proposals include sufficient resources for the Manor Hospital to deal with the additional pressures created by the expected increase in the number of patients from Staffordshire.

Yours ever

Valerie Vaz

VALERIE VAZ MP

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WILLIAM CASH, M.P.

HOUSE OF COMMONS
LONDON SW1A 0AA

Mr Alan Bloom
The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Thursday 26 September 2013

Dear Mr Bloom,

Re: Consultation on the Trust Special Administrators (TSAs) publication of their draft recommendations on Mid Staffordshire NHS Foundation Trust

In my response to the consultation, first I would like to make clear that I strongly support the first submission already provided to you by the Member for Stafford, Jeremy Lefroy MP, on behalf of the Stafford Hospital Working Group – and I pay tribute to Mr Lefroy for all the work that he does in chairing that group and on behalf of the hospital and for all his constituents.

I urge you to take account of the views expressed by my constituents, particularly at the consultation meeting at St Dominic's Priory School in Stone on Tuesday 13th August. My own constituents contributed to the Stafford Hospital Working Group as a comprehensive way of responding seriously to the TSA consultation. The vital issues are of serious importance to my constituents. In relation to your proposals, I urge that the operation of Stafford's A&E be reviewed on a regular basis by the Trust board with the aim of returning to 24/7 operation. I welcome the enhancement to the Medical Assessment Unit (MAU) and the specialist support for the frail and elderly. I strongly oppose the recommendation in maternity services to remove consultant-led delivery from Stafford (Recommendation 5). I oppose the recommendation for inpatient Paediatrics and the Paediatric

Assessment Unit that children should no longer be admitted as inpatients to Stafford Hospital (Recommendation 6) and I oppose the recommendation that children will be assessed at Stafford's Paediatric Assessment Unit the hours of which will be reduced from 24/7 to 14/7 (Recommendation 7). I urge you to carefully consider and support the proposal that a level 3 critical care unit at Stafford be maintained in the manner recommended in the Stafford Hospital Working Group submission. I will not repeat to you the major issues of national and local importance as already detailed within that first submission but I add one vital matter which is on the importance of the arrangements required to support my constituents who live in rural and deeply-rural areas.

I must point out that I am entirely supportive of the working group addressing this factor in section '15.0 Travel' of their report, because for most people currently using the services at Stafford and who will need under these proposals to travel to UHNS or RWH, travel time will increase, in some cases by 30-45 minutes if travelling by private transport – and for longer if, for example, the M6 is slow-moving. While that submission identifies residents of the more remote rural areas served by Stafford, this also interacts with the other concerns the report identified, including: women going into labour; children and their parents needing emergency care between 10pm and 8am when the proposal is that there is no access to Stafford and; those without cars who rely on public transport and who are likely to be on a lower income. For those of my constituents in rural and deeply-rural areas, where any or all of the above may apply in making arrangements for them to travel to hospital, I would urge you to note how this concern is highly relevant to a constituency such as mine. The Stafford part of my constituency has some deeply rural areas, such as High Offley, that are very much more remote than the streets of Stafford and other towns with good arterial connections to the M6. This will affect villages within my constituency to differing degrees including Eccleshall, High Offley, Woodseaves, Gnosall, Sandon, Weston, Stowe by Chartley and other areas. There are of course figures given about how quickly people can get to UHNS and other hospitals but I simply and strongly reiterate the point that somebody might have a stroke, a mother may be giving birth, or a farmer might be caught in some dreadful tragedy in a dark field in a remote area and they cannot wait another hour or longer to receive immediate medical care and attention. That is, of course, why we need a full accident and emergency service and time is of

the essence, for example, for safe childbirth. At the moment, we have been going through a hiatus since Stafford Hospital's 24/7 A&E department was temporarily reduced to 14/7 from 1 December 2011 but it must not remain for long because my constituents need a full A&E service, especially for those in deeply rural areas, as well as for more built-up areas in the urban parts of Stafford and the adjacent areas.

It is important therefore to make provision for the assessments provided to you in section 15.0 of the report on behalf of the working group, when it states that increased travel time for patients and visitors is a serious consequence of the proposals and that the CPT report used data which I and others do not recognise. Taken into careful consideration with section 6.3 on 'Access' of the working group report that travel times to the alternative providers proposed would be longer and depend on roads which are frequently congested, all essential services identified in that report must be protected.

Yours ever,

Bill

Dear TSA

Please find attached a further response to the consultation from J Lefroy MP. This part of the response is an alternative proposal to that put forward for consultation.

With kind regards

James Cantrill

James Cantrill
Office Manager
Jeremy Lefroy MP, Stafford Constituency

ALTERNATIVE PROPOSAL BASED ON THE TSA'S PREMISE OF THE DISSOLUTION OF MSFT

1.0 Agreement that the Mid Staffordshire Foundation Trust (MSFT) should be dissolved.

My alternative proposal fully accepts the TSA's basic premise that MSFT should be dissolved and Stafford and Cannock Hospitals be merged with other NHS Trusts.

This is a very important proposal and should not be disregarded lightly in the understandable and necessary concentration on which services are provided where.

1.1 It will be the first time that a Foundation Trust has been dissolved and will mark a very significant change in the structure of the NHS. It is almost certainly likely to lead to much more networking between specialist acute hospitals and acute DGHs. In my opinion, this can only be to the benefit of patient care and safety and I welcome it.

1.2 The dissolution of MSFT should also mark a clear statement of intent by Monitor that it will not accept any further 'fudged' applications for Foundation Trust status. Better that Trusts take a good time to prepare themselves and ensure that they will be financially sustainable for 10-20 years ahead than that they should rush to gain a status which has proved such a problem for MSFT.

2.0 Alternative proposal

2.0 My proposal is that Stafford should immediately be taken over by UHNS (Cannock being taken over by Wolverhampton or Walsall) in shadow form, at the latest by 1st January 2014. This would be to ensure that hospital management was placed on a stable footing, giving security for staff and patients. Work could then begin on forming a new Trust, with a newly constituted Trust Board.

2.1 All services would be delivered on the current sites as now but work could immediately begin to achieve cost savings, by reducing executive management and back office functions from both sites and bringing former MSFT costs more into line with the NHS average.

2.2 Work would also immediately start on networking clinical services across sites. Where there was a clear clinical and patient safety case for a transfer of a specialist service between sites, it would be made and consulted on. This has already happened on several occasions such as with the transfer of acute stroke and major heart attack services some five years ago and more recently with vascular and urological surgery.

2.3 Services such as full consultant-led paediatrics and maternity - where provision as close as possible is especially important for patients and their loved ones, is clearly desired by the local community and contributes to reducing health inequalities - should be retained at Stafford for the whole transitional period of 4-5 years.

This would also have the advantage of allowing the use of these services to rise to its normal long-term level, which has been adversely affected by the problems arising from the poor

quality of care set out in the HCC and Francis reports.

2.4 As has been pointed out elsewhere in this response, retaining a full Critical Care Unit (CCU) at level three is vital as support, not just for paediatric and maternity services but also for those which the TSAs propose to retain (especially A&E and acute medicine). There is room for cost saving in the plan put forward by the CCU department and described in this response.

There should also be the opportunity for additional funding through the regional critical care network. Keeping Stafford as a CCU3 site is important in maintaining the robustness of the region's and nation's critical care infrastructure.

2.5 The impact of the proposals for transferring major emergency surgery from Stafford should be considered much more carefully before a final decision is taken. Consideration must be given to the impact on other services, both in Stafford and in the Trusts to which the service would be transferred.

2.6 The Trusts with which Stafford and Cannock would be merged would – backed by the CCGs and supported by transitional funding from the Department of Health – give guarantees that full consultant-led Maternity and Paediatrics as well as Level Three Critical Care would continue to be provided at Stafford through the transition period, with the aim of assessing their sustainability in the long-term.

2.7 The proposal to collocate a GP-led Urgent Care Centre alongside A&E either at night-time or 24/7 should be considered again. There was much support for this from local clinicians before the CPT process started and there is clearly support from the local community for a 24 hour urgent care presence at the hospital. Although a 24 hour A&E service is always desirable, I believe that Stafford Hospital presents a great opportunity to pioneer new ways of delivering urgent care. As part of these proposals, consultation with local clinicians regarding a GP led Urgent Care Centre through the night and possibly running alongside A&E during the day would be a priority.

2.8 Very importantly, the opportunity should be taken to integrate acute and community services across the whole region. The hospitals at Stoke, Stafford, Wolverhampton, Walsall and Cannock can be used as key hubs for integrated community care rather than as 'boxes' to which patients are sent from the community, and from which they return to the community. This will undoubtedly help to ease the increasing demographic pressure on acute services in the coming years. The commissioners and the trusts can work with NHS England to develop an example of best practice in the region for the entire NHS.

2.9 The proposals for Cannock are welcome as they increase services at Cannock.

3.0 Similarities and differences with the TSA proposals

In conclusion, my proposal would be almost identical to that of the TSA's in four of its most important respects:

a) It would see the dissolution of MSFT, which is not sustainable as an organisation, but ensure that services could continue to be provided at Stafford and Cannock.

b) It would help to improve recruitment and retention of staff at all sites (Stafford, Cannock, Stoke plus Wolverhampton and Walsall) by providing a greater range of opportunities and experience within single organisations.

c) It would help to improve the quality of services by much greater networking, allowing staff to learn from each other rather than remaining relatively isolated in smaller units.

d) It would provide a four to five-year transition period which would be supported by revenue funding through the NHS/Department of Health to allow the Trusts and services to bed down.

Part of this support should be to enable UHNS and where necessary the other Trust(s) into which Stafford and Cannock would be merged to address legacy problems such as the £50m pa cost of the UHNS PFI.

Where my proposal differs from the TSA's is in that:

a) It does not see the need to remove full consultant-led Maternity services, Paediatric services and a full CCU3. Rather it considers these essential to providing good quality services to the population currently served by MSFT.

b) It proposes a greater emphasis on developing integration of acute and community services, fully in line with Government, NHS England and local CCG policy.

4.0 Finances

This analysis is predicated on the following:

1) The figures are taken from the TSA proposals;
2) The period being examined is 4 to 5 full financial years from 1 April 2014 to 31 March 2018/2019;
3) Stafford retains its current maternity, paediatric services and CCU3 with some specialist emergency surgery transferring to UHNS if it is deemed necessary and clinically safe.
4) The estimated additional capital costs for all sites (see below, 4.2) are reduced to an additional budget of £100 million over 4 to 5 years given that there will be fewer services transferred.

4.1 Baseline

The anticipated overspend for MSFT in 2013/4 is £20.2m and is taken as the baseline. (In fact it is currently predicted to be £18-19m but I will assume £20.2m in accordance with the TSA figures).

4.2 Additional Costs

The TSA anticipates additional annual costs for the services currently provided by MSFT at £29.1 m pa.

a) £10.5 million of this relates to the cost of additional capital expenditure, i.e. 5% of the current capital expenditure cost which is assumed to be approximately £200m.

If the additional capital expenditure (which is already considered by some NHS professionals I have consulted to be very high) is reduced by half, the figure would reduce to c £5.5m.

b) Inflation and the impact of reduced revenues are estimated to cost £17.4 m per annum. Given that, under my revised proposals, revenues would not fall as much for the Stafford and Cannock sites because more current activity would be retained, it is reasonable to assume that this inflation/revenue impact would be perhaps £4m less at £13.4 m.

It should also be noted that these inflation and tariff pressures will apply to all acute Trusts and in particular the smaller ones.

This is a point which I have raised frequently in and out of Parliament. It needs to be addressed by Monitor who take on responsibility for tariffs from 1 April 2014 and the Government.

c) The additional ambulance costs are forecast at £1.2 m. With my revised proposals, many of the forecast ambulance transfers should not be necessary. However, my assumption is that the TSA's additional cost for ambulances is too low, given the increased number of transfers under their proposals. Hence I do not propose any change to this figure.

Hence my estimate for total additional costs is £20.1 m instead of £29.1 m.

4.3 Additional savings

The TSA estimates total annual savings of £40.8m as follows:

a) £11.6 m per annum can be saved through reducing executive management and back office functions and bringing current level of overheads to the NHS average.

This reduction over 4 to 5 years appears reasonable. However it is also reasonable to assume that a portion of the reduction in shared overhead costs should be allocated to the Trusts taking over MSFT. This is a point which has been made to me by the Chief Executive and Chairman of UHNS.

My assumption is that about £6m per annum is attributable to shared overheads and hence £3m should be removed from the annual savings attributable to MSFT.

However if the balance of £5.6m in the TSA's calculations is assumed to represent the annual savings from reducing MSFTs' costs to the NHS average when they are estimated to be 18% higher, that seems too low given a cost base of £170m pa. At that level, MSFT's costs could be reduced by some £30m without affecting services. This does not seem to me to be reasonable. However an increase in the savings per annum from £5.6m to £9m over 4 to 5 years in bringing MSFT's costs down TOWARDS the NHS average would appear possible.

b) £8.6m can be saved from a combination of reductions in various clinical and ward costs which would no longer be required under the TSA's draft recommendations.

Given that my proposal is to retain most of these services, the large majority of these savings will not be achieved. However some support services (which can be effectively combined on one site) will be moved so it is assumed that £7.0m of the £8.6m of savings will not be achieved and hence just £1.6m achieved.

c) £6.2m can be saved from staff and non-staff services due to closer networking. I am assuming that this will continue to be possible as I support the merger of the Stafford and Cannock Hospitals with other larger trusts.

d) £4.0m can be saved by reducing surplus space at Stafford and Cannock. I am assuming that this will continue to be possible as most of this relates to Cannock where my proposals are the same as those of the TSA.

e) £10.4m can be saved through general cost improvements such as more bulk purchasing. This is in line with savings expected by all trusts. This figure seems ambitious to me but it is not affected by the difference between my proposal and that of the TSA.

Hence my estimate of total savings per annum by 2017/18 is £34.2m.

Taking these changes together, the result is

£ millions

Current baseline. (£20.2)
Additional costs. (£20.1)
Additional savings. £34.2

Net 2017/18. (£6.1)

Therefore the ongoing loss under my proposal is estimated to be no more than that under the TSA 's current proposal and possibly a little less.

The reason is that the reduction in the annual cost of the additional capital expenditure together with a lower decrease in revenues and a faster move towards NHS average costs would more than offset the additional costs incurred by maintaining services which the TSA proposes to move away from Stafford.

This still leaves an annual deficit which, as with the TSA's proposals, needs to be dealt with by the end of the 4-5 year transition period.

