15B.

OXFORD REGIONAL HEALTH AUTHORITY

STOKE MANDEVILLE HOSPITAL

NATIONAL SPINAL INJURIES CENTRE

OPERATIONAL POLICIES AND DESIGN BRIEF

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INTRODUCTION

The effects of traumatic spinal injuries have been recognised as a clinical problem for thousands of years but until recently all the patients died soon after injury. Even as recently as the 1914-18 war when general anaesthesia and abdominal surgery were well advanced there had been no change, and 80% of the paraplegic patients wounded in this war were dead within three years of injury, mainly from pressure sores and urinary tract infections.

However, in 1936 Donald Munro in Boston had the vision to realise and the determination to demonstrate that if these two complications could be overcome there was no reason why the paraplegic patient could not lead a useful, active life.

With the advent of the Second World War doctors who had seen the appalling results of the First World War were responsible for organising the medical services and one of them, George Riddoch, had the inspiration to establish spinal injuries centres throughout the United Kingdom and to this end Sir Ludwig Guttmann set up the Spinal Unit at Stoke Mandeville Hospital which was one of a chain of centres throughout the United Kingdom to deal with the spinal injuries resulting from the War.

The National Spinal Injuries Centre was opened in 1944, initially the patients were all ex-servicemen and they arrived late after injury with all the complications of paraplegia, pressure sores, severe urinary tract infections, contractures coupled with the complications of misconceived treatment such as suprapubic cystotomies.

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The approach at Stoke Mandeville was to provide an integrated service for these patients based on a general hospital not a separate rehabilitation centre. The philosophy was a very conservative approach based on the adage of "non nocere", do not harm the patient. The fracture of the spine was treated by postural reduction instead of early laminectomy and fusion, the sores were allowed to heal with minimal surgical procedures instead of extensive plastic surgical procedures and the bladder was drained by an indwelling catheter instead of suprapubic drainage. This was coupled with inspiring leadership, great psychological insight and tremendous motivation by Sir Ludwig Guttmann. A first class physiotherapy service was developed and sports and games were used to facilitate rehabilitation. As a result many of these ex-servicemen were salvaged to useful and productive lives. These patients stayed for as long as three years after injury and underwent a comprehensive programme of vocational training in leather work, boot or watch repairs and were only discharged home when they had achieved total independence in every way.

The treatment at Stoke Mandeville was extremely successful and the other units in the South of England closed down and their patients were transferred to Stoke Mandeville.

The next major development was the admission of civilian patients so that the service of the spinal unit was no longer exclusively devoted to ex-servicemen but had begun to serve the population of the South of England and the number of beds was rapidly expanded. The Centre was then taken over from the Ministry of Pensions and became a Health Service Hospital. It soon became apparent that if the patients could be admitted immediately after injury many of the complications of mis-management such as pressure sores, contractures and severe

urinary tract infections could be prevented. This inevitably meant that the associated injuries, and something like 50% of patients with spinal injuries have severe associated injuries, had to be dealt with at the Centre instead of the receiving hospital so that the facilities of the district general hospital were increasingly called upon.

This policy of early admission was a resounding success, the unit increased in size reaching a maximum of 190 beds in about 1966 and at that time about 50% of patients were admitted within two days of injury. Coupled with this policy of early admission it became apparent that there was a change in the pattern of patients being admitted, apart from them having associated injuries many more patients with cervical injuries were coming to the Centre, possibly in the early days they died at the receiving hospital or possibly there has been a real change in the incidence of this condition. Patients with cervical injuries required much longer rehabilitation and they eventually achieved much less in physical terms than patients with a low lesion. They also threw a much greater strain upon the resources of both medical and nursing staff as they required much more physical and psychological support.

Mortality amongst the patients with cervical injury was high as few patients were treated on respirators prior to 1966. The overall mortality from respiratory failure, pulmonary embolism, and other cause was in the neighbourhood of 12%. There have been further changes in the pattern of treatment given since 1966. There has been a reduction in the number of manned beds at the Centre resulting in two very unfortunate effects on the admission policy. Firstly, far fewer patients are being admitted soon after injury. In a series reviewed by Dr Silver of 100 patients admitted between 1970

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and 1974 42 patients were admitted within 48 hours of injury. In a similar series, admitted between 1976 and 1980 only 18 were admitted within 48 hours of injury. This has inevitably led to the regression to the situation that pertained in the early days of the Centre, patients being admitted late after the initial injury. The decline in these acute admissions is probably due to the fact that the hospitals throughout the country have intensive care units where these patients can be looked after but the main reason is because patients are being offered to the Centre on the day of injury and cannot be accepted due to the shortage of beds.

Secondly, review, i.e. the regular supervision of all patients after discharge, is now not possible and patients instead of being seen early before complications have occurred are only being seen when they are in advanced stages of renal failure or with intractable pressure sores. The shortage of beds means that these patients may never be re-admitted and die at home when they could be successfully treated.

<u>Nursing Patients with Spinal Cord Injury</u>

The key concepts; prevention of complications, and optimum quality of life define the philosophy of nursing care within the Stoke Mandeville Centre. It has now been proved that the complications of spinal injury are not an inherent part of the condition. Expert nursing management is based on the clear understanding of the implications of paralysis and many of these are preventable.

The routine nursing care of patients is repetitive and continuous and aimed at observing progress and preventing unnecessary complications. This helps to maintain the paralysed body healthy and ready to achieve maximum physical independence through a programme of rehabilitation. Without this type of skilled care the

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other members of the rehabilitation team are unable to function effectively towards the final goal of integrating the patient back into society. Throughout the patient's stay in the Centre, the spinal injury nurse forms a close supportive relationship with both patients and their family. An ongoing programme of education regarding the effects of paralysis, self management, care and advice, exists between nurse and families as a whole. Opportunity to establish this close relationship automatically presents itself through the type of nursing which is both physically and psychologically demanding to all staff but particularly to the nucleus of permanent staff.

The nurse has to care not only for the paralysed patient who may develop complications but may also be expected to exercise skills in other fields of nursing care such as maternity, orthopaedic, plastic surgery, gynaecology etc. Patients with spinal injury may be admitted to the Centre for any medical or surgical condition not necessarily associated with their spinal cord lesion. Nursing skill must therefore be comprehensive.

Size of New Unit

The size of the new unit consisting 120 beds was agreed as a result of a study, see Appendix A, carried out in 1979 by Drs Queenborough and McNeilly. This study was a case-note review of all first admissions to the Unit and a sample of readmissions during the preceding two years. This survey identified four types of patients :

(a) New Acute — These are patients who have suffered a recent traumatic spinal injury following, for example, a road traffic accident or a fall.

(b) Pathological — These are patients who have some disease process affecting the spinal cord e.g. a tumour.

(c) Re-admission — These are patients who have already been admitted before to the spinal injury centre with either a traumatic or pathological lesion and who required readmission for review, surgery, rehabilitation etc.

(d) Private — These are patients from abroad who are referred for treatment to the Centre.

At the time the survey was being conducted a new unit was already being planned for Odstock and it had been agreed that this unit would serve the two regions in the South West of England - Wessex and South Western Regions - and would consist of fifty beds. The survey was used to calculate bed requirements for the population of the regions of the South East of England i.e. Oxford, the four Thames and East Anglian Regions. The number of beds was, therefore, calculated from the current admission rates of the four types of patients described above. An estimate of the incidence of traumatic spinal injury was made from the admission rate on the assumption that all new spinal injury patients are admitted to hospital. There was an overall admission rate of 5.2 per million per year new traumatic cases from the South East of England. However, it was noticed that the further away from the Spinal Injury Centre the area of residence was, the lower the admission rate and this was taken to mean that not all patients who lived a distance away were admitted to Stoke Mandeville Hospital. It was also assumed that admission rates for pathological, re-admission and private patients would continue at the same population rate as before.

Given a population of 17,610,000 for the South East of England, this indicated a need for a total of 123 beds - 53 beds for new acute traumatic spinal injury cases from the South East of England and a further 70 for the remaining categories.

It is considered that the decline in admission rate with distance from the unit represented an "unmet" need in that an increasing proportion of patients were being treated in local hospitals rather than at a specialist spinal unit. Given more local services it would be expected that the present Oxford Region admission rate for traumatic cases of 8.1 per million per annum would apply to the population served and this would indicate a need for a further 30 beds.

When account is taken of the increasing population and the increasing incidence of traumatic spinal cord injury the bed requirement rises by about another 17 beds. This produces a total requirement of about 170 beds to serve the whole of the South East of England.

It was, therefore, decided to build a new unit at Stoke Mandeville Hospital of 120 beds to serve the Oxford, North West Thames, North East Thames and East Anglia Regions and that another unit serving the South East Thames and South West Thames Regions and consisting of about 50 beds should be built.

Future Development

Medical care has changed over the years, there are now many more medical staff with doctors training as specialists in the care of these patients and with the consultant in Spinal Injuries responsible individually for the total care of the patient from admission to discharge. This is essential for the psychological and physical rehabilitation of the patient.

different methods and policies of treatment being developed at the Centre with much progress in treatment being achieved.

As knowledge has increased the medical management has become much more complex. The development of excellent units throughout the world has provided a stimulus and a challenge. This can only be met by the twin provision of a new Centre to treat patients and a proper Research Institute where developments and treatment can be monitored and studied.

Research work has always been an integral part of the work of the Centre. In the early days Sir Ludwig Guttmann carried out work on autonomic disturbances and this has continued until the present day. There have also been numerous other studies on respiratory function, metabolic consequences of spinal injuries such as stone formation, urinary tract infection and in addition very practical developments of aids for the disabled, very comprehensive statistical analysis of mortality pathology, and work prospects of studies of different methods of treatment. It is upon this research work as well as the excellence of the treatment that the reputation of this Centre has been built and this has been responsible for attracting staff at all levels to come and work there. The Centre has treated the largest population of spinal patients of any centre in the world and it is vital that this unique experience is properly documentated and that further research continued.

The outstanding feature of the Spinal Injury Centre is the community spirit which has developed over the years. This has maintained the high moral of staff and patients in adverse conditions. It is essential that the new unit will foster this spirit and high moral.

MANAGEMENT OF IN-PATIENTS

1 PATIENT CARE POLICY

It is agreed that progressive medical and nursing care will be practised within the Centre. Progressive patient care means the grouping of patients according to the degree of illness and dependence on the nurse.

The classes of care which have been identified for these patients are :- (a) Acute nursing care (not the same as ITU); (b) high dependency and intermediate dependency, and (c) self care/low dependency. Patients requiring the extra attention of an Anaesthetist will be transferred to the hospital Intensive Therapy Unit.

It is intended that the acute nursing care area, the high/intermediate care area and the self care/low dependency area will each be the responsibility of separate nursing teams, but nurses working in the self care/low dependency area will assist with, and get to know, patients in the intermediate dependency area.

2 ACUTE ADMISSIONS WARD

The number of beds in this Ward for first admissions with new lesions (both traumatic and pathological) will be 70. These beds will be divided into 4 areas: Acute Nursing Care and Admission Area (6 beds); two High/Intermediate Dependency Areas (24 beds each); Self-Care/Low Dependency (16 beds).

ACUTE NURSING CARE AND ADMISSION AREA

All patients with new lesions being admitted to this Centre for the first time will go through the acute nursing care and Admission area, from which they will be filtered to the appropriate dependency area of the acute admission wards according to their dependency.

Patients will arrive at the ambulance bay, which should be adjacent to the acute nursing care and admission area, from whence they will be wheeled on the ambulance trolley to the examination room forming part of that area.

The patient will be assessed in the examination room by the doctor who will decide whether the patient is to be transferred to a bed straight away or remain on the trolley. If the patient is transferred to a bed in the examination room, he/she will then be moved in the same bed, after examination, to one of the bed positions in the acute nursing care and admission area. The length of stay in the acute nursing care and admission area will vary from half an hour to several weeks.

The activity spaces required in the acute nursing care and admission area are as follows :-

1 x single bed bay (to permit use by either sex)

2 x 2 bedded bays

1 x Single bed room (thoroughly soundproofed for disturbed patients)

Examination/Treatment Room (sized to take bed, patient trolley, resuscitation and examination equipment)

Nurses Base

Sisters Office (with switch through telephone to nurses base and patient/nurse call)

Doctors Office

Relatives waiting room with en-suite W.C.

Dirty Utility Room

Clean Utility Room

Cleaners Room

Linen Bay (enclosed)

Equipment Store

Staff W.C. (including handbag lockers)

Ward Pantry

Storage bay for mobile x-ray machine

General Store

2 x Physiological Examination Rooms (required for clinical research).

HIGH/INTERMEDIATE DEPENDENCY AREA

This will comprise 2 x 24 bed areas.

One of the high/intermediate dependency areas must be designed to permit flexibility of use for both male and female patients, ensuring privacy and providing separate male and female lavatory facilities.

