

DEPARTMENT OF HEALTH AND SOCIAL SECURITY

SUBJECT

REGISTERED NUMBER
UNI 15 2

SERVICES FOR PARAPLEGICS
- STOKES MANDEVILLE
~~CONFIDENTIAL~~ ^{stet}

RELATED PAPERS

BEGINS
3.3.80

ENDS
March 83

TRANSIT MARKINGS

BRING FORWARD MARKINGS ONLY

Date To Whom Doc. No.

Date	To Whom	Doc. No.	Referred to	Date	Referred to	Date
			Mr. S. Baker	27/8		
			ASG/16 JMA	16/2/80		
			BISOS (to JMA)	17/2/80		
			BISOS (to JMA)	18/2/80		
			BISOS (to JMA)	19/2/80		
			BISOS (to JMA)	20/2/80		
			BISOS	2/3		
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To be noted after settlement by

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DESTROY/REVIEW ON

DAY	MONTH	YEAR
N	10	1982

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SEE CIRC HQ 80/72 PTV

INDEX NOTED PK (INIT)

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 Not War Bank 1A.

Copy letter 11.2.80 Lord Armstrong Willamson Bank 2A

Copy letter 3.4.80 " " " 3A

Draft letter 4A

Min 21.4.80 Perrie / Wainwright 5A

Min 22.4.80 Dr Tait 6A

Min 22.4.80 Myers / Scott-Wright 7A

Note of meeting All Party Loyalist
 group 15.4.80 8A

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Min + Design Brief - Switch 14A+P

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Min 17.6.80 Tait / Willment 16A

Min 18.6.80 Arthur / Switch C.G.T. 17A

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Min 12.9.80 Switch / Myers + Lind 21A

Extract Daily Telegraph 23.6.81. 22P

Extract Daily Express 7.7.81. 23A

Extract Daily Express 24.8.81 24A

Sub Editor Correspondence with Spinal
 Injuries Assoc. 25A

DAILY MIRROR

Crisis^s for Jim

DISC JOCKEY Jimmy Saville's £10 million dream spinal centre at the world-famous Stoke Mandeville Hospital, Bucks, has run into a cash crisis and may not be completed in time for its official opening by Prince Charles on August 3.

The local health authority responsible for running the unit say

they are £700,000 in the red and have appealed for extra funds to meet the deadline.

Now cuts in other local services are being considered to pay for running the centre.

District administrator Roger Titley explained that originally central government was going to pay but that was being negotiated.

12/1/82

Miss O'Toole

file on UNI 15.

Mr Alcock

AYLESBURY VALE HEALTH AUTHORITY AND STOKE MANDEVILLE SPINAL INJURIES UNIT

1. I enclose some background papers for MS(H)'s meeting with Mrs Miscampbell and Mr Roberts on 24 March. (Flag C looks more forbidding than it is. It is, in fact, quite easy to follow and quick to read. However, I have summarised the figures at Flag B).
2. Mrs Miscampbell's letter at Flag E sets out the District's case. Briefly, they believe themselves to be seriously underfunded, and despite the Region's scepticism about the purity of the targets as calculated, their DFT would seem to support their contention. They are therefore highly critical of the decisions that the Region has taken about sub-regional allocations, believing that more should be done to move them closer to target.
3. Notwithstanding the District's legitimate attempts to improve their allocation, there is still the separate question of their inability to live within their cash limit and the fact that they have allowed an overspend of some £0.7m to develop. Although Mrs Miscampbell would no doubt hotly dispute this, and although the evidence suggests that the seriously overspending budgets all relate directly to patient care (nurse staffing, drugs, medical supplies and equipment) it would appear that management did not get to grips with situation quickly or forcefully enough and are now being forced to react in a hurry.
4. The Region's allocation decisions are carefully and logically explained in their document at Flag C. They would contend that DFT is only one factor to be taken into account; that the calculation of targets is still far from perfect and likely to fluctuate year on year; and that, whilst they cannot improve Aylesbury's situation "at a stroke", they have made some concessions towards it and their longer term strategy would be to achieve relative equity between Districts.
5. In their attempts to achieve savings Aylesbury have put together a package (see Flag F) which includes a reduced level of beds when the new Spinal Unit opens later this year. In terms of politics and policy this move is highly contentious and less than sensitive. It has already received some publicity. Officials have already made it clear that these decisions will rest with Ministers (see correspondence at Flag H). MS(H) will wish to make it clear that for reasons relating to national policy for spinal injuries Ministers would wish to see facilities protected at present levels.
6. Aylesbury Vale DHA will meet on 23 March to discuss their proposals and they may well get considerable press coverage. Meanwhile, the Regional Chairman and officers, who have a sneaking sympathy for the District's predicament, are urgently looking to see if they can help further - despite a very clear decision by the RHA itself that it would not respond to pressure from one District which might lead to perfectly legitimate counter-pressure from others. We should be able to provide a quick up-date on these developments when we meet Mr Clarke on Thursday.

7. Mr Morris and I shall be in attendance at the meeting.

March 1983

Mrs L Fosh
RL2C
Room 1527 Ext 816
Euston Tower

cc Dr Melia
Miss Davidson
- Miss Winterton



Department of Health and Social Security
Euston Tower 286 Euston Road London NW1 3DN

Telephone 01-388 1188 ext

*file -> UNI 15
9/10 Jones*

Miss O'Toole

P M Cooke Esq
Administrator
Oxford Regional Health Authority
Old Road
Headington
Oxford

Your reference

Our reference

Date

16 March 1983

Dear Peter

We spoke about the difficult decisions facing Aylesbury Vale Health Authority in attempting to get to grips with their overspend problem and their need to realise savings in the order of £1.5m. They are still working on a package of proposals, but I explained that there was some speculation - which had been reported in the press - that the new Spinal Unit at Stoke Mandeville might be opened at a reduced level.

This letter is by way of a marker of the Department's direct involvement in any plans in respect of the Spinal Unit. As you will readily appreciate, in political and service terms the future of the unit is a very sensitive issue. In addition to this, we are about to launch the new arrangements for the central funding of supra-regional services, and spinal injury is one of the 4 areas already identified in this category. It is true that the new arrangements are unlikely to have a practical impact on health authorities in 1983/84, but implicit in the paper accepted by Chairmen and the interdisciplinary groups, is the principle that services should be maintained and protected at their present levels at least until a national strategy for the specialty has been developed. We would not wish to see any decisions taken - particularly as an unplanned response to overspending problems - which would pre-empt the work of the proposed Forum.

I should like to impress on you that Ministers would expect to be consulted before any steps were taken in the direction of adjusting the level of services to be provided at Stoke Mandeville - *in the Spinal Unit.*

I am copying this letter to Roger Titley.

Yours sincerely

Lynne Fosh

Mrs L Fosh

file

DAILY TELEGRAPH

THREAT TO SPINAL UNIT *6*

NURSES and ancillary staff pressed yesterday for a ban on the opening of the £10 million National Spinal Unit at Stoke Mandeville due to be performed by the Prince of Wales in August.

The protestors, members of five unions, in the Aylesbury Vale health area, fear losing their jobs under proposed £1,500,000 cuts in this year's spending.

They say the area health authority is in the red only because it has to fund the spinal unit, which is used by patients from all over Southern England, and a burns and plastic surgery unit at Stoke Mandeville.

Mr Roger Tittley, the area administrator, said the authority had overspent by about £700,000, but that it was "under-funded" considering all the services it provided.

He said that 75 per cent of the authority's cash resources went on wages and that staff numbers would have to be cut as a matter of urgency.

Not enough money

Mrs Iris Kears, secretary of the local Conseq branch, which has 800 members, said: "There is no way we can allow this new spinal unit to be opened when there is not enough money to save our jobs." The unit has been built with the aid of a fund launched by Mr Jimmy Savile, the television personality.

File

Mrs Winterton

Mr Jones

Dr Collins

Mr Godsell

Mr Parkinson

Mrs Dyer

Mrs Grove

Stoke Mandeville - Proposal to save costs by not opening20 beds

1. RL have informed us that Aylesbury Vale Health Authority have an estimated overspend this year of £700,000 and that next year they will need to save £1½m. A package of proposals is to be put to a special health authority meeting on 23 March and this will include a suggestion that only 100 of the proposed 120 beds in the new special unit at Stoke Mandeville should be opened.
2. The District believes it is being underfunded by Region and RL think there is some truth in this. This matter may be raised at a ^{future} Prime Minister's Question Time ~~today~~ and RL's briefing states that no decisions have been made. The HA Chairman is to meet HS(H) later this month to discuss the measures.

UNI 15 pages
file

Mr. Jones
10/13

DAILY MIRROR

2. Hospital unit faces crisis

HEALTH service cutbacks are threatening staffing levels at a vital new spinal unit being built with charity cash.

Fund raising led by Jimmy Savile had already netted £10 million for the unit, due to be opened by Prince Charles at the world-famous Stoke Mandeville Hospital, Bucks, in August.

But the local health authority wants to cut the workforce in all its hospitals because it had overspent by £700,000 in the current year.

Union leaders will fight the moves.

3

Stoke M. File
LNI 15

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SPEECH NOTES FOR MS(SS)'S VISIT TO NEWBOLD GRANGE HIGH SCHOOL,
30 SEPTEMBER 1982, TO ACCEPT DONATION TO THE JIMMY SAVILE
REBUILDING APPEAL FUND FOR THE SPINAL INJURIES CENTRE AT
STOKE MANDEVILLE HOSPITAL

I am delighted to be here today and it gives me great pleasure to congratulate you all and thank you for all the efforts you have made through your collections and various fund-raising activities to raise this money for such a deserving cause.

Background

Before I accept your cheque I would like to say a few words about Stoke Mandeville and why the Jimmy Savile Rebuilding Fund was started.

Stoke Mandeville Spinal Injuries Centre was set up in 1944 to provide a service for military personnel but since 1953 has been fully a part of the National Health Service. These war-time huts have been used as wards ever since and are certainly showing signs of old age! It was to replace them that Jimmy Savile started his fund in January 1980.

You may well ask why the Government did not rebuild Stoke Mandeville instead of leaving it all to Jimmy Savile and the generosity of the public. The answer is that Governments cannot do everything that needs doing as quickly as everyone might like. We are already building two completely new spinal units - one at Salisbury and one in North London - to add to the six spinal units we already have in England. Without the Rebuilding Appeal however it would have been several years before the Stoke Mandeville unit could have been rehoused in the new premises it so richly deserves.

The Stoke Mandeville Spinal Injuries Centre has of course a world wide reputation for treating patients with severe back injuries. It treats an average of 750 in-patients and 2,000 out-patients each year. The length of stay for most patients is 6-7 months, and a number return for follow-up treatment, so, for many, Stoke Mandeville becomes a second home. The new unit will not only make

it easier for the medical staff to care for these patients, but the more cheerful surroundings and better facilities will help patients to feel even more at home and to adjust to a new way of life. I understand the amount you have raised at Newbold Grange, is enough to buy a special bed for the new unit, which can be named after your school. Many of the beds at the Centre are used for young people injured in road accidents. It gives me great pleasure to think you have all worked so hard and contributed so much to help people who have been injured in this way, and are being taught how to develop new skills to help them in their future lives.

The foundation stone for the new unit was laid by Prince Philip, Duke of Edinburgh, in November 1981 and so work on the new unit is well underway. It should be ready to admit patients by 1984. About 7 million pounds have now been raised, but there is still some way to go to meet Jimmy's final target of £10 million. The cheque you give me today will help the fund move even closer to its target.

It gives me the greatest pleasure to come here today to accept this cheque on behalf of Jimmy and Stoke Mandeville. Thank you for all your hard work and generosity.

File

Miss Winterton

Stoke Mandeville - Provision of Spinal Service beds

1. You asked me to check on recent PO's & PQ's which mentioned the need to retain 'old' beds at S.M. after the completion of the new unit.
2. You will recall that at a meeting on 8.1.80, a proposal was made that S.M. would retain beds in the 'old' ward to cover the period 1985-1990 pending the operation of a unit in S.E. Thames Region. The new Jimmy Saville Unit at S.M. was intended to provide 110-120 beds (now joined up to 120) and a balance of 16-26 (now 16) would be retained in the old ward(s).
3. We have never been this explicit in any PO's or PQ's from 1979 to date, although we have announced our intention of planning a unit in S.E. Thames (e.g. PO MIN-H 2301/4 from Sir George Young to John Wakeham, MP (c) Maldon: several times to Spinal Injuries Association).
4. We have, however, said - in PO MIN-H 2301/4, and attached Press Release - that S.M. will be "retaining sufficient of the existing wards to maintain the service at its present level".

units mentioned in the context of the PO or
Press Release were Odslock and Stannmore.

5. In conclusion,

(i) it would go against Department's stated policy
if beds in 'old' unit were closed before Stannmore
and Odslock became fully operational.

(ii) it would not be against published policy
if 'old' beds at SM were not returned after this
date

We could agree with RL's suggestion that
Oxford RHA/ Aylesbury HA should not be pressed
to keep beds at the 'old' SM open, without
threat of embarrassment. However, it would be
naïve not to expect some lobbying, from SA &
An Party Disablement Group, about progress of a
further unit in SE Thames with the overall
situation in bed numbers at Stoke Mandeville.

Paula Asher
CSSC
AFH 81511 x 7713

1 - 10 - 82.

cc Dr Collins
Mr Jones - then for unit 15.
Mrs Parkinson

**PRESS
RELEASE**

Telephone 01-407 5522

80/10

23 January 1980

WHAT'S SPECIAL ABOUT STOKE MANDEVILLE

The National Spinal Injuries Centre, established in 1944 and handed over to the NHS in 1953, was the first specialist unit for the treatment of spinal injury cases. In the early days many of its patients were severely wounded service men in World War II. As a result of work pioneered by Sir Ludwig Guttmann and others, lives that would have been irretrievably ruined became possible again. A bleak future was replaced by the very real hope of a return to a better life than they ever thought possible.

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. Almost half the male patients admitted are the victims of road accidents (60% are under 30 years of age). The other patients have mostly been injured at work, in the home, or in sports such as hunting and swimming.

For a paralysed patient, the centre becomes his home and patients stay, on average, 190 days. Most patients continue to regard the centre as their second home to which they return from time to time for assessment and further treatment.

A number of other spinal units have been established, but Stoke Mandeville continues to be regarded, both nationally and internationally, as the national centre for spinal injuries and patients are referred from all over Great Britain and from many other countries. It remains above all a source of invaluable inspiration and expertise in this field.

What is the problem?

It comes as quite a shock to realise that patients at the Stoke Mandeville unit are still being cared for in the original hatted accommodation

provided in 1944. As much as possible has been done to provide a bright homely atmosphere, but the buildings are rapidly becoming obsolete and in constant need of patching up. These buildings have to be replaced if the high standards of excellence are to continue. There is no immediate hope of NHS funds in the current economic climate.

Why can't the NHS pay?

The NHS has been squeezed of finance and has not sufficient money to pay for all the many worth while projects that it would like to fund. The NHS has not neglected expenditure on accommodation for spinal injury patients. In addition to five new units' funded in the last few years, NHS funds are being made available to two new schemes at Odstock and Stanmore. But there are many competing demands for resources, and to be fair, other services must receive attention.

What is needed?

At least £6 million to provide a new unit of 110-120 beds on the Stoke Mandeville site retaining sufficient of the existing wards to maintain the service at its present level until new units elsewhere are available, and to replace the worst of the existing staff accommodation. The new facilities would form part of a network of units being established in the Southern part of England (the Northern half of the country is already reasonably served). But Stoke Mandeville would continue to be recognised as the national spinal injuries centre, caring for patients referred for treatment from home and overseas.

FOOTNOTE

	Number of beds
Midlands SIU, Oswestry, (Established in 1963)	46
Lodge Moor SIU, Sheffield (Established in 1954)	64
Southport Paraplegic Unit (Established in 1950)	35
Pinderfield SIU, Wakefield (Established in 1954)	31
Hexham SIU, Hexham (Established 20-25 years ago)	20

Total DH Document 07. Page 15

There will be two further units by the mid 80s at Odstock Hospital, Salisbury,

The Health Authorities concerned (Aylesbury Health District, Buckinghamshire AHA and Oxford RHA), have already established a project team to plan ahead - the ambitious aim is to open in 1984. The decision on what the new unit will be like is an important one but perhaps even more important is that patients and staff, those who will find the money, and those who run it when it is built, should be happy with it.

MEETING TO DISCUSS STOKE MANDEVILLE SPINAL UNIT AND FUTURE PROVISION
OF BEDS IN THE SOUTH 3 SEPTEMBER 1982

Present

Miss P Winterton (Chair)
Mr A Caddell (NO)
Dr M Collins (SMO)
Mr A W Jones
Ms F Maynard

1. Report of Visit to Stoke Mandeville

Dr Collins mentioned that this was her first visit to a spinal unit and as such had no standard of comparison. She gave a report of the visit paid to Stoke Mandeville Spinal Unit by herself, Mrs Parkinson and Miss Winterton. This visit arose out of the All Party Disablement Group and their discussions with Dr Illis who wanted funding for neurological research. They were met by Dr Frankel who showed Dr Collins and Miss Winterton around the existing wards whilst Mrs Parkinson was shown around by the Nursing officer. All three were later taken around the new buildings by the Nursing officer who had had a major part in its planning. The new buildings were lavish, but even the old buildings (which will eventually be converted into geriatric wards) were in much better condition than we had been led to believe.

Conservative treatment with particular attention to prevention of bed-sores, appeared to be the main philosophy. Miss Winterton remarked that OT's and physio-therapists were not very much in evidence on the wards, they were not introduced to any. Social rehabilitation seemed to be left largely to other patients. Social worker provision was very limited and the psychiatrists only worked there for two hours each week.

Miss Winterton said the unit seemed to be living on its reputation. On the whole the approach seemed to be good, but very conservative, physical treatment (better than that available at a District General Hospital) but very little experiment with new methods of treatments. There appeared to be little evidence of teamwork in the rehabilitation of the patients. Liaison with local services for return of patients to their home environment seemed to be limited - possibly because of the paucity of social workers at the unit.

2. Beds

Stoke Mandeville's new unit will have 120 beds and in order to maintain numbers of beds at a level thought to be necessary in the South, it had been envisaged that 16 beds in the old unit would remain open. The number of beds required is calculated by looking at the ratio of incidence of spinal injuries to the population in the South - this came to 200 which will be the number available when Odstock and Stanmore open and including the extra 16 at Stoke Mandeville. It was agreed that it was unfortunate that so many beds had to remain at Stoke Mandeville. The money would have been better spent in setting up an additional unit at, say, Sidcup.

It was generally felt to be unsatisfactory to keep the 16 old beds open; they would be isolated from the new unit and therefore unsuitable for initial treatment of patients. The different consultants appeared to have different approaches to their patients and this threw doubt upon the possibility of using the beds effectively as a joint follow up unit. Moreover there are already problems of staffing and management which would be exacerbated by having an isolated group of beds and Oxford RHA are unwilling to fund them. A decision had to be made about whether it was worthwhile maintaining the beds in view of the disadvantages.

3. Research

A proposal had been received suggesting that research should be carried out involving patients who had been treated in one ward at Stoke Mandeville. The CGT was not enamoured of the specific proposal, particularly the fact that it was limited to one group of patients, but it did feel that research involving patients from several units would be useful. They would pursue this discussion when they had had an opportunity to study the existing proposal more carefully.

4. Future Activities

It was felt that it would be worthwhile comparing Stoke Mandeville with other units and discussing issues with other people involved. Dr Collins agreed to arrange to visit Pinfiefields unit in Wakefield, if possible jointly with an administrator and this could be used as a basis for comparisons.

1. Miss Winterton - if you concur
2. Mrs L Fosh

NATIONAL SPINAL INJURIES CENTRE - STOKE MANDEVILLE HOSPITAL

This was my first visit to a Spinal Injuries Unit. Factual information about Stoke Mandeville is already fully documented. The following is simply an account of impressions.

These were very mixed. Dr Frankel met and welcomed us; the general atmosphere was hospitable with no hint that we were taking up precious time.

Initial 'discussion' was between Dr Frankel, the unit administrator, Miss Winterton, Mrs Parkinson and myself. Discussion is in inverted commas as this really turned out to be a fairly detailed history from Dr Frankel of the development of Spinal Injury Units and Stoke Mandeville in particular. Questions about the general philosophy of the unit tended to be evaded.

During the day we visited two wards in the old accommodation, the intensive care unit, the physiotherapy department, hydrotherapy, the large and seemingly lavish new Spinal Unit which is still under construction and at lunch time, the bar of the patients sports complex. During this lunch time interlude no attempt was made to introduce us to other medical and professional members of staff although we stood only feet away from some.

We saw the occupational therapy department from the distance only and met no OTs.

As far as one could establish, generally by observation, the relationship between Dr Frankel and his patients was extremely good but there was little evidence of professional teamwork.

The standard of accommodation in the 'old' buildings was to my mind quite reasonable - certainly better than expected.

There is almost no expert care and treatment of the psychological problems of these traumatically disabled patients and social work input is minimal.

Patients are admitted to acute wards as soon as possible after the accident and usually are discharged from these within 6/7 months. There is a strict routine for prevention of bed-sores which is generally successful. After discharge patients are recalled for follow-up. This takes up bed-space which in view of the waiting list is perhaps questionable. It might be argued that follow-up should take place at the appropriate DGHs but there is some doubt that the required expertise exists at all DGHs.

To help throughout there is a hostel on site for patients who no longer require hospital accommodation but for whom there is no supportive home in the community.

All in all, this probably gave us a broad brush picture of a Spinal Unit, but left a lot of questions unanswered. It will be interesting to compare with other units.

Gray Bell

DH Document ID: 19
Med CDN B1111 AFH

44

State Nashville Special
Unit - reductions in no. of
Ded.



Mr. Collins 19/8
For info. a.
M. Sweeney 9/8

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
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288 EUSTON ROAD
LONDON NW1 3DN
TELEPHONE 01-388 1188 Ext 911

UNI 15.

Dr R Rue
Regional Medical Officer
Oxford Regional Health Authority
Old Road
Headington
Oxford OX3 7LF

6 August 1982

Dear Dr Rue

RE: SPINAL INJURIES UNIT - STOKE MANDEVILLE HOSPITAL

I am sorry to have been so long in replying to your letter of 13 July 1981 and your other enquiries about the provision of spinal injuries beds. You are concerned that a reduction in the numbers of spinal injuries beds at Stoke Mandeville from 136 to 120 should not lead to a reduction in the overall bed provision for patients with lesions of the spinal cord in the south of England.

I have made enquiries of my colleagues on this point and they tell me that an interim unit of 16 beds - but with only 10 beds currently in use - was opened in October 1981 at the Royal National Orthopaedic Hospital, Stanmore, and that, when the new spinal injuries unit at Stanmore is completed and functioning in early 1983, then the total number of spinal injuries beds there will rise to 24; in addition to this, the new 48 bed unit at Odstock Hospital, Salisbury, is due to be opened in mid 1983. This means that, when the number of spinal injuries beds at Stoke Mandeville is reduced to 120, the overall number of beds available in the south of England for patients with lesions of the spinal cord will be 130, but this will increase within a year or so to 192.

With regard to the wider issue of the overall needs of the spinal service: there is unfortunately no reliable epidemiological data on which to base an estimate of the number of beds needed. Studies have shown the incidence of new spinal injuries to be in the order of 12-15 new cases a year per 1,000,000 population; there is also evidence that the life expectancy of paraplegics and tetraplegics is increasing; furthermore, the duration of treatment for each new case and the need for re-admission for the treatment of complications has been shown to be as dependent on personal and social factors as on specifically clinical ones. Such evidence as we have however suggests that we need, as a minimum, between 200 and 250 beds distributed throughout the southern half of England.

As you know, the need for a unit in the South East Thames Region has been identified and a SETRHA Working Party has recommended that St Mary's Hospital, Sidcup, would serve as the ideal location for a 50/60 bed unit. A unit of this size would complete our long term plans for the south of England and raise the number of spinal beds to around 240/250.

I hope this is of some help.

Yours sincerely

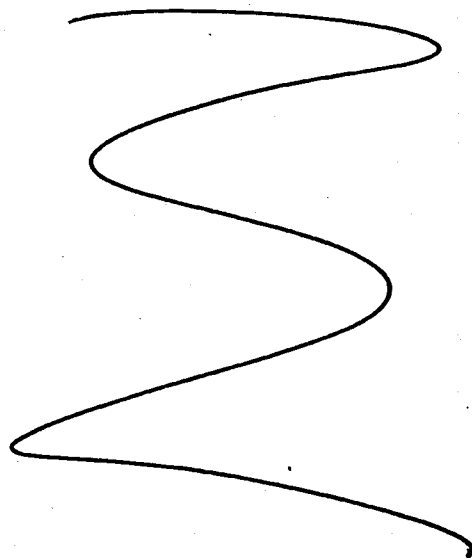
N P Melia

N P Melia
Senior Medical Officer

Dr Collins
Miss Sweeney

Mr. J. P. - all my suggested amendments have been taken on board.
Mr. Melia - to see what Mr. Dixon can do

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UN 15

NEWS

Patient services face cuts in Oxford

Oxford RHA may face restrictions on patient services because of its fast growing population and low growth margin.

Following the ministerial review with Oxford last month, Junior Health Minister Geoffrey Finsberg said: 'Even holding some services at present levels means some reduction in access to services by patients,' in a letter to Oxford RHA chairman Gordon Roberts.

Once again Mr Finsberg emphasised that services for the elderly, the mentally ill and the mentally handicapped should be given priority, even if this meant adjusting the regional strategy. He realised though that 'the implication of a reappraisal of your strategy is that, if fresh priorities are established some developments have to be further deterred'.

The letter outlined the main areas where the region had agreed to take action. One such area was manpower control. Mr Finsberg pointed out that the region had agreed to 'develop a system linking manpower and financial information as a basis for control and monitoring and also for forward planning'. Another area was concerned with collaboration with local authorities and joint finance.

'You mentioned,' Mr Finsberg wrote, 'the tendency of

local authorities to use joint finance monies to make good shortfalls in their own resources.' He referred to the region's desire for a joint forum 'at the highest level' to promote the cause of joint forward strategic planning, with the region playing a strong 'facilitator' role.



Brian Bailey, South Western RHA chairman.

A similar follow-up letter was sent to Brian Bailey, South Western RHA chairman, following the region's recent meeting with Health Minister Kenneth Clarke. Mr Clarke reminded Mr Roberts of the importance of regional monitoring. While he accepted that the region's management style and philosophy was revolutionary, Mr Clarke pointed out 'that there was an important strategic and management role for the region in setting and monitoring regional policy objectives as well as in monitoring districts'

performances'. He then confirmed the tasks agreed on at the meeting.

This included deciding with the districts on a common minimum data set for manpower information about each staff group, supplied by the region. Comparable district-based systems were expected to be introduced within 12 months.