4.4 National policy impact on NHS finances between now and the end of the transition period

There are several changes in NHS financing which may occur between now and the end of the transition period of 4-5 years.

a) The review of per caput funding for CCGs should result in a fairer allocation of funds to CCGs in South Staffordshire. Currently, the South Staffordshire CCGs have a funding shortfall of c£40m per annum under the 'fair shares' calculations. Of this, £20m is attributable to the Stafford & Surrounds and Cannock Chase CCGs.
b) Tariffs, which are currently squeezing acute and emergency services, will be under review as responsibility for the tariffs passes to Monitor in 2014. It is quite possible that the tariff system, under which the TSA proposals are made, will change substantially.
c) The necessary changes to integrate acute and community services as well as health and social care are very likely to see more pooling of funding which is currently segregated.
d) The impact of a continued rise in the population as well as increased life expectancy may see public and hence political attitudes change towards health and social care funding.

For all these reasons, it is prudent and reasonable, while taking the important decision to dissolve MSFT, not to make substantial changes on financial grounds to good and safe clinical services, which are greatly valued by patients, when they may be financed on a very different basis by 2017-2018.

Joan Walley, Member of Parliament for Stoke-on-Trent North

Response to the Trust Special Administrators' recommendations on the future of hospital services in Mid Staffordshire

My response to the Trust Special Administrators' (TSAs') consultation is the result of wide-ranging discussions that I have had over recent months with local health authorities, healthcare providers, community groups, and members of the public. The TSAs' proposals are the most significant issue currently affecting North Staffordshire and I raised early concerns with the TSAs and Jeremy Hunt, the Secretary of State for Health, regarding the unacceptable lack of consultation with both the public and healthcare providers in North Staffordshire.

The fact remains that the procedure for a hospital in administration only allows for consultation in the area served by the hospital. What the procedure does not allow for is for an equivalent consultation amongst those in the receiving area whose health services will be acutely affected by the proposed reconfiguration of services. Their voice should be heard too.

Broadly speaking, I agree that the TSAs' proposal for University Hospital of North Staffordshire (UHNS) to play a leading role represents the best possible solution to the challenges at the Mid Staffordshire NHS Foundation Trust (MSFT), but I remain deeply concerned that the details have not yet been sufficiently worked through. UHNS will be profoundly affected whatever the outcome of the inquiry into the future of Stafford Hospital, so the issues raised by the consultation must be scrutinised in a wholly collaborative way to ensure that UHNS is able to provide high quality care whilst remaining financially sustainable.

Finally, as a Stoke-on-Trent MP, I am reluctant to comment on what the solution for Stafford should be. I expect there to be full consultation with all stakeholders to reach a broad consensus. In the event that UHNS is invited to take on new responsibilities, there are concerns which I ask to be taken into account. Maternity services particularly feature here and the people of Stafford should determine what arrangements best suit them, particularly given the distance from Stafford to Stoke-on-Trent and traffic congestion problems. It is also the case that there appears to be lack of clarity about birth projections for Stafford in the TSAs' report and an absence of birth projections for the UHNS area. This needs to be fully addressed.

My principal comments on the proposals are as follows:

Consultation process

I have consistently highlighted my concerns throughout this inquiry about the failure of the statutory TSA process to allow for meaningful consultation in the UHNS area. In a letter to the Health Secretary, I acknowledged that this is primarily a matter for people in Mid Staffordshire but I maintain that the solution being proposed is of equal significance to people in the UHNS area.

It is my firm belief that the implications for healthcare in North Staffordshire were insufficiently addressed by the report, particularly in respect of the impact on UHNS and its local health economy, and it is not clear what would be required from healthcare services in North Staffordshire in the future.

It would appear that neighbouring NHS Trusts have been viewed as potentials bidders and not as collaborative partners in a transparent process. I fear that discussions with UHNS and the Stoke-on-Trent CCG have taken place at arm's length and that the necessary detailed assessments will follow the consultation process. There is now an urgent need for other parties to immediately come to the table, including Government, to consider if there is genuine potential for reconfigured services of the form proposed in the report, and if so, what extra funding is needed and how appropriate are the current tariffs.

The timescales suggested by the TSAs' process are patently ludicrous. The complexity of the details are yet to be fully understood and worked through and, coupled with the strength of public and professional feeling about the proposals, means that it is wholly unrealistic to suggest that the proposals can be redrafted within 15 working days.

The failure to spell out the implications for North Staffordshire means that the limited timescale for final approval could be destabilising to UHNS. This needs to be acknowledged and addressed and I call on the TSAs and Government to factor in extra time to take account of the need for detailed consultation with local health and social care providers to ensure that the proposals are viable.

Maternity services

I remain unconvinced of the veracity of key assumptions relating to the proposal to close the maternity department at Stafford Hospital, not least due to the lack of meaningful engagement to test the TSAs' proposals. At the first public consultation meeting in Stafford, it was highly revealing that midwives from Stafford Hospital claimed not to have been consulted on the development of the TSAs' recommendations. It appears, therefore, that the future configuration of maternity services is based on a paper exercise. Why has there been no direct contact with the personnel who deliver key services as part of the official process? I will continue to seek assurances about how any transition can legitimately take place without the necessary direct contact with hospital staff.

Data from the Royal College of Obstetricians and Gynaecologists' Census Report 2012, published in September 2013, confirms that the birth projections given for Stafford Hospital in the TSAs' report had been underestimated by 600 per year. Additionally, assessments relating to future birth forecasts for North Staffordshire are missing from the analysis and, until this is quantified, it is unreasonable to expect UHNS to make an informed decision about its ability to extend its maternity service, maintain high standards of care and to remain financially viable.

Additionally, it is of real concern to me that maternity services offered at UHNS could be at risk of becoming impersonal, given that nearly 6000 babies are already born at UHNS each year and the TSAs appear to have significantly underestimated the number of births at Stafford Hospital. I am also interested to understand how the proposals complement David Cameron's pre-election pledge in 2010: "Parents in many parts of Europe have a system that is more and more local – with more choice. And they also have lower rates of infant mortality. Why can't our parents have the same? With our maternity networks, they will."

In light of a lack of accurate detailed forecasts of birth rates for Stafford, Stoke-on-Trent and Newcastle-under-Lyme considered in the TSAs' report, it is vital that no rash decisions are made at this stage.

The future of services

The TSAs' proposals are dependent on a changed model of community healthcare intended to take the strain away from acute hospital services and ensure that fewer people are treated in hospital. The requirement for greater integration and collaboration between healthcare providers is widely recognised as fundamental to an effective and sustainable modern health care system. Regrettably, however, the TSAs proposals do not go far enough in pointing a way forward for greater integration between hospitals, GPs and community services. The TSAs appear to be relying on this enhanced community model as an opportunity to achieve savings, to partially plug the financial gap in the proposals, and yet the costs of reconfiguring services have not been considered or made explicit.

Sadly the warning signs are already there in the *Fit for the Future* programme which has failed to deliver as it was intended due to a lack of funding.

I fully support the objectives of a fully integrated and collaborative health economy and urge the TSAs to undertake a comprehensive appraisal of existing services and set out the shared aspirations for the future configuration of services. The GP commissioning groups are a vital partner in this.

Financial appraisal of UHNS

For UHNS to become responsible for running future services at Stafford Hospital, as well as treating additional patients in Stoke-on-Trent, its financial arrangements must be urgently resolved by Government, including:

- The current and ongoing PFI debt (I understand this to be c£31m this year)
- The additional capital and revenue costs required to deliver the Stafford proposals (currently estimated at c.£18m)
- The costs of an increased level of patient demand
- Ensuring that an enhanced community service provision is adequately resourced to enable long-term capacity issues to be addressed.

Transport Costs

1. **Ambulance services – Emergency and Patient Transport Services (PTS)** - a far more detailed appraisal is required as to the costs for emergency and PTS services arising from the proposed reconfiguration and this needs to be costed into the overall proposal.

2. **Access to UHNS**
   Many of the comments about the proposals made to me have focused on anxieties about how patients will access UHNS. This includes patients and visiting relatives who would have a considerable distance to travel from Stafford, incurring significant cost in doing so, and patients in North Staffordshire who find access difficult on account of public transport costs and insufficient car parking provision.

   This is despite assurances from Government that social policy issues such as access to health services are factored into strategic policy making. Yet this does not appear to be a priority for the TSAs.

Summary

While I accept that UHNS is best placed to take responsibility for managing future services at Stafford in the event that there has to be an alternative provider, I am overwhelmingly concerned that the procedure does not allow sufficient time to understand the consequences and delivery costs of the new proposals. There is currently no clarity about how the TSAs have reached their recommendations, however these are important decisions which cannot be rushed and must be more fully considered and assessed. I recommend that there should an extension to the timetable so that all the options can be appraised and that the redrafting period should be expanded to include a plan of action of exactly what will be required to put the recommendations in place.

Finally, there needs to be a clear commitment from Government to make the extra investment required and to reassess the tariff system. Failure to do that would simply transfer the problems of Stafford hospital to UHNS. The Government must urgently agree how to resolve satisfactorily the additional resources and systemic changes that will be required to ensure that UHNS is able to fulfil any new role.

HEALTH AND EQUALITY IMPACT ASSESSMENT

Submission by Jeremy Lefroy, Member of Parliament for Stafford

The protected characteristics under the Equality Act (2010) which I believe are most affected by the TSA's proposals are:

Age, Gender (Pregnancy and Maternity) and Disability

1.0 Age

1.1 Children and young people

The major effect of the TSA's proposals on children and young people will be the reduction in paediatric services offered at Stafford Hospital.

Currently Stafford offers a 24/7 consultant-led Paediatric Assessment Unit (PAU) and in-patient paediatric service. This means that children and young people in the catchment area for MSFT will receive treatment for all but the most serious conditions which require a highly specialist children's unit.

Under the TSA's proposals, the PAU will operate 14/7 and there will be no inpatient paediatrics. There will not be a paediatric consultant rota at Stafford.

While there will still be elective surgery on children, the TSA's figures (Volume Three page 74) show that children and young people up to the age of 19 attend Stafford much more for non-elective than elective admissions. In 2012/13, non-elective admissions for those aged 0-19 comprised 26% of the total non-elective admissions. ***Children aged 0-9 had the highest percentage of non-elective admissions of any age group (19% with the next highest being those aged 80+ at 16%).***

It is clear from these figures that children and young people are substantial users of Stafford's services, particularly when they need emergency or urgent care. Given the propensity of children to become sick quite rapidly, having a 24/7 consultant-led service in the area is highly valued by parents and children alike, as has been demonstrated by the strong support for the service from local people.

It is equally the case that children often recover quickly which means that having local in-patient capacity, whether in the 24/7 PAU or Shugborough (children's) ward, not only relieves pressure on other more distant hospitals which would be required to admit patients, it also makes it much easier for parents and other relatives to visit. This is of great importance to all patients, but especially children and young people.

There are three main disadvantages to the TSAs' proposals for the children and young people in the MSFT catchment area:

i) There will no longer be a night-time service for sick children who would normally attend Stafford. At present, even with a 14/7 A&E, sick children

can attend the consultant-led PAU at Stafford at night. However, in future, parents will need to take children at night to Stoke, Walsall or Wolverhampton each of which is at least 18 miles away.

ii) Children attending the 14/7 A&E at Stafford will no longer have access to a consultant paediatrician's opinion on site if considered necessary by the A&E doctor in attendance.

iii) Children will not be admitted for overnight stays at Stafford, thus putting a greater burden on parents who will have to travel further to visit and make additional childcare arrangements for their other children.

While there will be an impact on all families, it will be most substantial on those without private transport and on low incomes. Taxi fares between the MSFT catchment area and the alternative hospitals are at least £25-35 each way, sometimes more at night.

The TSA's proposals therefore are likely to result in a reduction in the quality of services for children currently attending Stafford. They may also result in an increase in inequality of access to services for all children and in particular those from low income families.

1.2 Those aged 60+

The TSA's proposals to have a 14/7 A&E department as well as to retain acute medicine and introduce a 'frail elderly unit' are a great improvement on the original CPT proposals which proposed none of these.

Just over 35% of non-elective admissions to Stafford in 2012/13 were for people aged 60 and over. This represents an average of 23 people aged 60 and over who would have had to have been admitted to other acute hospitals every day of the year if Stafford had not been able to accept non-elective admissions. The TSA proposals would mean that many (though not all) of those would still be admitted.

The most substantial impacts of the TSA's proposals on those aged 60+ are:

i) The proposed removal of major emergency surgery to major acute sites. The number of emergency operations affected is said to be an average of four per day. It is likely that a higher percentage of these will be among those aged 60+ than under 60. As a result, patients and their relatives/loved ones will need to travel further for their treatment and to visit. Set against this is the possibility of better clinical outcomes as a result of the major surgery being performed in a specialist centre.

However there is a question over the actual number of patients who will no longer attend A&E at Stafford as I have set out in my main response (section 2.4) to the consultation.

"I do not follow the reasoning behind the figures given for the percentage of patients who currently access A&E at Stafford who will do so in the future if non-elective/emergency general surgery and trauma surgery is no longer provided at Stafford. It is stated as 70%. This implies an average of 84 attendances per day compared with the current 120 (378). However elsewhere in the report (441), it is stated that there are an average of 4 cases per day (2 emergency surgery and 2 trauma). If it is only these cases which will no longer come to A&E in Stafford, the average number of attendance would be reduced to 116 and not 84. It is not at all clear how the figure of 84/70% is reached.

Either the figure is incorrect or there will be other categories of patients who currently come to A&E at Stafford who will not do so in the future.

If the average number of attendance is indeed 116 (ie 120 less 4 emergency surgery/trauma), then the statement that "The TSAs do not propose any changes to how the vast majority of local patients currently use the consultant-led A&E department at Stafford Hospital" (p24 consultation booklet) is correct.

However. if the average number is 70% of the current average (ie 84 instead of 120), the statement is not accurate as 70% cannot accurately be termed "the vast majority".

If that is the case, then the impact of the proposal on those aged 60+ will be much greater as many of those 30% will be people over the age of 60.

Before any decision is made on the removal of emergency surgery, the full facts must be presented and a proper detailed consultation held.

ii) The proposed change from a level three Critical Care Unit (CCU) to a level two with short-term level three for 4-6 hours and transfer to level three elsewhere will disadvantage patients and in particular elderly patients who are the most likely users of CCU level three. Reasons for this have been set out in my main response to the TSA's proposals (section 9.0ff). I set these out in full below because they are important in considering the impact on health equalities for older people. This is not to say that there will not be an impact on all age groups. However, given the dependence of elderly patients on CCU level three, losing this full-time service will have a greater impact on them.