High dependency patients require a large amount of nursing care and time and the average length of stay in this area can be between 6 to 8 weeks.

These patients will progress to intermediate dependency, needing a lower level of nursing care and less time, and some will then progress to self care/low dependency.

Intermediate dependency patients are steadily improving and progressing towards self care/low dependency. The average length of stay in the intermediate category is about 5 months for a paraplegic and about 9 months for a tetraplegic. Some patients, however, will never progress to self care/low dependency. Following admission other patients may proceed directly to the intermediate category depending on their need for nursing care.

The activity spaces required for each high/intermediate dependency area are as follows :-

High/Intermediate Dependency Area - 1 x 24 bed area (to cater for Male Patients)

2 x single bed rooms 2 x 2 bedded bays 1 x 4 bedded bay	10 beds - high dependency
2 x single bed rooms 2 x 6 bedded bays	14 beds - intermediate dependency

Nurses base

Flower bay

Sisters Office (with switch through telephone to nurse base and patient/nurse call)

Doctors Office (sized to accommodate a bed)

Treatment Room (for medical procedures, large enough to admit a bed. Washbasin)

Clean Utility Room

Dirty Utility Room (sized to store 2 toileting trolleys, 3 linen skips and facilities to clean and store urine drainage bags)

Cleaners Room (small)

Linen bay (enclosed - sized to accommodate clean pillows and also storage of clean linen trolley)

Ward Store

Equipment Store

Patients Utility Room

Staff W.C.

Ward Kitchen

Day/Dining area (to include meals serving; for 6-8 patients)

Wheelchair storage bay (with charging point Minimum of 6 chairs inc 2 electric)

Storage Room (for patients suitcases and clothes hanging)

Patients lavatory facilities :-

6 x Assisted W.C's (with small WHB)

6 x Washroom Cubicles (curtained) to include razor points at basins

1 x Bathroom - to include W.C., bath and wash basin

1 x Bathroom - with raised bath for assisted bathing

1 x Bathroom with Arjo shower facilities to accommodate shower trolley

1 x Shower Room - glazed and tiled with sloping floor to runaway. Thermostatically controlled shower - large enough to accommodate self propelled chair. Should be close to W.C's.

High/Intermediate Dependency Area - 1 x 24 bed area (to cater for Male/Female Patients)

2 x single bed rooms 2 x 2 bedded bays 1 x 4 bedded bay	10 beds - high dependency
2 x single bed rooms 2 x 6 bedded bays	14 beds intermediate dependency

Nurses base

Flower bay

Sisters Office (with switch through telephone to nurses base and patient/nurse call)

Doctors Office (sized to accommodate bed)

Treatment Room (for medical procedures, sized to admit bed. Wash basin)

Clean Utility Room

Dirty Utility Room - (sized to store 2 toileting trolleys, 3 linen skips and facilities to clean and store urine drainage bags)

Cleaners Room (small)

Linen Bay (enclosed - sized to accommodate clean pillows and also storage of clean linen trolley)

Equipment Store

Ward Store

Patients Utility Room

Staff W.C.

Ward Kitchen

Day/Dining area (to include meals serving; for 6-8 patients)

Wheelchair storage bay (with charging point. Minimum 6 chairs)

Storage Room (for patients' suitcases and clothes hanging)

Patients Lavatory facilities :-

MALE

4 x assisted WC's (with small whb)

4 x washroom cubicles - to include razor points at basins

1 x bathroom - to include WC, bath and wash basin

1 x shower room - Glazed and tiled with sloping floor with runaway. Thermostatically controlled shower - large enough to accommodate self propelled chair. Should be close to WC's.

FEMALE

4 x Assisted WC's (with small whb)

3 x washroom cubicles

1 x bathroom - as male

1 x shower room - as male

SHARED

1 x bathroom - with permanently raised bath for assisted bathing

1 x bathroom - with Arjo shower facilities to accommodate shower trolley.

SELF CARE/LOW DEPENDENCY

In association with the two high/intermediate dependency areas, there is to be a self care/low dependency area to which some patients will progress. This 16 bed area will be the responsibility of one nursing care team. (Members of this team will assist with, and get to know

patients progressing from Intermediate Care in order to ensure continuity of care). Self care patients are at a stage of learning their independence with minimal supervision. It is the next step towards home. Thus the accommodation for these patients should be closely associated with the daily living facilities, and should, as far as possible, resemble the home situation. This area must be designed to permit flexibility of use by both male and female patients to ensure privacy.

The activity spaces required for this area are as follows :-

1 x single bed room with en-suite bathroom, inc WC (could be used by mother and baby if necessary)

7 x single bed rooms

4 x 2 bed rooms

Nurse base

Clean Utility Room

Dirty Utility Room - (sized to store 2 toileting trolleys, 2 linen skips and facilities to clean and store urine drainage bags)

Flower Bay

Sisters Office (with switch through telephone to nurses base and patient/nurse call)

Doctors Office (small)

Treatment Room (sized to admit a bed, for medical procedures. Wash basin)

Cleaners Room (small)

Linen bay (enclosed - sized to accommodate clean pillows and also storage of clean linen trolley)

Equipment/Storage Room (large with plenty of shelving)

Staff WC

Patients Utility Room

Ward Kitchen (inc use by patients. Dining facility for 4 patients)

Day Area

Storage Room (for patients suitcases and clothes hanging)

Wheelchair charging bay (to have air pressure point)

Patients lavatory facilities :-

6 x bathrooms - to include razor points, WC, bath and wash basin. (1 with shower cubicle area)

3 x WC's (1 x narrow toilet for training purposes, 2 x assisted)

1 x Shower Room - Glazed and tiled with sloping floor to runaway. Thermostatically controlled shower, large enough to accommodate self propelled chair. Should be close to WC's.

3 RE-ADMISSION WARD

For re-admissions, 50 beds are to be provided in two 20 bed areas, one for surgical patients, the other for medical patients; and a 10 bed area for Follow up, Short stay and Day patients.

Again these wards must be designed to ensure privacy for flexibility of use by both male and female patients, in multi-bed bays and single rooms, with separate lavatory facilities for males and females.

One of the six bed bays in the medical ward is to have facilities to treat patients who are potentially infective and who may require more intensive nursing care.

In the surgical ward, a special preparation suite for pre-operative cases is required. The suite will comprise two rooms, one for bowel preparation and skin washing, the other for skin preparation.

Assessment of patients for re-admission will take place in the Out-patients section of the Centre.

The Out-patient section will function on an 8am-5pm Monday to Friday basis. Re-admission patients arriving at the Centre outside these hours and at week-ends will be directed to the appropriate area of the Re-admission ward, where they will be assessed.

Day patients, including private cases, attending for regular therapy or minor surgery will be cared for in the 10 bed area.

The activity spaces for these bed areas will be as follows :-

Re-Admission Ward (surgical) - 20 beds (to cater for Male/Female Patients)

4 x single bed rooms

2 x 2 bedded bays

2 x 6 beeded bays

Nurses base

Flower bay

Sisters Office (with switch telephone to Nurses base and patient/ nurse call)

Doctors Office (sized to accommodate a bed)

Treatment Room (for medical procedures, sized to admit a bed. Wash basin)

Clean Utility Room

Dirty Utility (sized to store 2 toileting trolleys 3 linen skips and facilities to clean and store urine drainage bags)

Cleaners Room (small)

Linen Bay (enclosed - sized to accommodate clean pillows and also storage of clean linen trolley)

Equipment Store

Ward Store

Patients Utility Room

Staff WC

Ward Kitchen

Day/Dining area (to include meals serving)

Wheelchair storage bay (with 2 charging points. Minimum of 10 chairs)

Pre-operative preparation suite (comprising Treatment Room and

Bathroom - with Arjo shower facilities to accommodate shower trolley)

Storage Room (patients suitcases and clothes hanging)

Patients lavatory facilities :-

MALE

3 x Assisted WC's

3 x washroom cubicles - to include razor points at basins

1 x bathroom - to include WC bath and wash basin

FEMALE

2 x assisted WC's

2 x washroom cubicles

1 x bathroom - as male

SHARED

1 x Bathroom - with permanently raised bath - for assisted bathing

1 x Shower Room - Glazed and tiled with sloping floor with runaway. Thermostatically controlled shower - large enough to accommodate self propelled chair. Should be close to WC's.

Re-Admission Ward (Medical) 20 beds (to cater for Male/Female Patients)

3 x single bed rooms

1 x single bed room with en-suite W.C. and air lock lobby (for isolation use)

2 x 6 bedded bays (1 x 6 bedded bay for potentially infective patients)

2 x 2 bedded bays

Nurses base

Flower bay

Sisters Office (with switch through telephone to Nurse base and patient/nurse call)

Doctors Office (sized to accommodate a bed)

Treatment Room (for medical procedures, sized to admit a bed. Wash basin)

Clean Utility Room

Dirty Utility Room (sized to store 2 toileting trolleys, 3 linen skips and facilities to clean and store urine drainage bags)

Cleaners Room (small)

Linen Bay (enclosed - sized to accommodate clean pillows and also storage of clean linen trolley)

Ward Store

Equipment Store

Patients Utility Room

Staff W.C.

Ward Kitchen

Day/Dining area (to include meals serving)

Wheelchair storage bay (to accommodate minimum of 8 chairs + 2 charging points)

Examination Room (bed for re-admissions when OPD closed)

Storage Room (for patients suitcases and clothes hanging)

Patients lavatory facilities :-

<u>MALE</u>

4 x Assisted W.C's

4 x Washroom cubicles - to include razor points at basins

1 x Bathroom - to include W.C., bath and wash basin

<u>FEMALE</u>

3 x Assisted W.C's

3 x Washroom cubicles

1 x Bathroom - as male

SHARED

1 x Bathroom - with permanently raised bath for assisted bathing

1 x Bathroom - with Arjo bath facilities

1 x Shower Room - glazed and tiled with sloping floor with runaway. Thermostatically controlled shower - large enough to accommodate self-propelled chairs. Should be close to W.C's.

Re-Admission Ward (Follow-up/Short stay/Day patients area) 10 beds (to cater for Male/Female patients)

2 x single bed rooms .

2 x 2 bedded bays

1 x 4 bedded bay

Nurses base

Sisters Office (with switch through telephone to Nurses base and patient/nurse call)

Doctors Office (small)

Examination/Treatment Room (for medical procedures, sized to admit a bed; Wash basin)

Clean Utility Room

Dirty Utility Room (sized to store 2 toileting trolleys, 2 linen skips and facilities to clean and store urine drainage bags)

Cleaners Bay

Relatives Waiting Room

Linen Bay (enclosed - sized to accommodate clean pillows and also storage of clean linen trolley)

Ward Store

Equipment Store

Patients Utility Room

Staff W.C.

Ward Kitchen

Day Area

Storage Room (for patients suitcases and clothes hanging)

2 x Day Patients Rest Rooms

Patients lavatory facilities :-

MALE

2 x Assisted W.C's

2 x Washroom cubicles - to include razor points at basins

1 x Bathroom - to include W.C. bath and wash basin

FEMALE

3 x assisted W.C. with washing facility

1 x Bathroom - as male

SHARED

1 x Bathroom - with permanently raised bath - for assisted bathing

1 x Shower Room - Glazed and tiled with sloping floor with runaway. Thermostatically controlled shower - large enough to accommodate self propelled chairs. Should be close to W.C's.

4 CHILDREN AND ADOLESCENTS

A paediatric environment will not be provided in the Spinal Unit. Children (up to age 15 years) with new lesions will be transferred from the Acute Nursing Care and Admission Area to the Paediatric Department as soon as possible after admission, subject to clinical agreement.

4 beds within the Paediatric Department will be required for these patients (including re-admissions).

Teenagers over 15 years will be accommodated within the Spinal Unit and should be nursed together if of the same sex.

5 PRIVATE PATIENTS

No special facilities are to be provided.

On admission, private patients with new lesions will progress through the acute nursing care area as in the case of NHS patients and thereafter it will be a medical decision as to where these patients are cared for dependent on their medical condition. Private patients who are re-admitted will be nursed in accommodation appropriate to their medical condition.

OUT-PATIENTS DEPARTMENT

1 FUNCTION

The Out-Patient Department will cater for paralysed patients attending for medical check-ups, examinations, clinical assessment, advice, x-rays and fertility assessment and advice.

2 PATIENTS

Two types of patients will attend the Unit on a day basis -

Day Patients (including private patients) attending for regular therapy and minor surgery will be cared for in the 10 bed area of the re-admission ward, not in the OPD.

Out-Patients will attend for: (1) routine review; (2) dressings of pressure sores, sometimes because of the absence of Community Nurse support, but usually because the patient does not wish to have that service. This enables the Medical and Nursing staff of the Unit to note a patient's progress, or otherwise, often while awaiting a bed for admission; (3) routine catheter changes are carried out for patients where difficulty has been encountered, eg urinary tract complications, very spastic patients, etc.