Mr Clarke emphasised too the need for a redistribution of resources in order to accommodate more services for the elderly and psychogeriatrics.

'It will also be necessary,' he wrote, 'to quantify the extent to which other services will be affected by such redistribution'.

In relation to services for the elderly, particular attention was to be given to improving the level of hospital and day care provision. For psychogeriatrics the first step, he said, will be district-level quantification of the need for acute assessment and for long stay beds in local hospitals, day care facilities and community support.

He emphasised too, the scope for improvement in joint planning arrangements with local authorities.

Six ministerial reviews have already been carried out at Trent, Mersey, Oxford, South Western, Yorkshire and East Anglia.

New low energy hospital

Wessex RHA is providing £13,366,000 towards the cost of a £17.6m 'low energy hospital' on the Isle of Wight.

Work began on the 191-bed hospital the first low energy hospital in Britain yesterday. The DHSS is allocating £2.5m to the project which it will be monitoring. The Isle of Wight DHA is putting forward £1m capital and the EEC has given a grant of £637,000.

According to a regional spokesman the hospital will use half the energy of a normal nucleus development. Most of the money, he said, would be saved in 'suppressive measures'. These will cover air handling and distribution in clinical and catering departments, catering equipment, humidification and 'reduced service distribution losses.'

The capital cost of these measures would be £56,000 but they would bring a saving of over £32,000 a year, according to the spokesman. Solar panels, he said, are both expensive to install and bring very little saving, so these may not be used.

Further energy savings will be made using double-glazing and special insulation, locating major energy-using departments close to energy-producing areas and an energy centre where waste heat can be captured and re-used.

NEWS IN BRIEF

South West Thames RHA is setting up a Drug Information Service to serve the region's 130 hospitals. The service, which will be operational in about six months, will provide specialist information on thousands of drugs currently in use. It will give details on side effects, reactions with other drugs and comparisons with more powerful or cheaper drugs. Initially based at St Luke's Hospital, Guilford, it will be linked by computer with the central information service at the DHSS.

Work on the second scheme of the redevelopment of Brynffran

Hospital, Llanelli, Dyfed, is to start in mid-August. Tenders for the £1.98m main works contracts were authorised by Secretary of State for Wales Nicholas Edwards, last week. The main contract will be awarded to G E Wallis and Son Ltd. The scheme will provide a second, 30-bed geriatric unit to replace existing ward beds and a 30-bed unit for elderly mentally infirm patients who are to be transferred from St David's Hospital, Carmarthen.

The first major NHS solar heat project has opened this month. The £1.6m catering

complex at Torbay Hospital, Devon includes an array of solar panels which make up one side of the building. These are expected to provide nearly half of the hot water needed for the complex. Half the cost of the £130,000 project is being met by the Department of Energy. The new complex also houses a computer to improve the service to patients and staff and to monitor food stock and preparation.

Yorkshire RHA has awarded contracts for two schemes towards the redevelopment of Scarborough Hospital.

Hospital kitchens are to be extended and upgraded in a £282,000 programme and a new emergency access road is being built at a cost of £156,500. Construction work on the main part of the hospital should start next Spring, providing 180 beds. X-ray, outpatients, accident and emergency departments and support services.

Humber ambulance service has reported substantial savings after switching its fleet to run on gas instead of petrol. The money saved will be used to pay back on conversion costs within months.

Miss Sweeney
NSIC Stoke Mandeville

I promised to let you have relevant papers from our files setting out the strategy for the development of the spinal centre in the south of England

The draft was never circulated as of Mrs Pether's note of 1.50 mention the proposal to keep SM based at the until the opening of a third new unit in the south. As it did not send a revised draft - we assume these stand

This strategy was agreed by MS(11) following Mr. Pether's submission of 1.50 to Mr. Knight (see para 6) See also draft press release for the building appeal - marked X - when this principle was repeated

We have commenced our intention of planning a new unit - see reply on Pether to John Wickham MP - also to the Spinal Injuries Association (where chairman is Lady Macdonald) However Mr. Pether & PC have explicitly put us the word for not to go forward with this unit



Spinal Injuries Association

DEPARTMENT OF HEALTH & SOCIAL SECURITY
Alexander Fleming House, Elephant & Castle, London SE1 6BY

Telephone 01-407 5522

From the Joint Parliamentary Under Secretary of State

PO(MIN-II)2301/4

John Wakeham Esq MP

Handwritten notes:
- E. H. VAUGHAN
/ LIAISON
N. L.

7 February 1980

Handwritten:
D. 3.6

Further to Dr Gerard Vaughan's letter of 17 January, I am now replying on behalf of Dr Vaughan who is at present out of the country, to your letter of 22 November about the correspondence you received from the Essex Group of the Spinal Injuries Association concerning hospital facilities for spinal injury patients in that county. I am sorry for the delay in sending this reply.

Firstly, I should emphasise that the Government fully accepts that patients with lesions of the spinal cord, whether resulting from injury or disease, should whenever possible be treated in specially designed and designated spinal units. Whilst it is desirable for patients to be treated as near to their homes as possible, it is not practicable to provide such specialised units which need immediate access to a wide range of acute services (notably operating theatres, orthopaedics, neuro-surgery, urology, plastic surgery and neurology) in every Health Region. The service must be a supra-regional one, providing a network of specialised units.

I am certain that the Essex Group will be aware that to some extent we are the victims of history in that there is an uneven geographical distribution of spinal units. There are approximately 200 beds in the northern half of the country divided between Hexham, Sheffield, Southport, Wakefield and Oswestry. Such evidence as we have suggested that we need a minimum of between 200 and 250 beds distributed throughout the southern half of England.

At present the only spinal unit in the south is Stoke Mandeville where there are 156 beds (36 are temporarily out of use). To improve the services in the south, a 48 bedded unit has been planned at Odstock Hospital, Salisbury and it is hoped that work will begin in May and that it should be operational in 1983. Planning is also well advanced on a smaller 24 bedded unit at the Royal National Orthopaedic Hospital, Stanmore, which it is hoped will be operational in 1982. The need for a further 50 bedded unit in the South-East Thames Region has been identified and when such a unit is functioning this will complete our present plans in the South of England. The problem of finding funds will not however be quickly resolved and until such time as the new units at Odstock and Stanmore are fully operational, it is important that the service provided by Stoke Mandeville is maintained at its present level. You may like to see the recent Press Releases issued by the Department about Stoke Mandeville, copies of which are enclosed.

I would add that some of the recent concern over the financing of Stoke Mandeville Hospital arose from the fact that some patients at the National Spinal Injuries Centre come from outside the area administered by the Oxford Regional Health Authority. There was uncertainty about the adequacy of the allowance made in the Health Authority's revenue allocation for the cost of patients from other parts of the country. Clearly this was an important factor and when Dr Vaughan visited the Hospital he announced that in future the cost of this service would be identified in the Authority's allocations.

We have also made enquiries of the North East Thames Regional Health Authority since it is their responsibility for providing specialist medical facilities in Essex. As the RHA has no comprehensive facilities akin to those at Stoke Mandeville, spinal injury patients in the North East Thames region are referred to that Hospital, or to other national units, or to one of the RHA's major orthopaedic units, although these are not equipped to give a service similar to that at Stoke Mandeville.

I hope this information will go some way to assure the Essex Group of the Spinal Injuries Association that the Department is fully aware of the need to improve the geographical distribution of spinal unit beds and that with the opening of new units at Odstock and Stanmore in the next few years, the position in the south of England will be improved considerably.

I hope the ... help

George Young

SIR GEORGE YOUNG

ENCs

Reference D2/71/145C

LSA

MS(H)

is X acceptable?

JFK 16/1

Mr Knight

The Minister will recall that in the context of his visit to Stoke Mandeville in November, he asked for a statement of the strategy for the spinal service in the South of England. This is set out in the annexure and it depends on the implementation of a proposal put out by the South East Thames RHA for a unit to be sited in their Region, probably at Queen Mary's Hospital, Sidcup.

Planning on the 48 bedded Odstock unit is now complete and it is hoped that work will begin in May, and that it should be operational in 1983. It is also hoped that the small 24 bedded unit at the RNOH Stanmore will be operational in 1982. The problem of finding funds for a unit in the South-East will not be quickly resolved and it may well be 1990 before planning could be completed. However there is clearly a need for another unit and I should be grateful for the Minister's confirmation that we may proceed on the basis that we may in principle accept the SE Thames Region's working party's recommendation while making clear that we are not in a position to say when the money can be found.

As the Minister is aware, the problem of Stoke Mandeville is being dealt with separately. However its resolution - as the annexure suggests - would fit in with the proposal to complete our long-term plans in the South by provision of a 50 bedded unit in the South-East.

G M Bebb

G M BEBB
SH2C
B517 AFB
Ext 6132

16 January 1980

16 1.00
Yes. Agreed
EW

OUTLINE OF A STRATEGY FOR THE DEVELOPMENT OF SUPRA-REGIONAL
SPINAL UNITS IN THE SOUTH OF ENGLAND

1. Patients with lesions of the spinal cord, whether resulting from trauma or disease, require the specialised treatment and support of a combination of doctors, nurses, remedial therapists and social workers. This is essential not only in the acute stage for each patient requires continuing assessment and many require subsequent treatment as complications arise. While the specialised treatment and rehabilitation should be carried out in special units it is also essential to develop the necessary rehabilitation and follow-up in close liaison with community services (health social services, housing and employment) in the patient's home area.
2. As it is not practicable to arrange the development of the specialised resources needed in each Health Region the service must be a supra-regional one, consisting of a number of Spinal Units. The Spinal Unit should be located in a DGH with a well developed rehabilitation department and with access to a range of acute services, notably operating theatres, radiology, microbiology, and in particular orthopaedics, neurosurgery, urology, plastic surgery and neurology (the demand for these being partly determined by the basic speciality of the consultants in the Unit).
3. The number of beds needed nationally depends on the incidence, and the duration of treatment of new cases, the prevalence of para and tetraplegia, the frequency of complications and the extent to which the service is deployed in the treatment of non-traumatic lesions. Therefore there can be no reliable epidemiological data on which to base an estimate of the number of beds needed. Studies have shown the incidence of new spinal injuries to be in the order of 12-15 new cases a year per 1,000,000 populations; there is also evidence that the life expectancy of paraplegics and tetraplegics is increasing; furthermore, the duration of treatment for each new case and the need for re-admission for the treatment of complications has been shown to be as dependent on personal and social factors as on specifically clinical ones.
4. The need to maintain close links with community health and local authority services in the patient's home area makes the geographical distribution of beds as important as their overall number. There are approximately 200 beds in the northern half of England divided between Hexham, Sheffield, Southport, Wakefield and Oswestry. Although the evidence is empirical only, it supports the opinion that it is sufficient. The consensus view among experts is that 50-60 beds is the optimum number for a unit, having regard to consultant cover and other factors including a notional catchment area equating to approximately two Regions. To some extent and notwithstanding any new plans for units we are the victims of history; the units are where they are. As a result it is not possible to produce a completely rational plan taking account of both incidence/prevalence and the distribution factors. The latter will be affected by regional considerations such as the amount of heavy industry, the incidence of traffic and sporting accidents. Such evidence we have however suggests that we need as an absolute minimum between 200 and 250 beds distributed throughout the Southern half of England.

5. It has been found difficult to recruit staff in sufficient numbers for a Unit the size of Stoke Mandeville, and patients are at some disadvantage if they and those who provide the community-based services which they require, are at too great a distance from the specialised treatment centre. While the nominal number of beds is 150, for many years SM has had only 136 operational beds. To improve the services in the South of England a 48-bedded unit is being built at Odstock Hospital, Salisbury, and a smaller 24-bedded unit at the RNOH, Stanmore (this is below the optimum size but other factors related to the RNOH's organisation led to this decision). The need for a unit in the South East Thames Region has been identified and a SEETRHA Working Party recommended that St Mary's Hospital, Sidcup would serve as the ideal location for a 50/60 bedded unit. The Region should be told that there is no possibility of central funding being available in the near future - certainly within the next five years.

6. There are current plans to increase the number of beds available in the South of England by 24. If the number of beds in a newly built SM were reduced to some 110 when the proposed Unit in SE Thames was opened the number of beds available in the South of England would be in the order of 234, and experience in the North suggests that this would be sufficient. However, until such time as the new Units were fully operational it would be essential to maintain the service at SM at its present level, possibly by keeping one or two of the existing wards in operation to complement the service in a newly built Unit.

STOKE MANDEVILLE SPINAL INJURIES CENTRE - REBUILDING APPEAL

Stoke Mandeville Hospital was built in 1940 as part of the Emergency Medical Service network of the time.

The National Spinal Injuries Centre (NSIC) was set up within the hospital in 1944 to treat patients, particularly servicemen wounded in World War II, who suffered spinal cord injuries. Prior to the establishment of the Centre, the outlook for patients of this kind was poor. Today, as a result of the work pioneered at Stoke Mandeville, the majority of patients return to live and work in their own community.

Originally the Centre was run by the Ministry of Pensions, but in 1953 it was handed over to the Ministry of Health to become part of the National Health Service. [Announcing this change the then Prime Minister, Winston Churchill, gave the following undertakings:

"So far as medical treatment is concerned, such special facilities as war pensioners at present enjoy will be fully safeguarded and, in addition, the Minister of Health and the Secretary of State for Scotland will be able to call on the facilities of the whole National Health Service to ensure that the necessary treatment of war pensioners is given by the hospital best able to provide it."

"..... the general position of the pensioners and their treatment will not on any account be allowed to deteriorate."]

That position still obtains today.

Since the 1950s a number of other spinal units have been established in England and Wales.

	<u>Number of beds</u>
Midlands SIU, Oswestry	46
Lodge Moor SIU, Sheffield	64
Southport SIU	35
Pinderfield SIU, Wakefield	31
Hexham SIU, Hexham	20

DH Document 07. Page 30
Total: 196

X

In addition to the five units existing in England (and one in Wales) two further units will be brought into use in the early 1980s at Odstock Hospital, Salisbury, Wiltshire and at the Royal National Orthopaedic Hospital, Stanmore, London.

In all spinal units patients are admitted for treatment in the acute stage of their condition and on discharge receive continuing assessment and the treatment of any complications. Rehabilitation takes place in close liaison with local health and personal social services, housing and employment in the patient's home area.

Despite the development of the newer units, Stoke Mandeville enjoys a unique reputation both nationally and internationally and patients continue to be referred there from all over Great Britain and other countries as well (patients were admitted from 25 other countries in the period 1976/78).

Indications are that the incidence of new spinal injuries is of the order of 12-15 cases per million population. Stoke Mandeville treats an average of 700 new and old in-patients and 2,000 out-patients each year. Causes of injury are road traffic accidents (occurring particularly among young men under 30 years of age), accidents at work, or in the home, and sporting accidents.

The average stay at Stoke Mandeville for newly injured patients (including children) has been 190 days. Patients have a particularly warm and close relationship with the Centre which they return to from time to time for assessment, advice or further treatment. While much has been done to create a bright homely atmosphere in the Centre, patients are cared for in the original hatted accommodation erected in 1944 and these buildings are rapidly becoming obsolete. Increasingly they require large sums to be spent on maintenance to keep them weatherproof and warm.

The NHS has not neglected expenditure on accommodation for spinal injury patients. In addition to the five units provided in England since the establishment of Stoke Mandeville, £4.2m and £1.2m are being made available for the two units to be built at Odstock and Stanmore respectively. But it

would not be right to ignore the many competing demands of other services for NHS resources on grounds of both equity and practical need, and there is no immediate prospect of finding NHS funds for Stoke Mandeville. Nevertheless, something must be done to replace the existing facilities at Stoke Mandeville both to ensure that patients do not suffer and that this essential unit should develop and maintain its national and international reputation.

About £6m is needed to provide a unit of 110-120 beds and to replace the worst of the existing staff accommodation. The new facilities would form part of a network of units now being established in the Southern part of England (the Northern half of the country is already reasonably served), but Stoke Mandeville is commonly regarded as the National Spinal Injuries Centre caring for patients referred for treatment from home and overseas. As services are built up elsewhere in the South of England, the pressure on Stoke Mandeville will decrease. In the long term a total of 110-120 beds will be needed at the national centre, but until the plans elsewhere reach fruition (not before 1990), the NSIC will continue to provide 136 beds. It is hoped that 110/120 of these would be in the new unit, the balance being found by the retention and upgrading of one of the present wards.

Working together, the people responsible for managing the NSIC (Aylesbury Health District, Buckinghamshire AHA and Oxford RHA) have established a project team to plan a new NSIC. The Centre will continue to be located on the site of Stoke Mandeville DGH to ensure access to the full range of support services that a unit of this kind requires. They are pursuing an ambitious programme, to plan and design the unit in 1980 and 1981, to commence building in 1982 and to open in 1984. The only thing they need is the money to make the scheme a reality.

327
~~444~~C

Mrs Petrie

STOKE MANDEVILLE APPEAL: SPINAL INJURIES UNIT

Thank you for my copy of the draft minutes of the meeting. I have discussed with Dr Tait and there is one point of principle which concerns us. We do not think that the meeting was empowered to "reach general agreement". We can only propose and Ministers will dispose. It follows that I will quickly prepare a short submission to which Dr Tait's strategy paper will be annexed to obtain Ministerial agreement to what is proposed. I do not foresee any difficulty about this but I do not see how we can write to SE Thames in however nebulous the terms until we have authority to do so.

I suggest therefore that the preamble to para 2 should say "..... the meeting took note of the proposals for the development of Spinal Units (not Spinal Injury Units) along the following lines:- "

Other points:

para 4 (i) after 'request' in line 1 add "and subject to formal Ministerial agreement".

(ii) after 'provision' in line 5 "without any commitment to timing" full stop. It is better to leave it as vague.

para 5. It seems to us that we ought not to get involved in this question of Army facilities. We would prefer the para to read "Dr Forsythe raised the question of sharing Army facilities injuries. He would undertake wished."

para 10. i. "Subject to Ministerial approval DHSS etc"

ii. delete.

One small point. Dr Frankel is Chairman of the Spinal Injuries Review Committee (see list of those present).

9 January 1980

G M BEEB
SH2C
B517 AFH
Ext 6132

cc Mr Thorpe-Tracey
Dr Rivett
Dr Tait
Mr Suckling
Mr Collingwood

Mr Thorpe-Tracey
Dr Rivett

STOKE MANDEVILLE APPEAL : SPINAL INJURIES UNIT

A draft note of the meeting attended by Dr Malcolm Forsythe is attached.

Mr Collier indicated that RL3 would press ahead with action at Paras 4 and 5 (SUBJECT TO YOUR VIEWS). If I can add anything please let me know.

Pamela Petrie
RL1
ET.1532/Extn.884

8 January 1980

Copied to:

Mr Bebb } With papers
Dr Tait }

Mr Suckling }
Mr Collingwood } With papers
St.Mandeville File }

A
X

NOTE OF MEETING : EUSTON TOWER : 2 JANUARY 1980 : SPINAL INJURY SERVICES
IN SOUTHERN ENGLAND.

Present:

Dr Forsyth - RMO South East Thames Region
Dr Frankel - Chairman of the Spinal Injuries Review
Dr Rue - RMO Oxford Region ^{Committee}

DHSS

Mr James Collier (Chairman)
Mr G Bebb
Mrs P Petrie
Dr F Tait

1. The meeting was called to consider/potential/developments for Spinal Injuries Centres in Southern England, and the place of Stoke Mandeville within that framework.

2. Drawing on papers circulated prior to the meeting by Oxford Region and by the Department, the meeting reached general agreement about the scale and distribution of Spinal Injury Unit services in the southern part of the country along the following lines:

i. Existing Provision

Nominally Stoke Mandeville has 150 beds, but in practice the operational total has hovered around the 136 mark for a number of years.

ii. Requirements

Planned developments at the Royal National Orthopaedic Hospital, Stannore (24 beds due for completion by mid-1982), and Odstock (50 beds scheduled for completion at the end of 1982) goes some way towards providing a better distribution of services, but a need for a further unit of some 50/60 beds remains. The current South East Thames Regional Plan suggests that such a unit might be located at St Mary's Hospital Sidcup subject to suitable financial arrangements being made. It is thought unlikely that public funds can be made available for **DH Document 07. Page 35** within the next ten years.

iii. Pattern of Provision 1980-1990

	1980	1983	1985	1990s
Stoke Mandeville	Notional 150 Operational 136	136	110) New Bldg 26) Old Ward	110
Odstock	-	50	50	50
RNOH	-	24	24	24
New Unit SE Thames (? Sidcup)	-	-	-	50
TOTAL:	150(136)	210	210	234

(Dr Frankel stressed that consultants specialising in Spinal Injuries felt that there should be a nationally recognised centre of a slightly larger than average size, and that a permanent unit of a 110 beds at Stoke Mandeville was consistent with this approach).

In considering the size of unit required permanently at Stoke Mandeville, the chart above shows that account has been taken of the long-term ^{intention} to develop a unit in the South East Thames Region. To cover the transitional period 1985 to the 1990s, it is proposed to retain one of the existing Spinal Injury wards at Stoke Mandeville so that there is no diminution of bed provision following the rebuilding of the Stoke Mandeville Unit.

- iv. [Dr Tait may wish to insert any crucial references in the Oxford RHA paper not already covered in the paragraphs above.]

3. In outlining progress to date on the fund-raising front, Mr Collier emphasised that money was being raised specifically for the rebuilding of the Spinal Injuries Unit at Stoke Mandeville, and not for Spinal Injury services in general. The target for the Stoke Mandeville Appeal would probably be in the region of £5-6 million.

The Department confirmed that for the foreseeable future no central funds were likely to be available to finance the building of a further spinal injuries unit in the South East once work on the centrally funded scheme at Odstock was completed; there was a general understanding that South East Thames Region could not be expected to provide money for the creation of ^{a new} supra-regional facility from within this regional capital allocation. The question of a further independent fund-raising effort at some stage was not ruled out at local or national level, although it would be ill-advised to consider such a national initiative in view of the immediate Stoke Mandeville Appeal.

4. At Dr Forsythe's request, the Department agreed to respond to the tentative proposal contained in the South East Thames RHA Strategic Plan concerning the possibility of establishing a unit at Sidcup. Specifically it undertook to write (RL3) to the Region conveying agreement to the principles of provision ^{without any commitment to} the timing [however being subject to the availability of finance, and manpower, particularly consultant manpower.]

5. The possibility of sharing Army facilities provided in London for the treatment of servicemen with acute spinal injuries was also discussed. The Department agreed to approach MOD in the first instance, and if this proved successful, Dr Forsythe would then undertake more detailed consultations on behalf of the Region if the Authority so wished.

6. Dr Rao reported that a joint Regional/Area/District project team had been established to look at the re-development of Stoke Mandeville Hospital as a whole. Its first task was to produce a development control plan

to
for the Stoke Mandeville site and follow this by preparing a design brief for the Spinal Injuries Unit. Dr Rue saw detailed planning taking approximately one year with construction starting in 1982 and completion of the Unit in 1984/85. The RHA would almost certainly use outside contractors for the project because of pressure on RHA resources from existing and planned commitments. Dr Rue thought it would be possible to produce graphic material for publicity purposes within 3-4 months if required.

7. Mr Collier wished to consider further how fund-raising and planning activities might be linked over the next few years. He would discuss this matter with Mr Saville and others and report back.

8. On the question of the location of Spinal Injuries services for children, Dr Frankel expressed the view that in a redeveloped Stoke Mandeville Hospital the Children's Unit should be located if possible adjacent to the Spinal Injuries Unit in preference to locating children's beds within the Spinal Injury Unit itself.

9. Dr Frankel referred to the possible creation of an Institute for Spinal Injuries. In the past an attempt had been made to establish a link with Oxford University through, for example, the creation of a Chair for the speciality of spinal injuries, but there appeared little enthusiasm for the idea. He would like to see facilities for some teaching and research in the rebuilt Stoke Mandeville Unit. Dr Rue expressed concern that the new unit at Stoke Mandeville carried the prospect of increased recurrent expenditure which would be difficult to meet, and that any teaching and research associated with the Unit would need to be funded entirely from free monies. At present the Region envisages planning facilities to meet service needs only.

10. ACTION

1. DHSS to confirm agreement in principle to South East Thames RHA for the creation of a 50-bed unit in the South-East in accordance with the Region's proposals as resources of money and manpower permit. (RL3) (Para 4 refers)

- X
- ii. DESS to approach MOD about the possibility of using Army facilities in the South-East in the immediate and longer term for the treatment of spinal injury patients. (RL3)
 - iii. Stoke Mandeville Project Team would be pressing ahead with a Development Control Plan for the Stoke Mandeville site and with a Design Brief for the spinal injuries unit. Mr Collier to advise if graphic publicity material is needed for the National Fund-Raising Campaign in addition to routine project publicity.
 - iv. Mr Collier to advise on liaison mechanisms between fund-raising and planning activities.

RL1

4 January 1980



Your reference
Our reference

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
EUSTON TOWER
280 EUSTON ROAD
LONDON NW1 3DN

TELEPHONE 01-308 1189 EXT 884

17 December 1979

*Copy in Collier
in Bebb
Dr Tait*

*For info
21/12/79
2-5A
(No paper)*

Dear Doctor Rue/Forsythe/Frankel
STOKE MANDEVILLE - SPINAL INJURIES UNIT

I am writing to confirm that a meeting has been arranged for 2 January 1980 at 11.00 am in Room 1532 Euston Tower, to discuss an outline strategy for the development of Spinal Injury Units in Southern England, and more specifically, against the background of a large-scale public appeal for funds, the place of the Stoke Mandeville Unit within such a strategy.

The following people have been invited to participate: Doctors Forsythe and Rue, Dr Frankel representing the Spinal Injuries Review Committee, and from the Department, Mr James Collier, in the Chair, together with Mr Bebb, Dr Tait and Mrs Petrie. Lunch will be provided. ←

Dr Tait has prepared a paper (enclosed) setting out some ideas on policy and locations. In view of seasonal difficulties with the mail, it might be as well to table any other contributions at the meeting.

Thank you for agreeing to attend at such short notice.

Yours sincerely

Pamela Petrie

** we aim to finish the meeting by
lunchtime. The RMO's have
been moved to Sheffield*

Dr Lee

*W. P. Halliday
New Spinal Unit*

*1211
1111
-24A -13A X*

SPINAL INJURIES UNITS - STOKE MANDEVILLE

I attach a copy of a letter I have received to-day from Dr Forsythe. You will see that both he and Rosemary Rue apparently are not adverse to the proposition that the Stoke Mandeville Unit might be re-built with, say, 60 beds and the remaining 60 beds be sited at Sidcup. Malcolm Forsythe has written to me following a meeting we had with the RMOs a few weeks ago. He appreciates that I do not have this subject within Med OS1. I understand that a formal submission has been made to the Department, but in any case he is sending me another copy. Since this was not one of my subjects I did not discuss this in any detail with Dr Forsythe, for example I have no idea where he hopes to recruit the staff with the appropriate expertise to make a unit at Sidcup viable. It is not my understanding that neurosurgeons find this work of particular interest. I spoke to Dr Forsythe to-day on receipt of his letter and indicated that I would be passing it to the divisions with this subject responsibility for their consideration and that he will be getting a reply in due course.