"Without Critical Care consultants, there are three areas of great concern:

i) Acutely ill patients.

Track and Trigger systems are now a fundamental part of managing the acutely ill patient. These are well embedded at Stafford and are a standard

across all acute trusts. Outreach services from Critical Care are a basic response to the deterioration in a patient on the ward. The Critical Care medical staff provide the support and first line of outreach. It is very important to have early recognition of deteriorating patients so that appropriate measures are put in place to turn around the course of the illness or escalate the treatment levels promptly. This service currently manages 200-300 patients per month. To remove it would pose a considerable risk to the safety of patients at Stafford. The presence of Critical Care to Level 3 intensive care provides the full patient pathway to safely manage the patient.

ii) Acute Critical Care period

The Acute Critical Care period is vital to the outcome of the patient. Expertise in Critical Care management of all organ systems failures is required and not just intubation and ventilation.

The acutely ill patient with sepsis is a classic common example. Guidelines drive care to be given quickly with experts administering an guiding the therapy. These patients are inherently unstable and many could not be transferred in an ambulance. This stabilisation requires a critical care facility where everything is organised. Sometimes these patients require days of therapy before they could be considered stable enough for transfer.

A facility and staff to manage these patients with the relevant equipment is therefore essential. If that facility is in place, then transfer becomes unnecessary unless clinically indicated.

iii) Transfer of patients

Where there is a benefit to the Level 3 patient, then transfer must be considered. This is well recognised for:

a) Paediatric patients – where expertise is centralised at major centres such as UHNS or Birmingham;
b) Neurosurgery.

Transfer is risky and requires expert personnel trained in the transfer of the critically ill. Where expertise and capacity is available locally, there is no benefit, only risk, in a transfer to another unit.

An example of this is pneumonia, the commonest medical condition presenting to critical care. These cases are admitted through A&E and are treated by acute physicians but sometimes deteriorate to require Critical Care for advanced oxygen therapy and sometimes ventilation. They often require 3 weeks of Critical Care stepping down to Level 2 at some point

and then back to ward level care when appropriate. Stafford can safely manage these cases with local respiratory speciality help and have done for many years.

Another example is acute peritonitis. Even though Stafford can manage all the Critical Care elements of the treatment, if there are no surgeons or facility on site, the patient after stabilisation may need a transfer to receive the surgery at the right time.

Transferring patients introduces other risks. If key staff are taken out for a transfer they can be absent from their role sometimes for many hours putting other services and patients at risk.

Another consequence of the removal of Level 3 Critical Care would be the transfer of potentially ill patients. Clinically and ethically, the tendency would be towards transfer before patients became unstable, not afterwards. This would place a large increase in demand on beds at UHNS and result in a decrease in acute medical cases at Stafford putting the viability of the overall model at risk. In addition, the stabilisation of Level 2 patients for transfer would have to make them Level 3 as part of the safe transfer protocol. This would increase the number of level 3 patients at the receiving hospital, putting greater pressure on level 3 beds there, and would be to the detriment of the patient.

Absence of Level 3 care in Stafford would also limit the evaluation of patients referred to critical care. Currently the CCU sees many patients at the request of other consultants to assess their suitability and for very many it is not the right therapeutic pathway. Under the TSA model, that selection would not be available and so many patients would have to be placed in Critical Care and transferred without any assessment of survival. That assessment cannot be done adequately over the telephone.

The number of beds required under the TSA model for Level 2 (HDU) is therefore inadequate as it does not take these factors into account."

2.0 Gender (Pregnancy, Maternity, Care of Sick Children)

The TSA's proposals substantially to remove consultant-led obstetric, gynaecological and paediatric services from Stafford will be to the particular disadvantage of women who, together with their families, use these services at Stafford.

i) Women who are pregnant would no longer have the choice of childbirth at Stafford. Those for whom Stafford is currently the hospital of choice would have to travel further afield to UHNS Stoke, RWH Wolverhampton or Manor Walsall – all of them at least 30-45 minutes away under normal road conditions and for those with access to private transport. By public transport, the journey times are at least double.

ii) Women who would currently give birth at Stafford would, under the TSA's proposals, be at greater risk of not reaching a hospital in time to give birth with the nearest hospitals being at least 30-45 minutes away under normal road conditions (and on the assumption that private transport is available).

iii) If women had to attend Stoke, Wolverhampton or Walsall instead of Stafford, all of those maternity units would become larger. Stoke in particular would rise to at least 7,000 births per year (and possibly more depending on the increase in the birth rate in the current catchment area. This would make it one of the largest in the country. The loss of a medium-sized unit at Stafford would therefore not only place additional pressure on the other regional units, it would also mean that women who wished to opt for a smaller (2000-2500) sized unit would no longer have that choice. The Prime Minister is on record making the case for such a choice.

iv) Women tend to be the main carers for children. Therefore, when children are unwell and need treatment at or admission to hospital, the main burden of taking them to hospital and visiting falls on them. So to reduce paediatric services, particularly overnight stays and 24/7 admission and assessment, will mean that caring for their sick children will increase considerably the demands on their time.

v) The proposed removal of consultant-led service also means that there will no longer be obstetricians and gynaecologists available on a rota to A&E physicians to offer expert advice when women present there with O&G conditions.

3.0 Income

The TSA's proposals risk increasing health inequalities for those on the lowest incomes who currently depend on Stafford hospital for maternity and paediatric services in the following ways:

i) There will no longer be a 24/7 Paediatric Assessment Unit (PAU). The proposal is to replace it with a 14/7 PAU. This means that from 10pm to 8am children will not be admitted for assessment at Stafford. Parents will therefore need to take them to hospitals further afield (Stoke, Wolverhampton, Walsall or Burton) all of which are at least 18 miles away from Stafford.

By private transport, this is likely to take at least 30 minutes extra at night, more for those in some rural areas.

Most of those on the lowest incomes do not have access to private transport and will thus be dependent on taxis, the only form of public transport available at that time of night. While costs will vary, they are likely to be in the range of £25-35 for each direction, a very substantial part of their weekly income.

If a child has to remain in hospital for a night or two, there will be additional visiting costs. Although visiting could be done by public transport, travel times would be much longer and possibly restrict families visiting their children. It is likely that parents will choose to incur the much higher costs of taxis to ensure that their child is visited as frequently as possible.

If parents are unable to afford the taxi costs at night, they are likely to call out the emergency services – understandably but perhaps unnecessarily if the condition is worrying, but not an acute emergency. This will place an additional burden and expense on the ambulance service.

ii) The same additional costs for those on low incomes will be incurred by women who can no longer have their babies at Stafford, and their families.

iii) It is recognised that having regular visits from family and loved ones is an important part of recovery and recuperation. It therefore follows that anything which makes those visits more difficult will slow down recovery and recuperation.

Visits are particularly important for children and mothers with new-born babies for reasons which are obvious.

The TSA's proposals will make visiting children and mothers with new-born babies more difficult for all. However the hardest impact will be on those on the lowest incomes who are least likely to have access to private transport to make frequent visiting possible; and for whom, whether or not they have private transport, the additional costs of such visits will be harder to meet.

4.0 Disabilities/long-term conditions

There is substantial concern over how the TSA's proposals will affect children and young people with long-term conditions which can quickly become life-threatening, such as asthma and Type One Diabetes.

For those who have crises, it is vital that they receive treatment as soon as possible and Stafford provides this effectively. Removing consultant cover and a 24/7 paediatric admissions service at Stafford means that children and young people will have to travel further and longer if the crisis occurs when the PAU is not receiving

patients. This puts them at a serious disadvantage when it comes to receiving the emergency treatment required in a crisis.

AIDAN BURLEY, MP FOR CANNOCK CHASE

01 SEP 2013

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HOUSE OF COMMONS

LONDON SW1A 0AA

The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

01 SEP 2013

30 September 2013

Dear Sirs,

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

Please find set out on the following pages my response to the consultation on the future of local health services currently provided by Mid Staffordshire NHS Foundation Trust (MSFT).

Overall I believe that Stafford Hospital should immediately be taken over by the University Hospital of North Staffordshire (UHNS) and Cannock Chase Hospital should be run by Wolverhampton **but also used by Walsall**, in both cases **at the latest by 1st January 2014.** I strongly support the dissolution of MSFT which has been an unmitigated disaster for our local Health economy.

Overall I believe the TSA's proposals maintain most local services and in the case of Cannock Chase Hospital significantly increase and improve the offering. I am opposed to taking maternity out of Stafford hospital as I do not believe the clinical case has been made for a move to a bigger centre when the existing one is medically and financially sound. I believe the recommendations around paediatrics are more soundly based and support moves to keep children out of hospital unnecessarily. *If either service is moved, I believe a 'shuttle bus' or similar must be provided from Cannock and Stafford to UHNS to help overcome health inequalities cause by the increased distances some patients and parents will have to travel.*

In particular I warmly welcome the involvement of both the Royal Wolverhampton Hospitals NHS Trust and Walsall Healthcare NHS Trust in the delivery of services in Cannock Chase hospital, and support the likely application for £21m to refurbish Cannock Hospital. Cannock hospital needs **100% utilisation**, and needs upgrading. It must 'come to life' again, and be used to its fullest capacity and potential.

Yours sincerely,

Aidan Burley MP

Questions on emergency and urgent care at Stafford Hospital.

Recommendation 1: Emergency and urgent care at Stafford Hospital.

Question 1

Tend to support.

Question 2

I believe the clinical safety reasons behind the recommendation to retain an 8 am to 10 pm A&E service and not reinstate a 24 hour service and generally understood by my constituents. However there is understandable public concern that the permanent loss of a 24 hour local facility will lead to extended journey times to alternative A&E facilities – especially for people travelling from Cannock. More importantly people believe that *extended journey times will negatively impact the health of the patient being transported – and this is the problem.*

Given there is strong medical evidence that this is not the case (for many conditions) there needs to be greater public awareness made of the clinical case for longer ambulance times to 24 hr A&Es, and a proactive communications campaign by UHNS that *already* stroke, major trauma and heart attack go to Stoke. This is not known by the vast majority of the general public, as evidenced at the public meetings, and there needs to be a public education campaign about it to embed and accept the proposed changes in the public consciousness.

Recommendation 2: Inpatient service for adults with medical problems at Stafford Hospital.

Question 3

Strongly support.

Recommendation 3: Frail Elderly Assessment service at Stafford Hospital.

Question 4

Strongly support.

Recommendation 4: Beds available at Stafford Hospital for recovering patients.

Question 5

Strongly support.

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

Question 6

Strongly support.

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

Question 7

I very much welcome the proposals for an enhanced Frail Elderly Assessment service and hope that this service will work more closely with adult health and social care services than currently.

Questions on maternity services in Stafford

Recommendation 5: Maternity services in Stafford

Question 8

Strongly oppose.

Question 9

Despite the birth 'numbers' issue being well explained by Hugo Masce-Taylor at the public meetings, it is still not clear why having a lower than 'recommended' number of births per year than the Royal Colleges suggest is in fact a medical safety issue - especially when it is acknowledged that the maternity unit is operating safely at present, and healthy babies are being delivered at above the national average.

Whilst there may be a "direction of travel" towards having larger, 24-7 consultant led obstetrics units, I do not believe the case has been made that *that in itself* is a reason for closing a perfectly good midwife led maternity unit, which I understand does not negatively contribute to Stafford hospital's deficit.

Losing child birth facilities at Stafford will also mean women from Cannock Chase will have to use Wolverhampton and Walsall much more, and therefore additional capacity will be needed at these sites. I would estimate 400-500 more births a year would need to be carried out at Walsall Manor alone, and this would need increased infrastructure on their site – at a cost of many £million (£14m?)

It could therefore be argued that this money could be invested into the facilities at Stafford instead, rather than into other NHS Trusts, and thereby preserve the facility.

Clearly I welcome the continuation of routine pre and post natal care at both Cannock and Stafford Hospital, and hope this can be expanded under the exciting plans to increase activity at the Cannock site.

Questions on services for children in Stafford

Recommendation 6: Inpatient service for children at Stafford Hospital.

Question 10

Tend to support.

Recommendation 7: Paediatric Assessment Unit (PAU) at Stafford Hospital.

Question 11

Tend to support.

Services for children in Stafford (recommendations 6-7).

Question 12

Tend to support.

Recommendations 6 and 7: Services for children in Stafford

Question 13

At the public meetings the clinical safety and resource reasons for the recommendations around paediatrics were well explained and seemed more logical and robust than their equivalent for maternity. There is clearly a need to keep children out of hospital, and a higher than average admittance rate at Stafford at present. There needs to be more 'care in the community' and those children that really are ill and need to stay in hospital overnight, should be cared for in 24-7 facilities with all the necessary equipment.

However if these recommendations do become reality, more facilities should be provided to allow parents to stay overnight with their children in the specialist centres, especially in Stoke. Again, transport issues are a major concern for my constituents, and some form of shuttle bus service needs to be laid on to get parents to and from the major centres.

Questions on major emergency surgery at Stafford Hospital

Recommendation 8: Major emergency surgery at Stafford Hospital

Question 14

Strongly support.

Question 15

Heavy traffic conditions may make transporting patients slower than the TSA predict.

Questions on critical care at Stafford Hospital

Recommendation 9: Critical care at Stafford Hospital

Question 16

Strongly support.

Question 17

No comments.

Questions on elective and day cases at Stafford Hospital

Recommendation 10: Elective care and day cases at Stafford Hospital

Question 18

Strongly support.

Question 19

No comments.

Questions on Chapter 7 of the consultation document

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

Question 20

Strongly support.

Question 21

I strongly support the recommendation that beds should be available at Cannock Chase hospital for recovering patients, especially since the facility was designed to allow patients to recuperate from more major operations in larger centres. This is supported by the CCGs who want to transfer more care nearer to patient's homes, and will be welcomed by local people and their families. Some consideration should be given to whether other care (eg adult health and social care) could be provided during these stays, so that the hospital becomes more integrated with other providers and more of a 'one stop shop' to help patients with all their conditions.

Recommendation 12: Elective inpatient surgery at Cannock Chase Hospital

Question 22

Strongly support.