Most of the patients will spend anything from one hour to a whole day in the department and will usually require to spend a large percentage of this time occupying a bed and requiring some nursing assistance.

3 LOCATION

The OPD should be sited to permit easy access from the main entrance/ reception area and should be conveniently located for the x-ray department and the 10 bed area of the Re-admission Ward. Proximity to the records department would facilitate access to case notes and x-rays.

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4 RECEPTION

The Out-Patients reception will form part of the main entrance/ reception area of the Unit (described in the Section on Administration and Main Entrance). Patients will be directed to the Out-Patient waiting area, which should be sized to accommodate up to 6 wheelchairs and escorts. The waiting areas should be comfortable and un-clinical, with smoking being permitted if desired. A facility for the display of information leaflets on help for the disabled, aids, associations, etc should be provided within this area. There will also be a need to park ambulance trolleys here, and a bay suitable for two trolleys should be provided.

5 ACCOMMODATION

Detailed below is information on certain rooms.

Examination Rooms - ten rooms will be required, all of which should be sound attenuated. Six rooms should accommodate a bed, bedside table, minimum of two chairs, ambulance trolley, wheelchair and treatment trolley. Three larger rooms should be provided for designated purposes, viz:

a dirty dressings/procedures

b Fertility assessment (electroejaculation), including use of ECG machine

c proctoscopies etc.

One extra large room will be required as a re-admission examination room. Teaching of 6-8 students (medical/nursing) takes place here. The heating of all rooms should be capable of being boosted, as patients under examination run the risk of hypothermia. Lighting in all rooms should be good with angle-poise lamps over the beds for examination purposes. All the examination rooms should have blinds to enable them to be darkened for neurological examinations. X-ray viewers should be provided. There will be a need to provide storage for routine examination equipment and stationery.

Bay for Weighing Platform is required adjacent to the examination rooms. The platform should be set into the floor and should take a wheelchair.

A Pantry is required for beverage preparation. Light refreshments will be prepared for patients who have been required to fast prior to under-going certain investigative techniques.

The activity spaces for the OPD are as follows :

10 x Examination Rooms (inc 3 large and 1 extra large)

Sisters Office

2 x Doctors Office

Dirty Utility Room

Clean Utility Room

Cleaners Room

Linen Bay

Equipment/Storage Room

Staff WC

Pantry

2 x Patients WCs

Waiting area with information display (for 6 wheelchairs and escorts)

Ambulance Trolley Bay (2 trolleys)

Weighing Platform Bay

Fuller information on all accommodation required is detailed in the room data sheets.

ADMINISTRATION AND MAIN ENTRANCE

1 Main Entrance and Reception Area

The main entrance to the Unit will be through a draught lobby having inner and outer sets of automatic sliding doors. The lobby will open on to a Reception Area which would include a waiting area with seating to cater for up to 10 persons and a room for a porter, who will assist patients arriving by car and will undertake a variety of other portering duties.

2 Reception Desks

Opening on to the Reception Area will be a Reception Desk behind which will be an office space.

The clerk/receptionist will direct re-admission patients, out patients, day patients and visitors, deal with queries from patients, relatives and visitors, and will maintain the patient index system. Her duties will also include typing, sorting of case notes and filing.

Working within the same office space will be the Ward Clerk to the Out-Patients Department. Her duties include receiving and booking in out-patients and patients arriving for re-admission, making case notes available, as well as other duties within the Out-Patients Department. Because of her reception work another Reception Desk will open from this office space on to the Out-Patients Department waiting area (see Out-Patients Department Operational Policy).

The clerk/receptionist and Out-Patient Department Ward Clerk would be able to cover each other's reception duties during busy periods, tea and coffee breaks, meal times, etc.

The Reception Desks should have easy communication with the Secretarial Suite and records storage area. If the Secretarial Suite is to be located on the first floor, communication could be by a

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"dumb waiter" system and in this case stairs should be nearby. Access to the Out Patients Department will also be required.

The Reception Desk will be manned by hospital staff during office hours only, although it is intended that voluntary assistance, eg an ex-patient, would be on duty until 10pm. Thereafter a notice would direct enquiries to an area staffed on a 24 hour basis, eg the 10 bed area of the re-admission ward with queries, etc being dealt with by a member of staff from this area. The Reception Desks and the associated office space should be capable of being secured when not manned.

3 <u>Secretarial Suite</u>

This will comprise an Administrator's office, and two offices for 3 typists each.

4 <u>Records and X-ray Storage</u>

These facilities should be adjacent to the secretarial accommodation. Storage for 10,000 current records will be required in this area. A further 5,000 secondary records will also require storage space, but this need not be within the Unit. An A4 case note folder will be used for all records. Medical and nursing records will be stored together.

5 <u>Medical Staff Accommodation</u>

Office accommodation for 5 consultants and 1 senior registrar will be required. These offices will not be required for use as examination rooms.

A doctors mess will also be required.

6 <u>Additional Office Accommodation</u>

Three offices will be required for Social Wor[illegible] DH Document 07 Page 1931
be for a secretary. A small sub-waiting area should be provided

adjacent to these rooms. The domestic supervisor will also require an office.

7 <u>Visitors WCs</u>

Two WCs for visitors use should be provided off the main entrance, one of which will be sized for the disabled.

The accommodation described at items, 3, 4, 5 and 6 above may be located on the first floor.

WHOLE UNIT ACCOMMODATION

In addition to the In-Patient and Out-Patient areas of the Unit there will be a need for additional non-clinical supporting facilities. Information on this common activity accommodation is listed below.

(A) Large Central Store Room - essential for storage of equipment other than beds, which is not in regular use on Wards. This will permit sharing throughout the Unit, cut down on equipment being duplicated and often lying idle. Should have shelving racks plus sectional area so that equipment can be grouped - making it more identifiable. Should have heating and lighting facilities and washable floor covering.

(B) CSSD Store - to provide back-up storage for CSSD items. Shelving will be required.

(C) Bed/Wheelchair Store - to accommodate a minimum of 12 spare beds. This store should accommodate one or two spare wheelchairs only, which can be booked out to patients awaiting delivery of their own chair or whilst a chair is being repaired.

(D) Bed/Wheelchair Workshop - should be adjacent to, and with direct access to bed/wheelchair store. To facilitate maintenance of specialised beds and chairs storage facilities for spare parts are required. On receipt, new chairs will be checked over, and modified if necessary, prior to issue to the patient.

(E) Hairdressing Salon - fitted out with two chair positions for needs of male and female patients, covering all types of hair care from cutting to 'perming' etc. Visiting hairdressers may use facilities at specific times. Wash-basins and hair-dryers should however, be available for patients' use particularly

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the evenings and weekends, when relatives and friends may wish to assist the patients, or the patient may wish to make private arrangements with a visiting hairdresser. Some patients in early stages of rehabilitation will still require hair shampoos to be carried out under nursing supervision at ward level.

(F) Book Store - for book trolley. Shelving will be required for reading aids, ie stands, projection and talking books.

(G) Audio Visual Centre (comprising Preparation and Storage Room, Office and Viewing Room) - for the educational training of patients, relatives, friends and staff. Viewing Room should be large anough to accommodate 12 wheelchairs, plus escorts ie relatives or staff. Useage 5-6 days a week, flexi-hours, for showing and preparation of films.

(H) Visitors' Lounge - a quiet place for visitors to meet with patients. Should be near to catering facilities and public telephone booths. Domestic atmosphere with access to courtyard if possible.

(I) Patients' Recreation Room - comprising a variety of areas for patients to pursue recreational activities. Some areas must be separate and may require sound attenuation depending on situation, such as TV Room and Music Room (for playing records etc). Billiards, table tennis, darts should all be set out and ready for use when desired. Pottery and painting may also merit a quiet section, but not soundproofed.

(J) 6 Quiet Rooms - should be large enough to accommodate at least 2 wheelchairs plus an able bodied person. Useage is multi-purpose. 4 should be standard layout with chairs and tables and would be used for private interviews (eg Solicitors, Social Workers etc), quiet study and exams. The remaining 2 rooms to

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have convertible couches, toilet and wash-basin facilities for use as "Love Nest" and as overnight room for relatives of critically ill patients. These rooms should be comfortable and non-clinically furnished.

(K) 2 Seminar Rooms - sized to take up to 30 able bodied persons each. To be used for staff meetings and group therapy sessions for patients. One room should have projection facilities and associated storage.

(L) Offices (2) for Clinical Teachers - one for in-service training, and one post-basic training.

(M) Nursing Officer's Office - should be large enough to accommodate secretary, with partitioning to ensure privacy of interviews, etc.

(N) Staff Changing Rooms (1 male, 1 female) - for all grades of nursing and ancillary staff. Should include WC, washing and shower facilities.

(O) Staff Rest Room - for use at meal breaks when staff do not wish to use hospital central dining room or to leave the Unit. A beverage vending machine will be required.

(P) Central Linen Store - provide a back-up facility when main hospital linen store is closed eg weekends, bank holidays etc. Shelving will be required with space under for linen trolleys.

(Q) Cleaning Equipment Store - for major items of cleaning equipment used throughout the unit, eg scrubbers, polishers, suction cleaners, etc.

(R) On-Call Rooms - two rooms, with shower WC and WHB, will be required for Medical/Physiotherapy staff who require to be on-call.

(S) Disposal Area - for temporary storage of items for disposal.

(T) Public Telephones - for use by disabled persons will be provided at the Main Entrance (2), in the High/Intermediate Dependency Area, on the Medical and Surgical Re-admission Wards, and the Dining/Recreation area.

(U) Greenhouse for use by wheelchair patients.

Accommodation listed above at items E F G I J K L M N O R may be accommodated on the first floor.

CLINICAL SUPPORT SERVICES

1 OPERATING THEATRES

The type of surgery that will be undertaken will include exploration of the urinary tract and surgical treatment of pressure sores. This involves major and minor surgical procedures carried out under general and local anaesthesia. Day surgery cases will be operated on in the main hospital operating theatre department. It has been established that 8 operating sessions per week are required for spinal patients and that these sessions could be made available in Theatres 3 and 4 of the new Wing on a shared basis with ENT surgery.

It will not be possible to start these additional operating sessions with the nursing staff presently available but if the current theatre nursing staff vacancies of 17 against the recognised establishment were filled, no additional theatre nursing staff would be required.

A need for additional theatre instruments has been identified with regard to these additional operating sessions for spinal patients and the cost of this provision needs to be taken into account.

The distance from the Unit to the Theatre suite should be as short as possible (optimum travel time should be about 1 minute), because of the risk of cardiac or respiratory arrest and also to minimise the time spent by staff away from their ward posts. Patients will be mainly transported to Theatre on a theatre trolley, but certain patients, particularly with recent spinal injury lesions, will be moved on the Egerton Electric turning bed. To avoid hypothermia, a heated enclosed corridor between the new Wing Theatres and the Unit is essential. To avoid bumping and jarring of the trolley or bed which can be hazardous particularly in a patient with a recent spinal injury with an unstable fracture the floor must be smooth and free of uneven joints.

2 X-RAY

Facilities are required for urodynamic studies associated with television x-ray procedures, screening (IVP) and general routine procedures. In addition, a mobile x-ray machine will be used in the acute nursing care and admission area. This mobile machine will be used only rarely therefore no radioprotection is required in the area in which it is to be used. At a future date and subject to resource availability, whole body scanning facilities may be required.

It has been estimated that 10-12 IVPs will be carried out each day, 5 days a week. It is considered that an IVP radiodiagnostic room, a general RD room and urodynamic room are required. These should be located as an extension to the existing main hospital x-ray Department.

The activity spaces required and room data sheets will be forwarded.

3 ELECTROMYOGRAPHY (EMG)

EMG facilities are a necessary requirement of this Unit. EMG investigations will be carried out in a special EMG suite associated with the Unit. The following accommodation is required :

Neurophysiology Laboratory (with Faraday cage)
Dark room (with film store).

These facilities will be used by both in-patients and out-patients and patients from the District General Hospital and need not necessarily be sited on the ground floor. These facilities may also be used for research purposes.

4 DENTAL

General dental practitioner's surgery facilities are required for in-patients. This surgery, approximately 5m x 5m and capable of admitting a bed, should be close to the in-patient areas. Anaesthetic facilities, compressed air, suction and a number of socket outlets are required. The floor and ceiling should be designed to accommodate the dental chair and light respectively. This accommodation need not be on the ground floor.

5 PATHOLOGY

Whole hospital policy relating to arrangements for the collection and testing of specimens will apply. A special biochemistry laboratory should be provided as part of the Unit and the activity spaces associated with this provision are as follows :

Biochemistry Laboratory

Office

Sluice.

This accommodation should be related to the two physiology laboratories in the acute admissions are but, as it does not need to be accessible to patients, it is suggested it could be sited on the floor above the physiology laboratories.