N P Halliday
N P Halliday
Med OS1
1835 ET

14 November 1979

cc Mr Wormald
Dr Lees
Dr Sweeney
Dr Rivett

(1) Dr Lees 14/11

(2) Mrs Gleadow for information.

*J. P. Halliday
14/11*

X
138
248

South East Thames Regional Health Authority

Randolph House 46-48 Wellesley Road Croydon CR9 3QA
Telephone 01-86 8877 Telex SETRMA 947113

Your reference

Our reference

Date

JMF/SJF

12th November 1979

Dr. N.P. Halliday,
Senior Principal Medical Officer,
Department of Health and Social Security,
Euston Tower,
London,
NW1 3DH

Dear Norman,

At the last RMO's meeting I mentioned to you our enthusiasm for developing a spinal injuries unit to serve the South East corner of England including parts of North East and South West Thames, to be located at Queen Mary's, Sidcup site. Our enthusiasm is heightened by the fact that the IHPC may well be recommending the Brook Neurosurgical Unit to move to Queen Mary's, Sidcup and also the fact that Rosemary Kue is not particularly keen to re-build 120 beds at Stoke Mandeville. I am very anxious that with all the attention that is being attracted by the financial difficulties at Stoke Mandeville the long term strategy is not ignored and I wonder whether within the Department you would like to give this matter some urgent consideration with a view to establishing some long term policy along the lines the RMO's indicated to John Evans at our last meeting.

This is just one example of where we need national coordination of recognised multi regional specialties. I know that I mentioned this to you at the RMO's meeting but I wanted to follow the matter through further.

Yours sincerely,

J.M. Forsythe,
Regional Medical Officer

cc Dr. T.K. Sweeney

37A +
37A

37c

Mr Collier

EAL

STOKE MANDEVILLE

Yesterday Mrs Petrie sent Dr Tait and myself a first draft of a Press Handout in connection with the national launch and asked for immediate comments. I told her that we had made some amendments and she asked us to let you have a copy of the amended draft as early as possible this morning. A copy is attached.

There is one small point on your minute of yesterday enclosing the draft questions and answers for the press conference. On answer 7 it would be safer to say in line 4 "plans which we hope will materialise in the South-East". I have today sent a minute to MS(H)'s office about Sidcup (copy attached) which will show why I do not think we can be too specific about Sidcup.

Emergency

in the hospital
in World War II,
ment of the Centre,
a result of the
ts return to live

but in 1953 it
the National
Minister, Winston

G M BEBB
SH2G
B517 AFR
Ext 6132

16 January 1980

cc Mrs Petrie
Dr Tait
Mr Scott Whyte

fully
and the
on the
sure that
the

d their
iorate."]

Since the 1950s a number of other spinal units have been established in England and Wales.

	<u>Number of beds</u>
Midlands SIU, Oswestry	46
Lodge Moor SIU, Sheffield	64
Southport SIU	35
Pinderfield SIU, Wakefield	31
Hexham SIU, Hexham	20

Total: 196
DH Document 07. Page 43

Mrs Fosh

NSIC STOKE MANDEVILLE: DR RUE'S LETTER OF 13 JULY 1981

1. Your minute of 2 August about the long term strategy for the development of the spinal service in the south of England, and Dr Melia's draft reply to Dr Rue refer.
2. As far as Dr Melia's draft is concerned, we agree with you that this should satisfy her for the time being. I have made a few minor suggestions to the draft - see attached - to reflect our view that Spinal Units should also cater for patients with lesions of the spinal cord resulting from disease (eg spina bifida) as well as injury, and provide subsequent re-admission for check-ups and the treatment of complications.
3. However, we do not feel at this stage that we can agree to your suggestion that Oxford RHA/Aylesbury HA should not be pressed to keep beds at the 'old' NSIC open. We have considered the points you raised, and whilst we accept that Oxford does have several major priorities in the near future, we cannot accept that these were unknown in 1980 when the proposal to retain one of the existing wards at NSIC "to cover the transitional period from 1985 to the 1990's" was made. Admittedly Odstock and Stanmore will improve the situation in the south, which is only currently served by Stoke Mandeville, (and the small interim unit at Stanmore) but Oxford were made aware of the need to provide 136 beds (120 in the new unit) until such time as a new unit at Sidcup was operational.
4. In our opinion, the only thing which seems to have changed since 1980 is Dr Rue's assertion that Oxford will not be able to provide the revenue for maintaining 16 beds in the old unit. Perhaps RL could confirm that this is true, and ask the Region for their revenue estimates.
5. If this is true, we may then wish to consider with FB2A (to whom I am also copying this minute) the possibility of obtaining central funds for a limited period to keep the 'old' beds open. The escalating costs of Odstock and Stanmore and the increasing difficulty of obtaining central reserves for major capital developments such as Sidcup make it imperative to keep all the available spinal service beds open if we are going to improve the facilities in the south of England.

Paula Arthur

PAULA ARTHUR
CS3C
B1511 AFH Ext 7713

5 August 1982

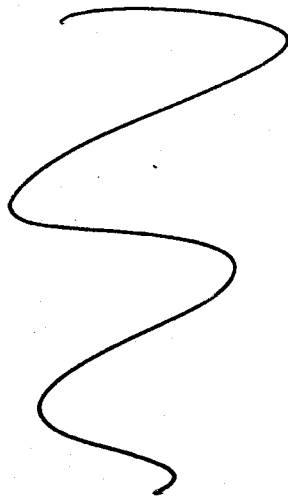
cc
 Mr Collier
 Dr Collins
 Miss Davidson
 Mr Harris
 Mr Jones
 Dr Melia

Mr Morris
 Mrs Parkinson
 Miss Winterton

} without attachment.

No salary Please file on UN1 15.

BLACK PAGE



Mrs Fosh

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5 August 1982

cc

Mr Collier
Dr Collins
Miss Davidson
Mr Harris
Mr Jones
Dr Melia

Mr Morris
Mrs Parkinson
Miss Winterton

} without attachment.

Ms Daley Please file on UN1 15.

As you know, the need for a unit in the South East Thames Region has been identified and a SETRHA Working Party has recommended that St Mary's Hospital, Sidcup, would serve as the ideal location ^{for} a 50/60 bed unit. ~~If such a unit A~~
is in fact proceeded with, then it will raise the number of spinal injuries beds
in the south of England ^{and} to around 240/250

I hope this is of some help.

Yours sincerely

N P Melia

Mrs Arthur:

NSIC STOKE MANDEVILLE: DR RUE'S LETTER OF 13 JULY 1981

1. We spoke recently about Dr Rue's letter of 13 July 1981 and the draft reply prepared by Dr Melia on which Dr Collins commented in her minute of 21 July 1982.
2. The number of beds required for spinal injury patients in the South of England both at present and in the future is a matter on which we look to SH and their professional colleagues for advice. However, in framing your view as to what will be an acceptable number of available beds in the South of England when the new 120 bed unit at Stoke Mandeville opens in 1983, I would wish you to bear in mind the following points:-
 - i. Despite what appears to have been said at the meeting of 2/1/80 referred to by both Dr Tait and Dr Collins, we in RL had rather assumed that Stoke Mandeville NSIC might expect relief from the coming on stream of the Odstock and Stanmore units, and would not have to struggle on, at present bed levels, until the 1990's. I note from the material prepared for the Business Ma. sham oral question in the House in July 1981 (PQ2884/1980/81) that SH appeared to share RL's view. In note 6 of the Notes for Supplementaries it is said "It has always been made clear that the new spinal injury unit at Stoke Mandeville will contain 120 beds, and it is anticipated that the short fall of some 12 beds over existing provision will be met by the facilities coming on stream at Odstock and Stanmore". Nothing on these lines was actually said (to the best of my recollection) in the House during the discussion - but I rather wish it had!
 - ii. Oxford RHA already have great difficulty in finding the revenue resources to develop services for their rapidly increasing population. 'New money' for the NHS over the next few years is going to be very limited so their problems must grow worse. The Aylesbury Vale Health Authority will, no doubt, find it difficult enough to open the new 120 bed unit at full capacity (new accommodation invariably seems to eat up more revenue resources than the old!) without being expected to keep some dozen or so beds open in the old unit concurrently. Oxford RHA have other major priorities for their limited growth resources - the new DGH for Milton Keynes due to open in 1984, and development of mental handicap and mental illness services in the Region (a major item picked up on the fairly recent Regional Review meeting with Minister). With this background, the RHA and DHA are unlikely to see the keeping open of spinal beds in the old unit as a priority - even if the Department were able (as SH have hinted?) to give them additional resources specially for this purpose.
 - iii. The vacated space in the old NSIC has been earmarked for upgrading to house some 110 geriatric and psychogeriatric patients at present at Tindal Hospital, Aylesbury, thus enabling this hospital to be closed by 1985. The closure of this unsatisfactory hospital has long been a Regional and District aim.

iv. Finally, you will recall the confidential information we received within the last year from Mr Michael Rogers alleging that there were fairly serious management problems at the NSIC. The Chairman of the RHA, Mr Gordon Roberts, has taken on board the discreet and confidential follow-up to the allegations which are believed to have some substance. There are hopes that the move to the new NSIC will enable some of these management problems to be tackled more effectively. The running of old and new units concurrently would certainly not help matters.

3. Having considered these points, I hope you will feel able to agree that we should not press Oxford RHA/Aylesbury Vale HA to keep beds at the old NSIC open when the new 120 bed unit is occupied in 1983. Certainly we in RL would advise strongly against it on the grounds of finance, management problems, quality of service provided, and fairness to the Region. We need not spell this out publicly to the RHA — or anyone else — as yet. Dr Melia's draft seems to say enough to keep Dr Rne satisfied for the present.

Lynne Fosh

Mrs Lynne Fosh
RL2E
Room 1526 Ext 816
Euston Tower

2 AUGUST
July 1982

cc Dr Melia
Dr Collins
Miss Davidson
Mr Collier
Mr Morris

Reference.....

*Approved - need beds
can't afford 16 beds*

Dr Melia

RE: SPINAL INJURIES UNIT - STOKE MANDEVILLE HOSPITAL

- You have asked for comments on your draft reply to Dr Rue's letter of 13 July.

- Having only just taken over this subject I confess to being a little baffled by the background.

- Dr Rue's letter of 13 July 1981 seems to be at variance with the note of the meeting of 2 January 1980 as recorded in the file in my possession. Min 2iii states "to cover the transitional period 1985-1990s it is proposed to retain one of the existing Spinal Injury Wards at Stoke Mandeville so that there is no diminution of bed provision following the re-building of the Stoke Mandeville Unit".

- Dr Frank Tait expressed his concern about the content of Dr Rue's letter in his minute of 31 July 1981 (copy attached).

- I note that you made enquiries of Dr Rivett and Dr Wales on 2 June 1982 about bed provision. I do not have copies of their replies but the figures in your draft reply coincide with those of the minute of 13 July 1981 (except Odstock recorded as 50 beds and your letter gives 48). However we are still left with the fact that although there will be an additional 72 beds by 1983, if the 16 beds in old accommodation at Stoke Mandeville are closed we will be short of perceived requirements agreed at the meeting and indicated in your draft reply (paragraph 3 minimum of 200-250).

This is regrettable.

I imagine this has already been discussed but should we not have a further meeting as Dr Rue and Dr Tait have suggested.

Mary Collins

MARY COLLINS
Med CDN
B1111 AFH
EXT 7409

21 July 1982

cc'
Mrs Fosh Miss Winterton
Mrs Arthur ✓
Dr Yarrow o/r

for copying Mike.
Special Units
STO/88 MANDRILL

Mrs Arthur

1. I do not think there is any possibility of meeting the RHA's request. The meeting on 2 January 1980 was arranged at MS(H) request and as the note indicates the proposed unit at Sidcup for which no date had yet been fixed, was included. It was this which enabled SM to reduce from 136 to 110 in the 1990's. I find it difficult to understand how Dr Rue allowed this situation to develop. The meeting at which she was present clearly stated that it is proposed to retain one of the existing spinal injuries beds at SM "to cover the transitional period from 1985 to the 1990's". There was no suggestion that it should be "until such time as the Odstock unit came into her existence" (her letter of 13 July).
2. I do not know anything about the arrangement for level transfer, but if Dr Rue has made this arrangement she has made it in full knowledge of the previous commitment to retain 26 beds in the old unit.
3. We know of long delays in admissions, and worrying shortfalls on review cases for SM. It is impossible to predict to what extent these will be remedied by the new units at Odstock and RNOH. In view of the number of cases involved I think we must think in terms of decades not years. We do not need the SIA to press; our awareness of service needs is sufficient.
4. MS(H) was involved in all these discussions and was present when the initial agreement was reached (19 November) and when the press notice referred to by Mrs Sweeney was discussed. Is a further meeting at that level required.

31 July 1981

FRANK TAIT
Med CPL
B1111 AFH

Spinal Injuries - Beds

Dr Rivett
Dr Wales

RE: SPINAL INJURIES BEDS IN THE SOUTH OF ENGLAND

I am sorry to be bothering you with this but Oxford RHA are concerned because within less than a year from now they will be reducing the number of Spinal Injuries beds at Stoke Mandeville from 137 to 120 (to be provided in the new "Jimmy Savile" Unit). Consequently they need to be assured that there will be additional provision in the South of England to make up for this loss of 17 beds. Also Ministers have previously given assurances that the number of beds at Stoke Mandeville will not be reduced until other additional beds have been provided elsewhere.

I would be grateful therefore if you could let me know how many new additional Spinal Injury beds have recently been provided (or will be provided - and, if so, roughly when) at 1. RNOH Stanmore Dr Rivett and 2. Odstock Dr Wales.

It should then be possible I hope to provide Oxford with some defence against the criticism that they are reducing the size of the Stoke Mandeville Unit.

There is of course, no question of Stanmore or Odstock actually being asked to take patients who are currently being treated at the Stoke Mandeville Unit.

Thank you.

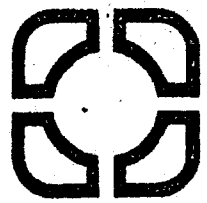


N P Melia
Room 1815 Ext 911
Euston Tower

2 June 1982

cc: Dr Collins
Miss Sweeney

Child 15/7/81



Oxford Regional Health Authority

Old Road, Headington, Oxford. OX3 7LF Telephone 0865 64861 Please ask for

extension

your reference

our reference

11/38/6/SIC ERR/VD

13 July 1981

Dr N Melia
Department of Health & Social Security
Euston Tower
286 Euston Road
London NW1

Dear Norman

SPINAL INJURIES UNIT, STOKE MANDEVILLE HOSPITAL, AYLESBURY

I am writing to you on this subject in the hope that you can effect the necessary co-ordination between those doctors at the DHSS who now are responsible for this Supra-Regional subject.

In January 1980 it was agreed between the Regions concerned and the DHSS that if 110 new beds were opened at Stoke Mandeville there would be a need for an additional 26 beds, currently provided at Stoke Mandeville, during the 1980s, ie until such time as the Odstock Unit came into existence and a redistribution of responsibility was made. You may have heard that thanks to Jimmy Savile we are building a 120 bed unit at Stoke Mandeville which is planned to take patients in the summer of 1983. It seems to us therefore that there will be a shortfall of 16 beds at this time. It would be highly undesirable for operational reasons to retain 16 beds in an old sub-standard ward on the Stoke Mandeville site and the preferred course would clearly be for 16 places to be offered in 1983 in Odstock or elsewhere so that the inter-Regional distribution is adjusted from that date. It is certainly not possible for this Region to provide the revenue for maintaining an additional 16 beds as we have agreed that we shall be making a level transfer in revenue terms from our existing spinal injuries service into the new unit.

I wonder if you or one of your DHSS colleagues could co-ordinate some further discussion as to how this problem is to be solved. I enclose a copy of the note of the last combined meeting referred to above and look forward to hearing from you.

Yours sincerely

Regional Medical Officer

cc Dr I G
DH Document 077 Page 53

Dr Collins
AFH B1111

Re SPINAL RESEARCH - Your Minute of 15 July 1982

I Dr [redacted] Regional Neurologist wants funding or a facility to do research on electrical stimulation of spinal lesions.

He has alienated most of his relationships with neurological colleagues in the Region, but he is accepted as a first class physician and researcher.

The districts have objected to "top slicing" to fund the Regional neurological service.

II There are proposals to fund a Neurological Rehabilitation Chair at Southampton which will have Ashurst YCS as a facility. Dr [redacted] Senior Lecturer in Neurology at the University is the favoured candidate.

Whether the Chair is to be funded should be decided by September 1982. The RMO/DMOs are to discuss this issue on Tuesday 27 July.

The problem is financial. The Region/District/Medical School have raised £250,000 and £½ million is required. The EEC and DES have not been able to help.

Should it be impossible to fund the Chair a consultant in Rheumatology and Rehabilitation will be appointed to run a district service based in Southampton/Ashurst.

III Ashurst YCS unit is being increased from 12-20 beds to provide a district support service for long/short stay disabled. [redacted] is consultant to the unit until he commissions the Spinal Unit at Odstock in 1983. He is supported by a general practitioner and a senior clinical medical officer who liaises with the community. It is recognised that more physiotherapy and occupational therapy is required.

The patients who are mainly suffering from muscular dystrophy are grossly disabled. The YCS Southampton who are too disabled to respond to treatment are kept on the acute wards.

IV It is therefore apparent that Dr [redacted] will have to find other facilities for his research.

26 July 1982

cc: Dr Rothman

Elizabeth Wales
Elizabeth Wales
Room 1814 Ext 924
Euston Tower

A Rue
Lord RHA

July 1982

RE: SPINAL INJURIES UNIT - STOKE MANDEVILLE HOSPITAL

I am sorry to have been so long in replying to your letter of 13 July 1981 and your other enquiries about the provision ~~of~~ spinal injuries beds.

You have pointed out that with the opening at Stoke Mandeville ^{of} the new Spinal Injury Unit of 120 beds it would be highly undesirable for operational reasons - as well as being very difficult from the point of view of available revenue - to retain 16 spinal injuries beds in the old sub-standard accommodation. You are therefore understandably concerned that a reduction in the numbers of spinal injuries beds at Stoke Mandeville from 136 to 120 should not lead to a reduction in the overall bed provision for ^{patients with lesions of the} spinal injuries in the south of England. _{could}

I have made enquiries of my colleagues on this point and they tell me that an interim unit of 16 beds has now been opened at the Royal National Orthopaedic Hospital, Stanmore, and that, when construction of the new unit is completed in a few months time, the total number of spinal injuries beds ^{at Stanmore} will rise to 24; in addition to this, the new 48 bed ~~unit~~ ^{unit} at Odstock Hospital, Salisbury, is due to be opened in mid 1983. Consequently within a year or so there will be an additional 72 ^{for} spinal ^{patients} injuries beds in the south of England, which means that, even if the number of spinal injuries beds at Stoke Mandeville is reduced to 120, the overall number of beds available in the south of England will still be increasing from 136 to 192.

With regard to the wider issue of the overall need ^{of the services,} for spinal injuries beds there is unfortunately no reliable epidemiological data on which to base an estimate of the number of beds needed. Studies have shown the incidence of new spinal injuries to be in the order of 12-15 new cases a year per 1,000,000 population; there is also evidence that the life expectancy of paraplegics and tetraplegics is increasing; furthermore, the duration of treatment for each new case and the need for re-admission for the treatment of complications has been shown to be as dependent on personal and social factors as on specifically clinical ones. Such evidence as we have however suggests that we need, as a minimum, between 200 and 250 beds distributed throughout the southern half of England.

STOKE MANDEVILLE S.I.U.: POSSIBLE SUPPLEMENTARY QUESTION

Question: What is being done to improve the efficiency of the patient re-call system at Stoke Mandeville?

Suggested Reply: I gather that no formal complaints about difficulties with the recall system have been received either from individual patients or from the Spinal Injuries Association. It is quite possible that delays have occurred, and a contributory factor would have been that a radiologist post has been vacant for about 12 months. A new radiologist will be taking up post in September.

However if difficulties have arisen, this is very much a matter to be resolved locally and I know that the health authority would be very willing to discuss these matters and look into individual cases where there are problems.

PQ 2684/1980/81

Wednesday 1 July 1981

HOUSE OF LORDS

PARLIAMENTARY QUESTION FOR ORAL ANSWER

THE BARONESS MASHAM OF ILTON

To ask Her Majesty's Government what progress is being made in building the two new spinal injury units at Odstock Hospital and the RNOH, Stanmore, and with the rebuilding of the spinal injury unit at Stoke Mandeville Hospital.

THE BARONESS YOUNG

I am pleased to say that excellent progress is being made.

48
The main building works for the Odstock Unit are expected to start in August and will take two years to complete. Preparatory work is already under way.

24
Building at Stanmore should start in November and be completed by May 1983. A temporary unit will be opening later this year to provide a service until the work is completed.

1/6 temp
beds.

120
Detailed layout plans for the rebuilding of the Spinal Injuries Unit at Stoke Mandeville Hospital have been agreed by the project team and essential preparatory building works will shortly be completed. The main works can then begin and will take about two years to complete.

10 APR 11 1980
HQ 2884/1980/81

GENERAL SPINAL UNIT POLICY

1. Need for specialised facilities

Her Majesty's Government fully accepts that patients with lesions of the spinal cord - whether resulting from injury or disease - should whenever possible be treated in specially designed, staffed, equipped and designated units.

Spinal units need access to a wide range of services and professional skills to provide patients with the necessary specialised treatment and rehabilitative services. This is essential both in the acute stage and in follow-up care as patients may require further admission to hospital should complications arise.

2. Location of Spinal Units

It is not practical to develop such very specialised resources in every Health Region. The service is a supra-regional one consisting of a number of Spinal Units. Spinal Units are ideally located in a District General Hospital with a well developed rehabilitation department and with access to a range of acute services (notably operating theatres, radiology, microbiology, and in particularly orthopaedics, neurosurgery, urology, plastic surgery and neurology).

3. Rehabilitation

As far as rehabilitation and follow up services are concerned, it is essential that these are developed in close liaison with community services (viz health, social services, housing and employment) in the patient's home area.

4. Number of beds needed

There can be no reliable epidemiological data on which to base an estimate of the beds required nationally as this depends on incidence of injury, duration of treatment of new cases (longer for tetraplegia than paraplegia), the frequency of complications etc. However, we know that the incidence of new spinal injuries is in the order of 12-15 new cases per year per one million population and there is evidence that the life expectancy of paraplegics and tetraplegics is increasing. Studies have also shown that the duration of treatment for each new case and the need for readmission for the treatment of complications is as dependent on personal and social factors as on specifically clinical ones.

5. Where beds are needed

It is not possible to produce a completely rational plan taking account both of incidence/prevalence and distribution factors. This is because the existing units are where they are.

There are approximately 200 beds in the northern half of England (at Hexham, Sheffield, Southport, Wakefield and Oswestry) and these units treat a significant proportion of cases in which the spinal cord has been damaged by disease other than injury, although injury cases have priority. Their ability to extend the range of services in this way suggests that the number of beds is sufficient.

Evidence suggests that we need a minimum of between 200-250 beds distributed throughout the southern half of England. The developments at Odstock, Stanmore and Stoke Mandeville will result in 192 beds being available hopefully, in 1983. The need for a further unit in the south east has also been identified and is included in the Department's longer term plans.

48
124
120
192

6. Will the 120 beds which are to be built at Stoke Mandeville directly replace the beds currently available in the hospital?

The number of Staffed available spinal injury beds at Stoke Mandeville is currently 132. As at 25 June, 129 of these were occupied and there was a cold waiting list of 50 patients - 30 of whom were re-calls.

It has always been made clear that the new spinal injury unit at Stoke Mandeville will contain 120 beds, and it is anticipated that the shortfall of some 12 beds over existing provision will be met by the facilities coming on stream at Odstock and Stanmore.

In the longer term, the Department hopes to see a further unit in the South East Thames Region.

NT

Mr C T Brown

PQ FROM BARONESS MASHAM: NO. 2884/1980/81

As promised in Mr Grimstone's minute of 25 June, I now enclose a supplementary question and answer which covers the discrepancy between the number of beds at SM now, and the number to be build into the new unit. Nobody is quite sure where Lady Masham's figure of 24 comes from!

I also enclose a copy of the press cutting referred to. You might like to put it on the file - but it is so innocuous that I do not think that additional briefing is necessary.

... directly replace

... Stoke Mandeville
... and there was a

... at Stoke Mandeville
... of some 12 beds
... in stream at Odinstock

... in the South East

Lynne Fosh

Mrs L Fosh
RL2E
Room 1527 Ext 816
Euston Tower

26 June 1981

cc Mr Collier
~~Mr Myers~~
Mr Morris
Mr Shaw
Mr Thorpe-Tracey

Ann Arthur

1-29-81

Mrs Alexander x915
Mrs Gadenovskiy x 860

11.45 DEJ
Elizabeth House
York Rd.

ORDS ORAL PQ NO. 2884/1980/81: THE BARONESS MASHAM OF MALTBY

Notes for Supplementaries

Q: Will the 120 beds which are to be built at Stoke Mandeville directly replace the beds currently available in the hospital?

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In the longer term, the Department hopes to see a further unit in the South East Thames Region.

TUESDAY 23 JUN 1981

£12,000 a day puts Savile's helpers in a happy fix

By DAVID FLETCHER *Health Service Correspondent*

THE Jimmy Savile appeal for rebuilding the spinal injury centre at Stoke Mandeville Hospital, Bucks, is in danger of being strangled by its own success.

Donations of nearly £12,000 a day are still pouring in more than 17 months after the appeal was launched.

A total of £6 million has been raised so far but the deluge of letters, donations and inquiries is a problem for the hospital which has no special staff available.

The clerical side is dealt with by eight medical secretaries in their spare time and they take a mass of paperwork home.

One, Mrs Silvia Nicol, said: "We get about 10 letters each day containing cash, cheques and postal orders and send a 'thank you' to each one. On top of that we often get 600 visitors on Saturdays and Sundays."

It was marvellous that so much money was being raised but there was a backlog of replies.

Donation not gifts

"We get daily examples of people's generosity," said Mrs Nicol. "We had a couple celebrating their ruby wedding who asked friends not to give them presents but to send a donation to Stoke Mandeville instead."

But despite the administrative difficulties of coping with such a huge inflow of money the hospital is still keen to encourage donations and has high hopes that the total will reach as much as £10 million.

The appeal was launched by Jimmy Savile in January last year when he promised to "fix it" for the hospital to get a new building. Part of the spinal injuries unit is still housed in wartime huts.