Question 23

I warmly welcome the proposed increase in the scope of elective inpatient surgery at Cannock Chase Hospital – however it is important to remember that patients and GPs must *choose* to go there. There needs to be a proactive battle for 'hearts and minds' in particular of GPs, to persuade them to send more patients to Cannock Hospital. Local patients and GPs need to be made aware that, as with any facility, it is a case of 'use it or lose it' – Cannock was underutilised and as a result nearly closed. This trend can only be reversed by people positively choosing to go there.

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

Question 24

Strongly support.

Question 25

All of this feeds into the key overall aim for Cannock Hospital – which is for the building to be 100% utilised as a facility, to its maximum potential; that way it can never be threatened with closure again due to underuse. There is also a fiduciary duty to taxpayers to get the maximum public value out of a publicly funded asset such as a hospital.

Increasing the range of day case procedures is likely to contribute to this aim, however in the likely event that Wolverhampton NHS Trust cannot use 100% of the facility (as they themselves have stated) then Walsall MUST be offered a chance to use the remaining space in the hospital, or indeed other healthcare providers such as GP surgeries.

It is not good enough for Wolverhampton to only plan to use part of the facility, say 85%, and then say *'we do not need to use the rest of the space as the facility is financially viable due to the tariffs we can achieve using the 85%'.*

ALL empty space MUST be offered to other providers, starting with Walsall, as **there is both an economic and moral case to make maximum use of a publically funded facility.** It is not just a case of whether Wolverhampton can make it financially viable – every inch must be used to improve the health needs of local people, in the most deprived part of Staffordshire after Stoke. Spare space could even be offered to local charities, for free, who can use the hospital as a base. These aims must be made clear to Wolverhampton, as it is what local people deserve, and the only way to make total best use of the facility.

Questions on Chapter 8 of the consultation document

Recommendation 14: Organisational plans for Mid Staffordshire NHS Foundation Trust

Question 26

Strongly support.

Question 27

The sooner MSFT can be dissolved and the new organisational structure moved to the better, and I strongly believed this must be done by 1st January 2014.

Final Comments

Question 28

The granting of Foundation Trust status in 2009 to MSFT was a political decision forced upon them from the top rather than based on any clinical or financial viability. It directly led to the problems we see today and the very TSA process we are currently engaged with. The fact that this will be the first FT to be dissolved, after just 5 years, shows what a catastrophic failure that decision was and this error must never be allowed to be repeated.

From a Cannock Hospital perspective, being stuck in a Trust with Stafford did us no favours, and in fact the negligence shown towards Cannock as all the focus went on the problems of Stafford is what led to the near closure of our hospital due to neglect and underuse.

We now have a once in a generation opportunity to bring Cannock Hospital to life again, by removing the ghost of MSFT, and being run by a Trust which actually wants to use and improve the facility, not by a negligent and arrogant Stafford management team that let Cannock Hospital wither on the vine. This will require investment of many millions to refurbish the hospital to modern standards, for example by removing all the wooden panels and replacing with stainless steel, as well as modernising the ageing operating theatres. I strongly urge the TSA to support the application for funds of up to £21million so that the hospital can be brought up to the best of modern standards – that is no less than my constituents deserve, after the years of neglect and near closure they have suffered.

I welcome the fact that the TSA's proposals maintain the provision of nearly all services at both Stafford and Cannock Chase Hospitals, and in the case of Cannock greatly improve them. There has been huge concern locally for a long time concerning the massive under utilisation of Cannock Chase hospital (48% not used according to MSFTs own figures) and the recommendations being consulted on will hopefully see far greater utilisation of the facilities by Wolverhampton NHS Trust (85% according to their own statements.)

However, the consultation document itself cautions that the proposed expansion of services still will not fully utilise the available space and so **I urge the Trust Special Administrators to immediately identify arrangements that will ensure 100% of the space in Cannock Chase Hospital is used by local healthcare providers from Day 1.** There is both a moral and fiduciary duty to get the maximum use out of a public facility such as a hospital, and there are many providers including charities and local GPs who could be offered space there and use that base to improve the lives and health outcomes of local people.

An open offer must also immediately be made by the TSA to Walsall NHS Trust, who remain very keen to use the facility. They offer a different range of services to Wolverhampton and these would use up further spare capacity and complement the other services being provided. The solution is not Wolverhampton or Walsall, it is Wolverhampton AND Walsall, working side by side, with Wolverhampton as the major partner and facilities manager. Wolverhampton working alone using part - but not all - of the building and refusing to countenance any other

trust or provider using spare space, even if they have made the facility financially viable, is not acceptable to me or my constituents. I will continually raise questions in parliament if this situation is allowed to happen. The only acceptable solution is 100% use of the building, and the best way to ensure that is to have multiple tenants, based on the plans published so far.

There remain real concerns at the permanent loss of 24-7 A&E, critical care, maternity and paediatric services. The clinical reasons for some of these changes have been made with greater conviction than others. The clinical case for the changes to paediatrics seems more logical and robust than that for maternity. In both cases, there is a lack of public awareness of the reason for the "direction of travel" to every larger and 24-7 facilities. There is also a real lack of awareness that *already* stroke, major trauma and heart attack go to UHNS, and an assumption that longer ambulance journey times are worse for patients, even if they end up at better facilities. That is why a proactive information and publicity campaign must be organised immediately to explain the 'realities' of the current situation and the clinical benefits of the proposed changes to local people.

Finally, Stafford and Cannock hospitals are well served by public transport. My constituents will find commuting to hospitals further afield more difficult and expensive, especially on public transport. That is why I believe a shuttle bus between Cannock and New Cross hospitals must be laid on to guard against social health inequalities.

Aidan Burley, 30th September 2013.

TRISTRAM HUNT MP

HOUSE OF COMMONS

LONDON SW1A 0AA

Office of the Special Administrator
Mid Staffordshire NHS Foundation Trust
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ST16 3SA

Friday 27th September 2013

Dear Sirs,

RE: CONSULTATION ON THE PROPOSALS OF THE TRUST SPECIAL ADMINISTRATOR FOR THE MID STAFFORDSHIRE NHS TRUST

Thank you for the opportunity to participate in the consultation by the Mid Staffordshire NHS Trust Special Administrators on your proposals for the future arrangements of clinical care in Stafford and Cannock Hospitals.

I would, however, like you to note my dissatisfaction that you felt unable to consult directly with the residents of Stoke-on-Trent and North Staffordshire. It is clear that any proposals made will have an impact upon, and mean changes for, the University Hospital of North Staffordshire.

While Healthwatch in both Stoke-on-Trent and Staffordshire were able to, with support from local authorities and Clinical Commissioning Groups, host their own events; it appears that impact on Stoke-on-Trent and North Staffordshire is of secondary concerns.

In responding to your recommendations, I shall constrain my specific comments to recommendations 1 -10 as these are directly related to Stafford Hospital and will be the recommendations that impact upon the University Hospital or North Staffordshire and my constituents.

In responding to your consultation, I wish to make it clear that I believe there are other significant questions that require answers which sit outside of your remit. The most pressing of which is the wherw any capital or revenue funding needed to introduce these new services is to come from and the financial system put in place to raise the money. This is a matter which falls within the Department of Health and I shall be making further representations to them directly.

My over-arching comment on recommendations 1 – 10 is focussed on the need to ensure capacity at the UHNS and for the funding to be put in place before any action is taken. At present, the UHNS is in receipt of £5million 'bail-out' in order for it to continue to provide the services it does for the people on Stoke-on-Trent and North Staffordshire. I cannot be the case that recommendations for the future provision in either Stafford Hospital or UHNS are made in a way which would worsen the financial state of the UHNS and it should also not be the case that any additional money is simply taken from other parts of the NHS, including Clinical Commissioning Groups.

UHNS is also a well-respected regional trauma centre and is it seeks to consolidate is specialism to underwrite its own financial position; it would be unacceptable for patients from Stoke-on-Trent and North Staffordshire to find themselves compelled to access service in Stafford which they currently enjoy in the UNHS.

Member of Parliament for Stoke-on-Trent Central

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Website www.tristramhunt.com

Recommendation 1 – I would support the retention of the 14/7 accident and emergency services at Stafford Hospital. I believe that it is important that the residents of Stafford have the comfort of knowing they can access emergency care for the majority of the week. While in principle I have no objections to the use of the UHNS A&E provision for the other 70 hours a week, there needs to be a sufficiently robust management plan in place to ensure that capacity at UHNS is not stretched beyond its own Capabilities and level of services are maintained. I am not sure too what the impact will be on those who are having to travel to UHNS for A&E treatment given the distances involved.

Recommendation 2 – I would support the retention of adult inpatient services as Stafford Hospital.

Recommendation 3 – I would support the creation of a 14/7 Frail Elderly Assessment service for older people in Stafford. I would however, object in the strongest possible terms, should frail and elderly people from North Staffordshire find themselves being assessed at this unit in Stafford. As you will be aware, any hospital admission process for frail or elderly people can be disconcerting but this would be heightened for residents in North Staffordshire who may find themselves in a position where they are away from their homes.

Recommendation 4 - I support this recommendation and agree that it is important for the residents of Stafford to be able to access recovery beds in their own locality.

Recommendation 5 - I support the use of the UHNS for the delivery of babies and would agre that pre and post natal care should be delivered from Stafford Hospital. Again, this comes with the caveat that the level of births from Stafford remain stable and that there is sufficient capacity within UHNS to deal with the new births it will be asked to handle. Given, too, that birth rates fluctuate, I would want to be certain that there is a contingency plan to deal with increased birth rates in either Stafford of North Staffordshire [or both]. At the moment, the evidence would suggest that it would be a small number of additional births per day but should this number increase, there would need to be a reconsideration of the arrangements.

Recommendation 6 - The treatment of Children must be safe and secure. I would support the proposals to admit children into neighbouring specialist hospitals so long as there is sufficient capacity and funding to support such a move. Again, I would want to be certain that in absolute emergencies the additional travel time to admit children from Stafford into a hospital is not so long as to expose them to a greater risk.

Recommendation 7 - As with my comments regarding the provision of A&E service on a 14/7 basis, I would support any service being retained in Stafford and would support the out of hours work taking place, if needed, at UHNS so long as there is sufficient consideration given to the logistical arrangements of transporting patients and that the funding is in place to pay for the service and capacity exists at UHNS to deliver the service without diminishing the service is already provides.

Recommendation 8 - Of all the recommendations proposed, this is the one which causes me most concern for the people of Stafford. I fully accept that digital technology can allow for consultations to take place remotely and for information to be shared with specialists quickly and easily anywhere in the UK. I do, however, have concerns that the complete removal of all major emergency surgical provisions could place some patients in a position of greater risk by delaying their surgery as a result of travel times.

Recommendation 9 - I support the recommendation and agree that should recommendation 8 be implemented, then an urgent transfer service for acutely ill adults must be established.

Recommendation 10 - Elective care and day cases should remain in Stafford and I would support this recommendations.

My final point as part of this consultation is the way in which any change is managed and monitored. The moving of services from Stafford Hospital to UHNS will take time and, presumably, will not be a simple over night switch? Therefore, I would like to see both Hospitals engage with local authorities and members of parliament to demonstrate that there is a clear transition plan which lay out how the services will be transferred, how any additional costs will be met and how these changes will be communicated to the patients.

I should also like to know, to whom, the Hospitals are held accountable? Considerable changes could take place and it is imperative that they are done so in a way which is open and transparent. For this to happen, there must be clear accountability to a recognised, local and independent body who can monitor the process. I would be grateful to know what thought the Trust Special Administrators have given to these points.

Overall, I want to ensure that any changes do not exacerbate the existing financial situation that two hospitals find themselves in nor do I wish to see my constituents have a diminished service from UHNS or be obliged to attend Stafford Hospital.

Yours sincerely,

Tristram Hunt MP
Labour MP for Stoke-on-Trent Central

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26 SEP 2013

HOUSE OF COMMONS
LONDON SW1A 0AA

25 September 2013

Mr Alan Bloom
Trust Special Administrator
Mid-Staffordshire NHS Foundation Trust
Freepost Plus RSGR-CRGE-EHLE
MSFT-TSA Consultation
Ipsos MORI, Research Services House
Elmgrove Road
Harrow
Middx, HA1 2QG

Dear Mr Bloom,

As you will know, Walsall Manor Hospital have taken in a large number of patients, arising from events at Mid-Staffordshire hospital. I understand that emergency admissions at the Manor for those living in Staffordshire have risen around 40% for the last year.

It is expected that there will, in fact, be further increases in patients who would otherwise, presumably, have been admitted to Mid-Staffordshire NHS Trust. I therefore hope that, arising from the public consultations for those using Stafford and Cannock Chase hospitals, there will be sufficient resources for the Manor to be able to provide a good service to residents in Walsall, including of course my constituents, as well as taking on the additional responsibility from patients in Staffordshire. Walsall NHS Trust state that this will require capital investment and additional facilities like £14 million, along with full revenue funding under the NHS tariff.

As one of the Members of Parliament in the Walsall borough, I obviously don't wish to see any deterioration in hospital facilities for local residents because of the extra patients the Manor has taken on from outside; at the same time I fully understand all the reasons why some patients in Stafford and Cannock need now to be treated at the Walsall hospital and quite likely this will continue for some time. It is therefore essential, in my view, this is fully taken into account when deciding extra funding for the Manor.

Yours sincerely,

David Winnick MP

7. Local Authorities and Councillors

Mrs. Sheree Peaple, Group Secretary

The Labour Group of Councillors, Staffordshire County Council

Q2

We concur with this recommendation. We would have serious concerns if it were proposed to remove the Accident and Emergency department from Stafford Hospital, due to the potential threat to safety which would be posed by longer journeys and also the additional pressure which would be placed on already stretched resources at other centres.

Q7

Recommendation 2 - We support this recommendation.

Recommendation 3 - We support this recommendation. We are mindful of the need to provide better integrated care generally, and particularly for older people. We would hope that the proposed Frail Elderly Assessment Service will help to achieve this and support the proposal that "the service will have clear referral systems in place so older people get the most appropriate care."

Recommendation 4 - We support this recommendation. Overall, we are generally in favour of the recommendations around inpatient services for adults at Stafford Hospital.