6 PHARMACY

No special facilities within the Unit are required. The whole-hospital-policy relating to pharmacy arrangements will apply.

7 REHABILITATION

The present main facilities consist of two separate physiotherapy areas, an occupational therapy area, an archery and indoor games area and a hydrotherapy pool. These areas are not immediately

adjacent to each other and it is generally agreed that, ideally, a fully integrated whole hospital Rehabilitation Department is required, sited as near as possible to the Spinal Injuries Unit with certain areas in the Department specifically designated for the use of spinal injuries patients.

Although it is recognised that the existing facilities are inadequate, it is accepted that it wil not be possible to replace these facilities at the present time and that new provision should be limited to providing additional physiotherapy accommodation and an occupational therapy 2 bedroom flat for spinal injuries patients. These new facilities will form the nucleus of the new whole hospital department and, for this reason, must be sited appropriately to allow for expansion in the future (say, for 2000 m^2).

As most of the existing facilities (ie OT, hydrotherapy and archery) are to continue in use for a number of years, it is essential that an enclosed heated link corridor is provided between the new Spinal Injuries Unit and the South Corridor to give covered access to these facilities.

The new physiotherapy accommodation required is as follows :

Gymnasium Area - must have a minimum ceiling height of 3 metres with adequate floor space for treatment of 3.5m x 1.75m for each patient. Experience indicates that up to 50% of inpatients of a Spinal Injuries Unit attend the Gymnasium for treatment for varying periods of up to a half day at any one time. Space also needs to be set aside for gymnastic mats, fixed purpose built graduated stairs unit, etc. Walls and ceilings must be capable of withstanding the fixing of Stanco Suspension Frames.

Assessment/Splint Area - for patient assessment by medical practitioners/physiotherapists and for splint/appliance measurement/ fitting.

Storage Area - for equipment not in use.

Patients' WCs with lobbies (2)

Staff Base - a bay off the gymnasium area.

As the existing department is split between two locations (ie South and North corridors) it is suggested that, as an interim measure, when the new Spinal Unit is opened and the existing ward accommodation in the South Corridor is vacated, it should be adapted and upgraded for physiotherapy purposes so that the North corridor facilities could be closed until the DGH Department can be added on to the physiotherapy area used by spinal injury patients only. This is not part of brief for the New Spinal Injuries Centre.

Occupational Therapy

The following accommodation is required for the pre-home management flat :

- 2 bedrooms (1 single, 1 double)
- Kitchen/Dining Room
- Sitting Room
- Bathroom (with WC and shower)
- Assisted WC (with whb)
- Entrance hall.

This facility will be provided as part of the OT Department and adjacent to the new physiotherapy facility so as to form an integral part of the rehabilitation services.

There is also an immediate requirement for the shallow end of the existing hydrotherapy pool to be made level for walking training. This area should be 6 feet wide across the width of the pool. Consideration should be given to doubling the length of the archery hall to 50 metres if and when resources permit. (This, again, is not part of the New Spinal Injuries Centre).

NON-CLINICAL SUPPORT SERVICES

1 CATERING

It is proposed to introduce a cook/chill system of catering for the whole hospital when a new central production unit is built as part of the next phase of development. All food which requires cooking will be prepared and cooked in the central unit on a daily production basis, then chilled and stored at 3°C until required. Each day food in a chilled state will be issued to peripheral kitchens where it will be reheated, plated and then distributed in trolleys to wards. Washing-up will occur at these peripheral kitchens.

One of these peripheral kitchens will be required to serve the Spinal Injuries Centre. However, since the proposed new system of cook/chill will probably not be available until towards the end of this decade, it is proposed to use this kitchen on a modified basis to provide an improved service to the Spinal Injuries Centre. In the intervening period, the majority of the food will be prepared and cooked in the existing main central kitchen and distributed in bulk food trolleys directly to the wards. However, for patients and visitors using the patients' dining room a form of cafeteria/waitress service will be available.

All crockery and cutlery will be washed-up in this kitchen. Only beverages and light refreshments should be provided from the ward kitchens.

A patients dining room to accommodate 60 people, most of whom would be in wheelchairs is required. This should be sited adjacent to the kitchen and should include a servery. Patients will be served their meals at dining tables by staff. Visitors may obtain meals

from the servery on payment of relevant prices.

Vending machines are to be provided for use when catering staff are off-duty.

These facilities are not for use by the staff who should use the main hospital staff centeen.

The accommodation required is as follows :

Regeneration area

Service area

Trolley park (6 trolleys)

Larder

Refrigeration storage area

Wash-up area

Disposal area

Cleaners room

Staff Changing and WCs

Office

Plant Room

Patients Dining Room

Vending machines area

Servery

2 SUPPLIES

The whole hospital policy will apply based on ward requisitions for hardware and crockery, medical stores and dressings, cleaning materials and stationery. Consideration is currently being given to introducing a topping-up service for hardware and crockery, dressings and cleaning materials.

A topping-up service operates for bedding and linen. Activity space requirements have been included in the whole unit accommodation.

3 DOMESTIC SERVICES

All cleaning throughout the whole hospital is carried out under contract. Cleaners rooms and a central cleaning equipment store are to be provided (see whole unit accommodation).

4 DISPOSAL

A disposal area is to be provided (see whole unit accommodation) for the temporary holding of dirty linen and waste awaiting collection.

5 STAFF CHANGING

Facilities for non-resident male and female staff changing have been included in the whole unit accommodation.

6 STAFF TRAINING

Facilities have been included in the whole unit accommodation.

SITING, WHOLE HOSPITAL COMMUNICATIONS, VEHICULAR ACCESS AND PARKING

1 SITING

An area to the west of the existing temporary covered way linking the New Wing to the old isolation wards (now used as general medical wards) has been proposed and agreed as the site for the new Spinal Injuries Centre. This site was selected because it would involve the least replacement consequences but demolition of some buildings including possibly a residential unit for married personnel will be unavoidable.

2 LINK CORRIDORS

An enclosed heated link corridor is required between the unit and the New Wing operating department and x-ray department.

An enclosed heated link corridor is also required between the unit and south corridor to provide covered access to the existing Physiotherapy and Occupational Therapy Departments, Archery Hall and Hydrotherapy Pool. This link will bisect the service road and may also involve the replacement of some residential units of South Home to achieve the required route.

The preferred width for these link corridors is 3000mm (10'0").

3 VEHICULAR ACCESS

Access for all vehicles to the Centre's main entrance would be via Entrance 2 from Mandeville Road, which would terminate in a cul-de-sac at the point where the proposed new covered way crossed the existing service road.

All vehicles to the hospital site, other than to the Centre, would use the other existing entrances, the rear of the site being linked to Entrance 4 between the Staff Social Club and the Nursing Residential Accommodation (South Home). The existing link road to

the east of the New Wing will need to be extended. Some single residential accommodation (about 10 rooms) would be lost in order to achieve this proposed route.

A separate vehicular access for delivery of stores and disposal purposes is required, preferably from the east side of the Unit.

4 AMBULANCES

Patients arriving by ambulance will be new admissions, re-admissions, out-patients and day patients. There should be a covered arrival ambulance bay into which three vehicles can be reversed. Two of these bays should be related to the Main Entrance (Reception) and the third bay must open into the Acute Nursing Care and Admissions Area.

Space for a further four ambulances should be provided nearby so that waiting ambulances can be parked off the arrival bay.

5 HELICOPTER LANDING PAD

A roadway leading from the existing helicopter landing site to link into the road network is required.

6 PATIENTS' CARS

Many patients for re-admission, out-patient appointments and day cases will travel to the hospital in their own transport and on arrival, may need to park their cars close to Main Reception under cover and from where they can ring a bell for assistance if required from the driving seat. Three places of this sort will be needed, which should be regarded as of short duration for patients parking. Should parking be required for longer periods, then there should be someone available on the staff who is trained to drive a car that

has been converted for a spinal injured person, who can move the car to the main parking area.

7 STAFF AND VISITORS CARS, MOTORCYCLES AND BICYCLES

It is not the policy on the hospital site to reserve car parking spaces for individuals and the close proximity of other hospital buildings will cause a greater demand on car parking facilities in the area than would normally be the case. Furthermore, as a National Centre there should be provision for a greater number of visitors to stay for longer periods of time than is the case in the General Hospital area. It is considered that provision for 120 cars is necessary, which should meet the needs of staff and visitors to the Centre. This allocation excludes space for patients long term parking. Three spaces should be provided at the Main Entrance for on-call staff.

The car parking area is that area immediately off the road leading to the main OPD and is bounded by the road and the existing footpath linking the Phase 1 building to the YDU. A footpath linking the car park to the new unit will be required. In addition, a separately identified space should be provided for motorcycles and bicycles.

8 COACHES

Space for at least one coach to park will be required.

9 LIGHTING

The whole parking area should be well illuminated at night.

10 SIGNPOSTING

Sufficient external signposting, directing drivers as necessary will be required.

RESEARCH INSTITUTE

As mentioned in the introduction, a research institute where developments and treatment can be monitored and studied is required. However, in view of the limited financial resources at present, it is suggested that certain clinical research facilities be provided at the same time as the new Unit and that the main research institute be provided when funds are available.

The clinical research facilities which are to be provided as part of the new Centre are two physiology laboratories.

The main research institute will be used by doctors, nurses and remedial therapy staff and will consist of a number of laboratories and other associated rooms. Details have not been formulated but, for development planning purposes, it is estimated that an area of approximately 400m^2 will be required The Institute should be sited in close proximity to the Spinal Injuries Centre, possibly on an upper floor and the present scheme should take account of the needs and location for this future development.

SPECIAL DESIGN FEATURES

1 The whole Unit - Should be designed with the wheelchair user in mind, and detailed fixtures and fittings should be approved prior to permanent fixing. Particular attention should be paid to the guidance contained in "Designing for the Disabled" (Selwyn Goldsmith).

2 Protection of Surfaces - Walls, doors and corners should be protected and surfaces emitting heat must be screened.

3 Ramps - Gradients must be in accordance with "Designing for the Disabled" guidance.

4 Temperatures - The surface temperature of radiators must not exceed 50°C and the temperature of hot water in patient areas must not exceed 40°C.

5 Window sill heights - Generally, the glazing level should be as near to the floor level as possible or, at least, at a height which will allow patients to see outside from a sitting position in a wheel-chair or the lying position in a bed.

6 Doors - The width, position of doors, and door fitments are critical and need to be agreed during the design stage.

7 Mechanically operated doors - Will be required in the main entrance.

8 Light switches - In patient areas light switches should be at suitable level for wheelchair users and those with minimal hand power - suggest rocking switches and require agreement during the design stage.

9 Lifts - Must be capable of taking a bed. Should be fitted with a mirror opposite the entrance. The control panel should be positioned

and fitted at a level convenient to wheelchair users and should be touch operated. A touch operated telephone should also be sited at level usable by wheelchair patients.

10 <u>Telephone booths</u> - These must be specially designed for wheelchair users. The telephone should project far enough from the wall to enable the patient's knees and the chair footrest to slide underneath it.

11 <u>Outside areas</u> - Patios for wheelchairs and beds should be provided together with raised flowerbeds. Where appropriate, balconies should be provided for patients to sit outside. These areas should be accessible via French windows.

ENGINEERING POLICIES AND DESIGN GUIDANCE

1 The Engineering Services are to be designed in accordance with standards and policies defined in the relevant Hospital Building Notes, and Hospital Technical Memoranda and other N.H.S. Technical information which may be brought to the designers attention.

2 Where Main Engineering Services are required to serve the Centre, they will be extended from existing main Hospital Supplies in a manner which will also provide a link for subsequent phases of the Hospital Development.

3 Main Engineering Plant and equipment should, where possible, be concentrated in housing located and designed to allow ease of access and maintenance without interference with the running of the Centre.

4 External Engineering

4.01. Heat Source - A M.P.H.W. boiler-plant provides heat to the recently completed OPD/A & E building via 12" dia. mains at 90 p.s.i.g., 280°F flow and 240°F return. New heating mains will be required to serve the Centre; the size and location of connections are to be agreed.

4.02. Heating and H.W.S. Calorifier plant and controls. Two secondary heating calorifiers are to be provided, each sized at two-thirds load.

Two H.W.S. calorifiers are to be provided having a combined capacity equal to two hours consumption at peak hourly demand and having a heat-up period of two hours.

All circulating pumps are to be in duplicate.

The automatic control system used in the existing hospital is pneumatic. If the extent of automatic controls required

in the Centre does not justify pneumatics, electronic controls are acceptable.

4.03. Cold Water mains, storage and treatment. New mains are to be run to the Centre; the size and location of connections to existing mains are to be agreed. The designer is to determine by reference to the Water Authority whether the mains pressure is adequate for his needs and if necessary provide water pressure boosting plant.