11/184
Miss Winterton

LADY MASHAM'S QUESTION ON 1 JULY

It's been rather a complex job coordinating information for Lady Masham's PQ on Spinal Units but the fruits of our labour to date are attached. What still needs to be done is:

- i) A note on Lady Masham's 24 bed point
- ii) A note covering the recent Daily Telegraph article about Stoke Mandeville.
(Mrs Fosh is doing i) and ii) and will forward separately to Mr Brown)
- iii) Something about general spinal unit policy
(which is for you)

You will see from Mr Brown's attached minute that Lady Young wants a briefing meeting - I would guess this might best be handled by someone from your side and by Mrs Fosh. (Odstock and Stanmore are both factual and the nuances arise on Stoke Mandeville and on the general policy). Someone will need to explain Stoke Mandeville to Lady Young and tell her what to say if she is questioned about the money raised, the money needed, or the mechanics of the Appeal.

Mr Shaw has discussed and agreed the above line.

25 June 1981

copy to: Mr Brown
Mr Collier
Mr Morris
Mr Shaw
Mr Thorpe-Tracey

Mr Arthur P. 3576
H. Major
I tried to ring Mr Collier but no reply. I don't think it is necessary at the moment. J.P. Hawley Young is worried at the briefing you could arrange for her to have a word with Mr Collier afterwards
purca
26/6

Miss Winterton
if it seems
necessary I will
talk to Lady Young.
A.T.C.

BACKGROUND NOTE

1. Introduction

1981 is the International Year of Disabled Persons. The "That's Life" (Esther Rantzen) BBC television programme on Sunday 29 March featured spinal injuries. (A copy of the transcript is at Annex A) It suggested that if everyone with a broken spine was handled correctly, from the moment they were injured, fewer people would be paralysed.

The programme claimed that nurses and doctors in general hospitals were not adequately taught how to handle spinal injuries, and that the public should have education in how to handle casualties.

2. Training

Doctors

Education in the care of spinal injuries is part of their training in general care of accident victims. Clinical care of accident and emergency patients has been enhanced by the recognition by the Medical Profession of the new specialty in Accident and Emergency in 1971 and there are now some 130 Accident and Emergency Consultants in post. On site care of accident victims has improved with the increasing number of general practitioner immediate care schemes. The Department of Health and Social Security cannot determine the content of the training syllabus for doctors. This is a matter for the universities and Royal Colleges. If, however, the Department was supplied with evidence that there was a problem here, it could draw the attention of the Royal Colleges to it and thus help to influence future training. ~~The Department does not have any evidence to suggest that clinical care of such~~

~~patients is inadequate.~~

The Department is ^{authorising an increase in} ~~increasing~~ the number of training posts for doctors in spinal injury.

Nurses

Education in the lifting and moving of patients and the emergency treatment of fractures is part of general nurse training. At the post-basic level, the Joint Board of Clinical Nursing Studies has produced a curriculum for Accident and Emergency Nursing which includes the care of spinal injuries. To date, 14 courses have been approved and 337 certificates awarded. The content of training syllabuses for nurses is the responsibility of the General Nursing Councils.

The general public

The St John Ambulance Association and the British Red Cross Society take the lead in the first aid education of the public. (These bodies receive financial support from the Department of Health and Social Security) Both organisations include in their training the movement and care of casualties with back injuries. Where fire, falling masonry, traffic etc, are an immediate danger to a casualty, he must, in any case, be removed to a safer place.

3. DHSS Policy for hospital patients with lesions of the Spinal Cord.

Patients with lesions of the spinal cord, resulting from trauma, disease or congenital abnormality, require specialised treatment and rehabilitative services. They also require continuing follow

LAST PQ

BACKGROUND NOTES
SUPPLEMENTARIES

~~patients is inadequate.~~

The Department is ^{authorising an increase in} ~~increasing~~ the number of training posts for doctors in spinal injury.

Nurses

Education in the lifting and moving of patients and the emergency treatment of fractures is part of general nurse training. At the post-basic level, the Joint Board of Clinical Nursing Studies has produced a curriculum for Accident and Emergency Nursing which includes the care of spinal injuries. To date, 14 courses have been approved and 337 certificates awarded. The content of training syllabuses for nurses is the responsibility of the General Nursing Councils.

The general public

The St John Ambulance Association and the British Red Cross Society take the lead in the first aid education of the public. (These bodies receive financial support from the Department of Health and Social Security) Both organisations include in their training the movement and care of casualties with back injuries. Where fire, falling masonry, traffic etc, are an immediate danger to a casualty, he must, in any case, be removed to a safer place.

DH Document 07. Page 66

3. DHSS Policy for hospital patients with lesions of the

up and may require further admission to hospital for the treatment of complications. It is not practical to develop such very specialised resources in every Health Region. Spinal units do not therefore serve closely defined catchment areas but admit patients from a number of Regions.

It is generally accepted that the number of spinal units in the North of England is reasonably adequate but since the only unit at present in the South is Stoke Mandeville, the Department is giving high priority to the early provision of 2 additional units in the South. The new units will be at Odstock Hospital, Salisbury (48 beds) and at the Royal National Orthopaedic Hospital, Stanmore (24 beds). In the longer term (at least 10 years) it is also proposed to establish a unit in the South East Thames Region. It is hoped that the units at Stanmore and Odstock will be operational in 1982 and 1983 respectively. The new units will relieve the current pressures on Stoke Mandeville and will improve the geographical distribution of spinal unit beds in the South. The development of these units is not in conflict with the present developments of Stoke Mandeville.

The Department fully accepts that patients with such lesions, whether resulting from injury or disease, should whenever possible be treated in specially designed, staffed, equipped and designated units. Spinal units need access to a wide range of services and professional skills.

Substantial central funds have been allocated by the Department for both capital and revenue costs of the proposed new units at Stanmore and Odstock.

16 bed interim unit to be opened
later this year at Stanmore (in modernised
ward of main hospital).₃
Some spinal injury cases dealt with already.
Director + Nursing Officer in part. DH Document 07. Page 67
Dept has provided additional staff.

4. National Spinal Injuries Centre, Stoke Mandeville

The Spinal Injuries Unit at Stoke Mandeville was operating with 150 beds until about two years ago. As a result of the deterioration in the fabric of the Unit during the winter of 1978-79, two wards were closed for repair. It had been proving difficult to staff a specialised spinal unit of 150 beds in Aylesbury, and so, when the two wards became unusable, it was agreed to keep the bed numbers down to 120 and provide a reasonable service at this level. This presented no problems of availability of places for those patients requiring admission to Stoke Mandeville.

The Government's commitment to see the continuation of the National Spinal Injuries Centre was made clear earlier this year with the launch of the campaign with Jimmy Savile OBE to raise voluntary funds to rebuild the unit completely. The public response to the campaign has been encouraging.

The new NSIC will have 120 beds ⁽¹³²⁾ ~~at~~ at present.) The policy of providing a much more localised network of spinal injuries units in the South of England (one at Stanmore and one at Odstock) means that there will be an overall increase in available beds when the units are completed, and patients will not have so far to travel for treatment. N

5. Spinal Injuries Association

The Association's Chairman is Lady Masham of Ilton. It was formed in 1974 to promote the welfare of all those suffering from spinal cord injuries. Its aims include the collection and dissemination of information for the benefit of paraplegics and tetraplegics, their relatives and all concerned with their care and well being; promoting co-operation between statutory

and voluntary organisations, and staff involved in the field; promoting research surveys and development projects to improve facilities and services; and organising conferences, training courses, exhibitions and other activities aimed at helping paraplegics and tetraplegics and those caring for them. In June 1980, the SIA published a booklet entitled "Nursing Management in the General Hospital: the First 48 hours Following Injury"; the first in a series of booklets under the general title "People with Spinal Injuries: Treatment and Care".

NOTES FOR SUPPLEMENTARIES

1. Why isn't the Government doing more to ensure adequate training in the care and treatment of spinal injuries?

As I have already said the subject is covered in the basic and some post-basic training of doctors and nurses. The responsibility for the content of syllabi of medical and nurse training rests with the Royal Colleges and the universities and with the General Nursing Councils.

2. What can the general public do to help ensure that they do not aggravate a spinal cord injury?

I am grateful to the Noble Lord for giving me the opportunity to emphasise that anybody faced with this sort of casualty should be extremely cautious in giving any aid and should not attempt to move or handle the patient any more than is absolutely essential. Members of the public who have received training from the British Red Cross Society or the St John Ambulance Association will be well aware of this need for care and I would like to pay tribute to those organisations for the very useful training they provide.

3. Numbers of spinal cord injuries

There are over 500 new cases of spinal cord injury in England and Wales annually, and an even greater number of spinal column injuries without cord damage.

4. New spinal units

The Government are giving high priority to increasing the number of beds for people with spinal cord lesions by financing the building of new spinal units at Odstock Hospital, Salisbury (48 beds) and at the Royal National Orthopaedic Hospital, Stanmore, (24 beds). These units are expected to become operational in 1983 ~~and 1982~~ respectively.

Aug 83

May 83

The new units will relieve the current pressures on Stoke Mandeville and will improve the geographical distribution of spinal unit beds in the South.

The Department welcomes in principle the proposal for an additional 50 bedded unit at Queen Mary's Hospital, Sidcup, as part of the overall long term strategy for a national network of spinal units. However it is unlikely that it will be possible to make central funds available within the next ten years.

5. DHSS grant to Spinal Injuries Association

The Spinal Injuries Association first received a grant from the Department of Health and Social Security in 1977/78. This was one of £10,000 for general administrative expenses and publication services. The same level of grant aid was maintained in 1978/79, again being towards general administrative expenses and the cost of the Associations information and publication services. The grant for 1979/80 was increased to £15,000. Once again this was a contribution towards general administrative costs. A further grant of £15,000 was made in 1980/81 and an application for a grant for 1981/82 is currently being considered.

6. What research into spinal injuries is being carried out?

The main Government funded body undertaking research in this field is the Medical Research Council. The Council is directly supporting and giving grants to a number of research projects into the treatment and alleviation of spinal injuries.

ADD IF NECESSARY - I do not have details of the individual projects to hand today, but I will write to the Noble Lord with this information as soon as possible.7

Mr. Arthur,

This gives some
background on the £2m
given to the Jimmy Dore
Hoke Handville appeal.

Peter Smith

10/2/82

RLZE

1526 ET

(ext 850)

87/139

MR D CLARK

STOKE MANDEVILLE APPEAL

You rang me last night to tell me that the Prime Minister had decided to announce this morning (at 11.30) a Government contribution to the Jimmy Savile Appeal. You have been consulting the Secretary of State on the precise amount, but I have drafted on the basis of what I understood from you to be his provisional decision of £1 million.

2. I have not yet been able to contact Jimmy, but I have half-a-dozen calls out to him, and I will let you know if and when I have talked to him.

31 December 1981

A J COLLIER
D904 AMH
Ext 7607

Copies to:

- Mr Venning
- Mr Hulme
- Mr Rayner
- Mr Lillywhite —
- Mr Fawell

Mr Scott-Moncrieff

Mr Clark phoned me this morning (at 11.30!) to tell me that, after taking advice from Mr Collier, Seps had advised No 10 that we could make available £1/2 million (not £1 million) to the Fund; Mr Clark told me that he would be putting round a minute seeking bids for expenditure of this balance (£1/2 million)!

I have -

- a) phoned Derek Davis to inform him,
- b) assured Mr Clark that we can find the £1/2 million from within existing resources; and
- c) by way of his minute, asked Malcolm to arrange to pass the money to the Fund, through - presumably - the Oxford Region.

DH Document 07: Page 74

31.12.81

cc Mr D Harris

DRAFT STATEMENT AND SUPPLEMENTARY NOTES

Jimmy Savile Stoke Mandeville Spinal Unit Appeal

This has been the International Year of Disabled People. Our concern must continue; we must not let our involvement come to an end with the passing of 1981. But this is none the less a good moment, as we come to the end of the year, to give special recognition to what we owe as a community to the disabled. I am very happy to be able to say that the Government should make a contribution of [£1 million] to one of the most important causes of this past year - and one which has attracted the enthusiasm of people from all walks of life - Jimmy Savile's Appeal for the rebuilding of the Stoke Mandeville Spinal Injuries Unit.

Supplementary Notes

1. The target is £10 million, and the appeal has raised well over half. The Foundation Stone was laid by the Duke of Edinburgh in November and the Trustees intend that the Unit should open for business early in 1983.
2. The idea of the Appeal came out of a talk between Patrick Jenkin and Jimmy Savile, and Gerry Vaughan has maintained a close and continuing interest in it.
3. The vast bulk of the donations has come from the efforts and generosity of individuals, directly to the Unit or through the magnificent response to the Daily Express' enthusiasm.
4. The administration of the fund-raising has been undertaken by people at the hospital and elsewhere, working their spare time.
5. The grant will not affect the financial allocations to the Health Authorities.
6. The appeal's success is a great tribute to Jimmy and to the generosity of the people of this country.

Standard

31.12.87

Maggie gives £1m to Jimmy's fund

by Charles Reiss

JIMMY SAVILE got a £1,000,000 present from the Prime Minister today.

It is in aid of the £10 million fund he launched in 1983 to help launch a new mental unit at the Long Grove Hospital for the Disabled.

The gift brings the fund - launched less than two years ago in conjunction with the Daily Express - to around £10 million.

Mrs Thatcher announced the gift from the Government in a New Year message.

She said: "This is a good moment, as we come to the end of the year, to give special recognition to what we owe to a community to the disabled."

Mrs Thatcher added that the gift came at the end of the International Year of the Disabled People - but it was important that interest and support should continue into 1988 and beyond.

The gift is another mark of Mrs Thatcher's personal friendship with Jimmy Savile OBE - a frequent visitor to Downing Street.

The decision was taken after

the Prime Minister had talked to Social Services Secretary Mr Norman Fowler.

Prince Philip laid a foundation stone for the unit - which will be devoted to the treatment of spinal disabilities - in November. It is hoped it will open early in 1988.

Jimmy Savile was at his home in Leeds when Downing Street telephoned him with the news of the donation.

"It was a good job I was sitting down - otherwise I'd have fallen down in surprise," he said.

"This is tremendous news

for all the boys and girls, men and women, who have helped so far."

He said that although the Prime Minister - whose Chiquery house is about four miles from Grove - made the -bad - taken - a personal interest in the appeal today's news came "clean out of the blue."

He added: "Mrs Thatcher always likes to know how we're getting on and I know that she wanted to acknowledge this tremendous effort by British people and British industry."

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NATIONAL SPINAL INJURIES CENTRE AT STOKE MANDEVILLE HOSPITAL:
FOLLOW UP TO MS(H)'s MEETING WITH MR MICHAEL ROGERS ON 9 SEPTEMBER 1981

In his minute of 22 September to Mr Smith, Mr Knight asked for a draft letter for MS(H) to send to Mr Rogers. A draft letter, on the lines suggested in my minute of 14 September to Mr Knight, is now attached.

Signature for B1.

Mrs L Fosh
RL2E
Room 1527 Ext 816
Euston Tower

18 November 1981
received 20/11

*no comment
JCF*

~~De Faut~~
~~Miss Paine~~

*if you have any comments on the draft,
I suggest these are sent directly to PO,
after clearance by RL2E*

*No comment.
B. 23/11
Don't know the Department
have a copy of the report
on the papers of the meeting
with the Law of the Board?*

- 1. Mr Myers - to see. ^{pm 30/11} Paula Asher
B1511 x7713 24/11*
- 2. Ms Maynard O/R ~~ERM~~ 1.12.81.*

*- please find out from
RL. See X of draft letter.*

Paula Asher 24/11.

SSA

Reference

Mr P G Smith

NSIC: STOKE MANDEVILLE HOSPITAL

The Minister for Health has seen the minute dated 14 September by Mrs Fosh (who I understand is now on leave) about the follow-up to his meeting with Mr Rogers and his colleagues. Dr Vaughan would be grateful for a letter to Mr Rogers on the general lines set out by Mrs Fosh.

1981

JEX

J E KNIGHT
D614 AFH
Ext 7601

22 September 1981

cc
Mr Collier
Mr Morris
A.7 (with pps)

orry to have been
onsider in detail
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*Thisweeney,
may I have a draft pl. (Have
a word first if necessary.)
P. Smith
24/9/81*

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... that would interfere with their services to the NHS. The maximum part-time consultants (of whom there are about 3,000 in the country including I believe the NSIC consultants) are in fact consultants who occupy a whole-time post, and carry out its full duties, but who are permitted to undertake private practice without a financial limit. They receive 10/11ths of the whole-time salary. They have (unlike whole-time consultants,) to make formal minimum work commitments, which however are not regarded as "norms" or "total" commitments. This is part of the way through which Health Authorities can maintain control over the more flexible working arrangements of this type of contract. I should perhaps stress that authorities

CONFIDENTIAL

Mr Michael A Rogers



1981

Thank you for your letter of 11 September. I am sorry to have been so long in responding, but I have now had time to consider in detail the document you presented to me when we met in September. It occurs to me that there are a few general points on which I could usefully comment without approaching the health authorities, or breaching the confidentiality we have agreed to maintain in discussing these sensitive matters.

First of all, I think it would be helpful if I explained the way in which NHS consultants may quite legitimately, within the terms of their NHS contracts, undertake private practice. In the NHS, consultants can be appointed on a full-time or a part-time basis. Within the full-time group, there are two variations - the "whole time" consultant and the "maximum part-time" consultant. Both are expected to devote substantially the whole of their professional time to the NHS, and following new arrangements introduced at the beginning of 1980, both can undertake some private practice. However consultants are not expected to undertake private practice in a way or to an extent that would interfere with their services to the NHS. The maximum part-time consultants (of whom there are about 3,000 in the country including I believe the NSIC consultants) are in fact consultants who occupy a whole-time post, and carry out its full duties, but who are permitted to undertake private practice without a financial limit. They receive 10/11ths of the whole-time salary. They have (unlike whole-time consultants,) to make formal minimum work commitments, which however are not regarded as "norms" or "total" commitments. This is part of the way through which Health Authorities can maintain control over the more flexible working arrangements of this type of contract. I should perhaps stress that authorities

are entitled to expect the same degree of service from maximum part-time consultants as from whole time consultants, although with the latter there are no fixed or maximum hours of work. It should be borne in mind that virtually all consultant posts are advertised as "whole time/maximum part-time". Applicants for the post are not asked which option they would prefer, and the successful candidate makes the choice only after appointment. Consultants already in post may change from one option to the other if they wish, and only in cases of exceptional service need can authorities offer a whole time post without the maximum part-time option.

You may already know that the Oxford RHA have approved the establishment of a 4th consultant post at the NSIC. They hope to be in a position to advertise the post early next year. This appointment, when made, should ease some of the problems of medical cover you mentioned. On the question of the appointment of a Medical Director you know that this type of organisation for a clinical department is no longer common, not generally favoured, in the NHS or by the medical profession. However, as I explained when we met, there is no hard and fast rule about this and I am discreetly exploring the possibilities for the future.

You mentioned also when we met, the nurse staffing levels at the NSIC. We already had to hand within the Department some information on the nurse staffing levels at the NSIC and I am enclosing some tables which you may find interesting. They show that the average percentage turnover for trained nursing staff was 4% for the year ending July 1981: the equivalent figure for untrained staff 2.3% (with normal "peaks" to coincide with the end of training periods etc -) (We have no national figures for average percentage turnover of nursing staff but many Regions produce their own figures and, although not all calculated on exactly the same basis, these show turnover figures ranging from 8% to 14% per year). I am told that between 1977 and 1981 the ^{has been some increase in the} number of trained nurses for both day and night duty ^{and some} ~~has increased~~ ^{despite the} reduction in the number of beds at the Centre. The number of untrained staff has decreased slightly over the same period but not in relation to numbers of available beds.

X You know that the spinal injuries sector recent **DH Document 07. Page 80**

X which set out the required nurse staffing establishment for the Centre. This report is currently being discussed at District level. No doubt the Buckinghamshire Area Health Authority will take positive steps to remedy any deficiencies which are identified as a result of their consideration of the Report.

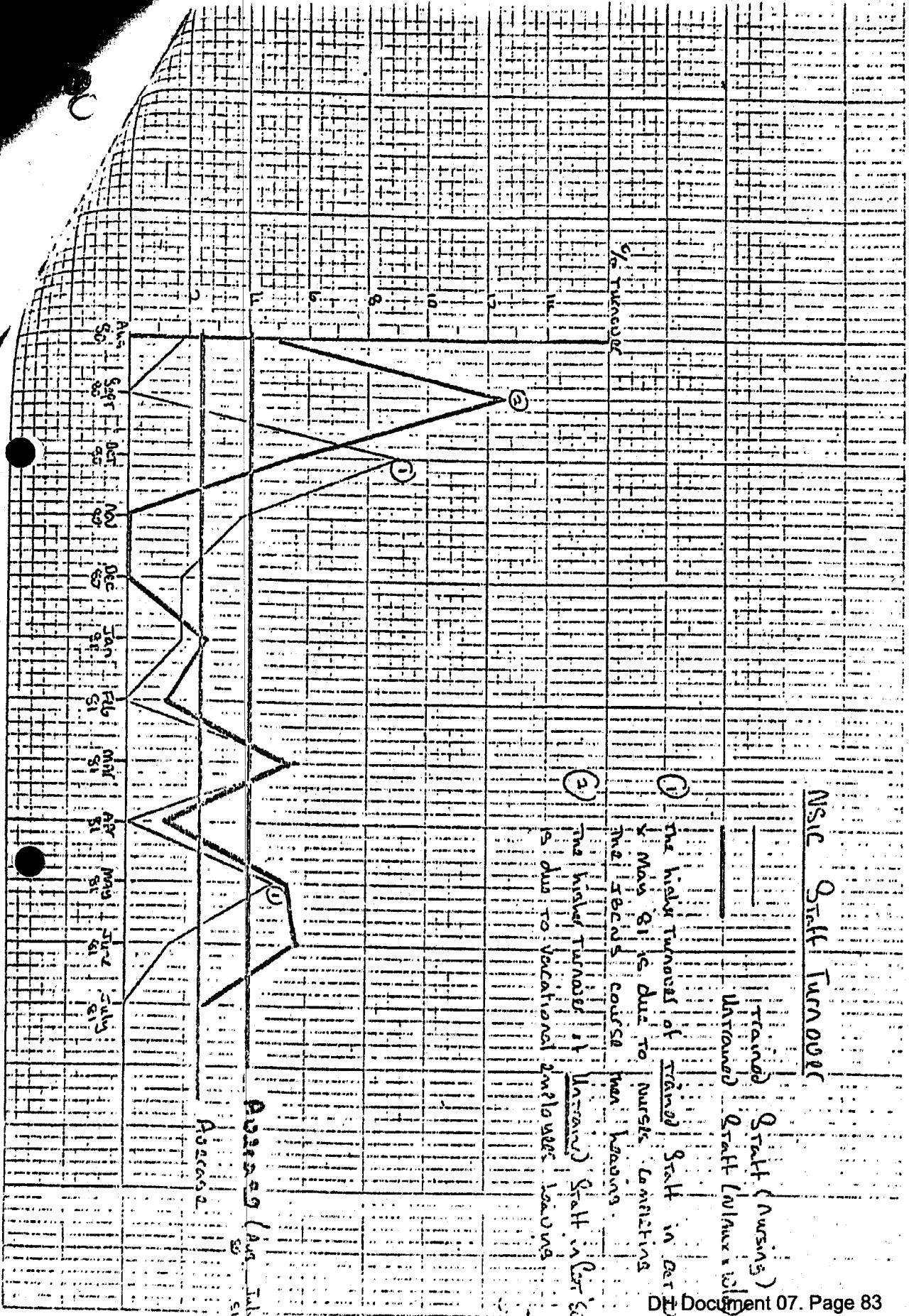
You spoke to me also of frictions within the NSIC because of distinctions between paying and non-paying patients in the Unit. I believe very strongly that the NHS has much to gain by the inclusion of private practice and there is no reason why conflict in standards should exist. Indeed, when we amended the health services legislation last year we included a provision to make quite clear that private practice in NHS hospitals must not, and should not, be to the significant detriment of services to NHS patients. And we agreed with the medical profession a set of principles which should guide doctors in providing services to paying patients. It included one that standards of clinical care and services provided by the hospital should be the same for all patients, though this was not intended to stop patients paying separately for extra amenities, or the practice that the day to day care of private patients is usually undertaken by the consultant engaged by them.

You also raised the question of Dr Ruth Jacob's unsuccessful application for a DHSS grant. In the strictest confidence I am told that her research project did not attract sufficient priority when measured against the fairly rigorous criteria governing the disbursement of central DHSS research funds and this was due partly to shortcomings in the way Dr Jacobs presented her research proposal.

Finally, let me say how glad I am that you found our meeting helpful. I hope you find these further remarks helpful also. I assure you I will continue to take a keen interest in matters affecting the NSIC.

With best wishes

NSIC - Nursing Trained Staff		Enrolled	In Post	Vacancies	A	B	C	III	I
Month	Year	Enroll	In Post	Vacancies	A	B	C	III	I
August	1980	58.73	50.80	7.93	-	0.02	0.09	0.71	7.11
September	1980	58.73	52.53	6.20	0.11	2.37	-	2.48	7.11
October	1980	58.73	69.99	8.74	0.94	2.56	0.02	3.52	5.7
November	1980	58.73	48.06	10.67	1.23	4.57	-	5.80	4.57
December	1980	58.73	47.06	11.67	4.02	3.31	0.81	5.90	4.57
January	1981	58.73	46.06	12.67	4.52	5.55	1.27	9.14	3.52
February	1981	58.73	48.06	10.67	1.44	3.95	0.44	11.34	1.57
March	1981	58.73	47.35	11.38	1.76	3.33	0.71	6.03	1.57
April	1981	58.73	51.35	7.38	2.76	2.78	0.98	5.80	5.58
May	1981	58.73	56.35	2.38	1.26	3.01	0.83	6.52	0.98
June	1981	58.73	55.35	3.38	0.98	3.46	1.39	5.10	2.78
July	1981	58.73	55.35	3.38	2.86	2.96	2.02	5.83	2.78
NSIC - Untrained Staff									
August	1980	72.5	72.5	-	-	-	-	-	-
September	1980	72.5	66.87	5.63	-	-	16.92	16.92	-
October	1980	72.5	63.87	8.63	-	-	12.05	12.05	-
November	1980	72.5	65.87	6.63	-	-	12.55	12.55	-
December	1980	72.5	62.76	3.74	-	-	14.43	14.43	-
January	1981	72.5	67.76	4.74	-	-	10.55	10.55	-
February	1981	73.03	68.67	4.36	-	-	10.75	10.75	-
March	1981	73.23	63.71	9.52	-	-	11.11	11.11	-
April	1981	73.23	71.23	2.00	-	-	10.35	10.35	-
May	1981	73.41	68.77	4.64	-	-	10.89	10.89	-
June	1981	73.41	66.24	7.17	-	-	11.53	11.53	-
July	1981	73.61	68.21	5.40	-	-	7.39	7.39	-



NSIC Staff Turnover

Trained Staff (Nursing)
 Untrained Staff (Laboratory)

① The high turnover of trained staff in Oct 51 & Nov 51 is due to nurses completing the 32nd course from Leavenworth.