Q9

We oppose this recommendation, which we feel is influenced too much by cost and not enough by concerns for patient choice. We have several issues in this area: first of all, women would have considerably further to travel when in labour, which has implications in terms of cost, reliability and availability of public transport, and the increased likelihood of babies being delivered in sub-optimum conditions en route to UHNS. Secondly, there are no guarantees that there would be appropriate continuity of care if post and ante natal appointments took place in Stafford but delivery was at UHNS. There has been no suggestion that there are any problems at Stafford's maternity or that it is in any way unsafe. We understand that this recommendation is based on advice from the Royal Colleges who cite safety and the costs of litigation. Their emphasis is on size of unit with a recommendation that a minimum of 6000 births is necessary to ensure 24/7 consultant cover. However, we are aware of many European examples of safe practice in much smaller units. We are concerned that the TSAa have been very selective in the UK evidence they cite in support of their recommendations. In addition, we query why Stafford has been singled out in this way - there are 35 places in England with small obstetric units i.e. fewer than 2500 births per annum, but there is no suggestion that all of these will be closed. The figures quoted for the number of births at Stafford - 1800 p.a. is also in question. We understand that the average over the past 6 years is 2170. We would ask whether the transfer of obstetrics and maternity offer demonstrably better and safer services, or whether the proposed reconfiguration is being driven by professional needs and self interest.

Q13

Recommendation 6 - We oppose this recommendation. Whilst we understand the arguments in favour of concentrating paediatrician resources in larger hospitals, we are mindful of the human cost for families, particularly those on low incomes, who have to visit or stay with a child in a hospital some distance from their home. If this recommendation is implemented, there will be a need for additional resources to allow parents/families to stay overnight, because of the distance to Stoke, especially for the residents of outlying areas of Rugeley.

Recommendation 7 - We oppose this recommendation. Whilst we appreciate that many paediatric nurses are both skilled and experienced, they may not have the same level of skills and experience as consultant paediatricians. Whilst we welcome the proposal to maintain a Paediatric Assessment Unit, we are concerned that valuable time could be lost whilst nurses consult with paediatricians at UHNS. We also have some concerns about the reliability of the proposed phone consultations. In addition, the limited opening hours mean that any assessment needed outside those hours will entail a long journey which will add to the risk to patient safety. Overall, therefore, we are not in favour of the current proposals for children's services.

Q15

We oppose this recommendation. We query whether it is in the best interests of patient safety to undergo a potentially lengthy journey to another hospital to undergo emergency surgery. We would query the extent to which this recommendation is motivated by cost rather than patient care or patient safety issues.

Q19

We support this recommendation. We are in favour of services being provided locally wherever possible.

Q21

We support this recommendation. We are in favour of patients being given the opportunity to recuperate as close to home as possible.

Q23

We support and welcome this recommendation.

Q25

We support and welcome this recommendation.

Q27

We neither support nor oppose this recommendation, but feel that there needs to be more information on how the interests of the residents of the areas served by Stafford and Cannock Chase hospitals would be protected.

Q28

Reputational damage is constantly cited by the TSAs, yet Stafford Hospital is now one of the safest in England. It appears very unfair to prevent Stafford from moving on.

Dear Sir,
I would urge you to reconsider the idea of removing maternity and Paediatric services away from Stafford Hospital.
Both of these services have and currently do provide excellent care for the people of this area and so it is questionable why these services have been highlighted to be removed.
Travelling to see loved ones is difficult for many, particularly if the patient is a child. Outpatient appointments to see the consultant could be impossible for some and therefore children's health could be placed in jeopardy.

Maternity services here have always been 1st rate, and to move this would in my view be wrong.
Travelling to hospital to give birth can be traumatic, but having to travel further could be potentially dangerous to both unborn child and mother, not to mention the potential for increased danger from people having to drive further in a stressed state. Also would this not alter birthing statistics as fewer children will be born in Stafford and increase statistical information elsewhere.

I would ask therefore if you could find a way to keep these services at Stafford for future generations

David Williams.

Councillor Huntington and Hatherton Ward

South Staffordshire Council

Stafford Constituency Labour Party

Response to the Mid Staffordshire NHS FT Trust Special Administrator's Draft Report

Introduction

Is change needed? The overriding reason for the Trust Special Administrator's proposals is financial with the intention of saving money. This is predicated on the assumption that a small number of patients will continue to choose to go to alternative hospitals in response to the considerable reputational damage suffered by Stafford Hospital. This in turn means reduced income for the Hospital Trust.

The second financial problem for the hospital trust also stems from reputational damage in that the hospital has faced difficulties in recruiting staff. It has faced expensive bank nurse costs and higher premiums in attracting key consultant posts. Uncertainty regarding its future has now exacerbated this further.

Furthermore, the past reputational damage should be neutralised by a change in management and new branding, along with the acknowledgment and wider dissemination by the Stafford and Surrounds Clinical commissioning Group and others of the unreliability of Standardised Mortality Ratios for estimating observed deaths compared to expected deaths in hospitals and which has now been widely discredited[1 2 3 4], and very good current safety reports at Stafford Hospital.

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1. Mohammed MA, Deeks JJ, Girling A, Rudge G, Carmalt M, Stevens AJ, et al. Evidence of methodological bias in hospital standardised mortality ratios: retrospective database study of English hospitals. Bmj 2009;338:b780.
2. Black N. Assessing the quality of hospitals. BMJ 2010 Bmj;340:c2066.
3. Hawkes N. Patient coding and the ratings game. Bmj;340:c2153. Lilford R, Pronovost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. Bmj;340:c2016
4. Lilford R, Pronovost P. Using hospital mortality rates to judge hospital performance: a bad idea that just won't go away. Bmj;340:c2016

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In addition, the administrators, the Clinical Commissioning Group and Government must take into account the exceptionally strong support and demand for a comprehensive range of health services in the Stafford locality, including for a 24 hour A&E service. This public support has been demonstrated by over 50,000 people who have signed local petitions and over 50,000 people who marched in support of Stafford Hospital.

Additionally, we believe the government is overstating the problems faced in Stafford for political reasons, in that the coalition government is promoting a private market with the health service, and that this provides an opportunity for them to try and make the introduction of private healthcare appear less unwelcome that it otherwise would. We believe that this privatisation fragmentation of the NHS fundamentally damages the NHS. Both government and health commissioners have a duty to maintain secondary health services and must ensure that cherry picking of services does not undermine the capability of hospitals to provide a complete range of secondary care.

We believe the main problem of small hospitals not having adequate specialist experience can be largely overcome by rotation of staff from larger hospitals. The principle should be that wherever possible, the doctors come to Stafford rather than all the sick population of Stafford and environs travel to other hospitals.

Being fair to patients: We believe the debt is being played up because of the financial imperative to unsure that private finance initiative (or PFI) schemes do not fail. This means that the government will continue to make good shortfalls in funding for PFI-built hospitals while hospitals whist non-PFI hospitals, such Stafford (and Lewisham in London) are easier targets to downgrade, regardless of population or clinical needs. Taking away up to a tenth of our services is not being fair to us and violates a key NHS principle of equity of access.

We can see no evidence that the Trust Special Administrators have taken into account that Stafford is a growth town, with another 10,000 planned homes to be built in Stafford local borough alone (Stafford Borough Council's Local Plan), or the two thousand extra MOD

personnel and their families who will also be based in Stafford. Projected growth needs to be serviced. Birth rates have been increasing at unprecedented rate. Other Hospital Trust's would need to grow to meet their own growth needs never mind the catchment area of Stafford Hospital.

Access to University of North Staffordshire Hospital or other hospitals poses a great problem: around one fifth of households do not possess at least one car or van[5]. Public transport is insufficient – there would probably be a minimum of three buses needed to get to University of North Staffordshire Hospital, taking up several hours travelling time, sometimes using multiple bus companies. There are no buses on Sundays. The people who need hospital services the most are the young, the old, the disadvantaged, the disabled and the sick. These are the very people least likely to be able to drive to hospital. The very people who need hospital services the most are those who are most disadvantaged by having to travel further. Many pensioners and young families cannot drive. The financial cost to individuals and their families and carers would also increase. For someone with no relatives, who has been scheduled for, say 8.00am surgery, with a pre-surgery assessment at around 7.00 am, how would a patient get there?

And even by car or ambulance, while on a good day, the journey may take less than 40 minutes, when there is heavy traffic or the motorway becomes congested, unpredictable delays could be fatal.

Visitors also find parking at North Staffordshire difficult.

Responses to recommendations

Emergency and urgent care

1. Our view is that Stafford Hospital should have 24/7 A&E facilities. Whilst we are happy that the severe trauma, stroke and cardiac patients be taken to specialist

[5] Equity Impact Assessment carried out for the TSA.

hospital facilities such as University Hospital of North Staffordshire, we need 24 hour A&E services.

Transfer of sick patients over long distances is associated with increased mortality rates, with a 1% absolute increase in death rate for acutely ill patients for every km above 5 km travelled by ambulance to an acute hospital[6] . The risk of additional deaths is greatest in patients with respiratory problems. Patients who need ventilation would be particularly at risk of death from longer travelling times as ambulance staff does not provide artificial ventilation.

The majority of hospital facilities should be provided at Stafford and ambulances should be able to bring people to Stafford.

Some of the other hospitals in the West Midlands, to where Stafford patients may be taken at night, may also face problems. For instance: Burton and Dudley, have been investigated[7].

A&E services are stretched throughout the country and there is no evidence that other hospitals will continue to be able to cope with extra patients from Stafford, particularly if there is a winter crisis.

Inpatient services for Stafford

2. Inpatient services should continue to be provided at Stafford.
3. A Frail Elderly Assessment Unit would be beneficial. Whether it would be sufficient if assessment cannot take place by a consultant at night time is another question. The public would expect appropriate care throughout the clock.

[6] Nicholl J, West J, Goodacre S, Turner J. 2007. The relationship between distance to hospital and patient mortality in emergencies: an observational study Emerg Med J. 2007 September; 24(9): 665–668. doi: 10.1136/emj.2007.047654 PMCID: PMC2464671

[7] Keogh B. Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report /PDF, 1.19Mb/. July 2013

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4. We would support beds in Stafford for patients to recover. However, too frequent bed moves, especially for elderly patients can be harmful[8] and patients are best kept as local as possible in order to avoid poor health outcomes. Rather, we wish to see patients being able to be treated and able to recover at Stafford.

Maternity services

5. We strongly disagree that women will not have the choice to have their babies in Stafford. Services are safe in Stafford. We have a low rate of Caesarean sections. The birth rate is increasing. The population of Stafford is earmarked for growth. The recommendations do not meet population needs.

Services for children

6. Of all of the Administrators' proposals, this is probably the most iniquitous and inequitable. Our hospital is not a fit and proper hospital if it turns children away. We oppose the recommendations on the following grounds:

a) The extra danger in travelling longer distances to further hospitals

b) A sick child needs not just medical care, but also the care of his or her parents. Mothers at the bedside can't divide up their time. For many families, this disrupts child care for other siblings. For a lone parent the choice may either be to neglect the sick child, leave other children at home unsupervised or jeopardise their education by bringing them out of school to accompany mum and sick sibling.

c) The cost and inconvenience to families, particularly those on low incomes or without transport.

d) Transport problems are greater families with children and compound childcare issues.

[8] McMurdo, MET and Witham, MD. Unnecessary ward moves Age Ageing (2013) 42 (5): 555-556 first published online July 28, 2013 doi:10.1093/ageing/aft079

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e) Risk of parents waiting till morning to call for an ambulance

7. Children who are sick enough to need a hospital should be seen by paediatricians, not by A&E doctors.

We believe the Administrators have insufficient knowledge about how paediatric services at Stafford are run, and about how care has been developed to meet local needs. Statements by the Trust Special Administrators are contradictory, for instance that the unit is too small, but also that there are too many trainees.

Major emergency surgery

8. We are extremely concerned about the suggested inability to undertake major surgery in Stafford. We do not think it acceptable that only minor operations can be performed at Stafford.

Specialist emergency surgery already goes out of Stafford. We are concerned that transfer of emergency surgery could have a knock-on effect of on routine elective surgery being cancelled at University Hospital of North Staffordshire and neighbouring hospitals.

There will be worse care in Stafford on the ward. Transportation of critically ill patients from Stafford to other hospitals will need dedicated staff to accompany them. This will mean depletion of staff on the ward and a reduced service until staff return, compromising patient care and safety.

For the ambulance service, a cost analysis would need to be undertaken as to there would be considerable increases needed to ambulance costs as well as to patterns of working.

Financial investment would be required in other hospitals – makeshift facilities would be needed. We have no evidence that there is extra capacity in other hospitals.

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The Royal College of Physicians has estimated that 2.5% of patients need top level acute care. This means that 97.5 % of people are able to be cared for in a good quality local hospital. We demand that Stafford be that good quality local hospital. Without full critical care facilities, Stafford hospital risks being significantly downgraded to a minor injuries unit plus outpatients clinics.

Staff rotation between hospitals should ensure sufficient expertise to allow but the most specialist levels of surgery to be available

Critical Care

9. There should be a full range of critical care.

For emergency surgery and for critical care proposed outside of Stafford, there would need to sufficient supernumerary specialist staff on standby to accompany very sick patients to other hospitals without compromising the rest of the service to remaining patients while staff were away accompanying very sick patients. In practice we feel this will take staff away from already understaffed wards.

The effect on other hospitals of Stafford patients may be overwhelming. Wolverhampton New Cross has already had to have portacabins. There would need to be extra costs for ambulance staff. We believe it would be safer to spend that money on patients in Stafford.

Cost of transportation has not been factored in - huge investment would be needed. There is no evidence to support this as a more cost effective model of care.

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Elective and day cases

10. We support retention of elective and day cases.

We believe health service changes should be driven by robust evidence based needs assessments, with meaningful input from all stakeholders - including clinicians providing the care, and from patients and their carers and families. The Trust Administrators have failed to carry out an in-depth robust, evidence-based needs assessment.

Labour
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Staffordshire County Council

Mr Mark Winnington
Cabinet Member for Economy and Infrastructure
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Tipping Street, Stafford ST16 2DH
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Website: www.staffordshire.gov.uk

Mr Alan Bloom
Joint Trust Special Administrator
Mid Staffs NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford ST16 3SA

Ref: MW-248/CM Your ref: Date: 1 October 2013

Dear Mr Bloom

Having taken great interest in the debate around your proposals on which you have consulted over the last number of weeks, I have come to the conclusion that my view is fully articulated in the attached letter from Philip Atkins, Leader of the Council.

I would add my strongest reservations around the proposals for maternity services, as stated, we should at least have a competent midwifery service. Finally, I would echo the huge concern within Local Authorities about the obvious funding gap which there has been failure to address.