A 24 hours supply of cold water will be stored; this will comprise separate tanks of raw water for down service and treated water for H.W.S.

The designer will determine the water hardness by reference to the Water Authority and provide treatment plant as necessary to satisfy the operational requirements of the H.W.S. system.

4.04. Gas (Domestic). A new mains is to be run to the Centre; the size and location of connection to the existing main is to be agreed.

4.05. Medical Gases.
Oxygen - A new main is to be run to the Centre; the size and location of connection to the existing supply is to be agreed.

Vacuum and Compressed air are required for the Centre, new plant will be required for this. (The design will be in accordance with H.T.M.22).

4.06. Main Electrical Supply.
An 11 KVA supply is to be run from an existing ring-main

unit to a new sub-station designed to serve the Centre with essential and non-essential M.V. supplies.

4.07. Standby Electricity.
The essential supply circuits of the M.V. board in the sub-station will be powered by a diesel generator set.

There will be sufficient diesel oil storage to allow 200 hours running.

4.08. External lighting. All new roads and footpaths will be illuminated by lamp standards which will be photo-electric controlled.

4.09. Telephones. Sufficient spare capacity exists on the PABX equipment to cater for the needs of the Centre. Cabling will be carried out by the Post Office.

4.10. Fire Alarm System. An automatic detector/break glass system will be required in the Centre and alarms must be relayed by cable to the Telephone Exchange and an indicator panel installed there.

4.11. Staff Location System. The existing V.H.F. location system will provide cover for the Centre; additional receivers will however be required - the number will be advised.

4.12. Radio and T.V. Piped radio and T.V. will be required to run from the existing hospital systems; it may be necessary however to boost the T.V. signal locally and this should be determined by the designer.

BUILDING DESIGN AND CONTRACT REQUIREMENTS

1 All aspects of the design, layout and specification shall comply in full with the requirements of the Brief, which comprises operational policies, schedules of accommodation and room data sheets.

No changes shall be made to any aspect of the Brief unless approved in writing by the R.H.A. Project Team on behalf of the Trustees.

2 All aspects of the design, layout and specification shall take account of the type of patients who will be using the new Centre, and the special needs of those patients.

3 The site area for the new Centre shall be as defined by the R.H.A. Project Team and the whole of the requirements for the new Centre shall be contained within the defined area.

4 Where Main Engineering Services are required to serve the Centre, they will be extended from existing Main Supplies in a manner which will also provide a link for subsequent Phases of the Hospital Development.

Information will be provided by the Project Team to enable the designers to fulfil this requirement.

5 All aspects of the design, layout and specification shall comply with all relevant statutory and other regulations and standards.

Particular reference is made to :

Fire precautions

Health and Safety

Energy conservation

Hospital Technical Memoranda

British Standards & Codes of Practice.

The architect shall be responsible for making all necessary submissions and for obtaining all necessary statutory approvals. The only exception will be planning approval, where submission will be made to the Local Authority by the R.H.A. Project Team under Circular 7/77.

The architect will be required to provide the Project Team with the necessary drawings and other information. The submission will be made after agreement of the final sketch plans and before any work starts on site.

6 Sketch plans, together with budget costs, shall be submitted to the R.H.A. Project Team who will arrange meetings involving the Joint Planning Team and architects to consider the plans.

No changes shall be made to the final (approved) sketch plans or budget cost unless approved in writing by the Project Team on behalf of the Trustees.

7 The budget shall include the Works cost, fees and equipment costs.

The equipment cost shall include all fixtures and fittings, including loose furniture as listed and specified on the room data sheets.

8 Following approval of the final sketch plan the architect shall produce detailed room layouts to a scale of 1:50 for each room.

The layouts to include plan and wall elevations and to include all fixtures and fittings, services, furniture etc.

Particular reference is made to patient WC's, showers, bathrooms, and washing cubicles where the layout, detail, specification and

8 (contd)

selection of fittings will be the subject of a special exercise and where full size "mock-ups" will be required to determine the exact requirements.

9 The contract for the Works shall be between the Trustees (as the Employer) and the selected contractor.

The architect shall advise the R.H.A. Project Team of the form of contract proposed.

10 The architect shall write into the contract certain constraints on the contractor concerning :

Site area and fencing

Access

Parking for contractor's staff

Canteen and other facilities

Allowable noise levels

Fire precautions

Water, Gas and Electricity for the Works

Telephones

Interruption to hospital engineering services

Insurances

Disposal of spoil.

A copy of the RHA Standard Preliminary Clauses can be obtained from the Project Team, but the detailed requirement of each of these constraints shall be the subject of discussions between the R.H.A. Project Team, architect and AHA representatives.

No contract shall be let, and no work allowed to start on site, until these requirements are agreed and written into the contract.

11 During the period of the contract works on site, no instructions shall be issued which change any aspect of the Brief, the final (approved) sketch plan or the approved cost, unless approved in writing by the R.H.A. Project Team on behalf of the Trustees.

12 A model of the final scheme will be required to help convey to both patients and interested parties the concept of the new Centre. It will also be of use for fund raising purposes.

SUMMARY OF SCHEME CONTENT

1 NEW ACCOMMODATION FOR SPINAL INJURIES CENTRE

	Gross Area (to nearest $5m^2$)
Acute Nursing Care and Admission Area	315
High Dependency/Intermediate Dependency Areas	1335
Self Care/Low Dependency Area	545
Surgical Re-admission Ward	630
Medical Re-admission Ward	650
Follow up/Short stay/Day patients re-admission area	465
OPD	395
Administration/Main Entrance	465
Whole Unit Accommodation	1300
Clinical Support Services	820
Peripheral Kitchen and Patients Dining	380
Total	7300

2 ASSOCIATED EXTERNAL WORKS

Main Vehicular Access

Ambulance arrival bays and parking spaces

Main Entrance car parking facilities for patients and staff (6 places)

Centre car parking (for 120 cars)

Vehicular Access for stores

Road link east of New Wing

Road link between helicopter pad and new Centre

Footpath between car park and Centre

Link corridors to New Wing and Old Wing

Paved outside areas and balconies

3 CONSEQUENTIAL REPLACEMENT RESIDENTIAL UNITS

Residential (Scale A) Units - 30 ($720m^2$)

Reference 1 L A

1 L P

1. Miss Winterton B517
2. Mr Myers B510
3. Miss Dyer } 1116 HH
4. Mrs Grove }
5. Miss Baddiley C202

RNOH SPINAL UNIT

You will be interested in this letter from Mr Kemp. I have not been able to ascertain the reasons for Dr Frankel writing to the RNOH on 16 July.

FRANK TAIT
Med CP1
B1111 AFH

28 July 1980

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CODE 18-78
(E.A.P. 4/78)

01-935 2776

107 HARLEY STREET
LONDON, W1N 1DG

WITH THE COMPLIMENTS OF

MR. HUGH KEMP

the Spinal Injuries Unit at Stanmore there has been very close liaison with the DHSS and Dr. Frank Tait has been actively involved.

As you know, we appointed a Consultant last night as an Orthopaedic Surgeon and as Director of the unit and I feel sure you will be pleased to know that the successful candidate was Mr. Ian [illegible]. I believe you already know him and I feel sure that as a result of this appointment there will be a very close co-operation between the RNOH and Stoke Mandeville.

We will of course be very grateful for your continued interest and help when it has started to function.

Yours sincerely,

Hugh Kemp, M.S., F.R.C.S.,
Consultant Orthopaedic Surgeon

c.c. Mr. T. Ferguson, Chairman of the Board of Governors
Dr. Frank Tait, DHSS

MR. HUGH KEMP

TELEPHONE
01-935 2776

107, HARLEY STREET,
LONDON, W1N 1DG

HCK/EAW

23rd July, 1980

Dr. H. L. Frankel, M.B., F.R.C.P.,
Consultant in Spinal Injuries,
Stoke Mandeville Hospital,
Aylesbury, Bucks.

Dear Dr. Frankel,

Thank you for your letter of 16th July, 1980. It was extremely kind of you to take the trouble to write to me and obviously I brought the letter to the attention of my colleagues. As you know, during the whole of the planning of the Spinal Injuries Unit at Stanmore there has been very close liaison with the DHSS and Mr. Frank Tait has been actively involved.

As you know, we appointed a Consultant last night as an Orthopaedic Surgeon and as Director of the Unit and I feel sure you will be pleased to know that the successful candidate was Mr. Ian Bayley. I believe you already know him and I feel sure that as a result of this appointment there will be a very close co-operation between the RNOH and Stoke Mandeville.

We will of course be very grateful for your continued interest and help when it has started to function.

Yours sincerely,

Hugh Kemp, M.S., F.R.C.S.,
Consultant Orthopaedic Surgeon

c.c. Mr. T. Ferguson, Chairman of the Board of Governors
Mr. Frank Tait, DHSS

PG

Mrs Petrie - Subject to your comments

Mr Collier

NSIC: POSSIBLE APPLICATION FOR EEC FUNDS

Your request for advice on Dr Frankel's idea to seek EEC funds for a research institute at Stoke Mandeville has found its way to me, so I am sending you a reply co-ordinating the views expressed en route by IR Division, FA and SH2. There are two main strands to the comments: the state of development of the research institute idea and the effect on available financing for other priorities if we succeed in obtaining EEC funds for the NSIC.

On the first, you know from Dr Frankel that he had made little or no progress so far in contacting a university or institute to discuss a possible link with the proposed unit at SM. SH2 feel that it is essential they have an academic link worked out before any attempt is made to obtain funding for it - from whatever source, but especially from the EEC. It would certainly be essential in making a case for funds to be able to show that the proposed institute had firm and reputable academic backing. The initiative for ~~foregoing~~ forging such a link will have to come from the NSIC itself, not from the Department.

SH2 have some vague recollection of the NSIC making an approach to Oxford some years ago for a link and being rejected. If this was indeed the case, it may have been at the back of the consultants' minds, and the fear of a further rejection may have pushed them to try to secure EEC backing to impress the universities when they make their case for a link-up.

The procedures for receiving grants from EEC funds are dictated by the Treasury. As you probably know, any money which comes from that source goes direct to Treasury and is subsumed in the budget. The money is earmarked for the purpose for which it is given but there is no net increase in public expenditure as a result of it: it merely offsets public expenditure. The outcome is SM's case might well be to protect the NSIC at the expense of some other unit to which we and the health authorities attach greater priority. In its present state I do not think we would want to give the NSIC such advantages, though we may have a change of heart with the passage of time.

At the moment, at least, an approach to the EEC for funds would probably be futile. The best solution appears to be to put the onus back on to the NSIC to work up their ideas for a link with an academic institution and their plans for the work of the proposed research institute. (They will need to do this whether or not they look to the EEC for funding). It will give us a breathing space and save any fruitless work within the Department. When the NSIC has organised itself, if it still wants to try for EEC funding we may be in a better position to help.

Assuming that you agree this line. I am attaching a draft reply to Dr Frankel for you consideration.

Julie Sutch

Mrs J Sutch
Room 1515 Ext 347
Euston Tower

11 July 1980

cc Mrs Firth, Mrs Petrie, Dr Tait, Mrs Fosh, Mr Lillywhite, Mr Seabourne, Miss Winterton

PG

Dr H L Frankel MB FRCP
Consultant in Spinal Injuries
National Spinal Injuries Centre
Stoke Mandeville Hospital
Aylesbury
Buckinghamshire HP21 8AL

As promised in my letter of 22 May I have sought views within the Department about your idea of getting EEC funds for the proposed research institute.

There are apparently sources of funding within the EEC which cover the sort of thing you seem to have in mind for the institute. As you might expect there are many demands on the available money, and no very encouraging signs that funds are at all easy to obtain. Given that, the case for any application made will need to be carefully considered and presented to have any chance at all of succeeding.

I am not sure exactly how far you have gone with the idea of a research institute other than what you said at the Liaison Group meeting, so it is difficult to be specific about the next steps, but what does seem essential is for you to have a link with a recognised academic institution firmly established and your research aims clearly defined and agreed before you take the idea of an application to the EEC any further. When you are satisfied that you have done all that is necessary and are ready to go ahead, our EEC experts in the Department will be happy to guide you through the procedures and help you on your way.

AJC

Mr Seabourne
IR1

NATIONAL SPINAL INJURIES CENTRE: POSSIBLE APPLICATION FOR EEC FUNDS

In Mr Sturges' minute of 11 June, you sought an RL view on the desirability of pursuing the possibility of EEC funding for the NSIC at Stoke Mandeville. Miss Winterton (SH) and Dr Tait also have an interest in this, and we have consulted them.

At present the idea of a research institute at the NSIC is at the very earliest stage: the desire of the consultant staff there has been established, but no action has been taken either to obtain ties with a recognised academic institution or to formulate terms of reference or coherent research plans. The time to consider seriously any application is therefore some way off and a decision about the desirability or wisdom of making a case for the NSIC need not trouble the Department yet. This gives us a welcome breathing space and spares us a decision which might be rather uncomfortable for us to take in public in the present circumstances!