② The higher turnover of untrained staff in Apr 52 is due to vocational employees leaving.

Nursing Staff

NSIC

* (These Funds) Estab. Trainers were prior to 3/12/81

Year	No of Beds	Wards Open	Day Duty	
			Funded Estab. Trained Staff	Funded Estab. Untrained Staff
May 1977	156	9	* 52.12 wte	79.92 wte
May 1978	148	7	* 55.21	78.95
May 1979	126	6	* 56.21	72.95
May 1980	134	6	* 55.75	72.00
May 1981	133	6	58.73	73.41

3M Night Duty Global Figure

May 1977

1981

Funded Estab. Trained Staff

85.67 wte

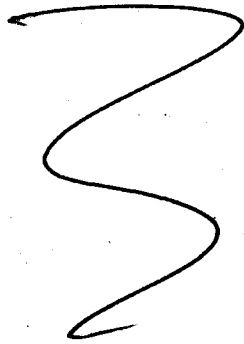
NS. 411

Funded Estab. Untrained

42.67 wte

< 1.77

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Nursing Staff

NSIC

(* These Funded Estab. Finances were prior to 3/1/81)

Date	No of Bids	Wards Open	Per Duty	
			Funded Estab. Trained Staff	Funded Estab. Untrained Staff
Mar 1977	156	8	* 52.12 WTE	79.92 WTE
Mar 1978	128	7	* 55.21	78.95
Mar 1979	126	6	* 56.21	78.95
Mar 1980	136	6	* 55.75	72.00
Mar 1981	133	6	58.73	73.41

3MH Night Duty Global Finance

Mar 1977

1981

Funded Estab. Trained Staff

Funded Estab. Untrained

85.67 WTE

42.67 WTE

NO S.ILL

51.77

251

Correspondence with
Spinal Injuries Association
and development of services
for spinal injury patients.

On the question of recall for check-ups, you will appreciate that responsibility for the arrangements for the day to day management of the NSIC rests, as with any other hospital service, with the local health authorities - (in Buckinghamshire AHA and the Oxford RHA. They must determine, within the resources being made available to them from central funds, the priority which they wish to attach to any particular improvement in the services they are providing. The Buckinghamshire Area Health Authority tell me that the Aylesbury District Management Team meets regularly (every three months) with the consultants at the NSIC and representatives of the Spinal Injuries Association and that the points you raise about the management and services at the NSIC have been discussed in detail at these meetings. Regional officers, who have been in close touch with NSIC requirements over the last year in the planning of the new NSIC, are fully aware of the problems.

Quite frankly, in the present economic climate, it is unrealistic to expect the health authorities to be in a position to make dramatic improvements in the services they are providing. Nevertheless, in the longer term the opening of the new, carefully planned NSIC itself and of the new units at Stanmore and Odstock, should lead to a lessening of pressures on the facilities at Stoke Mandeville. In the immediate future, the appointment of an additional Radiologist at Stoke Mandeville from 1 October 1981 is expected to ease the recall problem somewhat. The District Management Team are also now considering a report, from NSIC staff, making a case for an increase in nurse staffing levels.



*Mr. Allison 22/10
to note + file per
file
20.10*

COPY FOR INFORMATION

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6RY

Telephone 01-407 5522

From the Minister of State for Social Security and the Disabled

PO(MIN-SS)2819/47

Mr Stephen Bradshaw
Director
Spinal Injuries Association
5. Crowndale Road
LONDON
NW1 1TU

15 October 1981

Dear Mr Bradshaw

You wrote to Baroness Young on 27 July following the replies given to Lady Masham in the House of Lords on 3 July about development of services for spinal injury patients. I am sorry I have not been able to reply sooner.

I am sorry that you were disturbed by what you felt was a dismissal of the concern expressed about problems in the recall of patients for check-ups to the National Spinal Injuries Centre at Stoke Mandeville. This is a misunderstanding of Lady Young's remarks, which were intended to refer only to the absence of any recently received complaints (at either the Area Health Authority or the Department) about the actual system of recall itself.

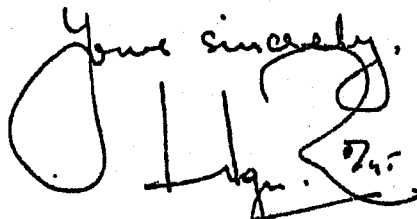
On the question of recall for check-ups, you will appreciate that responsibility for the arrangements for the day to day management of the NSIC rests, as with any other hospital service, with the local health authorities - (in Buckinghamshire AHA and the Oxford RHA. They must determine, within the resources being made available to them from central funds, the priority which they wish to attach to any particular improvement in the services they are providing. The Buckinghamshire Area Health Authority tell me that the Aylesbury District Management Team meets regularly (every three months) with the consultants at the NSIC and representatives of the Spinal Injuries Association and that the points you raise about the management and services at the NSIC have been discussed in detail at these meetings. Regional officers, who have been in close touch with NSIC requirements over the last year in the planning of the new NSIC, are fully aware of the problems.

Quite frankly, in the present economic climate, it is unrealistic to expect the health authorities to be in a position to make dramatic improvements in the services they are providing. Nevertheless, in the longer term the opening of the new, carefully planned NSIC itself and of the new units at Stanmore and Odstock, should lead to a lessening of pressures on the facilities at Stoke Mandeville. In the immediate future, the appointment of an additional Radiologist at Stoke Mandeville from 1 October 1981 is expected to ease the recall problem somewhat. The District Management Team are also now considering a report, from NSIC staff, making a case for an increase in nurse staffing levels.

Buckinghamshire AHA's share of Regional resources is not ungenerous; it is above its RAWP "target" in terms of revenue allocation and, in view of its increasing population, is likely to continue to receive a large share of any growth money made available to the Oxford Region over the next few years. A new method of accounting has been introduced within the AHA this year so that the sums spent on the NSIC may be more readily identified in the area's expenditure accounts.

You mentioned, also, the necessity for greater support for the NSIC from medical social workers. The Buckinghamshire AHA agree with you that this support needs to be strengthened and have been in correspondence with Buckinghamshire County Council on the subject. A number of discussions have taken place between consultants at Stoke Mandeville and the Social Services Department, who are also concerned about the number of social workers available to the NSIC. However it seems that the Bucks CC, because of the strictures affecting its own budget, cannot be as helpful as it would wish in allocating further resources to medical social work in the County.

I am sorry if you find my reply a little disappointing. I can assure you that there is no lack of appreciation on my part of the particular problems of people with spinal injuries. In the present financial climate we must recognise that we simply cannot make progress as quickly as we would all like.

Yours sincerely,

HUGH ROSSI

CH

Mr Myers

PO(MIN-SS)2819/47:

DUE DATE 24/8/81

CORRESPONDENCE 27 JULY 1981 BETWEEN MR S BRADSHAW DIRECTOR OF SPINAL INJURIES ASSOCIATION AND BARONESS YOUNG

Mr Bradshaw has followed up, on Lady Masham's behalf, the discussion in the House of Lords early in July on SIUs. His letter to Baroness Young goes wider than specific complaints about the NSIC at Stoke Mandeville and I hope I may look to you to provide a contribution to the reply on the wider issues.

You will see that we have written to Bucks AHA for comments on the local facts. For convenience, I am copying this minute (with the correspondence) to Dr Tait and Mr M Harris (funding of SIUS) as they may wish to send you comments direct.

W. J. H. R. S.

Mrs L Fosh
RL1E
Room 1533 Ext 846
Euston Tower

20 August 1981

rec'd 16.30.

cc Dr Tait
Mr M Harris FIB

Ann Arthur

As RLIE are coordinating a reply I think the file should be returned to them as soon as possible so that they have all the pgs to hand when they receive Bucks AHA reply to their letter of 14 August. Until we see their reply, and comments from Dr Tait and Mr Harris, we are not in a position to consider what form our contribution might take.

As I shall be away for two weeks A/L on from 21.8., I suggest you take copies of relevant pgs on this file, then return it forthwith to RL. In due course you will need to coordinate the SHZC contribution, which you should clear with Ann Winterton before passing to RL. *W. J. H. R. S.*



Department of Health and Social Security
Euston Tower 286 Euston Road London NW1 3DN

Telephone 01-388 1188 ext

Mr K G Walker
Area Administrator
Buckinghamshire Area Health Authority
Peveral Court
Portway Road
Stone
AYLESBURY
Buckinghamshire
HP17 8RP

Your reference

Our reference

PO(MIN-SS)2819/47

Date

14 August 1981

Dear Mr Walker

You may recall the oral questions, raised by Lady Masham in the House of Lords early in July, concerning Stoke Mandeville and other spinal injury centres. As a follow-up to that discussion, Mr Stephen Bradshaw, the Director of the Spinal Injuries Association has written to Baroness Young raising several points on the facilities and resources being made available for spinal injury patients.

His letter (of which I enclose a copy) refers to matters which require a reply from the national and Departmental viewpoints but it also raises a few points specific to the NSIC at Stoke Mandeville and I would welcome your comments on these. On recall of patients, I should like to know something of the present position, whether this reflects a deteriorating situation, and what plans if any the Area Health Authority have in mind to improve the situation. Do the plans include a computer assisted recall system which the Area Health Authority would consider to be of benefit? Would you comment also on the allegation that the NSIC is relatively poorly served by social workers. On funding of the NSIC, is it possible to identify, without undue efforts, the expenditure of AHA resources on the NSIC and how this compares with expenditure on other patients/sections of the hospital?

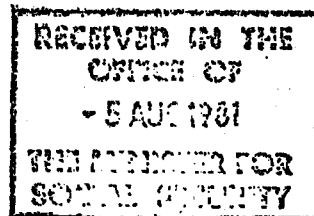
I should be grateful to have your comments on these points and any other information you consider relevant as soon as possible so that we may prepare a reply for Baroness Young to send to Mr Bradshaw.

Yours sincerely

Miss M T Sweeney

COPY MR R.C. TITLEY, District Administrator, Aylesbury - Milton Keynes H.D.

The Baroness Young
Minister of State
Department of Education and Science
Elizabeth House
York Road
London SE1 7PH



Spinal
Injuries
Association

5 Crowndale Road London NW11TU 01-388 6840

Chairman Baroness Masham of Ilton
Vice-Chairmen Mrs Wyn Howarth SRN SCM
& Mrs Patricia Pay MA PhD LLB
Hon Treasurer Paul Bush
Hon Consultants Miss I Bromley MSCP
Mr A G Hardy MBE FRCS
Mr P Smith FRCS
Director Stephen Bradshaw
General Secretary Mary Ann Tyrrell
Welfare/Development Officer Frances Hasler
Legal Claims Bart Hellyer LLB

27th July 1981

Dear Lady Young

REFERENCE YOUR STATEMENT HANSARD VOL 22, No. 108, Col 192
3rd July 1981

The Spinal Injuries Association (SIA) was pleased to see in your answer on 3 July 1981, Hansard Vol 22 No 108, Column 192 to our Chairman's written question, asking what progress is being made in the building of the two new Spinal Injury Units at Odstock and at the RNOH, Stanmore, and with the rebuilding of the Spinal Injury Unit (SIU) at Stoke Mandeville Hospital, that progress is being made although obviously not as rapidly as we would like. And also to see confirmation that a temporary unit will be opening later this year at the RNOH. SIA has been actively involved in bringing to the attention of successive Governments the need for new SIUS and has been involved in the planning of these new units so it is justly pleased that progress has and is being made.

However, the Association was disturbed to read that you dismissed our Chairman's concern expressed at the serious problem regarding aftercare 'Checkups' of the estimated 5000 ex patients from the National Spinal Injuries Centre (NSIC) by reporting that there have been no formal complaints from individual patients at Stoke Mandeville Hospital or from the SIA. The NSIC serves an area south of a line between the Wash and Severn with a population of some 23½M besides treating Service personnel and overseas people etc. (see enclosed copy of SIA's 1976 Submission to the Royal Commission on the National Health Service). Yet, despite repeated statements that funds should flow to the Centre via the Oxford Regional Health Authority and from other RHA's under the RAWP formula, this mythical extra money has never arrived and the Centre has consistently been starved of funds for staff and facilities with consequent cutbacks in acute and chronic service provision (see enclosed copy from Therapy 21st October 1977, SIA's Press Release 29th January 1979 and Stoke Mandeville Adjournment Debate 2nd February 1979 Hansard column 1934). In the above mentioned Adjournment Debate Mr Timothy Raison raised 'the current grave position of Stoke' reporting the collapsing ceilings, a shortage of nurses, physiotherapists, medical social workers and a waiting list for acute patients, let alone chronic patients for checkups.

DH Document 07. Page 92

Cont.....

He reported the £400,000 promised a year earlier 'is a mythical book-keeping transaction'. And despite a damning report on the state of the hospital from one of the consultants to the region and pleas for money to replace the rusting beds, no extra finance was given notwithstanding ministerial assurances. The beds and mattresses are in such a dreadful state that monies from charitable sources are being used to replace them gradually. This last example illustrates the lack of funding, indicating evidence of the fact that there have been so many major problems at the hospital that difficulties in regard to checkups have resulted in people not receiving the accepted level of aftercare under the NHS and are patently not a matter that can be resolved locally.

The facts regarding checkups indicate that they are simply not capable of solution by discussion with the Health Authority or looking into individual cases. Indeed, it was only on the 12th June that representatives of SIA, at the quarterly meeting with the consultants of NSIC and the District Management Team, organised by the Association, raised the problem of the Unit's inability to offer appropriate aftercare to the large numbers of ex patients who should be checked up every 2 years at least, as is the established practice of northern Spinal Injuries Units.

Northern SIUs in the country have a system of calling back patients every one or two years, yet, in view of the lack of facilities and undermanning over the years at NSIC, they have been unable to meet the recognised demand for checkups and thus have had to leave it to individuals whether or not they contact the Unit to request a checkup. We have members who have not gone back or been called back to the NSIC for 10 and even 15 years or more. This state of affairs, besides denying basic care under the NHS, is a waste of the country's resources as all too often people return with major problems which could have been prevented if a prophylactic approach could have been adopted.

We note with approval the Government's commitment to the concept of prevention both in Ministerial statements and the recently published document, 'Care and Action'. Further we see an adequate and effective check up system as being squarely in line with this commitment - if paraplegics are checked regularly then minor problems can be treated before they develop into major ones. Not only would this save individuals from pain, suffering and unnecessary hospitalization, but also, we would suggest, that it would prove cost effective in that fewer acute beds would be taken up and individuals would be free to work for longer.

It is a sad fact that the NSIC has not protested sufficiently vehemently at the underfunding over the years and has only publicised its problems or been forced to publicise when catastrophe strikes eg the collapse of ward ceilings. The DHSS accepts that specialist units are the correct places to efficiently treat spinal cord injured people, yet is the department aware that acute patients from last summer's accidents have had to wait the longest period ever for admission to the NSIC and some were only finally admitted at the beginning of summer 1981?

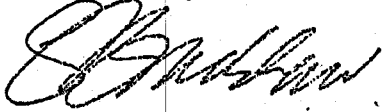
The waste in resources in human and financial terms of incorrect and extended treatment is incalculable. If the Centre is unable to cope with acute cases through lack of facilities and staff, how can they offer the accepted correct regular checkups to ex patients? Over the years the situation has regularly become critical on so many different counts at the NSIC that chronic problems tend to be ignored rather than acknowledged or solutions actively sought eg for years there has been between one and one and two thirds social workers at the Centre (136 beds) with an active case load of around 80 each, whilst at, for example, Southport SIU (36 beds) the one social worker has a case load of some 40 patients, yet has there been an outcry?

At SIA's meeting on the 12th June at the NSIC, it was suggested that a computer system is needed to overcome the administrative overload and process data on patients. This approach would also pave the way for more-effective research into spinal cord injured people based on the complex data needed eg level of spinal cord lesion and thus basic residual muscle function, record of treatment, potential complications and social conditions at home etc. The Government should consider the advisability of the approach adopted in the United States regarding the 14 federally funded regional spinal injuries units whereby statistics on all patients who enter those units and the results of their checkups in years following their leaving are fed into a central computer annually, analysed and published. This country has only the most approximate idea of the incidence and prevalence of traumatic paraplegia, in part due to its not being a notifiable condition, and numbers of people with damaged spinal cords never even attend a recognised SIU.

No doubt when the new SIUs are in service, the situation in the South will improve but it must be noted that even when the new units being built come on-stream, there will only be 192 beds in the South, although there were 196 in 1966. The years of neglect in offering checkups to spinal cord injured people can only be tackled by looking at the problem in total and organising a programme of discovering those who are not being offered proper aftercare under the NHS and, if necessary, organising checkups in local hospitals with X-rays of IVPs etc. sent to NSIC for evaluation. If the proposed SIU in Sidcup could be brought on-stream in 5 years rather than perhaps 20, then not only would there be the possibility of bringing acute and chronic care of spinal cord injured people under control sooner but also SIUs could begin to make their expertise more readily available to people with other disabilities who have never had the benefit of specialist knowledge developed in relation to traumatic paraplegia in the country's SIUs.

We stress again that the question of treatment and care of spinal cord injured people in the South of the country is not simply a matter of local Health Authority considering the situation or looking into individual cases but is a problem of national significance.

Yours sincerely



Stephen Bradshaw
Director

C.C. The Rt Hon Patrick Jenkin MP, the Secretary of State for
Social Services

Dr Gerard Vaughan MP, the Minister of Health

The Earl of Selkirk: My Lords, is my noble friend aware, in spite of the impressive answers she has given, that it is difficult for people to find out what benefits they may receive? For instance, is it not fair that a father with a severely disabled son should know exactly what his son is entitled to? I understand that in any case he is entitled to an attendance allowance, mobility allowance and invalidity allowance, but not to a supplementary benefit allowance. Can we be told at what figure deductions from any cash reserves start? I understand that the basic figure is £2,000. At what rate do the deductions progress after that?

Baroness Young: My Lords, as the noble Earl has raised a particular case I hope he will accept that it would be better if I wrote to him about the circumstances. On the point of people being entitled to supplementary benefits, I can say that one of the difficulties at present is that a person who receives invalidity benefit may well have an income which is above the supplementary benefit level and therefore would not be entitled to this. There is this poverty trap which comes into these particular cases. It may well be that these are the circumstances in which this particular person finds himself, but I will, if I may, write to the noble Earl about it.

Baroness Faithfull: My Lords, would not the Minister agree that it would be enormously helpful if there were an inquiry department in each supplementary benefit office, so that everybody would know exactly to whom they could apply at a supplementary benefit office for the detailed information they are seeking?

Baroness Young: My Lords, I certainly note the point made by the noble Baroness. I think that people going to supplementary benefit offices can always get the information they want, but if this is not clearly indicated—

Several noble Lords: No!

Baroness Young: If this is not clearly indicated, it would be a matter for local decisions.

Lord Wallace of Cosham: My Lords, is the noble Baroness aware that we are discussing a very complicated and involved matter? Would it not be advisable—I offer this suggestion—to set up a Select Committee to investigate the whole matter with a view to simplification and consolidation of the law involved?

Baroness Young: My Lords, that is really very wide of the original Question, but I should like to say to the noble Lord that over the whole area of social welfare the system of child benefits has reached a state which is intelligible and on which I think there is a great deal of agreement; the second-tier pensions system is very clear, and of course as that comes into full effect so we hope that less supplementary benefit will be necessary. We therefore believe that there will gradually be a simplification of the system in this particular way.

Spinal Injury Units

2.56 p.m.

Baroness Masham of Ilton: My Lords, I beg leave to ask the Question which stands in my name on the Order Paper.

The Question was as follows:

To ask Her Majesty's Government what progress is being made in building the two new spinal injury units at Odstock Hospital and the RNOH, Stanmore, and with the rebuilding of the spinal injury unit at Stoke Mandeville Hospital.

Baroness Young: My Lords, I am pleased to say that excellent progress is being made. The main building works for the Odstock Unit are expected to start in August and will take two years to complete. Preparatory work is already under way. Building at Stanmore should start in November and be complete by May 1983. A temporary unit will be opening later this year to provide a service until the work is completed.

Detailed layout plans for the rebuilding of the spinal injuries unit at Stoke Mandeville Hospital have been agreed by the project team, and essential preparatory building works will shortly be completed. The main works can then begin and will take about two years to complete.

Baroness Masham of Ilton: My Lords, I thank the noble Baroness for that interesting reply. May I ask whether she is aware that there is a very great and serious problem regarding the after-care of the patients of Stoke Mandeville Hospital, of which there are about 5,000 on their books? There is no computer service and the administration is overloaded and therefore very inefficient. Also, there is no call-back system, and many patients get into serious problems related particularly to their bowels, bladders and pressure sores. Could the Government look into this very seriously? Is the noble Baroness further aware that in the last week I have heard of two cases through general practitioners contacting me and asking whether they can send patients who are suffering from non-acute paraplegia for bladder and bowel treatment and advice?

Baroness Young: My Lords, I deeply regret that there should have been any difficulties, but my informant is that no formal complaints about difficulties of the recall system have been received either from individual patients at Stoke Mandeville Hospital or from the Spinal Injuries Association. May I suggest to the noble Baroness that if difficulties have arisen this is very much a matter to be resolved locally, and I know that the Health authority would be very willing to discuss these matters and look into individual cases where there are problems.

Baroness Masham of Ilton: My Lords, as chairman of the Spinal Injuries Association, may I ask the noble Baroness whether she is aware that unfortunately it has not got the correct information as to what the Spinal Injuries Association will be able to do for her with this?

Baroness Young: My Lords, I hope that the noble Baroness will write to me with her complaint in this way.

Copyright and Design Law: Green Paper

2.59 p.m.

The Earl of Gosford: My Lords, I beg leave to ask the Question which stands in my name on the Order Paper.

The Question was as follows:

To ask Her Majesty's Government when they expect to publish their Green Paper on the recommendations of the Whitford Committee on Copyright and Designs Law.

Lord Lyell: My Lords, the Government expect to publish the Green Paper on copyright and related topics in the middle of this month. It will be entitled *Reform of the Law relating to Copyright, Designs and Performers' Protection—A Consultative Document*.

The Earl of Gosford: My Lords, while thanking the Minister for that most welcome reply, I should like to ask him whether I may press him for a specific date when the Green Paper will be printed. Is he aware that the delay has been causing great concern among the creators of works, and that since the Whitford Committee Report of 1977 they have been aware that the Act of 1956 is unable to cope with the increasing technology?

Lord Lyell: My Lords, the noble Earl may, indeed, press me to try to give a more precise date, but I am afraid that I could not go further than my original Answer. The Government are, indeed, aware of the need to update the 1956 Copyright Act and, if the noble Earl can be patient till the middle of this month, he will certainly see the more precise ideas that are in the Government's mind at the moment.

Lord Jenkins of Patney: My Lords, is the noble Lord aware that the statement that this Green Paper is coming will be very widely welcomed? Would he be so good as to say whether it is expected that the Green Paper will cover the recommendations of the Whitford Report and, in particular, their recommendations in relation to performers' rights and to possible amendments to the Performing Rights Act?

Lord Lyell: My Lords, the Green Paper will have many recommendations, but I am afraid that I must ask the noble Lord to be as patient as the rest of us.

Lord Reilly: My Lords, may I ask the noble Lord the Minister whether he is satisfied that, if the recommendations of the Whitford Committee are accepted, they will compare favourably with the practices adopted in other European countries?

Lord Lyell: My Lords, I do not think that I could go quite as far as that. I am afraid that, once again, I must ask the noble Lord to be a little patient till the middle of this month. Perhaps we can then go into it in further detail.

European Council: Luxembourg Meeting

Lord Denham: My Lords, it may be for the convenience of your Lordships if I say that, at a convenient moment after 3.30 this afternoon, my noble friend the Foreign Secretary will, with the leave of the House, repeat a Statement that is to be made in another place on the European Council Luxembourg meeting.

London Docklands Development Corporation (Area and Constitution) Order 1980

3.2 p.m.

The Parliamentary Under-Secretary of State, Department of the Environment (Lord Bellwin) rose to move, That the order laid before the House on 27th November 1980 be approved.

The noble Lord said: My Lords, we are concerned today with the Government's proposals for setting up an Urban Development Corporation in a part of the Docklands area of London. We have before us four orders; the London Docklands Development Corporation (Area and Constitution) Order, an order to amend that, and two orders dealing with land which it is proposed to vest in the corporation, one dealing with land owned by the Port of London Authority and the other with land owned by the Greater London Council. I will deal, first, with the background to the Government's proposals for setting up an urban development corporation in Docklands, then with the two area and constitution orders and then, if I may, with the two vesting orders.

Section 134 of the Local Government Planning and Land Act 1980 enables the Secretary of State to designate an area as an urban development area if, in his opinion, it is in the national interest so to do. Section 135 empowers him to establish a corporation for the purpose of regenerating that area. As I explained to your Lordships' House during the proceedings on the 1980 Bill, the Government consider that the scale of the problems in London Docklands requires the establishment of such a corporation with sufficient resources and powers to regenerate the area. The House has already considered and approved a similar order under the same powers to establish an Urban Development Corporation for part of Merseyside.

My right honourable friend laid the London Docklands Development Corporation (Area and Constitution) Order 1980 in November last year. The area he proposed for designation as an urban development area was based on the area in which the Dockland Joint Committee functioned, but with certain exclusions and additions that I will come to later. Under the procedure for dealing with hybrid instruments, the order was open to petitions by people objecting to its provisions, 10 of which were, in fact, received and referred for a further inquiry by a Select Committee.

A committee comprising the noble and learned Lord, Lord Cross of Chelsea as chairman, and the noble Lords, Lord Amphill, Lord Alredale, Lord Nugent Guildford and Lord Underhill was appointed to consider whether, in the light of the matters complained of, the area specified in the order should be

Therapy

The Fortnightly Newspaper for the Remedial Professions

Volume 4, No. 9, October 21, 1977

Stark message on spines

Financial pressures force cuts at Stoke Mandeville

Unless the Government and the Department of Health and Social Security take rapid action, present and future spinal cord injured people will suffer, languish and die, lose their families and their jobs and all hope of returning to a normal life because of inadequate medical facilities and trained staff.

This is the stark message of Baroness Masham, chairman of the Spinal Injuries Association, in the wake of proposed cutbacks in the number of beds at the National Spinal Injuries Centre at Stoke Mandeville Hospital in Buckinghamshire.