Yours sincerely,

Mr Mark Winnington
Cabinet Member for Economy and Infrastructure

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Submission of Cllr R J Draper
Response to the Mid Staffordshire NHS FT
Trust Special Administrator's Draft Report

Introduction

My submission is made in a personal capacity and is not intended to reflect on any of the following groups or bodies I am member of, which include Stafford Borough Labour Group, Stafford Borough Council, Stafford Constituency Labour Party or Support Stafford Hospital. As a member of both Stafford's Borough Council and the Constituency Labour Party I support their submitted replies to the consultation. In consideration of the proposals for Stafford Hospital I will submit no comment on the proposals for Cannock Chase Hospital.

I currently serve as Secretary to Stafford's constituency Labour Party, and serve as Secretary to Support Stafford Hospital's organising committee. I was elected to Stafford Borough Council by the Littleworth ward in May 2011 and have served on the following committees: Community Services Scrutiny Committee, Audit and Accounts Committee, Stafford Borough Twinning Organisation and Stafford Borough Horticultural Committee and the Member Facilities working group. I am a member of both Mid Staffordshire NHS Foundation Trust, and South Staffordshire and Shropshire NHS Trust.

During the public consultation period I attended four of the Trust Special Administrator's consultation meetings in Stone, Stafford Cannock and Rugeley. I met with the Trust Special Administrators Alan Bloom and Professor Hugo Mascie-Taylor in a private meeting with Support Stafford Hospital's organising committee on September 10th. I attended the Borough Council's Special Health Scrutiny Committee on September 19th and its full Council on September 24th to consider the response of the Council to the Trust Special Administrator.

Response

After reading the Trust Special Administrator's draft report I must say that I was wholly underwhelmed at the level of detail provided within. It failed, in my opinion, to address any standard of academic rigour citing the development of the medicine and fleshing out the strength of the argument in favour of moving services away. It did not consider TSA designed alternative models and only presented Location Specific Services and Contingency Planning Team models as alternatives.

I did not find that the standard of report conducive to informing local people to such an extent as to be able to offer an unqualified opinion understanding the variety medical arguments that were considered. The TSAs position was to force local people to accept recommendations of Clinical Advisory Groups, Royal Colleges and other selected groups. The TSA did not include transcripts of these meetings so local people could have confidence over the process of how these meetings were conducted, to understand the questions that were asked and the remit that was presented to these 'specialist groups'.

I note the inaccuracy of the report the TSA have had to correct with regards to the Paediatric Assessment Unit, and ask what other inaccuracies have been made over the course of the process?

Organisational plans for Mid Staffordshire NHS Foundation Trust

I support the recommendation for Mid Staffordshire NHS Foundation Trust (MSFT) to be dissolved. However I do not think it is appropriate that Stafford Hospital is taken over by University Hospital of North Staffordshire. I believe the sites must come together and must work to form a new Trust Board. I believe that effective community representation must be sought and funding must be found to ensure that the prospective Board of Governors at the new Trust are competent, capable and challenging in the way they undertake their duties.

Emergency and urgent care at Stafford Hospital

I do not support your plans for Emergency and urgent care. I expect a full 24-hour Accident and Emergency department at Stafford.

Maternity services in Stafford

I do not support your plans for Maternity. I expect a consultant-led unit at Stafford.

Services for children in Stafford

I do not support your plans for Paediatrics. I expect the unit to remain 24 hours and to continue providing best practice care.

Response by Janos Toth
Labour's Prospective Parliamentary Candidate for Cannock Chase

The Trust Special Administrators'
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

29th September 2013

Dear Sirs,

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

Questions on emergency and urgent care at Stafford Hospital.
Recommendation 1: Emergency and urgent care at Stafford Hospital.
Question 1
Strongly oppose

Question 2
Ambulance journey times have been increased for many residents after 10pm until 8am. There is serious public concern at the loss of 24/7 A&E at Stafford Hospital. Rugeley residents in particular are getting a raw deal. UHNS and the Queens Hospital in Burton upon Trent are a considerable distance from residents on the Rugeley side of Cannock Chase. At the Rugeley consultation meeting, poor answers were given to questions from the general public. They were referred to other organisations and sign posted but it became apparent there were no answers

to distance, travel times and the means of getting to and from these far flung Hospitals.
Reports from New Cross and UHNS that they cannot cope with their own A&E patients are concerning. I have seen for myself ambulances queuing at UHNS due to a recent family member being ill. People were being treated in ambulances and both local residents from Stoke-on-Trent and the Cannock Chase area were both frustrated and angry.
Although it is correct to say that clinical safety must be paramount this should not be used as an excuse not to reinstate the full time cover. I support the reinstatement of around the clock (24/7) A&E service at Stafford Hospital.

Recommendation 2: Inpatient service for adults with medical problems at Stafford Hospital.
Question 3
Strongly support.

Recommendation 3: Frail Elderly Assessment service at Stafford Hospital.
Question 4
Strongly support.

Recommendation 4: Beds available at Stafford Hospital for recovering patients.
Question 5
Strongly support.

Inpatient services for adults at Stafford Hospital (recommendations 2-4)
Question 6
Strongly support.

Recommendations 2, 3 and 4: Inpatient services for adults at Stafford Hospital
Question 7
The proposals for an enhanced Frail Elderly Assessment service I welcome. This service should 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 in hospitals elsewhere. However distances and travel times are most important here, both for the patient and their family and friends. Again I have had no answers from the TSA dealing with this. I have had many Cannock Chase residents telling me how long it takes them to use public transport to visit family and friends in hospital. The use of taxis is expensive for many people.

Questions on maternity services in Stafford
Recommendation 5: Maternity services in Stafford
Question 8
Strongly oppose.

Question 9

The loss of the maternity unit at Stafford Hospital will cause transport problems for many women and their families. The numbers of births each year has been questioned a number of times and I would like this to be looked at again and independently examined.
Again this is a downgrading of Stafford Hospital which I do not support.
The continuation of routine pre and post natal care seems bazaar as women will go on to have their baby at another hospital. Both my children were born at Stafford Hospital and this would have been a hindrance rather than a help to us. However, I note compulsion is not included in your recommendation.

Questions on services for children in Stafford
Recommendation 6: Inpatient service for children at Stafford Hospital.
Question 10
Strongly oppose.

Recommendation 7: Paediatric Assessment Unit (PAU) at Stafford Hospital.
Question 11
Strongly oppose.

Services for children in Stafford (recommendations 6-7).
Question 12
Strongly oppose.

Recommendations 6 and 7: Services for children in Stafford
Question 13
The recommendations are a significant downgrading of medical service provision for children.
I do not agree with the downgrading of the Paediatric Assessment Unit (PAU) from a 24 hour to an 8 am to 10 pm service. The loss of the inpatient facility for children will cause travel problems for many Cannock Chase families. There will be an unfair burden on families in terms of costs and accessibility to their children.
If the Government rubber stamps the recommendations through, then, when children are admitted to specialist hospitals free accommodation should be provided for the parents so that they can stay with their children.
Overall, the recommendations to significantly reduce children's services at Stafford Hospital are particularly nasty.

Questions on major emergency surgery at Stafford Hospital
Recommendation 8: Major emergency surgery at Stafford Hospital
Question 14
Strongly disagree.

Question 15
This recommendation again downgrades Stafford Hospital and puts pressure on both local larger hospitals namely UHNS and New Cross. As far as I can see Stafford effectively becomes a holding hospital before shipping patients out to have major surgery.

Questions on critical care at Stafford Hospital

Recommendation 9: Critical care at Stafford Hospital
Question 16
Tend to support. (If the other Stafford Hospital downgrade recommendations are rubber stamped by the Government).

Question 17
As previously stated I would want to see 24/7 A&E provision and major surgery at Stafford Hospital. Therefore critical care would be integral to this.

Questions on elective and day cases at Stafford Hospital
Recommendation 10: Elective care and day cases at Stafford Hospital
Question 18
Strongly support.

Question 19
No further comments.

Questions on Chapter 7 of the consultation document
Recommendation 11: Step down care and rehabilitation at Cannock Chase Hospital
Question 20
Strongly support.

Question 21
I welcome the provision of "step down beds" allowing patients to recuperate closer to home. 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 when necessary home support arrangements have been put in place.

Recommendation 12: Elective inpatient surgery at Cannock Chase Hospital
Question 22
Strongly support.

Question 23
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 I would support.

Recommendation 13: Day cases (surgical and medical) at Cannock Chase Hospital
Question 24
Strongly support.

Question 25
The potential increase in the range of conditions dealt with would improve the service available and assist the viability of the hospital. I support more services being provided at Cannock Chase Hospital and feedback I have had from the public concurs this.

Questions on Chapter 8 of the consultation document

Recommendation 14: Organisational plans for Mid Staffordshire NHS Foundation Trust

Question 26

Strongly oppose.

Question 27

I support the recommendations for Cannock Chase Hospital. These will secure the future viability of Cannock Chase Hospital and that is to be welcomed.

I do not support the downgrading of Stafford Hospital. It is clear that this is a cost saving exercise and the Government are not funding the Mid Staffordshire NHS Foundation Trust with the finance it requires. I note that it has been reported that dozens of Hospital Trusts are in deficit. The whole TSA process has been expensive and the money could have been used to close the gap on the budget deficit. Furthermore, I believe the expenses of the TSA should be independently scrutinised as the public finds them unacceptable.

Final Comments.

Question 28

In terms of the Cannock Chase constituency it would be fair to say that the degree that residents will be affected will be dependent on which side of Cannock Chase they live.

I welcome the recommendations for Cannock Chase Hospital, but the fine detail needs to be looked at very carefully. Greater utilisation of the hospital will hopefully come about by the expansion of service offerings.

I am in favour of both the Royal Wolverhampton Hospitals NHS Trust and Walsall Healthcare NHS Trust (if this can be agreed) providing services at Cannock Hospital.

With Stafford Hospital however the situation is far from satisfactory. People in Rugeley who rely on Stafford Hospital seem to be getting a raw deal in terms of its NHS provision and this is not acceptable. The proposals say that:

Continued loss of full time 24/7 A&E cover
No babies will be born at Stafford
Children should no longer be admitted to Stafford Hospital as inpatients
The level of critical care provided at Stafford Hospital should be reduced
Major emergency surgery will not be undertaken at Stafford Hospital

If these proposals go through we will see people having to travel further away and Stafford Hospital will provide an inferior NHS service. Stafford in time will no longer be a District General Hospital.

Local people pay their taxes and national insurance in the same way as anywhere else in the country and should not have to accept second class NHS provision. One of the points raised throughout the consultation has been that we have less spent on

our health provision in southern Staffordshire than other parts of the country.

There are many people who are reliant on public transport. Rugeley and some of the outlying areas of the District will be most affected by transport issues. Local, free of charge, shuttle buses should be provided from Cannock to New Cross and from Rugeley to UHNS if the proposals are agreed by Government.

Dear Sirs,

Re : Mid-Staffs NHS Stafford Hospital : MSFT TSA Public Consultation

This process , which I believe is the first of its kind, has raised many serious questions.

These are not just about the process itself which has left many members of the community confused, frustrated, but worst of all , fearful for the outcome as the many questions show an alarming lack of substantiated knowledge upon which the draft proposals are concluded. It has left also left many people in no doubt that the guiding principal of the NHS proposal was fiscal and the mandate undertaken to critically produce an option that would balance the books as opposed to being patient care led. In doing so, the options of patient care/safety, health inequalities, patient choice, risk assessments of proposed action would appear not to have been in the forefront of the draft proposals, nor, the obligation to submit proposals that equal or better the current level of care within the Hospital.

I am sure that you will appreciate that the people of Stafford are especially sensitive upon such an approach as it was the focus on finance, rather than patient care , that led to the events which culminated in the Francis Enquiry. Upon this point the positive outcome for this Hospital must be emphasised. The new management structure at the Hospital and with its teams of dedicated staff put into effect that which had been lost and has successfully turned the performance and care structure around. This Hospital is now rated within the top 20 safest hospitals in the UK. The people have responded to this with two massive turnouts on street marches showing their support and confidence of their Hospital- one of 51,000 & one of [est] 30,000. In this we had representatives of all political parties , the church, MPs and councillors, voluntary groups – all supporting our OCL3 status, Maternity , paediatrics and other vital acute services.

I , like many, believe that the proposals as they are outlined are unsafe, unpractical and factually unsubstantiated in a town that has demonstrated its ability to [without any financial help] reverse the problems of care, re-establish a high level of safety, reverse its poor reputation from adverse media representation and now enjoys the highest recruitment enquiries for years of quality healthcare staff. This is not the signs of a Hospital in decline.

We are led to believe that surrounding Hospitals would take the services that these proposals would move elsewhere. Those that live in this area would dispute the practicalities of any such devolution.

Firstly, our surrounding Hospital locations are already creaking under the weight of their current numbers and yet we are told they can absorb the Stafford numbers – at the height of the negative press campaign patients were being referred elsewhere by both GPs and patient choice ; the result being Hospitals in Stoke and Wolverhampton & Walsall had to restrict patients, close their A&E and other depts. with the result that patients found themselves as far away as Hereford, ambulance times

were stretched way beyond their normal service which meant there were fewer ambulances around as they travelled further or had longer waiting times at hospitals to discharge their patients.

Secondly, there was the problem of an increase of fatalities. Whilst the true overall figures for any such fatalities induced by the longer ambulance trips at the height of the adverse opinion of Stafford Hospital are not known and it would be irresponsible to suggest this was down to the travelling time, never the less, the shortest time possible gives the patient the highest chance of survival. Also to be accepted is that all surround Hospitals are situated such that the ability to get to them in under 45mins is only providing that the arterial roads are free from gridlock or undue heavy traffic.... unlikely.

There is also the question of why has the proposals indicated transfer of certain units that are better suited, are growing in stature and are recognised as a better performance related on safety than the National Average ? I refer to Maternity and Paediatric. The suggestion is for our Maternity unit to be down graded against research which indicated that the birth rate within Stafford would decline over the next 5 years and that at present it fails to meet the 'turnover' of babies of a minimum of 2500 as it is only 1800 per year. It also states that its rational is based upon the criteria that a Maternity unit should have a minimum of 10 consultants against the current 4 in Stafford.

This research is illogical. The base platform from which I understand this decision was formed was on the assumption of past 'trends' and bears little recognition as to the current 'trend' and its reasons. To put into context ; the years 2011 & 2012 have shown a progressive increase birth rate that went from 1800 to 2013 and has a forecast currently of 2800. This is not allowing for the fact that the town has a building planning programme of 7500 further new home and that the MOD base is to expand with troops being withdrawn from Germany. Together, this will boost significantly the child bearing potential within the town and empathically revokes and decline.