I have sent a minute to Mr Collier outlining the case as we see it in RL and SH2, and a reply for him to send to Dr Frankel, both of which are copied to you. Subject to Mr Collier's views suggest we leave the matter there for the time being.

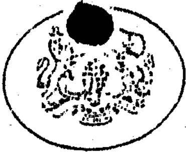
Julie Sutch

Mrs J Sutch
RL1
Room 1515 Ext 347
Euston Tower

11 July 1980

cc Mr Collier
Mrs Firth
Mr Lillywhite
Mrs Petrie
Dr Tait
Miss Winterton
Mr Fosh
Mr Sturges

127. 204/3 128.



DEPARTMENT OF HEALTH AND SOCIAL SECURITY
EUSTON TOWER
286 EUSTON ROAD
LONDON NW1 3DN
TELEPHONE 01-388 1188 EXT 347

9 JUNE 1980 AT DHSS

Your reference
Our reference

11 July 1980

To: Members of the Stoke Mandeville Liaison Group.

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I am enclosing a copy of the minutes of the meeting on 19 June.

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Yours sincerely

Mr Myers

Mrs J Sutch
Secretary

Miss Winterton – for information
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it was placed above the service unit the architects would have to know this before starting on the foundations of the service block. Mr Roberts undertook to ask the Regional staff to identify options for siting the research unit, to produce some costings and to report back to the Group.

NOTE OF MEETING OF THE STOKE MANDEVILLE LIAISON GROUP ON 19 JUNE 1980 AT DHSS (ALEXANDER FLEMING HOUSE)

Present: Mr A J Collier (Chair)
Dr H Frankel
Lady R E Mallalieu
Mrs P Petrie
Mr G Roberts
Mr R Titley
Miss M T Sweeney (A/Secretary)

Apologies had been received from Dr Rue.

1. Minutes of meeting on 27 February 1980.

Dr Frankel's suggested amendment to paragraph 3 ii. of the minutes was considered and accepted on the basis that it expressed the long term aim rather than the immediately obtainable position. Para 3 ii. would now read "Small children should be cared for in the Children's Department which should be adjacent to the spinal unit."

2. Progress

Mrs Sutch had circulated a paper (LG/SM/I)

Lady Mallalieu reported that the contractor was anxious to press ahead, but wanted an identified "client" to deal with. (See also para 4 below). Mr Collier reported that a Trust Deed had been drafted and was being referred to Trust Deed Lawyers. It would be circulated to the Liaison Group as soon as possible. Mr Collier noted the concern of the NHS representatives that any contract signed by the RHA as agents of the Trustees would ultimately have the backing of the DHSS.

3. Design Brief

The Group considered the design brief which had been circulated. There was general agreement that the project team had done an excellent job. There appeared some scope however, for pulling back a little on space requirements without affecting the agreed functional content of 120 beds. To this end, Mr Collier would write to Mr Roberts, thanking the Project Team for their work, and asking the Region to consider with the Project Team a greater flexibility in the use of space, particularly in the non service areas. A site control plan was essential and Mr Titley said this would be available shortly. The siting of a research institute was briefly discussed. If it was placed above the service unit the architects would have to know this before starting on the foundations of the service block. Mr Roberts undertook to ask the Regional staff to identify options for siting the research unit, to produce some costings and to report back to the Group.

Dr Frankel reported that he had had informal contacts with London University about a research institute, but that it was too early to do much on this front at this stage.

The Liaison Group agreed that once the design brief had been finalised and approved, there should be no second thoughts or interventions during the construction of the unit.

4. Responsibilities and Roles

A paper had been drawn up by the Department, at the Region's request, and had been circulated (LG/SM/2). The suggestions in the paper were acceptable but the Region would like to see the Department standing behind the Region firmly on matters of contract and construction of the unit. Ideally, the responsibility should be shared, and Mr Collier accepted this.

A meeting between DHSS and the Region had taken place on 8 May to discuss the building procedures to be followed in the Stoke Mandeville project. The following were identified as requirements:

a. a development control plan;

b. a statement of functional content;

c. revenue cost estimates;

d. budget costs.

Lady Mallalieu raised the question of the ownership of the Spinal Unit when it was completed. She considered it essential that the Unit should be run as an integral part of Stoke Mandeville District General Hospital and that there should be no restrictions enforced on the AHA in relation to the Spinal Unit which might prejudice the provision of health services in other parts of the hospital or district. Mr Collier confirmed that this would be so, and that the intention would be to provide for ownership in such a way that the AHA would continue to run the spinal unit in the normal way; whilst the matter was important, it did not require an immediate decision - it could be deferred for more detailed consideration by the Trustees and others in due course.

5. Any Other Business

Lady Mallalieu said that the AHA would arrange a small reception to thank the voluntary workers for their assistance. The cost would not be taken from the funds collected for the spinal unit, but be met by the AHA.

DH Document 07. Page 230

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Colonel A N Brearley-Smith
Director
Action Research for the Crippled Child
Vincent House
Springfield Road
HORSHAM
West Sussex
RH12 2PN

17 June 1980

Dear Andrew

Thank you for your letter of 21 May about the future of the National Spinal Injury Centre at Stoke Mandeville. I apologise for my delay in replying.

As you are, no doubt, aware, Stoke Mandeville is at present the only spinal unit in the South of England. The Department has given much thought to ways of correcting this uneven geographical distribution of beds, and we are at present increasing the level of service provision from one to three units in the southern half of the country. Planning is at advanced stage on new units at the Odstock Hospital, Salisbury, and the Royal National Orthopaedic Hospital, Stanmore and it is hoped that they will become operational in the early 1980s.

The cost of the new units is being met entirely from NHS funds, and this represents a high level of investment in the present difficult financial climate. In the face of many competing claims for other equally urgent developments, we are unable to increase further the already substantial funds available to the spinal injury service for the next few years. This means, that despite its present unsatisfactory state, Stoke Mandeville has to receive a lower priority than we would wish. It is therefore very important that until the new units at Odstock and Stanmore are operational, the vital service provided by Stoke Mandeville is maintained at its present level.

You will be well aware of the appeal launched by Jimmy Savile to raise funds to rebuild the unit. The Department has welcomed this campaign, which is seen as an example of the type of partnership between the Government and the public which has much to offer. It is hoped that it will enable the Stoke Mandeville unit to be rebuilt very much sooner than would have been possible if it were necessary to await the availability of NHS funds.

I have enclosed copies of recent Press Releases on Stoke Mandeville and Jimmy Savile's campaign which may be of interest to you. I hope that this will help to clarify the present situation for you.

Yours sincerely

Doreen Rothman

CH

1080

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Mr S Bradshaw
Director
Spinal Injuries Association
5 Crowndale Road
LONDON NW1

June 1980

Dear Mr Bradshaw

You were promised a progress report on the Stoke Mandeville appeal by Pamela Petrie: here it is. I hope it covers the points which you and your members would wish. There has been a good deal of publicity in certain newspapers lately which they may well have seen.

If you need to know any more, or just want to be kept in the picture, please give me a ring any time.

Yours sincerely

Mrs J Sutch

cc ~~Mr [illegible]~~ Mrs [illegible] for the file pl.
(I think it would be a good idea to circulate copies to Mrs [illegible] + C.G.T? [illegible])

[illegible] begin to clear the site for the new unit. There will be national TV and press coverage.

The building scheme

The design brief for the new unit is complete and will shortly be [illegible] to the consultant architects, the Fitzroy Robinson Partnership, for their [illegible]

STOKE MANDEVILLE: NATIONAL SPINAL INJURIES CENTRE

RE-BUILDING APPEAL

The appeal to raise funds to rebuild the NSIC at Stoke Mandeville was launched on [illegible] January, and received an immediate, favourable response from all sections of the community.

Donations

The donations are being received by the Buckinghamshire AHA pending the establishment of a separate charitable trust. They have received [illegible] of donations of varying amounts. The appeal has been "adopted" by [illegible] Holts car products and Ski yogurt, the [illegible] of England [illegible] Society and, not least, the Daily Express. The Daily [illegible] has received donations amounting to over £[illegible],000 in 4 weeks, and an offer from an industrialist to match whatever they raise up to a maximum of [illegible].

The building industry has become interested in Stoke Mandeville, [illegible] have offered to supply materials free or at cost.

Publicity

As well as coverage in the Daily Express and its sister newspaper, the [illegible], local press coverage is very encouraging, and [illegible] spreading throughout the country with reports of local groups who have raised funds for the appeal. A number of local radio stations in the N east and S west have devoted broadcasts to the Appeal. The next large-scale publicity event will be on 16 June when the demolition contractors will begin to clear the site for the new unit. There will be national TV and press coverage.

The building scheme

The design brief for the new unit is complete and will shortly be [illegible] to the consultant architects, the Fitzroy Robinson Partnership for their

to begin their work. Trollope and Colls will be the main contractors for the building.

<u>Trustees</u>

The establishment of a separate Trust fund is in hand, but it is not known when this will come into being.

Mrs Salker. 10A UNIT
P1. file.
A copy might also go on the Sidcup file
SW 2/5

Dr Tate. If you agree

Mr Myers ✓ Mrs Aitken ~~Mrs~~ Miss Winterton is dealing with this (∴ no need for any action by you in my absence on A/L) J Myers 1.5.

STOKE MANDEVILLE APPEAL. MINUTE FROM MRS PETRIE DATED 25 APRIL

1. The matter of the fourth unit is sufficiently important to make it imperative to attempt to resolve; the disagreement. Mrs Petrie accepts so easily in the third paragraph of her minute.

2. After discussion with SH Mr Suckling wrote to the SE Thames Regional Administrator and said "I can now confirm that we welcome in principle the establishment of a 50 place unit at Queen Mary's as part of the over-all long term strategy for providing a network of centres.........it is unlikely that funds will be available within the current strategic planning and it may well be 1990 I imagine before planning can be completed" (my underlining).

3. I find it diffiult to reconcile this with the statement in Mrs Petrie's draft letter which puts the 4th unit clearly in the present;" we are at present increasing the level of service provision in the southern half of the country and developing a pattern of services centred on not one, but 4 Units". The next sentence referred only to Odstock and RNOH but the clear impression is given (and I am sure intentionally) that we are currently engaged in devloping four units and this is not true.

4. I can accept that times have changed but the changes will I hope be restricted to matters of style rather than to morality. If the fourth unit is mentioned then it must be made clear that this is a long term plan and that planning (yet alone operation) for this Unit is unlikely to be completed for another ten years.

Frank Tait

FRANK TAIT
Med CPl
B1111 AFH

30 April 198o

cc Miss Winterton

UNI 15
9A

Mrs Althaw Mr [illegible] Mrs Salter.
Pl. file.
[illegible] 29.4
80 2/5

Mr ~~B~~ Myers
SH2C
B510 AFH

STOKE MANDEVILLE APPEAL

Thank you for your minute of 22 April commenting on the draft letter to Lord Armstrong.

There have been further developments in the stratosphere, and the whole business of a reply is now under revue. Your comments were, in the main, extremely helpful and I will keep them in mind and keep you in touch with further developments.

I think we shall have to disagree about whether or not the fourth unit should be mentioned in any public context. Since the proposal featured in the South East Thames Regional Plan (which is a public document), the Department was obliged to make some sort of response. RL cleared its lines with SH about how this should be done, and my reference in the draft letter is entirely consistent with the line Mr Bebb agreed towards the end of last year.

You mentioned that you did not like the reference to Jimmy Savile's concern about the deteriorating environment at Stoke Mandeville, but the point is that the Appeal is a joint effort sponsored by Dr Vaughan on behalf of the Secretary of State, and by Jimmy Savile; and it results from mutual concern about the condition of the Spinal Unit.

The Stoke Mandeville Appeal has brought into sharp focus the need to move with the times. If it is a bit strong to refer to the "Banks' image" in a letter (a reference which was inserted incidentally by the Minister), you would be very surprised to learn of the extent to which those of us directly concerned with the Appeal have had to rethink the traditional Civil Servant role in order to serve present Ministers. Times have really changed.

I am copying this minute to Mrs Sutch so that she can keep you in the picture as the Appeal moves forward. For the present, there is some doubt about whether a reply is to go to Lord Armstrong. *

* Doubt now removed. No reply going.

Pamela Petrie
RL1
Room 1532/Extn.884
Euston Tower

25 April 1980

Copied to: Mr Scott Whyte Dr Tait
Mrs Sutch

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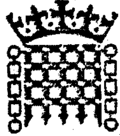
Research Assistant:
Raewyn Stone



01- 219 5472
01- 637 5400 ext. 210

with the
compliments of

ALL PARTY DISABLEMENT GROUP

Please find enclosed minutes of meeting which I will continue to send to you as I did to Gerrard Bebb

I hope you will find them of interest.