The Buckinghamshire Area Health Authority has been told it must live within its financial means, and the current pattern of the allocation of resources in the National Health Service holds little prospect of an increase in funds for the Oxford Health Region — which includes Buckinghamshire — for the next few years.

The AHA has been overspending at an annual rate of £1 million in an

allocation of about £26 million, and most of this has been in the Aylesbury and Milton Keynes Health District. The District Management Team has been asked to submit proposals to reduce expenditure by £600,000.

The AHA this month approved the majority of the Health District's proposals, which are now being forwarded to the Oxford Regional Health Authority and the Secretary of State.

The main saving is proposed in the closure — by March 31, 1979 — of Tindal General Hospital, which treats geriatric and psychogeriatric patients, and transferring services from there to Stoke Mandeville.

The authority is also recommending to the Oxford Regional Health Authority that the general practitioner maternity unit at Stoke Mandeville be transferred to the Royal Buckinghamshire Hospital.

The main service consequences of the decisions taken by the AHA will include a reduction in the total beds at Stoke Mandeville by 20 in

the acute specialties of general medicine and general surgery and 15 in the special units — spinal injuries, plastic surgery and the burns unit.

Included in the total number of beds at Stoke Mandeville now are 162 for general medicine and general surgery, 154 in the national spinal injuries centre, 58 for plastic surgery, and 18 in the burns unit.

Another hospital doomed for closure — by March 31 next — is

Keynes is the fastest-growing community in Europe and the Resource Allocation Working Party has based its calculations on figures two years out of date.

"It is absolutely appalling that anyone should consider cutting a service that is already inadequate", she told *Therapy*.

And Mrs Sheila Mann, acting superintendent physiotherapist for Stoke Mandeville Hospital, says, "If there are any changes we want

spinal injuries services.

At present, the centre as a whole of the southern half land.

One bright light on the horizon is that a new Government is to set up a 30-bed spinal unit planned for Oadstock, Sulis District spokesman told *Therapy* the department, in 8 *Priorities* documents, is the need for more provision of spinal injury beds.

But the Spinal Injuries Association suggests that the number of spinal cord injured people is increasing — "this is not to be considered decreasing number of beds and certainly not fall on Oadstock fully operational".

"We would further stress that at Stoke Mandeville is in the unique position of a national spinal injuries centre therefore the burden of it should not fall on the Health Authority and the Health Authority... they be assisted by the national government".

The plan which the Resource Allocation Team has laid before the AHA is highly critical of the AHA's decision to cut all.

The DAF has been facing very difficult decisions, Dennis McQuillan, chief physiotherapist, who adds, "that physiotherapy services will be affected at all by any cuts in the financial situation led it to take 'these or decisions', urges that effort be made to be made in preparation for a greater allocation service resources to Buckinghamshire, especially in the unique situation of population growth and the new city of Milton Keynes".

The AHA itself, while taking the financial situation led it to take "these or decisions", urges that effort be made to be made in preparation for a greater allocation service resources to Buckinghamshire, especially in the unique situation of population growth and the new city of Milton Keynes.

FRIENDS FOR PHYSIOTHERAPY DEPARTMENT

The physiotherapy department at Westway Hospital, which is entirely self-financing, will be formally opened on November 15, 1977, by Mrs. J. R. Chairman of the Town Council. The department will treat a wide range of conditions, as yet

"If there are any changes we want them to be progressive, not regressive"

the Winslow, an old building housing 50 mentally handicapped patients. This should save £100,000 a year.

Mrs Ava Purdie, secretary of the Community Health Council, who has written to the Prime Minister regarding the burden placed on the district, says the DHSS has not taken into account that Milton

them to be progressive, not regressive".

She says that so far there has been no communication with individual departments on any proposals — "we would like consultation and consideration on an individual basis".

Staff morale is "down a bit". Although her profession is not suffering from lack of staff it seems there will be a mixing of departments with different needs.

"We're worried that patients tend to get forgotten in this sort of situation".

Mrs Elizabeth Smith, chief speech therapist for the Aylesbury and Milton Keynes Health District, agrees with Mrs Mann. Although staff in her profession are also up to establishment quota, restrictions could affect them if they wanted to expand in, say, six months.

Founder shocked

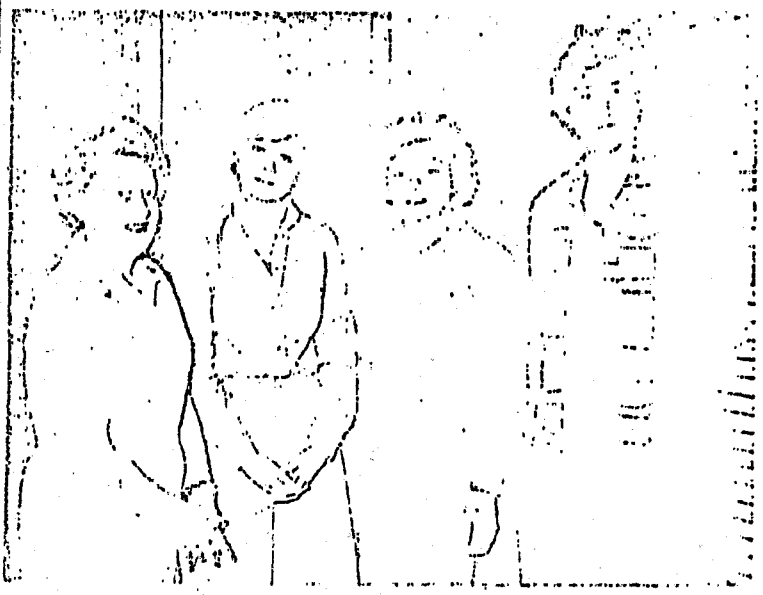
Professor Ludwig Guttmann, who founded the spinal injuries centre in 1914 for the treatment of the war wounded, finds the proposals to cut bed numbers "quite shocking".

"I'm strongly opposed to even cutting down on one bed. On the contrary, they should be adding more," he told *Therapy*.

Professor Guttmann, who is 78 and now director of the Stoke Mandeville Sports Centre for the Paralyzed and Other Disabled, says the consequences of further closure of beds at the spinal injuries centre would be "contrary not only to all principles of rehabilitation but to humanitarianism". He has written clearly in the Chronically Sick and Disabled Persons Act 1970 and the United Nations Declaration on the Rights of the Disabled.

Dr Hans Brandel, chairman of

Sharing viewpoints at Therapy Lecture



Dr. Document 07

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**Spinal
Injuries
Association**

126 Albert Street London NW1 7NF

01-267 6111

PRESS RELEASE

Monday, 29th January, 1979

Chairman Baroness Masham of Illon
Vice-Chairmen Mrs Wyn Howarth SRN SCM
& Mrs Patricia Pay MA PhD
Hon Treasurer Paul Bush
Hon Consultants in Spinal Cord Injury
Dr A G Hardy MBE FRCS & Dr L Michaelis MD
Fund-raising Chairman Lord Crawshaw
Director Stephen Bradshaw
General Secretary Bernice Wood

STOKE MANDEVILLE HOSPITAL BADLY NEEDS TREATMENT

The world's foremost hospital for the treatment of paraplegia (spinal cord injuries) is in danger of collapse.

In the last few months five wards have closed. Two have been patched up and re-opened. Three, however, are in such a bad state of repair, suffering from burst pipes and fallen ceilings, that total rebuilding must be the only sensible solution.

In the meantime, patients are being squashed into every spare corner. Prospects for patients and staff are as bleak as our winter. No beds, few amenities and little hope of any immediate change in their hospital's circumstances.

What Stoke Mandeville needs is a massive injection of Government action.

We must stop Stoke Mandeville from deteriorating any further. It's being starved of money so it can no longer afford the staff it needs. Nor can it afford the repairs that are necessary. In truth, it can hardly afford to go on. We must and we will correct this state of affairs both for the sake of patients present and future and for the dignity of spinal medicine here and throughout the world.

If there is no remedy for Stoke Mandeville, not only will a great hospital die but the National Health Service itself will also be sorely injured. Please let us do something now.

For further information please contact:
Stephen Bradshaw, Director
Spinal Injuries Association
Tel: 01 267 6111

Please note:

This Friday (2nd February 1979) Timothy Raison, MP for Aylesbury, is raising the problem in the House of Commons in an adjournment debate.

SPINAL INJURIES
ASSOCIATION

SUBMISSION TO THE ROYAL COMMISSION ON THE NATIONAL
HEALTH SERVICE

December 1976

126 Albert Street
London NW1 7NF
01 267 6111

REPORT TO THE ROYAL COMMISSION ON THE NATIONAL HEALTH SERVICE

SUBMITTED BY

THE SPINAL INJURIES ASSOCIATION

of 126 ALBERT STREET, LONDON, NW1 7NF - Telephone 01 267 6111

SUMMARY

1. Location and Size of Spinal Injury Units:
At least two more Units in the South of England are needed and expansion of existing Units to at least 40 beds.
2. Spinal Injury is a Speciality:
Career structure for Spinal doctors and development of specialist nursing training.
3. After Care Facilities:
Development of rehabilitation in private housing; Support systems for the spinally injured in the community; Residential homes and hostels.
4. Wheelchairs:
The need for a more efficient repair and maintenance service - 24 hours a day, 7 days a week.
5. Counselling Service:
The need for a professionally structured Counselling Service.
6. Appointment of an Advisor to the D.H.S.S.:
The Appointment of an Advisor to the Department is a matter of priority.

Members of the Spinal Injuries Association, including Spinal doctors and consultants, are willing to give evidence to the Commission to support this report.

1. Location and Size of Spinal Units in England and Wales:

There are currently seven Spinal Injury Units (S.I.U.s) in England and Wales, sited at Hexham, Southport, Wakefield, Sheffield, Oswestry, Stoke Mandeville and Cardiff. The number of beds in each unit is shown below.

<u>Unit</u>	<u>Beds</u>
Hexham	16
Southport	34
Wakefield	30
Sheffield	64
Oswestry	50
Stoke Mandeville	168
Cardiff	48
	410

* Stoke Mandeville have advised us today - 21st December 1976 that they recommend at least 50 beds per unit and preferably 60 beds. At present they have only 158 beds and have been recommended to reduce this to 130 beds by April 1977.

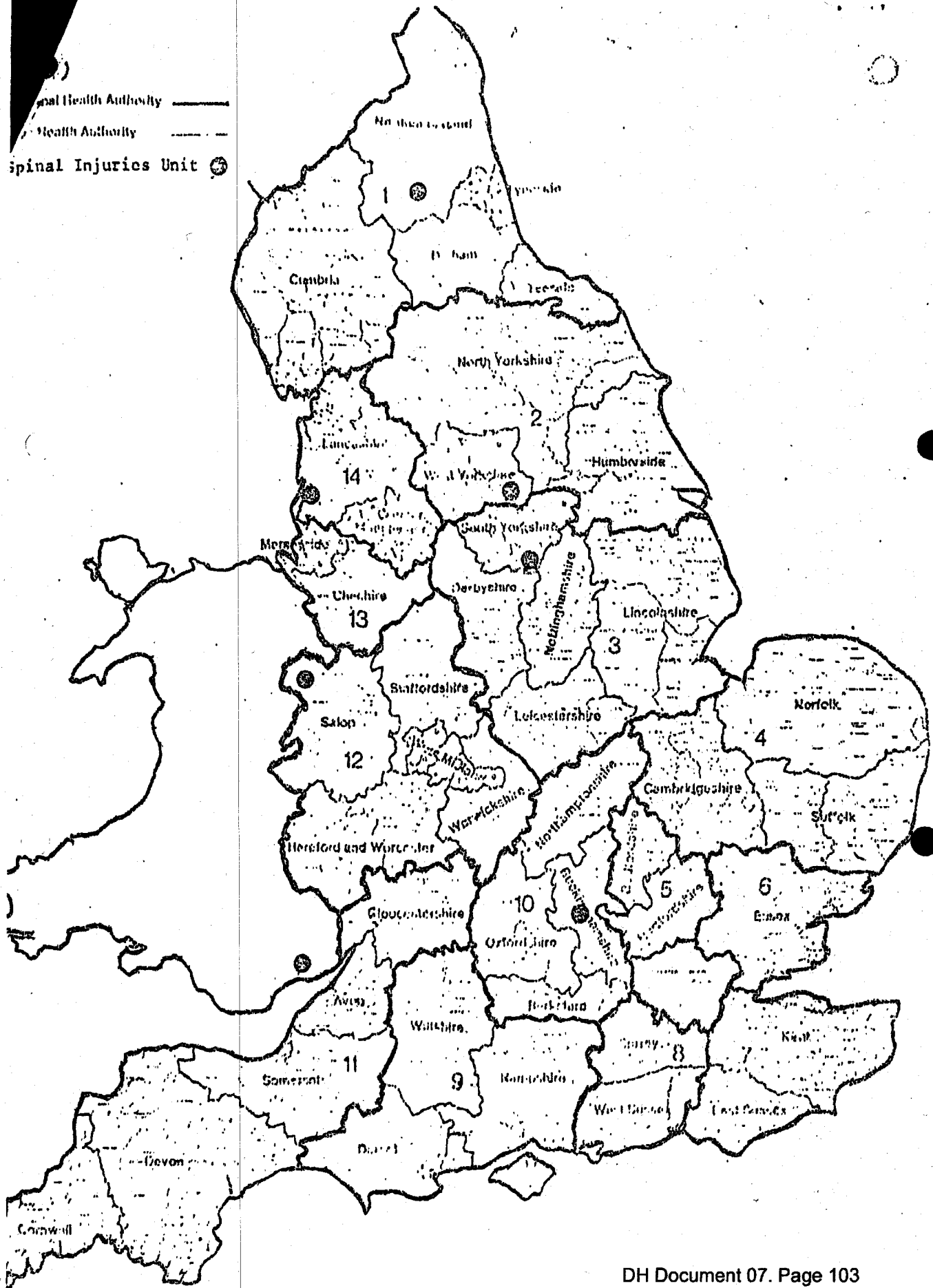
This latest information further demonstrates the drastic cuts that are being made in an already inadequate provision.

These figures represent a contraction from 455 beds ten years ago, almost all the contraction having occurred at Stoke Mandeville. There is no doubt that during this time the annual number of new spinal injury cases has increased substantially. In 1967 there were 303 traumatic cases and 171 non traumatic cases admitted to the above units; precise figures of the current incidence are not available, but it has been estimated that there are about 750 new traumatic cases in Great Britain each year - say 650 in England. The current number of established beds is insufficient to treat all these and at the same time to provide for the regular check-ups on all former patients which the best clinical practice demands, and for the readmission of patients if complications develop.

There is a grossly inequitable distribution of spinal injury beds in England (see map attached). The units are administered through Health Regions: combining the most recently available population estimates of Health Regions in the North, Midlands and West (Newcastle, Leeds, Manchester, Liverpool, Birmingham and Sheffield (Trent) and Wales - roughly a line from the Severn to the Wash) gives a population of about 26 million served by 242 beds, or 9.3 beds per million population. In this area there are six S.I.U.s, so distributed that virtually no-one is more than 120 miles by road from an S.I.U.

The remainder of England is served by Stoke Mandeville, near Aylesbury (spart from a small area around Bristol from where new cases are sometimes transferred to Cardiff) i.e. 23½ million population with 168 beds, or approximately 7.1 beds per million population. The evident shortfall in the south of England compared with the north is complicated by the fact that Stoke Mandeville has, per acute bed, more former patients on whom check-ups need to be done than any other unit, and thus needs to direct proportionately more of its resources to this service. For this and other reasons, the pressure on Stoke Mandeville is very great, with the result that many new patients from the south of England are transferred to northern S.I.U.s for treatment. This is logistically absurd, and means that visiting relatives and friends must travel even further than the already much greater distances they would have to travel (up to 300 miles) to reach Stoke Mandeville.

Regional Health Authority ———
 Health Authority - - - - -
 Spinal Injuries Unit ●



It is clear that the shortage of beds for spinal injury treatment is greater than is revealed merely by a 'beds per million population' type of figure. It is also desirable that the establishment of one or more new S.I.U.s should do something to facilitate problems of visiting associated with distance and communication between the hospital and the locally-based after-care and support services which are a vital part of spinal injury treatment. (We wish to point out that the establishment of a new S.I.U. can be done simply by changing the use of two wards in an existing hospital. Capital expenditure can in this way be kept to an absolute minimum).

The consultative document 'Priorities for Health and Personal Social Services in England' identified the urgent need for another S.I.U. in the south of England (paragraph 6.6). We suggest there is a need for two such units, one in the home counties which could share the load from the south-east with Stoke Mandeville, and one towards the south-west which will alleviate the geographical problems.

Each S.I.U. must be large enough to sustain two full-time consultants in Spinal Injury, to provide cover where necessary for sickness and holiday periods. Forty beds has been suggested to us by a consultant in Spinal Injuries as the minimum size. In addition, units must be sited within major hospitals, in order that a full range of investigative and therapeutic services are available.

Spinal Injury patients have an average length of stay of six months or longer, but in only one S.I.U. is there a day-room for the patients, despite the recommendations of a recent government publication (The In-patients' Day, HMSO, 1976). Even this day-room was financed by voluntary subscriptions. We urge the creation of more such rooms, so that patients do not simply 'hang around' on the wards. We suggest the establishment of 'Rehabilitation Houses' at the S.I.U.s, a dwelling unit at each centre staffed by a paraplegic or tetraplegic where patients should, for one week before discharge, be required to live independently of assistance offered by the hospital or family. For most patients such independence is possible but the opportunity to escape willing assistance, from the family in particular, rarely arises.

Because so many patients are unable to return to their former occupation, retraining facilities assume a particular importance in spinal injury rehabilitation. The extent of retraining facilities provided within or from S.I.U.s is variable, from none at all to full workshop facilities. It is absolutely desirable that retraining (or preparation for return to the same job if this is possible) should be started as soon as possible after the initial acute stages of treatment are through. It is important to re-examine the re-training needs of people with spinal cord injury, since it is far from evident that current provision is suitable, even for the majority of cases.

2. That Spinal Injury resulting in Paralysis is a Speciality:

The treatment of Spinal Cord Injury (SCI) is a highly specialised branch of medical practice, explicitly involving at least four conventionally recognised specialities, viz: neurology, neurosurgery, urology, plastic surgery, orthopaedics and rehabilitation and physical medicine. SCI treatment is closer to the idea of a regional super-speciality rather than one of the broader general medical or surgical specialities just mentioned. Whilst formal recognition as such is still lacking, posts have been advertised in SCI treatment, suggesting that the D.H.S.S. itself regards it as a speciality. At the clinical level, comprehensive management requires a team, and thus a team leader. If care is fragmented through a number of specialists having separate, but equal, responsibility for different aspects of treatment, it is the widespread experience of our members that treatment is inadequate. This fragmentation of responsibility was one of the reasons leading to the creation of the first S.I.U. in this country (Stoke Mandeville) in 1944. Others, notably Oswestry, have been created precisely because the care patients were receiving in the same hospital with responsibility fragmented was considered inadequate.

Lack of knowledge by clinicians of the specialist nature of spinal cord injury has led to many of our members developing complications entirely unrelated to the conditions for which they were admitted to general hospitals, but absolutely a reflection of the non-understanding of the care of spinal injury patients. In addition, facilities in general hospitals, even teaching hospitals, are frequently quite inadequate for use by spinal injury patients. Toilets are often inaccessible to wheelchairs, or the door cannot be closed behind, and there are rarely the appropriate handrails in either the toilet or bathrooms. Nursing support, either through lack of knowledge, or through lack of numbers, is often inadequate for the more severely disabled of our members. Even mattresses are frequently of a type that too easily damage the skin, and for many of our members especially the more severely disabled who are unable to turn themselves in bed, this is frankly dangerous.

Although strictly outside the terms of reference, we would urge the Royal Colleges to afford greater recognition than hitherto to training periods spent in spinal injury units. Nursing SCI patients, as well as being highly specialised, is physically very demanding. Special courses are run at Stoke Mandeville for training nurses from general hospitals which may be the first recipients of new cases, and after a year's work at Stoke Mandeville, a nurse may obtain a certificate establishing her competence in this area. It is thus a matter of continuing concern to us, and of detriment to the service as a whole, that the Royal Colleges (of Surgeons and Physicians) afford no recognition for post-graduate training purposes, to training periods spent in spinal injury units. We are aware that this point is strictly outside the terms of reference of the Royal Commission, but it is of particular importance if S.I.U.s are to attract the most able of new doctors into the service.

We are seriously worried about the deterioration in care of spinal injury patients. Due to the shortage of nurses trained in spinal injury and particularly for the future, the alarming shortage of spinal doctors. The consultants in Spinal Injury openly express great concern because there are no British doctors entering this field. Foreign junior doctors are training here and returning to their own countries and we feel this deplorable situation is primarily caused by the lack of a career structure in this country. We think it essential that every medical school include a teaching session in spinal injury and would suggest the following possible career structure to encourage more doctors to enter this field:

First Year - Pre-registration

six months Medicine, six months General Surgery

Second Year - Senior House Officer

say, six months neurosurgery and urology

six months plastic surgery, orthopaedics or physical medicine

Third Year - Six months at a spinal unit, and then a further year as Registrar at a spinal unit, becoming a senior registrar after 3½ years, and referred to as a spinal doctor. This would follow on to becoming a Consultant in Spinal Injuries.

We have members, including doctors and consultants in spinal injuries willing to give evidence to the Royal Commission on these and other points concerning the specialist nature of spinal injury treatment.

3. After-Care Facilities:

It is impossible to separate the initial treatment of spinal injury patients from the long-term follow-up and after-care that is required. The "stock" of surviving patients is still increasing and will continue to do so for some time yet. Proper medical follow-up of cases is becoming more difficult because there is less space for in-patient check-ups than hitherto but more cases to be seen. Out-patient check-ups, always a second-best procedure, are impracticable for anyone living more than 100 miles from his home unit.

The major problem of after-care facilities concerns accommodation. It must be recognised that spinal cord injury does not merely mean six months in hospital; it means a life-time in a wheelchair, and the environment outside the hospital must be such as to make that prospect physically possible for each patient. However well rehabilitated a patient may be within hospital, discharge to unsuitable accommodation of any sort leads in one case after another to deterioration in the patient's condition and to requests for readmission.

We briefly consider here two types of accommodation; private housing and residential homes and hostels. We take it as axiomatic that people with spinal cord injury should be encouraged to live in their own homes, which in a large proportion of cases need alteration to enable them to be used by someone in a wheelchair. Requests for alterations to housing or for re-housing of patients in hospital may involve both the Housing and Social Services Departments of the local Authority, links with which are maintained via the Specialists in Community Medicine in Environmental Health or in Social Services. However, outside hospital there is no one authority charged with overall responsibility for providing and co-ordinating services. Responsibility is fragmented, with different authorities having different administrations and different programmes which may or may not allow for co-ordination between at the time a request on housing is made from the hospital. Even the simplest alteration may take several months from the initial request to completion of the task; meanwhile, the patient may be discharged to unsuitable accommodation or he may simply wait in hospital for the alteration to be completed. This is bad for all concerned, and stems as much from a lack of integration of the services as from a lack of money.

Similar problems affect the provision of other services, e.g. domiciliary care. Requests for services may be made which the providers of the service may or may not be able to fulfill. Inadequate domiciliary support as much as inadequate housing may have medical sequelae resulting in readmission even though the original problem was not medical at all. There are particular problems in obtaining extempore domiciliary care if, for example, the family carer is ill; this is of critical importance for tetraplegics. The wider development of Cross-Roads type Care Attendant schemes could do much to help keep some of our members out of institutions, ultimately at far lower cost.

Problems of obtaining domiciliary care have occurred even when the patient's home is within the same local authority as the spinal injury unit at which he is treated. The necessary degree of co-operation and co-ordination becomes impossible for a patient in Stoke Mandeville whose home is in, say, Plymouth.

We accept that not all patients can ultimately be discharged home. There will be some who are so severely disabled that they must be looked after in some sort of residential accommodation, at least until more sophisticated support systems are organised in the community, and others for whom the home background is inappropriate to return to (for example, those who are rejected by their families following an accident). There is in this country only one long-term after-care hostel attached to a spinal injury unit, the Sir Ludwig Guttman Hostel at Stoke Mandeville with 30 beds. Despite the increase in the number of spinally injured patients, the number of hostel beds remains the same as ten years ago. An example of how the lack of after-care facilities reflects back into the units themselves is seen in one of the northern units where 20% of the assigned beds are occupied permanently by tetraplegics who have nowhere to go.

Patients who cannot be sent home, for whatever reason, are sometimes discharged to other hospitals or residential accommodation strictly unsuitable on a variety of grounds similar to those discussed in Section 2 above - inadequately designed toilets and bathrooms, lack of intensive nursing support, particularly needed for tetraplegics, and so on.

Some of our members have been a single isolated spinally injured patient in a residential home, even in units for the young chronic sick. The lack of knowledge by the caring staff of the appropriate care for spinally injured people, together with an unwillingness to listen to advice and the lack of other spinal injury patients with whom to discuss these problems, may lead rapidly to psychological depression and lack of self-care by the patient himself. An easy way to avoid this is not to permit single spinal injury patients in residential homes, but to group them in threes or fours. In this way individual isolation can be avoided and at the same time staff can also learn properly about the care of spinal injury patients, to the mutual benefit of all.

An alternative to the development of units for the young chronic sick is that consideration should be given to 'Fokus' type housing schemes, first developed in Sweden, where blocks of flats have one flat in ten reserved for the very severely disabled who would normally be in special hostels, but for whom there is a day and night attendant responsible for several of the special flats. In this way, integration of the disabled into the community is more easily achieved than by their separation in a special unit.

It is a common experience of Spinal Injury units for newly-injured patients arriving from other hospitals to suffer from pressure sores, and a long delay before admission to an S.I.U. will often result in complications of many sorts. Such developments are quite unnecessary as years of experience amongst the S.I.U.s have repeatedly shown that these complications can be avoided if the staff are properly trained and if they are sufficient in number. Few hospitals outside the S.I.U.s can provide the necessary expertise which is particularly important for spinally injured patients with incomplete neurological damage. Some spinal cord injury patients are now taking legal action for improper treatment and this could increase at great cost to the National Health Service. All the evidence points to the imperative need to swift transfer to an S.I.U. for all spinally injured patients.

4. Wheelchair Service:

Wheelchair services are administrated by Artificial Limb and Appliances Centres of which there are 19 major establishments in England. They are responsible for issuing wheelchairs (on loan) and for their repair. The normal procedure for repair is roughly as follows: an individual whose wheelchair is not functioning properly contacts the local ALAC by letter or telephone, informing them of the nature of the malfunction. The ALAC then contacts the approved ministry repairers who place the case on a list to be visited. At the visit the chair may be repaired on the spot or it may be taken away for repair and a substitute chair left instead. Variations on this procedure may involve direct contact between the patient and the repairers, or contact through a doctor to the ALAC and assessments by the technical officers of the nature of the necessary repair. It is with the repair service that this section is concerned.