Furthermore, this Hospital's maternity unit has the acknowledge successful & safety record well above the national average : on Elective Caesarean section rate 1.7% against the National of 2.8% on induced labour resulting in emergency caesarean section 16.4% against the national of 30.2% and also of spontaneous labours resulting in emergency caesarean section 5.5% against the national of 11.6%.... and this is without an ideal team of 10 consultants. Indeed if this 'desired' level of 10 was applied to all maternity units in the UK – then others would also fall short but perhaps without this Hospital's safety record ?
I would also bring to your attention the article in the Daily Mail September 30th by Sophie Borland wherein she highlights the problems facing maternity units where mothers are being turned away due to capacity already being reached. With an increasing population of birth bearing people due to the influx of the 'open door' policy of the EU and the huge numbers of immigrants into this country over the last decade ; it is recognised that the increase in birth rates in the UK is influenced by migrants-fact. Thus surrounding Hospitals in the likes of Stoke, Wolverhampton, Walsall and other areas that tend to have a higher ethnic mix will already have a huge strain on those Hospitals and so to encumber them with Stafford's projected birth rate is folly, unwarranted , or even dangerous.

Consider RCN's own declaration that the maximum birth rate of any unit should not exceed 8000pa. After this point the clinical care can suffer as the process become more of a production line and devoid of contact care. In the case of the Stoke Hospital they already have reached 6000 without taking into effect their natural growth rate. To place Stafford's birth rate on them would take them towards a projection 9000 and exceeds the RCN recommendations. It would also pose the need for more consultants as, on this number they would have to originate two separate teams to cope – would not the development of the Stafford unit be a better fiscal logic in the short to longer time ?

In conclusion, it would appear that many of the proposals are ill founded with the facts not fully researched adequately. It appears also that no dialog was undertaken with the Ambulance Service, the Hospital Depts or other significant areas that would easily shown that the proposals were , and are, flawed.

It my hope that these considerations along ,no doubt with many others ,will ensure that the correct decision is made and you endorse the keeping of our critical care status and associated Depts.

Yours sincerely

A P. Edgeller

Cllr. Ann Edgeller

Dear Sir / Madam

I am writing to you on behalf of the residents of Stoke-on-Trent in respect of the consultation process that is currently underway. I am aware that a series of consultation meetings (eight in total) have been scheduled for patients who reside in the Mid-Staffs area, however, I am concerned that a consultation event has not been scheduled to take place in the Stoke-on-Trent area.

Clearly the proposed changes at Mid Staffs Hospital will have a direct impact on UHNS and as such Stoke on Trent residents have an important and legitimate interest in this change. I am concerned that the information shared in the proposals so far does not enable us to understand the full effect which might follow the proposed changes, in terms of their likely impact on UHNS service capacity and quality, and the knock on effect that this might have on the Health and wellbeing of our residents. We need to be assured for instance that the difficulties we are already experiencing locally in terms of service delays and shortfalls in provision are not made worse, indeed are improved through these changes where possible.

I am therefore requesting that you consider including Stoke on Trent City Council and our Overview and Scrutiny Committee as full consultees in this process, and that City organisations such as Age Concern and Healthwatch should also be properly consulted locally.

I understand that our Overview and Scrutiny Committee have already called in this matter and requested the TSA to come to a meeting in September to discuss the proposals, and that additionally, Joan Walley MP is currently in conversations with you in the same regard, with a view to a meeting being established for all MPs to meet with you in September. It may be prudent for MP's to link into a meeting with the Overview and Scrutiny Committee, but this can be considered in more detail in due course.

I look forward to your response and proposals as to what the next steps will be and your assurance that full consultation is going to be arranged for the benefit of the citizens of Stoke-on-Trent.

Thank you and kind regards.

Councillor Adrian Knapper MARLA A.Inst.L.EX

Staffordshire County Council
Wedgwood Building
Tipping Street
Stafford ST16 2DH

The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

10 September 2013

Dear Mr. Bloom,

TSA Draft Recommendations

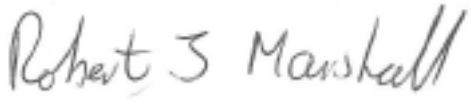
Thank you, and Gill, for attending the meeting of the Staffordshire Health and Wellbeing Board on 8 August 2013. The Board welcomed your openness and the effective way you articulated the rationale for the draft proposals that are now out for public consultation.

The Board will formally respond to the draft proposals over the coming weeks. Prior to our formal response we wanted to highlight the willingness of the Board, and its respective members, to facilitate a wider discussion around options that would support the demand management that will be a key component of ensuring a sustainable solution to the issues facing Stafford and Cannock Hospitals.

We fully understand and appreciate that your focus is currently around dialogue with the acute sector to ensure there are effective solutions to the delivery of the clinical services that have up to now been provided at the two sites. The Board however feels that the early engagement of key commissioners and providers of community based services would lead to important innovative options on the demand management side that would further shape the sustainable solutions arising out of the TSA process. The shift from acute to community based provision sits at the heart of the Health and Wellbeing Board's 5 Year Plan – Living Well in Staffordshire. The Board hasn't shied away from the challenges that the coming years bring in maintaining high quality and affordable healthcare across Staffordshire and we are eager to ensure synergy between our strategy and the proposals you are currently working up. This is especially the case, given the scale of the shift in demand, and associated funding, envisaged in the Board's plan, as this could have a significant impact on the longer-term sustainability of the configuration of services proposed by the TSA.

There are key partners on the Board who would value the opportunity to contribute more widely to the solutions being developed and have the existing networks in place to facilitate these wider discussions should this be appropriate. We would be happy to discuss further options for establishing this dialogue.

Yours sincerely,



Dr. Johnny McMahon
Joint Chair, Staffordshire Health & Wellbeing Board and Chair of Cannock NHS Clinical Commissioning Group

Councillor Robbie Marshall
Joint Chair, Staffordshire Health & Wellbeing Board and Cabinet Member for Health & Wellbeing, Staffordshire County Council

To: TSA CONSULTATION (RJD)
Subject: HEIA SG

I had the opportunity to attend the TSA Consultation meeting held in Rugeley on 18 September 2013. Unfortunately you did not include a venue in the "forgotten" town of Hednesford. It became apparent at that meeting (and I believe also raised at previous meetings) that one of the key concerns of service users in this area of Staffordshire is the distances patients and relatives have to travel to and from hospital locations, the inadequacy of public transport and the enormous costs involved

This is of particular concern to Hednesford Town Council as the area contains some of the most socially deprived in the whole of Staffordshire as defined by government statistics

In this respect it is understood that this fundamental issue is something being considered by a mainly anonymous selection of individuals known collectively as the HEIA SG
With regard to the establishment of the Group the Town Council, at the very least, would be interested to know the following:

1. What was the recruitment and appointment process for the selection and appointment of the Chairman and Members of the Group and did that follow best practice? For example the three principles of merit, fairness and openness, advocated by the Commissioner for Public Appointments

2. Who on the Group, with detailed local knowledge of the area, is representing the views of Cannock Chase and in particular Hednesford ?

3. How have the public been made aware of the existence of the Group and been given the opportunity to make submissions to the Group?

4. What steps has the Group taken to consult with and seek the views of users and democratically elected bodies such as the Town Council?

A reply would be appreciated by 1 October so that I can report this to the next meeting of

the Town Council

Peter Harrison JP BA (Hons)
Town Council Manager/Clerk
Hednesford Town Council

Staffordshire County Council

Mr Philip Atkins
Leader of the Council
Councillor for Uttoxeter Rural
County Electoral Division

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Website: www.staffordshire.gov.uk

Alan Bloom
Joint Trust Special Administrator
Mid Staffs NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford ST16 3SA

My Ref: PA / TK 209 Your Ref: Date: 26 September 2013

Dear Sir

Re: Staffordshire County Council Formal Response to TSA Draft Recommendations

Below is the formal response of the County Council to the Trust Special Administrators' Draft Recommendations. Broadly, we welcome the work of the TSA and appreciate the development of a thorough and detailed set of recommendations. However, we are concerned by the limited scope of the review and its lack of opportunities to resolve the wider clinical and financial problems facing Staffordshire.

Additionally, the County Council is disappointed that the £8.5million gap demonstrates the failure of the TSA to fulfil its remit, especially as it is likely that such a gap raises doubts about the short and medium term financial ability of the Trust to support the needs of both Stafford and Cannock hospitals during the transition phase, as well as the wider shift in resources and approach for the local health economy.

Overall, the County Council feels that the fiscal challenge to deal with the remaining £8.5 million gap presents a real risk of failure in the efforts to move both Stafford and Cannock Hospitals on to a more sustainable financial footing. We believe that these elements combine to create a situation where Stafford Hospital remains at considerable risk of either a clinical and/or financial failure.

Furthermore the limited parameters of the TSA remit, and hence its recommendations, prevent the necessary review of the broader local health economy. We are therefore concerned that this could undermine the strategy of the Health and Wellbeing Board (HWB), which seeks to prioritise resources for early intervention and prevention and community services. It could also hinder the development of an integrated health and care system. In the view of the County Council, therefore, aside from the remaining risk of operational failure, the TSA recommendations reflect a stop-gap solution that could have serious implications for the future development of both the health system and the social care system across Staffordshire.

the knot unites

From a geographical perspective, we also believe that, as they currently stand, the recommendations create an unacceptable fragmentation of the local health economy, shifting decision making and potentially resources out of the Staffordshire area – this represents a challenge in terms of community support and potentially an undermining of the County Council's Public Health responsibilities, as well as the priorities of the Health and Wellbeing Board (HWB). We also believe that the recommendations curtail the ability of the county's Clinical Commissioning Groups (CCGs) to commission services, by limiting their access and influence over the local health economy.

Detailed response

Strategic Direction – TSA narrow remit vs. wider strategic priorities in Staffordshire

The County Council firmly believes that a much wider review, of the acute health economy for Staffordshire as a whole, would be advantageous. This would give the opportunity to consider a wider range of options and solutions for both specialist Acute and integrated, Community-based Services.

Staffordshire and Stoke on Trent have a health economy with a disproportionate number of beds, and thus a disproportionate lack of community based services. It is the intention of the Health and Wellbeing Board, the CCGs and Councils to shift resources from Acute to Community Services. We estimate, with help from our work last year with the Kings Fund, that the shift from acute to community is in the hundreds, not tens, of millions of pounds. The TSA recommendations, which seem to be answering the question, "How can we keep these Hospitals open?", rather than "How can we improve the Health of our population?" goes directly against the local leadership of the economy.

A central element of the Staffordshire Health and Wellbeing Strategy is a major shift in focus across the health and social care system away from late intervention, at the point of crisis, and towards early intervention and prevention, and to support people effectively in the community. An important element of this approach will be the Public Health resource that now sits within the County Council. Linking to the County Council's broader 'Achieving Excellence' approach, we have committed ourselves to working across the public sector, recognising our limitations ('we don't always know best') and the benefits of partnership to meet clear outcomes based on insight and clear strategy. This clear strategy ensures that Public Health monies are utilised to maximum benefit, but integrated with the wider County Council, and accounts for crossover within the public sector for Staffordshire as a whole. This is crucially absent from the recommendations of the TSA.

The absence of a clear strategy, beyond a plan for the Trust itself, means that the possibility of a wider transformation and service redesign for acute services across the county will be hampered. As a consequence, we have little confidence that Stafford or Cannock's financial issues will be resolved on a sustainable long term basis. We also note that part of the solution for Mid-Staffordshire NHS FT appears to break up the provision of services currently delivered from Stafford Hospital, in order to make the inevitable burden, that partner Trusts will have to take on, appear to be a better deal.

Without a clear strategy, we believe that this 'selling off the family silver' reduces the long-term prospects for Stafford Hospital and merely moves burdens and demands around the health economy within Staffordshire, but without the fundamental review, prioritisation and strategy that are needed in order to ensure success.

We agree with the Health and Wellbeing Board that the narrow remit of the TSA recommendations could prevent a system redesign that would support the Board's strategy for a shift of provision from acute to integrated provision within community settings. As we have outlined in terms of Public Health, we are committed to support such a shift in provision and resources, but the potential that the services currently delivered through Mid-Staffordshire NHS FT, as a major element of the local health economy, might not be part of such a change, creates an unnecessary risk.

The priorities of the Health and Wellbeing Board and of our own Public Health team will have significant impact on acute services in Staffordshire. As such, a continued strategic development and re-design, developed in partnership with Commissioners, Acute and Community Trusts, must be facilitated by the Staffordshire Health and Wellbeing Board.

Financial Sustainability – the £8.5 million gap

This is the fundamental concern of the Council in terms of the TSA recommendations.

The Council recognises the progress that has been made in developing a service offer, over and above the Location Specific Services and the previous Contingency Planning Team Proposals. We believe, however, that the TSA has failed to meet its remit, due to the fact that it has presented a set of proposals that result in an annual £8.5 million shortfall.

Considering the strategic challenges outlined above, we do not believe that this gap can be successfully closed through the solutions proposed by the TSA. We feel that the changes are a short-term solution, but that this has medium- to long-term impacts that will undermine sustainability:

- Firstly, the closure of the ITU and diversion of services from Stafford Hospital could create a situation where recruitment of clinicians to the hospital becomes more difficult due to the limited opportunities at the site. We are concerned that this will inevitably lead to greater reliance upon locums, which would add a different financial burden and could lead to quality issues.
- Secondly, the TSA has not apparently assessed the impact of further loss of current staff on the ability to deliver the reduced services at Stafford Hospital.

The remaining gap presents a risk that undermines the confidence that local partners have in terms of the success of the TSA process. Furthermore, the projected period for unwinding the Trust appears to be exceptionally long, and the associated costs do not appear to be accounted for in terms of the gap – especially the possibility of challenge from the community, as happened in Lewisham. Put simply, the gap (and its apparent solution) appears to be a hypothetical 'best case' scenario, rather than reflecting reality.

Maternity Services

Staffordshire County Council believes that there should be a midwife-led unit at Stafford Hospital. The current recommendations are not acceptable, and we have no confidence that this option has been explored in a necessary depth.

Echoing the Health and Wellbeing Board's analysis, in terms of access, quality and a coherent pathway, the current TSA recommendation could lead to a disjointed maternity care pathway. Antenatal, delivery and postnatal care will be provided in different locations and with different teams to the birth. As a strategic principle, the Board wish to ensure that quality, clinical safety, workforce development and effectiveness should be the main driver for change in respect to adjustments made to obstetrics and maternity services.