HOUSE OF COMMONS
LONDON SW1A 0AA

Sincerely
Raewyn Stone

Countess of Loudoun,
Bill Walker, MP., Hugh
and Raewyn Stone.

alth Authority, Mr.
alist in Community
Titley, District
rs. H. Frankel and
Mr. S. Bradshaw,

cy de Knayth, John

to matters arising.

Wednesday 11 June.
Chronically Sick and
ciation for Disability
and Rehabilitation, Spastics Society, Disability Alliance, OUTSET, Age Concern and other major disablement organisations. The aim of the lobby was to draw attention to the fact that personal social services for disabled people provided under the Act were being disproportionately affected by cuts in local authority spending. Mr. Ashley said he hoped members of the Group would support the lobby and urge their colleagues to meet any of their constituents who attended it.

3. Mr. Ashley welcomed the representatives from Stoke Mandeville and said that all involved with disability were aware of the importance of the work in rehabilitation carried out at the Unit. Lady Mallalieu conveyed the apologies of Mr. I. Neuseibeh,

.../...

MEETING OF THE ALL PARTY DISABLEMENT GROUP ON TUESDAY 15 APRIL 1980 WITH REPRESENTATIVES FROM THE SPINAL INJURIES UNIT AT STOKE MANDEVILLE HOSPITAL, OXFORD REGIONAL HEALTH AUTHORITY AND BUCKINGHAMSHIRE AREA HEALTH AUTHORITY.

Present: Rt. Hon. Jack Ashley MP (Chair), John Hannam MP, Countess of Loudoun, Lord Segal, David Price MP, Michael Neubert MP, Bill Walker MP, Hugh Dykes MP, Richard Alexander MP, Tony Newton MP and Raewyn Stone.

Representatives from Stoke Mandeville:
Lady Mallalieu, Chairman, Buckinghamshire Area Health Authority, Mr. R. Bearne, Treasurer AHA, Dr. H. McNeilly, Specialist in Community Medicine, Oxford Regional Health Authority, Mr. R. Titley, District Administrator, Aylesbury and Milton Keynes AHA, Drs. H. Frankel and J. Silver, Consultants at the Spinal Injuries Unit and Mr. S. Bradshaw, Director, Spinal Injuries Association.

Apologies were received from Baroness Masham, Baroness D'Arcy de Knayth, John Patten MP, Lewis Carter-Jones MP and Alf Dubs MP.

1. The minutes of the last meeting were approved and there were no matters arising.

2. ACT NOW Campaign

A mass lobby of Parliament by disabled people was planned for Wednesday 11 June. The lobby was being organised by the Campaign to Defend the Chronically Sick and Disabled Persons Act 1970 and was supported by the Royal Association for Disability and Rehabilitation, Spastics Society, Disability Alliance, OUTSET, Age Concern and other major disablement organisations. The aim of the lobby was to draw attention to the fact that personal social services for disabled people provided under the Act were being disproportionately affected by cuts in local authority spending. Mr. Ashley said he hoped members of the Group would support the lobby and urge their colleagues to meet any of their constituents who attended it.

3. Mr. Ashley welcomed the representatives from Stoke Mandeville and said that all involved with disability were aware of the importance of the work in rehabilitation carried out at the Unit. Lady Mallalieu conveyed the apologies of Mr. I. Neuseibeh,

.../...

Chairman of the Consultants at the Unit and said that if any individual MPs wished to visit the Unit this could be arranged.

4.1 Mr. Frankel then gave the background to the Unit and its present problems. The Unit had been established in 1944 by Dr. Ludwig Guttmann and incorporated into the National Health Service in 1952. Fifty per cent of the Unit's patients were from road accidents and the remainder from industrial and sporting accidents and spinal diseases. There was no known cure for a spinal injury which severed the spinal cord, therefore, about one half of the patients had no organic improvement and the others suffered varying degrees of incapacity. The aim of the treatment was to achieve the maximum rehabilitation possible and to prevent further degeneration. The severe impairment of bodily functions caused by spinal injury often led to other problems such as pressure sores, urinary tract infections and depression. To prevent this the patient must receive adequate treatment immediately after the accident.

4.2 From the end of the War until 1966 the maximum size of the Unit was 196 staffed beds. This had now decreased: in 1978, 156 beds; 1979 100 beds and in 1980 140 staffed beds for the whole of Southern England. Mr. Frankel said that this provision was quite inadequate both for the number of admissions required and for follow up care. Standards had already been cut to the minimum. Other spinal units were planned at Sidcup (60 beds), Odstock (50 beds) and Stanmore (24 beds) but no progress had been made in constructing them.

4.3 Mr. Frankel said that the Unit's most urgent problem was the state of its buildings which were in an extremely delapidated state and should have been replaced ten years ago. There were now adequate numbers of staff available but financial contraints against employing them. A better level of staffing was necessary to enable the Unit to take more new patients as many were not receiving treatment quickly enough after the accident.

5.1 Dr. Silver discussed the work of the Unit in relation to current trends in medicine and future needs. He said that concepts of treatment had changed and, ideally, every patient should come back to the parent unit for regular checks. As Stoke Mandeville was the only unit in Southern England this was impossible. The result was that many of the Unit's patients were not receiving the regular check-ups which were essential to achieve maximum rehabilitation. There was also a need for better investigatory and treatment facilities. In addition, patients now expected more in the way of preventative measures such as decent housing, visits by social workers, but the numbers of social workers and support services were quite inadequate.

5.2 Dr. Silver said that a post-graduate research centre should be established at the Unit to ensure that Stoke Mandeville retained its leading position as a centre for treatment and research. It was hoped that the new unit of 120 beds planned at Stoke Mandeville would incorporate a research centre but there was no money available for the revenue consequences of the centre and assistance from the NHS would be necessary.

6.1 Mr. Bearne then outlined the financial problems of the Unit. The fundamental problem was that the Unit was competing for finance not only with existing services but in an area of rapidly expanding population where all new finance was tied to specific programmes such as the community hospital at Milton Keynes. Early in 1979, after the Buckinghamshire AHA had been given its resource assumptions it had produced a skeleton plan which indicated that, provided the AHA was allowed to go into debt, it could recover its position after three years and still open the new district hospital at Milton Keynes. However, the change of Government and subsequent requirement on AHA's to live within cash limits had forced cuts in services which had to be applied evenly across the specialist services.

7. There was then a discussion on the points raised. Mr. Price had two questions. The first was whether there was a fundamental dichotomy in Stoke Mandeville being a specialist unit in a district general hospital at the same time providing a national service and should the Unit be expected to service all of Southern England or only its Regional Health Authority area? Dr. Silver replied that he had come from a small spinal injuries unit in Liverpool which served only the Merseyside region. The benefits of such a small discrete unit was that it was easier for people to visit patients, there was a close relationship with hospitals in the region and more could be done socially for the patient. Dr. Silver said that spinal injury units should be organised on a regional basis with no patient having to travel more than sixty miles. Mr. Frankel agreed saying that 50-60 bed units were necessary to ensure adequate treatment and least travelling. However, the unit at Stoke Mandeville should be doubled in size and include a research centre as well as establishing other units in Southern England.

8.1 Mr. Price then asked what was the optimum maximum and minimum size of a unit? Dr. Silver replied that the minimum was 60 beds with two consultants and supporting staff and 120 beds the ideal double unit. At present, with 140 beds, Stoke Mandeville was not providing adequate follow-up and only admitting a very few cases of multiple sclerosis and other spinal diseases.

8.2 Mr. Hannam asked if there was not a problem of providing an adequate follow-up service for a double unit? Mr. McNeilly said that the plan was that the double unit at Stoke Mandeville would service the Oxford, East Anglian and North Thames regions and the other new units the rest of Southern England and this would ensure an adequate follow-up service.

9.1 There was then further discussion about finance. Mr.Hannam enquired whether the Unit had had discussions with the Minister about securing a broader-based source of finance? Dr. McNeilly replied that under the Resource Allocation Working Party (RAWP) formula Stoke Mandeville had been allocated additional funds for taking patients from other

.../...

regions but had not been allocated NHS funds as a centre of excellence and this additional finance was required if the Unit was to continue as a centre of expertise.

9.2 Lord Segal asked if the Unit had approached private sources for funds? Lady Mallalieu replied that a substantial amount was being raised by the Jimmy Saville Spinal Building Appeal Fund but this was only to provide new buildings and would not solve the problem if the revenue consequences of a double unit and research centre.

9.3 Mr. Hannam asked exactly what amount of money was required? Mr. Bearne replied that for 1979/80 £32 million had been allocated to Buckinghamshire AHA and this was £750,000 less than required with no provision for development. A minimum of £500,000 a year extra was needed merely to provide an adequate level of staffing at the Unit. According to the target allocation set by the Oxford Regional Health Authority (based on the RAWP formula), Buckinghamshire AHA was below its target allocation by 3.96%, a deficit of £1,750,000 and there was little prospect of the AHA reaching its target of 2½% below. Dr. McNeilly said that the problem was that the population of the Buckinghamshire AHA was increasing by 800,000 each year, a 15% increase over the next 15 years but the finance for the additional health services required had not become available until 2 years after the matching increase in population.

10.1 Mr. Walker asked if it was not the case that there were Royal Airforce spinal injuries units in the area which took NHS patients and, therefore, there were other facilities? Mr. Frankel said that this was so but there were mainly rehabilitative units and there was a problem if patients became critically ill.

10.2 Mr. Alexander followed up this point by enquiring whether Stoke Mandeville was the national centre? What was the situation in the North and Midlands where there was the problem of mining accidents? Mr. Frankel replied that there were excellent units in Sheffield, Southport, Ostwestry and Wakefield and patients from the North only rarely had to come to Stoke Mandeville. Dr. McNeilly commented that in fact the North was slightly better off with 7.6 spinal injury beds for million population compared with 6.5 beds in the South.

10.3 Mr. Hannam then asked if the other units were adequately financed by their AHA's? Dr. Silver said that they did receive more generous funding and this was largely because they were small, discrete units with which local hospitals felt closely identified but Stoke

.../...

Mandeville drew on so many different areas there was not the same identification.

11.1 Mr. Price said that Dr. Silver's comment had brought the discussion back to Stoke Mandeville's fundamental problem of being a specialist unit within a district general hospital within an AHA with the problem of a rapidly expanding population and inadequate financial resources. Mr. Price suggested that Stoke Mandeville might require special treatment; for instance, should there be a surcharge on the Southern region or the NHS to help fund the Unit? Mr. Bradshaw replied that in a letter to an MP dated 12 March 1980 the Minister, Sir George Young, had stated that if Stoke Mandeville was given a special treatment then other specialist units would demand the same. However, Mr. Bradshaw did not think that this was a valid arguement as there was no other super-regional specialist unit like Stoke Mandeville. Dr. McNeilly said that, in fact, the DHSS had accepted this point and there was a working group looking at the whole problem of super-regional specialities.

11.2 Mr. Hannam said that he could envisage the Government allocating additional resources to cover Stoke Mandeville's super-regional service and for the research centre but was unlikely to accept that it should be funding the normal running costs of the Unit which was the responsibility of the AHA as was the case with the units in the North. Dr. McNeilly replied that the units in the North were much smaller and did not have the expensive intensive facilities and expertise of Stoke Mandeville and they had received preferential treatment under the RAWP formula. However, it was hoped the problem of normal running costs would be overcome when the financial position of Buckinghamshire AHA improved but additional finance was urgently need to establish a research centre.

12. Mr. Ashley said that the All Party Disablement Group had been presented with a profoundly disturbing situation and would do all it could to assist the Unit.

The next meeting of the All Party Disablement Group will be on Tuesday 29 April at 5.30 p.m. in Room W1 with the Executive Director of the Muscular Dystrophy Group of Great Britain to discuss:

(i) the provisions of outdoor electric wheelchairs;

(ii) the role MPs can play in encouraging the establishing of voluntary branches.

Reference .... Mrs Salter
Mr Williams
Mrs Aitken
to see + file pl
22.4

Mr Scott Whyte

STOKE MANDEVILLE APPEAL

Please see Mrs Petrie's minute of 21 April to Miss Winterton.

I have discussed Mrs Petrie's draft reply to Lord Armstrong with Dr Tait and we have suggested a number of amendments. I attach a copy of Dr Tait's minute of 22 April on this subject.

There are two important points of substance in the draft reply which Dr Tait and I feel should be omitted. One is the reference to a fourth spinal unit in the South of England. There are no definite proposals for a fourth unit and whilst we have Ministerial approval in principle to plan in the longer term for a unit at Sidcup, it would be premature and potentially embarrassing to reveal these plans at this stage. The second is the reference to Jimmy Savile's concern about the deteriorating environment at Stoke Mandeville. It does not seem appropriate for the Minister to refer to Jimmy Savile's concern about the state of an NHS hospital. Any concern expressed should surely be his (ie the Minister's).