A wheelchair is the first and prime source of mobility for those with apinel cord injury, and it is of paramount importance that if it goes wrong it shall be repaired quickly. It is also of great importance that any substitute chair, however short the period of substitution, shall be as far as possible the same model as the chair being repaired; this is particularly important for tetraplegics whose physical capacity to adapt to an unsuitable chair is rather less than that of paraplegics.

It is not acceptable for the wheelchair repair service to operate on a 9 to 5 basis. A chair may go wrong in any one of a number of different ways at any time, and it is small comfort to one whose chair breaks down during Friday evening to know that by Monday morning they will be able to contact the ALAC.

Often worse than the delay in contacting the repairers is the time taken to effect the repair. We have evidence of intolerable delays here, up to six months in one case of a repair to the control module of an electric wheelchair. In this case, only two weeks was spent over the repair itself, the rest of the time being spent in administrative procrastination.

Such delays, whilst inexcusable, might not be intolerable were the substitute wheelchairs appropriate for the person concerned, but this is too often far from being so. It was certainly not so in the case cited, and we can provide evidence of grossly inadequate or frankly dangerous substitute chairs being offered. This is not to day that some chairs are always dangerous, merely that some chairs are always dangerous for some people - a child's chair for a man over six feet tall, for example, is another case on which we can provide evidence. What often seems to happen, in the case of non-electric wheelchairs at least, is that the approved repairers take with them on their rounds such spare chairs as they happen to have in stock. These may or may not bear any relation to the chairs they are going to repair, but will nevertheless be offered as a substitute if the original chair is taken away for repair.

There seem three possible solutions to this rather unsatisfactory situation:

- a) Each person to have a spare wheelchair of the same type as the one normally used, so that a repair will be effected on a chair not actually required at the time.
- b) A much larger stock of substitute wheelchairs to be held by the approved repairers, covering the full range of wheelchairs currently on issue, in order that an appropriate substitute chair is always available.
- c) A much quicker repair service (making a repair a matter of one or two hours, rather than days or weeks).

5. Counselling Service:

Members of this Association are particularly concerned that there should be a Counselling/Advisory service available to newly paralysed people in hospital, should they wish to make use of it. The Counsellors themselves should be spinally injured and have accepted and worked through the problems of spinal injury, as we feel the acceptance of long-term disability is more readily understood by fellow sufferers. They should be selected and approved by the Spinal Injuries Association. In the future, the Association would like to see spinally injured people as professionally trained counsellors employed by the National Health Service.

Other countries are forging ahead in this field. A comprehensive Counselling system has been in operation in the United States of America for spinal cord injuries both in the civilian and veteran hospitals for a number of years. The system is flexible in as much as both professional and experienced voluntary counsellors are used. It would seem that enormous benefit is derived by both the newly disabled people and the longterm disabled, in tackling the many problems presented by paralysis. At the Woodrow Wilson Rehabilitation Centre in Virginia, U.S.A., the spinal cord injury project is in an advanced state and much information on counselling is available from this source. Members of our Association have visited this centre and asked what similar counselling schemes are operating in the United Kingdom. They were amazed to learn that the country that pioneered the treatment and rehabilitation of spinally injured people has nothing comparable.

A well established and soundly based Counselling service would compliment existing work carried out by Medical Social Workers and perhaps even help eliminate the suicides that are occurring.

6. Appointment of an Advisor to the D.H.S.S.

As a matter of priority, the Association feels that there should be an Advisor in Spinal Injury to the D.H.S.S. in order that the Department may be kept informed and advised concerning the state of Spinal Cord Injury, treatment and rehabilitation in this country, which at present we feel is unsatisfactory.

**NATIONAL HERITAGE FUND
BILL**

Order for Second Reading read.

Hon. Members: Object.

Second Reading deferred till Friday next.

CO-OWNERSHIP OF FLATS BILL

Order for Second Reading read.

Hon. Members: Object.

Second Reading deferred till Friday 23 February.

**PUBLIC BODIES
(APPOINTMENTS) BILL**

Order for Second Reading read.

Hon. Members: Object.

Mr. Deputy Speaker: Second Reading what day?

Mr. John Wells (Maidstone) On the instructions of the hon. Member concerned, Friday next.

Second Reading deferred till Friday next.

STOKE MANDEVILLE HOSPITAL

Motion made and Question proposed, That this House do now adjourn.—[Mr. Ted Graham.]

4.3 p.m.

Mr. Timothy Raison (Aylesbury): The subject that I wish to raise today is that of the current grave conditions at Stoke Mandeville hospital. I say straight away to the Minister that, for once, the subject that I raise, although a health matter, has nothing to do with industrial action. I want to draw attention to a very different anxiety.

The House knows that Stoke Mandeville hospital is synonymous with the treatment of spinal injuries. However, I must make the point here and now that, although the treatment of spinal injuries is a very important part of the work of the hospital, it is only a part and that the hospital carries out the normal vital activities of a district general hospital, in the course of which it does some very distinguished work which is also jeopardised by what is going on there at present. However I intend to concentrate to some extent on the spinal injuries side of the hospital's work.

As it happens, last night there was a party at Stoke Mandeville to celebrate the thirty-fifth anniversary of the admission of the first patient on the spinal injuries side in 1944. It was held in the stadium for the paralysed and other disabled, and this stadium is really a monument to much that is best in our life here in this country.

As the Minister no doubt would expect, it was in many ways a cheerful party, as I think is any function that takes place in the stadium. It is a place that we should visit if we want to know about the idiomitable spirit of men. Behind that spirit lies the peculiar achievement of Sir Ludwig Guttman and his successors.

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**COMPANIES (DISCLOSURE OF
AUDITORS' SHAREHOLDINGS)
BILL**

Order for Second Reading read.

Hon. Members: Object.

Mr. Deputy Speaker: Second Reading what day? No day named.

**WATER SERVICES CHARGES
(REBATES) BILL**

Order for Second Reading read.

Hon. Members: Object.

Mr. Deputy Speaker: Second Reading what day? No day named.

**LEAD CONTENT OF PETROL
BILL**

Order for Second Reading read.

Hon. Members: Object.

Mr. Deputy Speaker: Second Reading what day? No day named.

[Mr. Raison.]

There was a somewhat sombre and ironical background to the party. Sir Ludwig spoke, and said that he had recently been to the opening of a new national spinal injuries centre in Israel. He had to make a contrast between that apparently splendid new set-up and the sad physical conditions at Stoke Mandeville.

I shall tell the Minister a little about what has been happening at Stoke Mandeville hospital in the past week or two. I have been told by the district administrator, who does an excellent job, that four wards are closed because of problems in the supporting structure for the ceilings. Since the bad weather at the beginning of January there have been numerous problems with the freezing of the water service and subsequent bursts.

During the weekend of 13 January a spinal ward had to be evacuated because of water coming through the ceiling. On 17 January attention was drawn to sagging of ceilings in that and other wards in the National Spinal Injuries Centre. As a result of an immediate inspection by the building officer, three further wards were taken out of use. Of the four wards that are out of use three are spinal wards and one is a geriatric ward which happens to be housed in the spinal unit corridor.

Arrangements were made for patients to be evacuated to other accommodation. It was fortuitous and perhaps ironical that because of nursing shortages in the remainder of the hospital there were two wards closed on the general corridor, one general surgical and one general medical. The wards were used one for spinal patients and one for geriatrics. Other spinal patients were accommodated in other parts of the National Spinal Injuries Centre, some of that accommodation being extremely inadequate. The sanitary annexes of the general wards are entirely unsuitable for paraplegic patients. That is an important matter, which has been referred to in an earlier debate.

That is the sombre picture at an institution that has a fame that is unquestionably world-wide. The only bright spot is that after these happenings took place and the ceilings showed trouble there has been a first-rate effort on the part of all concerned, including the unions,

to take emergency steps. A number of persons have commented on the high state of morale that has been in evidence in the hospital in dealing with these serious problems. Even so, patients are having to wait for admission.

I have been asked to say by the chairman of the spinal injuries unit that it is felt generally at the hospital that although the troubles are real and serious spinal injury patients in other areas who need admission to specialised care should not be put off by what is happening. The special expertise accumulated at an institution such as Stoke Mandeville is extremely important.

Patching-up work on the wards is proceeding. However, more radical action must be taken by the Government as a matter of great urgency. The buildings in which the spinal injuries unit is housed are long past what must have been their expected life, when they were erected during the war to deal with the possibility of a large influx of wartime casualties.

It is not merely a spinal injuries problem. Other wards are in the same decaying condition. Obviously, the spinal injuries unit must not draw off an unfair share of resources from other parts of the Aylesbury hospital complex.

It is not only a matter of the ceilings caving in at Stoke Mandeville. There are other defects that must be overcome, including the heating service pipes in the wards, which are old and must be replaced, the lagging, which must be renewed, the energy conservation measures which must be improved, and the electrical services, which must be re-wired. More importantly, I am told that the main engineering distribution services to the whole hospital have been deteriorating over the years. The cost of renewing these will be substantial and will strain the scarce resources. There are many difficulties with the boiler system.

Money is vital to meet this need. Where will the money come from? I believe that this can only be dealt with as a national problem. As far as the spinal injuries side is concerned, we are talking of an institution known as the National Spinal Injuries Centre. It is not the only centre that we have in the United Kingdom but it is the only one in the South of England. It therefore plays far more than a regional role.

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national institution in that sense and in the sense that it is known throughout a large part of the world as one of the areas where British medicine has achieved great triumphs. Although there is to be a further institution at Odstock, that is still some way off.

In spite of that, we have seen a reduction in the number of beds in the hospital for spinal injury patients from 106 in 1966 to 156 today. Not all the beds are in use, due to staff shortages. It is not only a building problem. There is a shortage of nurses, although it is not grave, but there are other serious shortages. There is a shortage of physiotherapists, who have a particular role to play in the treatment of spinal injury patients. There is a shortage of medical social workers, which is partly due to the financial position of the county council. These workers are of great importance in the delicate operation of returning people with spinal injuries from hospital to the community.

Capital and revenue are needed. On revenue, the Minister will recall that about a year ago he visited Stoke Mandeville and was told of the problems. Following his visit, it was agreed that there should be a change in the formula by which money was allocated to regions and areas, and that a special spinal weighting factor should be introduced to provide more money. It was expected that this new factor would produce an additional £400,000. None of this money has appeared, and the staff at Stoke Mandeville are anxious to know what has happened to it. There is a horrible feeling that none of this money will appear. Although the national allowance has been made, the Oxford region is spending up to its so-called RAWP level and the £400,000 is a mythical book-keeping transaction. In other words, the decision in practice was meaningless.

My main point concerns the building programme. Should we go on patching up indefinitely an old building, or can we go all out for a new building to be erected as soon as possible? That is bound to take time, probably four or five years. But until 1974 such a building was firmly in the programme. Since then it has had to be taken out. I hope that the Minister will say when we can expect the new building and whether the Government will

provide funds for it. In providing funds, it must be made plain that we are talking of a national institution.

The region has other great calls on its resources, and it is not possible for it to find this extra money. It has to make hospital provision for the growing city of Milton Keynes. That is siphoning off a good deal of money which one hopes might otherwise have been available for Stoke Mandeville. Of course Milton Keynes must have hospital provision, but somehow or other the Minister must take on board the crucial need to provide additional funds.

In doing this, the Government should accept the responsibility for the fabric of the new building. Perhaps we should look to other sources of revenue. For example, the case of setting up a research unit under the auspices of the Medical Research Council is a very good one and I should like the Minister's comments on that as a source of additional money.

If the Government will come forward with money on an effective scale, I have no doubt that the great army of well-wishers of Stoke Mandeville would also chip in with money themselves. We could get a good fund-raising effort going to match anything the Government could provide. But the Government must provide. They must realise that this is a piece of national importance and that it requires a national contribution to get it back on its feet.

I hope that the Minister will make an affirmative statement that he sees this as a matter of national importance. I hope that the spirit that has always permeated Stoke Mandeville, ever since Sir Ludwig Guttmann founded the spinal injuries unit—"We will not take no for an answer"—will not be lost on the Minister and that we shall get a response from him worthy of this important matter.

4.16 p.m.

Mr. Lewis Carter-Jones (Eccles): I should like to identify myself totally with the remarks of the hon. Member for Aylesbury (Mr. Raison). In my role as British chairman of Rehabilitation International, I have been on many of my trips round the world by the esteem in which Stoke Mandeville is held by people who were trained by Sir Ludwig

[Mr. Carter-Jones.]

wards after him and after Stoke Mandeville. It is sad to see what excellent buildings those people have and how grateful they are to Sir Ludwig and Stoke Mandeville for their training.

As the hon. Gentleman said, this is a national institution capable of great work. There are easily obtainable solutions along the lines that he suggested. I hope that the Minister will give his full backing to the rejuvenation of the buildings, premises and facilities at Stoke Mandeville.

4.17 p.m.

The Minister of State, Department of Health and Social Security (Mr. Roland Moyle): I am grateful for this opportunity to say something about the backlog of maintenance work at Stoke Mandeville and the measures being taken to improve the situation because this is a matter of great concern to the people of North Buckinghamshire, to the nation and, to some extent, internationally. I have no hesitation in saying that I can put my support entirely behind measures to renovate Stoke Mandeville. Of course, how we do it is another matter altogether.

Stoke Mandeville is mostly huddled accommodation dating from the early 1940s. It has the national spinal injuries centre there, but it is also a district general hospital. The intention of the Oxford regional health authority and its Buckinghamshire area health authority is that there should be a phased replacement of the accommodation as part of a process of developing Stoke Mandeville as a district general hospital. A new wing of about 100 beds was constructed in 1975. The next major capital development on the Stoke Mandeville site—the hon. Gentleman particularly inquired about this—will begin in 1985-86. This will be the second phase of the district general hospital, and at today's prices will cost £1.8 million.

I shall come back to the building and maintenance work, but there is no doubt that Stoke Mandeville is under heavy pressure because of expanding population in the northern part of Buckinghamshire, associated with the new town of Milton Keynes, which, pending the development of its own hospital facilities, depends upon Stoke Mandeville and Northampton.

There was a proposal from the health authority to reduce the number of beds devoted to spinal injury patients, and it was in connection with that that I visited the hospital in April of last year. I rejected that suggestion because there remains a shortage of spinal injury beds in the South of England. This is another cause for the strain being placed upon Stoke Mandeville. However, the shortage of beds will be ameliorated by two new specialist units to be built, one for the Odstock hospital in Salisbury, and the other at the Royal National orthopaedic hospital at Stanmore.

As for the pressure from Milton Keynes, a new purpose built 102-bed community hospital for the town will come into use later this year, and that should provide a little immediate relief. Later, there will be the 260-bed first phase of the Milton Keynes district general hospital, which should come into operation at about the middle of 1984. That will provide further relief for the pressure on Stoke Mandeville and Northampton.

In anticipation of this eventual replacement, there is no doubt that the authorities have attempted to minimise all maintenance costs in recent years, particularly in view of the claims of other hospital building and capital projects in the region. It has now become increasingly clear—the current incidents have dramatised this—that substantial expenditure will be necessary to maintain existing buildings.

The Buckinghamshire area health authority has been aware of the maintenance problem at Stoke Mandeville for some time. For example, in May last year the area works officer placed a report before the authority saying that the hospital's roofs required attention, that the boilers and associated plant would have to be replaced over a period of time, that part of the gas supply needed to be renewed and that some wards needed to be rewired and upgraded. Although the process had already begun at that time, this maintenance work is estimated to cost a little over £2 million out of an estimated maintenance work bill for the whole county on hospitals of about £3.5 million.

The maintenance backlog at Stoke Mandeville was brought sharply into

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focus last month when, as a result of the bad weather, some water pipes burst and brought down sections of the ceiling in three wards in the national spinal injuries centre and in one geriatric ward. At the same time it became evident that the roofs of a number of other wards would need early attention because of problems associated with the deterioration of the supporting joists.

The four wards immediately concerned have been evacuated and the necessary repair work has already been set in hand. The health authority expects that patients will be able to return to these wards fairly soon. In the meantime, the 75 or 80 patients involved have been transferred to other wards in the hospital. None has had to be transferred to another hospital or sent home.

A press statement was issued by the Spinal Injuries Association on Monday. The basic facts in the statement are correct, but the slightly passionate conclusion that there were no beds and few amenities for the patients and staff, with little hope of any immediate change, and that the hospital was being starved of money is obviously untrue against the background of the facts as I have stated them.

Work on the wards is well on the way to completion. They should soon be reoccupied by patients. In 1977-78, £375,000 was spent on maintenance of Stoke Mandeville. That was more than half the health district's expenditure of £716,000, and it is estimated that a further £430,000 will be spent in 1978-79 out of the maintenance budget of £810,000.

There has been a certain amount of public confusion in the matter. For example, there was a reference to this problem on the "Thames at Six" television programme which was screened on Wednesday evening. Here again, the facts are correct but they should be put in context. Doctors who were interviewed referred to a halt of non-emergency admissions, reduction in emergency admissions and the problems of patients who had to wait in other hospitals before they could come to Stoke Mandeville. This is correct, but these are long-standing problems resulting from the intense pressure to which Stoke Mandeville is subjected—as a result of the shortage of spinal injury beds in the South of England and the pressure of

the growing town of Milton Keynes. They do not have any direct relationship with the recent maintenance problems to which I have referred.

I should like to set out in greater detail the various developments and improvements which the health authorities plan to carry out at Stoke Mandeville, in addition to the major redevelopment in the mid-1980s to which I have drawn attention. These are already outlined in the capital programme of the regional health authority, drawn up in 1978. One of the hospital boilers has been replaced and a second is being replaced. A third will be replaced in the near future. Work on upgrading the laboratory started in June last year, and should be completed in May this year. The other principal work on the building site is the construction of a 40-bed geriatric unit which was started in July 1978 and is scheduled for completion in July this year, although that will not be an additional source of beds. The beds will be used to provide acute geriatric services for patients who will be transferred from the nearby Tindal hospital. Although these beds will be additional on the Stoke Mandeville site, the number of geriatric beds in the district will not be increased.

The hon. Gentleman referred to the hospital engineering services. The sum of £200,000 is to be spent on these and work is planned to commence in the financial year 1979-80. There is an extension planned to the kitchen but I understand that the district management team has recently suggested that the renewal of the hospital's electrical mains distribution system should take precedence. Area and regional health authorities will have to consider that problem and decide which is the most important priority. The hospital pharmacy will have to be upgraded, starting in 1981-82, to play its part in taking the additional workload off the Milton Keynes district general hospital when that comes on stream in 1984.

The hon. Gentleman asked whether the Department should make special additional funds available for Stoke Mandeville hospital. It was the crucial part of his case. There are two arguments. The first concerns the backlog of maintenance.

I do not consider that it is appropriate to make available to health authorities

[Mr. Moyle.]

special additional finance to enable them to overcome particular local problems of that nature. I do not see why the policy should be changed in the case of a backlog of maintenance at Stoke Mandeville. Maintenance work is fairly predictable and financial planning, budgeting and programming should take account of it. Contingency funds for these purposes are not held centrally. It is for the Oxford regional health authority and the Buckinghamshire area health authority to provide for the maintenance requirements at Stoke Mandeville, as at other hospitals, from their capital and revenue allocations.

The Department does not hold any money back, apart from some small grants for research purposes. It hands all its money to the regional health authorities on the basis of the resource allocation working party formula. The regions are expected to provide the appropriate money to the areas within their boundaries on the same principle. The authorities are free, within those budgetary limitations, to apply the money as they think fit to provide the service for which they are responsible. This provides a way in which management is given the maximum freedom to manage locally, subject to general guidelines from the Department and the budgetary limitations on funds. They must provide for maintenance out of those funds.

The other argument is that the Stoke Mandeville spinal injuries unit is a national centre of excellence and therefore should be nationally financed. This is an argument that could apply to several hundred other units in the NHS. To the extent that any specialist unit is involved in treating patients from outside the region—and in this case it is to a considerable extent—an appropriate annual addition is made to the region's target revenue allocation calculated in accordance with the criteria laid down by the RAWP.

Patients who flow in to Stoke Mandeville from outside the Oxford region are regarded as Oxford region patients and

are funded according to the formula. This influences the actual allocation made to the regional health authority which should increase the AHA's target allocations by appropriate amounts. In the case of Buckinghamshire and Stoke Mandeville, the region has acted as indicated; indeed, the special weighting to which the hon. Member drew attention will come into a effect for the 1979-80 financial year. It is up to the region to make allocations to the Buckinghamshire AHA accordingly.

The Buckinghamshire AHA will meet on 7 February to consider a report on the most recent problems arising at Stoke Mandeville. It will be for the AHA to discuss with the Oxford RHA any case for additional funding either to accelerate the programme, or replace the hatted accommodation or to implement a new programme to refurbish the building. The plans to which I have referred are within the region's current capital programme and the fact that a good deal of work has already been put in hand clearly demonstrates that the health authorities have been aware of the need to develop and upgrade Stoke Mandeville site for some time.

The regional chairman and senior officers visited the hospital on 24 January and the regional health authority was now fully conversant with Stoke Mandeville's problems. I am confident that both the RHA and the AHA will co-operate effectively to ensure that the necessary remedial works and the new developments planned are accorded the appropriate priority within the Health Service in the Oxford region. I assure hon. Members that I share their concern for the welfare of both—

The Question having been proposed after Four o'clock, and the debate having continued for half an hour, Mr. DEPUTY SPEAKER adjourned the House without Question put, pursuant to the Standing Order.

Adjourned at twenty-seven minutes to Five o'clock.

1/15/6

Miss Whitehead

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with compliments

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Department of Health and Social Security
Euston Tower
288 Euston Road
London NW1 3DN

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DR. GERARD VAUGHAN

STRICTLY CONFIDENTIAL

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FOR THE ATTENTION OF DR. GERARD VAUGHAN

STRICTLY CONFIDENTIAL

Meeting with Dr. Gerard Vaughan. Wednesday 9th September 81 @ 2.00 p.m.

Venue: Alexander Fleming House, Elephant & Castle, London SE1 6BY
Tel. 01-407-5522

Introduction. Ask Minister if escorts may be present.

Purpose of meeting.

- a) To express our fears and concerns over the present and future efficient running of the N.S.I.C. at Stoke Mandeville Hospital.
- b) In so doing the above, not to over-look the continuing good work presently being carried out.
Our fears are not directed towards our own situations, we have been paralysed a number of years and know how to speak up if necessary.

Object.

- a) To ensure that future spinal cord injured persons obtain the best treatment available.
- b) To ensure that the pioneer work started by Guttman continues.
- c) To ensure that the public's money, donated for the rebuilding, is used ultimately in providing an efficient centre.

History.

Between 1944 and 1966 the Centre was under the Directorship of Dr. Guttman.
Between 1966 and 1977 this was continued under Dr. J. Walsh.

Following the retirement of Dr. Walsh in 1977, the post of Director was abolished. (According to Dr. Rosemary Rue, Regional Medical Officer, "Directors are no longer appointed in N.H.S. clinical specialties." ~~(Reference to the N.H.S. Clinical Specialties Committee)~~)

From thereon the "Division of Spinal Injuries" was formed, whereby a Chairman is elected every second year, to run for two years - not being permitted to chair the division for more than 2 years at a time.

Although to date only Consultants employed part-time within the Spinal Unit have been elected Chairman of the Division, there is nothing to presume that anybody who is a member of the Division couldn't be voted in as Chairman. Other members include consultants from areas outside the spinal unit.

THE OVERALL LACK OF MEDICAL LEADERSHIP AND ENTHUSIASM

1. The Centre lacks direction. With three part time Consultants, no-one is working full time towards the development and benefit of the Unit as a whole.
2. The Unit is now clearly divided into three individual kingdoms, which are 'Off Limits' so to speak, between individual consultants. Consultants now have acquired 'Their (My) Wards' thus establishing conflicting methods of treatments. This makes life very difficult for nursing staff - in particular those undertaking the Post-Basic course in Spinal Nursing.
3. As the Unit is divided (see plan), in theory some patients are unable to be re-admitted under the Consultant that previously cared for them.
4. Neither can some patients be seen for out-patient check-up care by the Consultant who originally cared for them.
5. Interpersonal relationships between the three consultants is obviously strained. Demonstrated in front of staff and patients.
6. There is too much conflicting medical opinion. Example:- Courses of antibiotics being changed 4 or 5 times during a long weekend by different doctors.
7. No decisions regarding discharged made at weekends. Example* Consultant not available to discharge patient on a Friday - patient goes home for weekend, returning Sunday or Monday morning to be discharged.
8. Sometimes all Consultants are away on holiday at the same time.

CHILDREN

Both N.H.S. and private patient children are being treated in adult wards. A limited number are transferred to the paediatric unit at later stages in their treatment.

ALLOCATION OF WARDS TO SENIOR MEDICAL STAFF

CONSULTANT ONE

1. Male Lesion
Ward (New)

1 Old Lesion
Female Ward

CONSULTANT TWO

1 Male New Lesion
Ward

1 Old Lesion Male
Ward

CONSULTANT THREE

1 Mixed New Lesion
Ward

1 Old Lesion Male
Ward

OUT PATIENT DEPARTMENT - 1 MEDICAL ASSISTANT

ATTITUDES OF SENIOR MEDICAL STAFF TOWARDS PATIENTS

1. Some members of the senior medical staff choose not to involve patients in details of their care. That is to say, patients have no say or control over their own destiny.
2. Consultants too often adopt the 'Lord and Master' attitude - "Do what I say or out you go" type of approach.
3. Senior medical staff fail to demonstrate interest or concern regarding patients domestic, work or family situation. Example:- A working paraplegic with family to support is called in by telegram for treatment, 11 days later is seen by the consultant.

THE DECREASING TIME CONSULTANTS ARE GIVING THEIR PATIENTS

1. All 3 Consultants are part-time.
2. They are becoming further involved in the development of private patient care.
3. More time is being taken up attending compensation court hearings, Medical Society meetings, Lecturing etc. Leaving little time at the bedside.
4. Will a 4th Consultant be appointed?

THE TOTALLY INADEQUATE STAFFING LEVELS, WITH PARTICULAR REFERENCE TO NIGHT COVER

1. Most nights only 1 nurse covering acute wards, together with 2 orderlies.
2. Patients become frightened to ask for help, being aware of the shortages and workload imposed.
3. Dying patients are left alone through staff shortages.
4. There exists an imbalance between trained and untrained staff.
5. Some relatives are willing to employ Agency staff during crisis periods - e.g. when their relatives are dying.

THE HUGE TURNOVER OF STAFF

1. Why is this?
2. Research by Dr. Ruth Jacobs.
3. Poor staff accommodation.
4. Constantly changing ~~change~~ staff is unsettling for patients. Rehabilitation is severely interrupted by, for example - change of physiotherapist.