Additionally, the County Council believes that a significant level of community concern is reflected in the opposition to the loss of maternity services. By looking again at the provision of services, we believe that there is more chance of getting the community to accept changes at the hospital.

Single 'Integrated' Acute Trust model: Clinical Safety, Quality and Effectiveness

The Council welcomes the TSA proposals are underpinned by an evidence-base of clinical safety and effectiveness. However, in the light of the Francis, Keogh and Berwick Inquiries, there is a need to ensure that issues such as Care Quality, Safety and Clinical Effectiveness are addressed in the most effective manner.

We believe that, in conjunction with the aforementioned reprioritisation of resources and focus in line with the Health and Wellbeing Strategy, there is a need for a single 'integrated' acute Trust for Staffordshire, as a sustainable provider of specialist acute services, developing and operating as a specialist centre of excellence, within a fully integrated system of health and social care within Staffordshire. Our aim is to improve the overall accountability and performance of the NHS, through a single body to reflect the clinical services, geographic need and funding that Staffordshire's fragmented health economy currently represents.

In terms of direct delivery, this would mean that, through a single Trust, the reprioritisation of resources and approaches could lead to the operation of appropriate low-level services – such as rehabilitation provision being delivered through integrated community services at the locality level. We believe that this will improve the clinical and financial situation of local hospitals whilst improving care quality and accountability. This combined with a wider integration of social care will lead to a health system not focused squarely on buildings and structures but on outcomes.

Whilst recognising the concerns about the size and scale of a single 'integrated' Acute Trust, we believe that it would facilitate the development of a more sustainable means of providing acute services, thereby allowing the agreed focus on prevention and early intervention. This option is not a simple suggestion, and would require a significant investment by all partners. We also recognise that this is beyond the remit of the TSA, but we feel that the future of Stafford Hospital, alongside the entire health economy, requires a fundamental review. This would allow for the incorporation of the main lessons from Francis, Keogh and Berwick around clinical quality, but also helps to address the main financial issues that the existing Trusts face.

I am also concerned that the TSA proposals to split the sites to different providers is unduly complicated and will take both considerable time and huge expense compared to a more straightforward approach of allowing one Trust, University Hospital North Staffordshire, to take over the work of the Mid Staffs Trust entirely. It is thus for strategic, deliverability and cost reasons that we urge a merger/acquisition with UHNS.

I and my officers would be happy to discuss our concerns and ideas in more depth.

Yours sincerely

Mr Philip Atkins
Leader of the Council

Simon W. Baker B.Ed MBA MISPAL
Chief Executive

Dealt with by: Mr M Forrester
Direct Dial: 01538 395518

Our Ref: MF
Your Ref:
Date: 27th September 2013

The Trust Special Administrators
Mid Staffordshire NHS Trust
Professor Hugo Mascie-Taylor,
Alan Bloom
Alan Hudson
Stafford Hospital
Weston Road
Stafford ST16 3SA

Dear Sirs

Formal response from Staffordshire Moorlands District Council to the public consultation on the future of the Mid Staffordshire NHS Trust

Staffordshire Moorlands District Council notes that the proposals made by TSA for the future of Mid Staffordshire NHS Trust will impact on the services received by the people of Staffordshire Moorlands. Specifically the proposal that the University Hospital North Staffordshire will manage services currently provided at Stafford Hospital. Given this impact Staffordshire Moorlands District Council feels strongly that formal public consultation with the communities and key organisations in Staffordshire Moorlands should have been undertaken before such proposals are submitted and must be undertaken before a final decision is made.

Staffordshire Moorlands District Council believes that the consultation period should be extended to allow communities excluded from the formal process to have their say, or otherwise a separate period of consultation should be undertaken in North Staffordshire.

Staffordshire Moorlands District Council is aware that the North Staffordshire Clinical Commissioning Group has a number of concerns about the proposal and that it is seeking reassurance that the proposal will not result in additional pressure on University Hospital North Staffordshire and thus a poorer service for the people whose health services they commission. Staffordshire Moorlands District Council supports the position of the North Staffordshire Clinical Commissioning Group on this matter and without such reassurance Staffordshire Moorlands District Council does not support the proposals put forward by the TSA for the Mid Staffordshire NHS Trust.

Yours sincerely

Councillor Sybil Ralphs MBE
Leader Staffordshire Moorlands District Council

www.staffsmoorlands.gov.uk
Moorlands House, Stockwell Street, Leek, Staffordshire Moorlands, ST13 6HQ. Tel: 0345 605 3010

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30/09/13

Cannock Chase Council

Please ask for: George Adamson
Phone: 01543 426629
E-Mail: georgeadamson@cannockchasedc.gov.uk

Your Ref:
My Ref: GA

23rd September, 2013

The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Dear Sirs,

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

Please find set out on the following pages the response from the Cabinet of Cannock Chase Council to the consultation on the future of local health services currently provided by Mid Staffordshire NHS Foundation Trust.

Overall the proposals seek to maintain local provision of services and are fully supported. There are some reservations concerning the increased distances that some patients will have to travel, and the difficulties this may cause.

We would particularly welcome the involvement of both the Royal Wolverhampton Hospitals NHS Trust and Walsall Healthcare NHS Trust in the delivery of services in Cannock Chase hospital.

I hope that our comments will be of assistance to you and taken into account in making your final decision.

Yours faithfully,

Cllr George Adamson
Leader of the Council

Questions on emergency and urgent care at Stafford Hospital.

Recommendation 1: Emergency and urgent care at Stafford Hospital.

Question 1

Tend to support.

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.

Recommendation 2: Inpatient service for adults with medical problems at Stafford Hospital.

Question 3

Strongly support.

Recommendation 3: Frail Elderly Assessment service at Stafford Hospital.

Question 4

Strongly support.

Recommendation 4: Beds available at Stafford Hospital for recovering patients.

Question 5

Strongly support.

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

Question 6

Strongly support.

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 8

Tend to oppose.

Question 9

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

Recommendation 6: Inpatient service for children at Stafford Hospital.

Question 10

Tend to support.

Recommendation 7: Paediatric Assessment Unit (PAU) at Stafford Hospital.

Question 11

Tend to support.

Services for children in Stafford (recommendations 6-7).

Question 12

Tend to support.

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 14

Strongly support.

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 16

Strongly support.

Question 17

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

Questions on elective and day cases at Stafford Hospital

Recommendation 10: Elective care and day cases at Stafford Hospital

Question 18

Strongly support.

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 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.

Walsall Council

Paul Sheehan
Chief Executive

Your Ref:
Our Ref: PS/RB
Date: 30 September 2013
Direct Line: 01922 652006

Mr Alan Bloom
Trust Special Administrator
Mid-Staffordshire NHS Foundation Trust
Freepost Plus RSGR-CRGE-EHLE
MSFT-TSA Consultation
Ipsos MORI
Research Services House
Elmgrove Road
Harrow
HA1 2QG

Dear Mr Bloom

On behalf of Walsall Council, I am writing in response to the proposals for the future of Stafford and Cannock Chase Hospitals as set out in your recent public consultation document.

The Council has been advised that Walsall Manor Hospital has already seen a significant increase in activity for Staffordshire residents as a result of recent events at Mid-Staffordshire NHS Trust with emergency admissions at the Manor Hospital for Staffordshire residents rising by about 40% in the last 12 months. Furthermore, it is understood that the proposals for the future of Stafford Hospital will mean that there will be a further increase in activity for the people of Staffordshire at the Manor Hospital.

The Council would therefore like to ensure that your proposals include sufficient resources for the Manor Hospital to be able to continue to provide a high quality service to the people of Walsall as well as treating more patients from Staffordshire.

The Council's Health Scrutiny and Performance Panel on 19 September 2013 has also considered the proposals on 19 September and resolved as follows:

Walsall Metropolitan Borough Council,
The Civic Centre, Darwall Street, Walsall, WS1 1TP.
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The Health Scrutiny Panel wishes to further explore the opportunities arising from the Mid Staffordshire Hospital dissolution and the additional pressure this will place on Walsall Healthcare Trust, and calls for this to be supported with the appropriate capital funding. This Panel supports the proposition that there needs to be a fair and open process to decide the future provider of services from Cannock Hospital. The Panel expects Walsall Healthcare Trust to be ready to respond to the challenges it faces following the dissolution of Mid-Staffordshire Hospital and will also continue to look closely at the services provided by Walsall Healthcare Trust to maintain an ongoing review of the impact on Walsall of the dissolution of Mid-Staffordshire Hospital.

The Council looks forward to hearing the impact of the proposed changes in Staff on the services at Walsall Manor Hospital in your final report.

Yours sincerely

Paul Sheehan
Chief Executive

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30 SEP 2013

Staffordshire County Council

Kath Perry, Chair
Healthy Staffordshire Select Committee

Staffordshire County Council
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My Ref: NP/TJ/Healthy Staffs Your Ref: Date: 25 September 2013

Dear Sir/Madam

Consultation on the Trust Special Administrators' Draft Recommendations for the future of Mid Staffordshire NHS Foundation Trust

The Healthy Staffordshire Select Committee has considered the draft recommendations for the future of Mid Staffordshire NHS Foundation Trust Consultation on the future of services for local people using Stafford and Cannock Chase Hospitals.

As part of their consideration of the proposals, the Committee met with the Trust Special Administrator of the Mid Staffordshire Foundation Trust. In the light of the importance of the recommendations, Members also met with the major stakeholders and have had the opportunity to question them in respect of the recommendations. Members met with the Chief Executives of the West Midlands Ambulance Service, Royal Wolverhampton Trust, University Hospital North Staffordshire and Walsall Health Care Trust, to discuss the proposals and gain their views on the robustness and viability of the options.

Members also met with the Chairs and Chief Officer for Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups, Dr Anne-Marie Houlder, Dr Johnny McMahon and Andrew Donald, to discuss the recommendations.

This letter provides a formal response to the recommendations from the Healthy Staffordshire Select Committee, as follows:

Emergency and Urgent Care

Members support the recommendation, that Stafford Hospital should continue to have a Consultant led Accident and Emergency Department between the hours of 8am and 10pm daily.

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However we would like the possibility of a General Practitioner led Out of Hours service to work alongside to be explored. We would also like it noted that there are concerns about the effects of the intended removal of Paediatric and Maternity care, as at present these services admit patients 24/7 and this would incur additional travelling time and distances to the University Hospital of North Staffordshire.

Inpatient services for adults

Members support the recommendation that inpatient services for adults with medical problems will continue to be provided at Stafford Hospital for those who need to be in hospital.

Members support the recommendation to create a Frail Elderly Assessment Service, but seek assurances that there is adequate and appropriate care in the community for the frail and elderly in order that the time of stay in hospital should be kept to a minimum and where possible admission could be safely prevented with the correct level.

Members support the recommendation that beds should be available at Stafford and Cannock Chase Hospitals for recovering patients subject to an assurance there was adequate bed and nursing capacity to meet the perceived demands.

Maternity Services

Members support the recommendation. However we would like to see, that other models of Maternity Care for local births are explored to determine suitability for introduction at Stafford, to mitigate concerns for Mother and Baby safety arising from journeys to other hospitals.

In addition consideration should be given to the implications of the £3.5m cost of retaining Maternity Services at Stafford should this result, in particular the effects on the provision of other services, Also explore the potential of networking to support a Stafford based maternity unit as its presence would enhance the reputation of the trust.

Services for Children

Members support the recommendation that children should no longer be admitted as in patients to Stafford Hospital and the services should stop as soon as other local hospitals have the capacity to accept them safely, following the assurances given by the Ambulance Services that they can accommodate the additional transfers and the extra distances involved safely. Consideration should be given to ensure adequate capacity to accommodate parents staying with the child.

Members support the recommendation that children will continue to be assessed at Stafford Hospital's existing Paediatric Assessment Unit but wish their concerns be noted regarding the lack of consultancy presence in the Paediatric Assessment Unit at Stafford.

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Major emergency surgery

Members support the recommendation that major emergency surgery should no longer be carried out at Stafford Hospital with the exception of minor surgical procedures which can be dealt with by A&E or where the patient can be stabilised by A&E and scheduled to return to Stafford Hospital for minor surgery.

It is noted that most major emergency surgery would instead be provided by a local larger hospital such as University Hospitals North Staffordshire NHS Trust or The Royal Wolverhampton Hospitals NHS Trust. The TSAs have already had initial positive discussions with UHNS about this. This means there will be no longer be a surgical assessment unit on-site A&E consultants at Stafford Hospital will be able to consult surgeons remotely at larger hospitals about patients surgical needs. Patients would be transferred to another hospital for surgery where required.

Critical Care

Members support the recommendation that a small critical care area should be retained at Stafford Hospital, but wish to see the definition of what a 'small' critical area for care is and how many beds it would have.

Elective Care and Day Cases

Members support the recommendation that elective care and day cases should remain in Stafford and that this would include Orthopaedic Surgery. However Members would like consideration to be given to expanding the service at Stafford as it may lift the profile and add to patient numbers.

Members support the recommendation that elective surgeries are retained at Cannock Chase Hospital. There should be new surgical specialities introduced, enhancing the current range of elective inpatient services for Cannock patients. This recommendation assumes that the on-going discussions with the National CAGs regarding safe overnight cover can be successfully resolved. We also support that the current range of day cases procedures (Surgical and Medical), including Rheumatology should continue at Cannock Chase Hospital and the range be increased where possible.

Who runs Stafford and Cannock Chase Hospitals in the future

Members acknowledge that to allow for the TSA's draft recommendations to work in a way that does not negatively impact the safety at other hospitals or their financial position it is recommended that the Mid Staffordshire Foundation Trust as an organisation be dissolved.

Members support the recommendation, however we are concerned in relation to the financial position as outlined in the proposals particularly the current and expected financial deficit and that the local CCG's would be expected to fund this.

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Members are disappointed that the TSA proposals have been unable to produce a 'break even' financial position and raise concerns in relation to the long term viability of the proposals. In addition, in the event of dissolution of the Trust we are concerned about the options for its replacement and if so what would the consultation process be in determining the provision of the services previously at Stafford and Cannock Hospitals. The Committee would also like it noted that they would have concern on the impact on surrounding Trusts in the event of this recommendation being implemented.

Yours faithfully

Councillor Kath Perry
Chair
Healthy Staffordshire Select Committee
Staffordshire County Council