I attach a revised version of Mrs Petrie's draft which incorporates Dr Tait's and my suggestions. I would be grateful for your views before I reply (in Miss Winterton's absence) to Mrs Petrie.

R Myers

R MYERS
SH2C
B510 AFH
Ext 6411

22 April 1980

cc Dr Tait
Miss Winterton (o/r)

Mrs Myers.

Thank you. I agree entirely on both main points (and, in general, much of the revised draft).

22/4

Note:
Copy of above minute and revised draft reply sent to Mrs Petrie 22.4.80. R Myers.

CODE 12-77

I entirely agree with Dr. Tait's minute
[illegible] Tate 22/4.

1. Dr Tate If you agree

2, Mr Myers.

MINUTE FROM MRS PETRIE. DRAFT LETTER TO LORD ARMSTRONG.

1. The purpose of this second letter(and I must say I find the initial letter with its immediate refernce to the Banks image an odd communication from a Minister) is to inform the Joint Appeals Committee of the Clearing Banks that the NHS is not neglecting the spinal injury service.

2. The first page of the letter makes this point . ~~It~~ It seems to me to be quite inappropriate for Minister to communicate to the Banks Mr Savile's concern about the deteriorating environment of Stoke Mandeville ; this is for Mr Savile himself. I would suggest therefore that the first line of the second page leads direct ly to the last paragr aph.

3. We cannot discuss the larger strategy for the South of England; the 4th unit is not yet a gleam in anyone's eye. I suggest the 3rd paragraph reads ;*

"To overcome these problems we are at present increasing the level of service provision in the southern half of the country. Work is already underway on ~~xxxxxxxxxxxxxxxxxx~~ New Units at Odtsock Hospital, Salisbury, and the RNOH, Stanmore, and the cost of these units, which is being met entirely from NHS funds, represents a high level of investment in the present difficult financial climate. The amount of money available to the NHS is of course limited, and in the face of many other competing claims for other equally urgent developments we are unable to incrase the already substantial funds available to the spinal injury service for the next few years. "

4. I wouldbe very glad to join RL in discussion of these points if they wish.

Frank Tait

Frank Tait.

22.4.

VP/L

157/. 5A

Miss Winterton
SH Division

STOKE MANDEVILLE APPEAL

With encouragement from the PM, MS(H) wrote to the Governors of the clearing banks inviting them to support J Savile's Stoke Mandeville Appeal. Individually the Banks replied that they would refer the matter to their Joint Appeals Committee and we have now had a further letter from Lord Armstrong. (Copies of correspondence attached).

It is not clear whether he is replying on behalf of the Appeals Committee or speaking only for the Midland Bank and I am looking into this. The main point is that he has declined to help on the grounds that he does not see why the Bank should do what the Government is not prepared to do ie rebuild Stoke Mandeville.

On referring back to the letter originally sent to Lord Armstrong it is possible to understand how he came to interpret the Minister's approach in this way, but their understanding is so far from representing the true situation regarding Spinal Unit services as a whole that I feel we should clarify the position. To allow things to stand as they are is damaging to both sides, it ignores successive Government s efforts in recent years and it would be extremely bad for the Bank's image if Lord Armstrong's reply got into unsympathetic hands, it is worth re-calling that not all the individual's involved in the Appeal are governed by the OS Act. Mr Collier asked me to draft a reply to Lord A and your views on the attached draft letter, (which will be for Dr Vaughan's signature), would be welcome; it seeks to demonstrate that considerable amounts of public funds are being invested now in the development of Spinal services and, whilst this does not involve the immediate rebuilding of Stoke Mandeville, the units under construction are intended to help with two of Stoke Mandevilles current problems (its huge catchment area and increasing demands). After that it becomes a matter of competing priorities. I suggest that there is not too much to be apologetic about in all this.

May I suggest that we need not be quite so "jumpy" in writing to the Midland Bank about outlining a "strategy" for spinal services in the southern half of England as we would be if we were writing to, eg the medical establishment? In speaking about 4 separate Spinal Centres the draft attached anticipates a favourable outcome to the formal consultations with medical and other interests which, I understand, have still to take place. But I do not think there are any real doubts as to the outcome are there?

I should be grateful for a reply within the next day or two if you could manage it and to save time am copying this to Dr Fr Tate whom I know you will wish to consult.

21.4.80

P Petrie

RL1 ET 1532 + 584.

cc Dr F Tate
J Sutch

The Chairman
The Midland Bank

Dear Lord Armstrong

I am grateful to you and your fellow Directors for giving some thought to my recent letter regarding the Stoke Mandeville Spinal Injury Centre Appeal.

Naturally I was disappointed and saddened by the Bank's response and am writing to you again because, in trying to be brief I omitted information from my earlier letter which might have led you to a different decision. It is so far from the case that we are unwilling to devote public funds to the development of spinal injury services that I felt I must write again to clarify the position.

The spinal unit at Stoke Mandeville enjoys a world wide reputation and we intend that it should continue to hold its place as a centre of excellence. At present, in addition to patients referred there from even further afield, it provides a service covering the entire southern half of this country including much of the Midlands. This arrangement ensures that S M patients receive a very high quality of care but it also poses problems. [There is a rising caseload in the field of spinal injuries and [this has to be met by] increasing facilities but Stoke Mandeville is already a large unit; in addition, the existence of one centre serving so large an area inevitably means that many patients have to be treated at some considerable distance from their homes over a period that is particularly stressful both for the patients and their families.

To overcome these problems we are at present increasing the level of service provision in the southern half of the country [~~and developing a pattern of services centred on not one, but 4 units (including Stoke Mandeville).~~] Work is already underway on 2 of these new units, ~~in Odstock and in London~~ at [illegible] and [illegible] ~~the cost~~ which is being met entirely from NHS funds, represents a ~~relatively~~ high level of investment in the present difficult financial climate ~~on one very specialised service~~. In the face of many other competing claims, we are unable to ~~do more~~ for spinal injury services from public funds for the next few years and this does mean, that despite its present unsatisfactory state, the rebuilding of Stoke Mandeville [together with the develop of the fourth spinal unit] has to receive a lower priority than we would wish, but do assure you it is a question of "when" rather than "whether."

DH Document 07. Page 246

It was against this background that Jimmy Savile expressed his desire to help. He knows the Stoke Mandeville Centre very well because of his voluntary work there as porter, fund raiser, and informal counsellor of patients and their families, which goes back over many years. He is well aware of what needs to be done but understands what we are doing first and why. He is extremely concerned however that a deteriorating environment would have an adverse effect on the patients and staff of the Centre and on the image of Stoke Mandeville throughout the world and he has offered to devote the greater part of his time, free of charge, over the next 3 years or so to raising funds for the rebuilding of the Centre. I greatly admire him for this and fully support him.

Mr Savile has made a good start and it is a measure of the general public's enthusiasm and goodwill that apart from one large donation at the beginning of the campaign, the money received so far has come in the main, out of taxed income in relatively small amounts, from a large number of individuals already hard hit by inflation.

Mr Savile has also received offers of help of a practical kind from industry and from the building professions, for example, offers of materials to be supplied free or at cost and offers to waive or reduce professional fees.

I hope that this additional information has clarified our position; it would be very encouraging to hear that it has also enabled you to reconsider your earlier decision. I do hope that you will.

If you feel that a discussion would be helpful I would be glad to make arrangements for you and I and Jimmy Savile to meet.

Yours sincerely

Gerard Vaughan

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Midland Bank Limited,

Poultry,
London, EC2P 2BX

Chairman.

D.H.S.S.
RECEIVED
-9 APR 1980
PRIVATE OFFICE

3 April 1980

Dear Dr Vaughan,

As promised in my letter of 11th February, I am able to reply to your earlier letter about the Spinal Injuries Centre at Stoke Mandeville now that we have had a chance to consider your suggestion that the Bank makes a contribution in response to the appeal launched by Jimmy Saville.

We have given a great deal of thought to your request but I regret to say that we do not feel that we can justify lending support to an appeal which is, in effect, asking us to fund an element of the National Health Service which the Government itself is not prepared to finance.

I am sorry to have to disappoint you.

Yours sincerely

Armstrong of Sanderstead

Armstrong of Sanderstead

Dr. G.F. Vaughan, FRCP., MP.,
Minister of State (Health),
Department of Health & Social Security,
Alexander Fleming House,
Elephant & Castle,
London SE1 6BY

MS(H) – To see

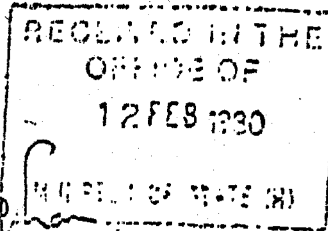
cc Mr. Ellis
Mr. [illegible]
Mr. [illegible]

9/4

Midland Bank Limited, 27

Poultry,
London, EC2P 2BX

Chairman.



11th February, 1980

Dear Dr Vaughan,

This is just a line to thank you for your letter of 8th February about the appeal for funds to rebuild the National Spinal Injuries Centre at Stoke Mandeville. I note that you have written to the Chairmen of the other clearing banks and I will arrange for the matter to be discussed at the next meeting of our joint Appeals Committee. I shall be writing to you again in due course.

Yours sincerely
William Armstrong

Armstrong of Sanderstead

Dr. G.F. Vaughan, FRCP, MP.,
Minister of State (Health),
Department of Health & Social Security,
Alexander Fleming House,
Elephant & Castle,
London SE1 6BY.

MS(H) – £500
JFK 12/2
Copy to Mrs Petrie

Registered in England (No 14259)
Registered Office Poultry, London, EC2P 2BX

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY
Telephone 01-407 5522
From the Minister of State (Health)

207/12

Robin Leigh-Pemberton Esq
National Westminster Bank Ltd
41 Lothbury
London EC2

8th February 1980

Dear Mr Leigh-Pemberton

I am writing to you personally, and to the Chairmen of the other three Clearing Banks, to see if you would be interested in helping our efforts to find the funds to rebuild the National Spinal Injuries Centre at Stoke Mandeville. It seems to me that this could be something which would create a good public image for your Bank; it is also, of course, a particularly worthwhile cause with which to be associated.

As you probably know, the unit is highly respected in this country and throughout the world both for its early pioneering work and for the continuing excellence of the treatment it offers to people suffering from spinal conditions. Stoke Mandeville now treats an average of 750 in-patients and 2,000 out-patients each year. Road accidents account for many of the patients, about half of whom are under 30 years of age. The other patients have mostly been injured at work, in the home, or in sports activities, but virtually all face a lifetime of restricted mobility in wheelchairs.

The centre has now reached a crisis. Patients are still cared for in the original prefabricated buildings provided when the unit opened in 1944 and, whilst a good deal of work has been done to provide a bright homely atmosphere, the buildings are in constant need of repair and are rapidly becoming obsolete. They must be replaced soon if the high standards of excellence are to continue, but until the general economic situation improves, there is little prospect of providing the funds for this purpose in view of the many competing claims for resources.

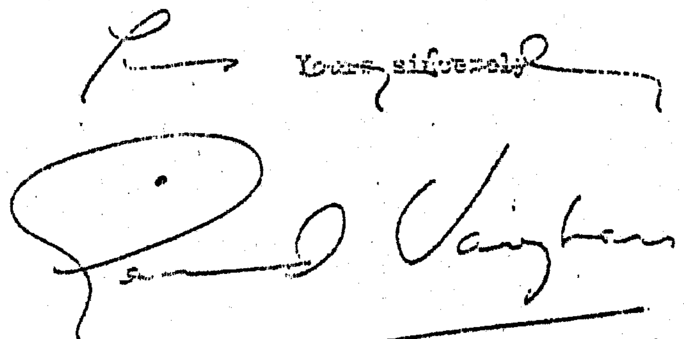
It is my belief, however, that many people in this country and overseas would be willing to contribute funds to ensure the continued future of the Stoke Mandeville Unit as a centre of excellence, and Jimmy Saviles' initiative in launching an appeal on behalf of the hospital now provides an opportunity for them to do so. The initial appeal target is £6 million, the sum required to provide new patient accommodation. If more funds can be raised however, there

is also the possibility of establishing an institute at Stoke Mandeville for research into the treatment of spinal injury. An overall target of £10 million would meet both requirements. Since the appeal was launched on 23 January, approximately £500,000 has been received in cash whilst offers in kind, relating to professional fees and construction costs, have had the effect of reducing the target by £2 million. I think you would agree that this is a most encouraging start.

Jimmy Savile is doing a tremendous job to stimulate wide public interest in the appeal and I, for my part, am approaching a very much smaller number of people who would perhaps like to be associated with the appeal or make a single donation to the fund.

I very much hope that you might feel able to assist us in some way; if you would like to discuss this then perhaps your office could contact mine and you and I and Jimmy Savile could meet.

Yours sincerely



GERARD VAUGHAN