THE GENERAL DETERIORATION IN ADMINISTRATION

1. As a National and International Centre, statistical records must surely be of paramount importance? Sadly these have not been kept since 1976!
2. The new Centre is designed to care for spinal injuries well into the next century, we already live in a technical age - Will the Centre be equipped with the latest Computer technology?
3. Individual senior members of the medical staff frequently take months writing letters, in particular to patient's G.Ps. On occasions they fail to write at all.
4. Patients are no longer called for routine check-ups.

THE PROBLEMS OF CHECK-UP CARE

1. Check-up or follow-up care is essential to the paralysed. Patients are however being discouraged to return to Stoke - being instructed to attend their local hospitals.
2. Some patients have great difficulty to be seen by the consultant who originally cared for them when they return for check-ups.
3. The out-patient check-up department is staffed by a full-time medical assistant, engaged primarily in this department. It has become apparent that he is covering a private nursing home twice or more weekly, when patients have appointments to see him in the out-patient department. Nursing staff employed within this department are constantly telephoning his home looking for him at times when he should be in the department.
4. G.Ps. again are not always informed of check-up results, neither are patients.

PRIVATE PATIENT FACILITIES WITHIN STOKE MANDEVILLE HOSPITAL

The Hospital as a whole is permitted to take 35 Private Patients. These can be distributed throughout all various units as and where the demand occurs.

Within the Spinal Unit it is customary for the Consultants to have four private patients each, however should there be less than the total permitted within the whole Hospital, the Spinal Consultants are within their rights to have up to (in theory) 35 Private Patients within the Unit.

The Spinal Unit at present should be 156 beds (not all of these are staffed), the New Centre will comprise 120 beds.

Will there be a corresponding reduction in Private Patient Beds?

PRIVATE PATIENT FACILITIES WITHIN THE COMMUNITY

Within 5 - 10 miles of Stoke Mandeville Hospital there are four Private Hospitals/Nursing Homes, all offering facilities for the Private Spinal Injured Victim. As it so happens, individual Consultants have interests and beds in one or more of these Private Homes. There is already evidence of Staff leaving the N.S.I.C. to work within these Private Homes, which we fear will slowly expand thus reducing the already stretched services.

The Private Homes would appear in certain circumstances not to be able to provide total care for the Spinal Injured victim for example: patients are admitted to the N.S.I.C. from the Private Homes for observations; blood transfusions; surgery etc.

Many of the patients resident in Private Homes attend the Spinal Unit at Stoke Mandeville on a daily basis for hydro-therapy, physio-therapy etc. This within itself puts unnecessary pressure and load on existing staff.

Within a Ward that houses both Private and N.H.S. Patients there exists two positive standards of treatment/facilities.

For example: Medical Staff are seen more frequently visiting their Private Patients.

At meal times a communal table is shared - menus are different - it is not unusual to see the better meal being thrown out!

NOTE

It is most unusual to see a Private Patient resident in Great Britain - 99% if not all Private Patients are from abroad.

THE PADDOCKS PRIVATE HOSPITAL

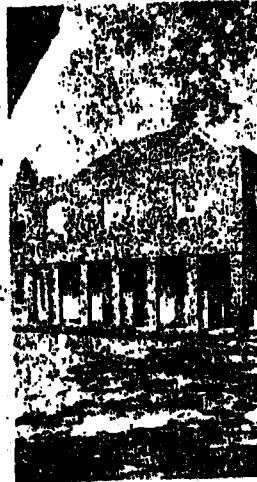
OPENS FOR BUSINESS!

Following completion of a £1.2 million extension The Paddocks Clinic at Princes Risborough, Bucks, has opened as a 43 bed private hospital.

It can now provide one of the most up-to-date operating theatres in the country, plus laboratory, pharmacy, static x-ray unit, and an out-patient department. It is one of the few private hospitals in the country that can provide full facilities for severe spinal injuries in which it has specialised over the past six years. A fully qualified surgical service and physiotherapists has been built up.

The Paddocks has built up an international reputation since it opened in 1975 under the guidance of administrative directors Mrs. J. P. Lewis and Mrs. J. I. Mossop. The hospital is under the constant supervision of a medical director.

The hospital is particularly well qualified to deal with any back problems and the intensive therapy associated with strokes and multiple sclerosis. All the facilities are now fully operational and available to specialists and general practitioners requiring private hospital treatment for their patients. The Paddocks Hospital comes within the scope of PPP and other recognised medical insurance schemes.



Although initially operating as an acute geriatric unit, by the end of the seventies it had become one of the best of its kind in the UK.

The modern red brick and slate building, designed to complement the original Edwardian house, provides 43 beds of which 18 are allocated to the spinal unit. The other 25 private rooms are designated for general surgical and medical cases (including children), with a number of emergency beds available.

LOCATION

The Paddocks Hospital is situated on the A4010 Aylesbury Road north of Princes Risborough with the main entrance in Queen's Road. The hospital is well placed for patients from many towns and villages in Buckinghamshire, Oxfordshire and Hertfordshire.

The hospital can arrange for a chauffeur-driven hire car to collect or deliver patients, on request. Car parking bays are available through the main entrance off Queen's Road.

A brochure is available on request from Mrs. J. P. Lewis at The Paddocks Private Hospital, Aylesbury Road, Princes Risborough, Bucks.

Nursing home to have spinal unit

THE Mid Bucks Nursing Home at Worlds End, Weston Turville, is to be extended to form a spinal injuries unit with operating theatre facilities.

The Development Control Sub-Committee of Aylesbury Vale District Council approved the planning application submitted by Dr. James Clarke subject to certain legal agreements.

But Weston Turville Parish Council has com-

plained that the proposed extension is too large for the site and will generate a considerable volume of extra traffic passing through the village both day and night.

The Parish Council points out that the site has a long history of planning applications of this type and that permission has already been granted for a smaller scale extension.

REST HOME

The background to the site, as far as the present applicant is concerned, began with a permission in 1978 for the use of the Old Rectory as a Rest Home for a maximum of 15 elderly people.

Since then, a number of planning applications and revised plans have been submitted to the district council for additional facilities.

The latest application, submitted by Dr. Clarke, was described by the council's chief planning officer, Mr. Gerald Balmer, as "a composite of those approved and favourably considered in the past".

POOL

It will comprise, at ground level, the use of the existing house as kitchen, sitting and dining rooms, bathrooms and so on, with the proposed extension at ground level including a hydrotherapy pool, gymnasium and nurses' area.

Two operating theatres, an anaesthetic recovery room, and other facilities, would be at first floor level, and 26 bedrooms are to be located in an L-shaped block linked to the main house.

FEELING HEALTHY

"Employers are looking at private insurance in lieu of extra wages."

PETER MONTEITH examines the

controversial question of private health

ECONOMY may be in the depths of depression with the number of work nudging three million, at least one sector of industry enjoying a healthy boom. Private medicine — the theme in which personal health is assured like cars — had

"We are not out to poach staff deliberately from the NHS."

its best ever year in 1980.

A survey carried out for the Department of Health showed a massive 30 per cent increase in business.

Private medicine is already well established in the Chilterns, and big expansion plans are on the way.

Last week it was announced that a new spinal injuries centre will be built at the Mid-Bucks Nursing Home at Weston Turville.

And early next year the new 81-bed Chiltern Hospital at Great Missenden — which will have new facilities for treating spinal cases — will be opening its doors.

But health unions in the Chilterns are not happy fearing that the new centres will lure staff away from the NHS, lowering health standards in the major hospitals.

They argue that the NHS system pays for the highly specialised training and the private sector — with little or no training facilities — benefits from it.

union committee for the health service in Bucks said this week: "We are very concerned, and the problem seems to be getting worse."

And David Tippins, district nursing officer at Wycombe General Hospital said: "We are concerned that a hospital at Missenden will be opening close to Amersham Hospital and that some of our staff may go."

"It is inevitable that if conditions of service are better some staff may be tempted."

"Already I have heard whispers that one of two consultants who have an interest in the Chiltern Hospital are being lured away from us."

But Michael Barsby, director of the Chiltern Hospital, rejects criticisms of private medicine.

He said: "Our company has opened two private hospitals recently in Windsor and Harrow and there has been no criticism at all from the health authorities that we have been poaching staff."

"Although we do not offer undergraduate nursing courses we do plan to run, at least at the Chiltern Hospital, courses for nurses returning to work after a spell away."

"In this way we hope to attract people who are not working at the moment. And of course the output of nurses each year exceeds the needs of the NHS."

"We do offer better facilities and conditions but we are not out to poach staff deliberately from the NHS."

The attraction of private health is of course the speed of treatment.

Many operations which mean many months of waiting on

the NHS can be done almost immediately.

And as BUPA — one of the biggest private medicine insurers — says the cost is no more than two packets of cigarettes a week.

They say that people are worried that the NHS itself might be hit by the recession and are putting the health of their families first.

Michael Barsby said: "There are two main reasons for the growth in private medicine."

"More employers are looking at private insurance for their employees in lieu of extra wages."

"And increasingly, groups of people such as the police are banding together and getting reduced premiums from insurance companies."

"While it is true we offer better wages, we are only about 10 per cent above the NHS rates."

"We feel this compensates staff for the benefits we cannot offer them that they get from the NHS, like better pensions."

"It is a bit of a fallacy to say the private health sector pays a lot more."

"We are offering a new facility to the community with the Chiltern Hospital."

A spokesman for The Paddocks private hospital at Princes Risborough said:

"You can argue that the private sector does not train its own staff but against that the NHS runs with large numbers of people who are not as expensive as the qualified staff we have to carry."

levels much higher and have more qualified staff on duty."

But despite assurances from the private hospitals, health unions are still worried about their growth.

Ron Barrett said: "Apart from the spinal injuries unit at Weston Turville, we hear that United Medical Enterprises are negotiating for a site in Milton Keynes which will obviously affect the new NHS hospital there."

Spinal injuries centre at Weston Turville. The spinal injuries centre is a springing unit around it."

At the moment both Wycombe and Amersham Hospitals are reasonably well staffed with nurses except for the intensive care unit at Wycombe.

But the position has only just improved at Amersham and there are fears that it could deteriorate when the new Chiltern Hospital starts taking on nursing staff.

"We are very concerned and the problem seems to be getting worse."

WHAT DO THEY DO AT "THE GABLES"?

The Private Nursing Home in Wendover Road, Aylesbury

THIS question is so often asked that perhaps some of the answers can be given here. A nursing home to many people suggests a home for the elderly -- not so with the Gables -- they have a very impressive operating theatre where they carry out a surprising number of operations -- some 500 a year.

In view of the regrettable decline of the National Health Service, the demand for private surgical procedures is constantly increasing and many Consultants use the facilities at the Gables and perform all types of surgery, things that are left on hospital waiting lists for years, such as hernias, varicose veins, vasectomies, surgery for

children, orthopaedic surgery, dental surgery and gynaecology. They also do a tremendous range of reconstructive and corrective plastic surgery. I learnt that hands crippled with arthritis can gain relief from surgery by replacing joints, children with "Bat Ears" can have this corrected; old injuries and scars can be skin grafted, torn tendons can be repaired or grafted, and many congenital deformities can be corrected. Some countries, where they do not know how to care for paraplegics, send their patients to the Gables for removal of bony areas that can and do cause pressure, and then these areas are skin grafted before the patients return home.

My interview for this article was fascinating, I learnt that if one was not satisfied with their face or figure, that too could be dealt with at the Gables. Micro-surgery, which has received great publicity recently, has also been performed at this local Nursing Home. There is a happy atmosphere at the Gables and great enthusiasm from everyone for the new wing which Mr. Terry Arnold of Hulcott commenced building in March and has completed a fortnight ahead of schedule, working from plans drawn up by the Architects Payne Cullen Partnership.



HEALTH UNIONS SLAM PRIVATE HOSPITAL PLAN

HEALTH service trade unionists have hit out angrily at plans for a private, 60-bed hospital at Great Missenden.

They are worried that the new hospital will attract nurses away from desperately understaffed local NHS hospitals and anxious that the consultants involved with the new Chiltern Hospital may spend less time with their NHS patients at Wycombe, Amersham and Stoke Mandeville.

The new hospital is being built by an American medical company on the Little Abbey Hotel site. It will include 20 beds for spinal injuries patients as well as an intensive care unit. Local consultants have together put £100,000 into the project which will cost around £4m to build and equip.

News of the plans have caused "great consternation" among members of the Bucks Joint Trade Union Committee which represents eight trade unions involved in local health services. Members are "very angry", said JUTC secretary Ron Borrett.

"Although we knew about plans for the Frankland Centre which was to have been a private nursing home on the same site, the first we knew about the change of plan to an acute general hospital was when we read the story in the Bucks Free Press," he said.

A statement issued by the JUTC this week describes the siting of the new hospital in Bucks as "an indictment of the provision made by the regional health authority for the health services in the county."

Change

Mr Robert Cleary, vice-president of the company behind the project, has said that the financial position of Bucks MHA which has prompted cut-backs in many local hospitals, was one of the reasons behind the choice of Great Missenden as their site.

The JUTC asks who gave planning permission for the change of use from nursing home to hospital. Theoretically, said Mr Borrett, all planning applications for private hospitals should be

concerned about the effect of the Chiltern Hospital on the new spinal injuries centre at Stoke Mandeville.

"They feel, too, that consultants will spend more time with private patients. Mr Borrett is sceptical about assurances that this will not happen.

Unfair

"I think it must detract from their work," he says. "They can only work so many sessions and the more time they devote to private practice then the less time they will have for their NHS patients."

Fifty-four consultants from Aylesbury and Wycombe health districts have put money in to the new project and will be attached to the

hospital while continuing their NHS work.

But perhaps the most worrying aspect is the effect on staff and particularly nurse recruitment, says Mr Borrett. At the moment there are 155 nursing posts vacant in Aylesbury health district and the situation in Wycombe is also bad. The opening of the Chiltern Hospital can only exacerbate the crisis, says Mr Borrett.

He says it is unfair that nurses trained in NHS hospitals at public expense should be "milked away" to the private sector.

"I have nothing against private medicine. I think it is OK - provided private medicine trains its own staff," said Mr Borrett.

● Private hospital news welcomed — P30

More beds for clinic

FOLLOWING completion of a £1.2 million extension, the Padlock Clinic at Princes Risborough has reopened with 43 beds.

A private hospital, it specialises in severe spinal injuries, and has now got one of the most up-to-date operating theatres in the county.

It is also equipped with a laboratory, pharmacy, static X-ray unit, and an out-patients department.

The hospital, which was opened in 1975, is particularly well qualified to give the intensive therapy needed by people suffering from back problems and multiple sclerosis.

THE EFFECTS ON BOTH PATIENTS AND STAFF

1. Patients are aware of conflicts within the Centre, which undermines their confidence in the services. Some believe they would be better off in a General Hospital. In fact that is not the case; the specialised knowledge still remains within the Spinal Unit.
2. When patients being treated in different wards meet, they exchange notes and question why it is that some are offered areas of rehabilitation that others are not. Such as group counselling sessions.
3. Staff (mainly nursing) are becoming exhausted and totally disillusioned with constantly having to 'make do' with the shortage of numbers. This involves always having to change duties, work overtime and double up when somebody is sick or on holiday.
4. Staff lack job satisfaction in certain areas.
5. As present senior nursing staff will mainly have retired within the next 10-15 years, it is vital to ensure suitable replacements are available.

CONCLUSION

We feel most problems would be overcome if the Centre was under the leadership of a full-time Director.

THANKS TO OUR SUPER READERS

JIMMY SAVILE'S marathon run means that Daily Express readers have now donated a total of more than £1,400,000 to the Stoke Mandeville Hospital Appeal.

"That's more than has ever been done by any paper in the world," said Jimmy. "The response by readers has taken all the aches out of my legs."

More than £25,000 was given to him before the race, another £42,000 has been sent to the hospital wishing him luck and Jimmy is confident of more than £50,000 to come in sponsorship cash.

"Thank you, everyone for everything," said Jimmy. "I've done my bit—can you do yours please and send the brass a bit sharper?"

If you'd like to add your congratulations send a donation to the Daily Express Stoke Mandeville Appeal, 4 Raquet Court, London EC4X 1BB.

Mo Salk
P1 file
SW
9/7

Set to go at Stoke Mandeville

BUILDERS Trollope and Colls are to start laying the foundations of the new Spinal Injuries Centre at Stoke Mandeville, Buckinghamshire on August 1.

Managing director Mr Harry Reeves said yesterday that access roads would be ready and the site cleared by then to enable his men to move in.

Trollope and Colls, part of the Trafalgar House group which also owns the Daily Express, is doing the work without profit.

Jimmy Savile, backed by the Daily Express, is leading the appeal for £10 million to pay for the new centre. So far more than £6,500,000 has been raised.

Mr Knight

MS(H) MEETING WITH MR MICHAEL ROGERS TO DISCUSS THE NATIONAL SPINAL INJURIES CENTRE AT STOKE MANDEVILLE HOSPITAL
(9 SEPTEMBER 1981, AT 2 P.M., D616 AFH)

1. MS(H) has agreed to meet Mr Michael Rogers to discuss, in confidence, the future of the National Spinal Injuries Centre at Stoke Mandeville.
Lady Davina de Knayth, Mr Philip Lewis and Mr Ivor Elms are also expected to attend the meeting. (A short note on what is known of the group is set out at Flag A on the briefing papers in the folder attached).
2. Enclosed are:-
 - Flag A: A note on those attending followed by the brief.
 - Flag B: Mr Rogers' letter to MS(H) detailing the points which the deputation wish to make.
 - Flag C: A note on the development of Stoke Mandeville and other Spinal injuries units in the South of England.
3. Mr Roger's letter to MS(H) of 15 July (Flag B) sets out the points causing concern to the group: the further letter promised has not yet been received. The points all relate to the detailed, inter-arrangements for running the NSIC and may touch upon, in some instances at least, sensitive ground—matters of clinical judgement, clash of personalities and ideas among the consultants in the NSIC. As far as is possible, the points are dealt with in the brief. We suggest that MS(H) should invite the group to explain their anxieties to him, with specific instances to illustrate their fears and allegations. The Bucks AHA and Oxford RHA (as appropriate) could then be asked to look into the complaints and furnish a report in due course to MS(H) or officials.
4. A number of points made in the brief are "gossipy" rather than strictly factual, and should be treated as confidential. Mr Rogers in particular is intimately involved with the Unit (see notes on those attending).
5. It might be constructive to mention that Mr Hugh Rossi, Minister for the Disabled, has been invited to visit the sports complex at Stoke Mandeville, and the NSIC, by the British Paraplegic Sports Association. He intends to accept the invitation, if possible, and to visit by the end of the year.
6. I shall attend the meeting with Mr P G Smith who will take the note.

7 September 1981

cc

Miss Davidson
Mr Smith
Mrs Arthur

Mr Myers

- to see, then to Mrs Hayward for UNI 15

Phoned RLE (after discussion with Dr Tait) told them to emphasize that complaints etc. should be taken up with those ^{at} ~~at~~ to resolve them
- via my minutes to Miss [unclear]

John 1109
Lynne Fosh
Mrs Lynne Fosh
RL2E
Room 1527 Ext 816
Euston Tower

Telephone:
Stoke Mandeville

FOA/2763/484

CONFIDENTIAL

RECEIVED
16 JUL 1981

PRIVATE OFFICE

15th July 1981

Dr. G. Vaughan,
Minister for Health,
Department of Health and Social Security,
Alexander Fleming House,
Elephant & Castle,
London SE1 6BY

Dear Dr. Vaughan,

Thank you so much for your letter dated 29th June, 1981, we are delighted that you are in agreement to meet with us, to discuss our fears about the future of The National Spinal Injuries Centre at Stoke Mandeville Hospital.

May I suggest that we meet, should it be convenient to yourself, at any time after 11.00 a.m., during the week commencing 7th September. If one of these days is suitable, would you be good enough to let us know where and at what time.

At the moment we have not had the opportunity to meet and draw up a detailed list of our fears concerning the Centre, this we plan to do before we meet you and as requested I will send you this in advance.

The areas of concern are as follows:-

1. The overall lack of Medical leadership and enthusiasm
2. Attitudes of senior medical staff towards patients
3. The decreasing time Consultants (who are already part-time) are giving to their patients.
4. The totally inadequate staffing levels, with particular reference to night cover.
5. The overall expansion and development of Private Patient services

Continued/

Continued/

-2-

6. The huge turnover of all grades of staff
7. The problems of check-up care
8. The failure to keep patients statistical records
9. The general deterioration in administration.

Yours sincerely,

M. A. Rogers

Michael A. Rogers

MS(H) MEETING WITH MR ROGERS TO DISCUSS THE NATIONAL SPINAL INJURIES CENTRE
AT STOKE MANDEVILLE

(2.00 P.M., 9 SEPTEMBER, ROOM D616 AFH)

PURPOSE OF MEETING

1. The meeting arose from Mr Rogers' written request (flag B) to meet MS(H) to discuss, in confidence, his anxieties about the future of the NSIC.

PEOPLE ATTENDING

2. The following people are expected to attend:

Mr Michael A Rogers : A tetraplegic and former patient at the NSIC. His wife is the senior nursing officer at the NSIC and he will therefore have a good (if perhaps biased) knowledge of the local situation. He is an active campaigner for improved services for Spinal injury patients but is not believed to be directly associated with any particular group such as the Spinal Injuries Association.

Lady Darcy De Knayth : A paraplegic. She has always supported Lady Masham strongly in the House, as the opportunity arises, on matters affecting Spinal injury patients and the disabled generally.

Mr Philip Lewis }
Mr Ivor Elms } Both former patients of the NSIC but we know nothing else about them.

BRIEF

3. The items for discussion listed in Mr Rogers' letter all concern the detailed management of the NSIC and touch, in some instances, on sensitive issues - matters of clinical judgement and perhaps relationships between the consultants themselves at the NSIC and medical/nursing relationships. (Some notes on these detailed points follow.) The complaints are general in nature and we suggest MS(H) invites the group to spell these out in detail so that the AHA/RHA, as appropriate, may be asked to look into them and report to MS(H) or officials. Generally, the AHA does not believe that there is anything seriously wrong at the NSIC or that services are deteriorating.

4. It might be constructive to mention that Mr Hugh Rossi, Minister for the Disabled, has been invited to visit the sports complex at Stoke Mandeville, and the NSIC, by the British Paraplegic Sports Association. He intends to accept the invitation, if possible, and to visit by the end of the year.

NOTES ON POINTS RAISED BY MR ROGERS (SEE FLAG B)

"The overall lack of medical leadership and enthusiasm"

"Attitudes of senior medical staff towards patients"

"The decreasing time consultants (who are already part-time^s) are giving to their patients".

5. All these relate to the consultants working in the NSIC but the complaints are general and without the back up of specific examples it would be difficult for the Department or MS(H) to ask the AHA/RHA to look at these matters. The group should be asked therefore to give detailed examples to follow up locally. (In confidence, if necessary).

6. The AHA/DMT are aware that the 3 consultants at the NSIC do not always see eye to eye. They are of equal status but each year they elect a Chairman of the Spinal Injuries Division to act as spokesman for the Unit and take the administrative lead. The current Chairman is Dr John Silver. Previously, the management of the NSIC had been under the care of a Medical Director but this post was discontinued on the retirement of Dr Walsh about three years ago. Since then the medical management of patients has been the responsibility of the individual consultants with none taking precedence over the others. This form of organisation accords with that in other sections of the hospital and in the NHS generally. Neither the profession nor the Department now favour the "Medical Director" type of medical management for such units. However, Dr Frankel, one of the consultants at the NSIC, who was Deputy Director before the retirement of Dr Walsh, is believed to have been somewhat disappointed at not being appointed overall Medical Director. It may be that Mr Rogers and his friends will raise the suggestion of the appointment of a Medical Director at the NSIC as a possible solution to what they regard as "overall lack of medical leadership and enthusiasm".

7. The AHA say that the consultants are all committed to their patients and are all competent in their work. They all have "maximum part-time" contracts but the AHA have no evidence to suggest that any of them are not fulfilling their contractual commitments. (Some are known to have private patient interests in the Area and these are considered below.).

"The totally inadequate staffing levels, with particular reference to night cover".

"The huge turnover of all grades of staff"

8. This complaint is assumed to refer to nursing staff. The AHA say that staffing levels are up to the established complement and have been so for the past three months. However, the Spinal Injuries sector has prepared a report seeking an increase in nurse staffing levels and this was presented to the District Management Team on 18 August. It is still being considered. The AHA admit that there had been difficulties in the past (about 15 months ago) in arrangements for staffing the Unit eg failure to advertise vacancies quickly enough, but these problems have been largely overcome. The AHA say, in Confidence, that the present District Nursing Officer, although an excellent clinical nurse has not had the managerial qualities to deal effectively with nurse staffing problems. (She is expected to retire shortly). However a newly appointed Area Nurse will take up duty in September, and will be given the task specifically of looking at the deployment and management of the nursing resources in the District, including the NSIC. The AHA are still considering the case for an increased nursing establishment, but they believe that better nurse management might be at least part of the answer to the NSIC problems.

On turnover of staff, information shows that the average % turnover for trained nursing staff was 4% for the year ending July 1981: the equivalent figure for untrained staff was 2.3% (with normal "peaks" to coincide with the end of training periods etc.) Over the years from 1977 to 1981 the number of trained nurses for both day and night duty has increased despite the reduction in the number of beds at the Centre. The number of untrained staff has decreased slightly over the same period (but not in relation to number of available beds).

Detailed information on staffing is attached as an annex to this note.

"Overall expansion and development of Private Patient Services"

9. 12 of Stoke Mandeville's 28 pay beds are located in the NSIC. (There had been 10 previously). Average occupancy of these private beds in 1980 was 10.4, which is high. There 864 private out-patient attendances in 1980.

10. No doubt because of the proximity of the NSIC, private facilities for spinal patients have been developed in the area. Dr Walsh, the former Medical Director of the NSIC, is associated with the Paddock Nursing Home at Princes Rise borough which has 12 beds for spinal patients. The Franklin Centre at Great Missenden is being developed to take spinal patients and the North Bucks Nursing Homes Association have sought planning permission for a development at Wendover which will include facilities for spinal patients. (Dr Frankel is believed to be associated with this latter development.).

"The problems of check-up care"

"The failure to keep patients' statistical records"

"The general deterioration in administration."

11. Again, these allegations are very general in nature and the group should be invited to give specific instances of the problems and complaints so that they may be considered by the AHA.

These three points have been raised by the Spinal Injuries Association - though once again not in specific terms - in a letter to Baroness Young. This followed from the criticisms made by Lady Masham in the House on 3 July. We are awaiting the AHA comments on the SIA's allegations before providing a reply for Baroness Young to send to Mr Stephen Bradshaw of the SIA. Mr Rogers and his companions are not thought to be closely linked with the SIA although they could be members.

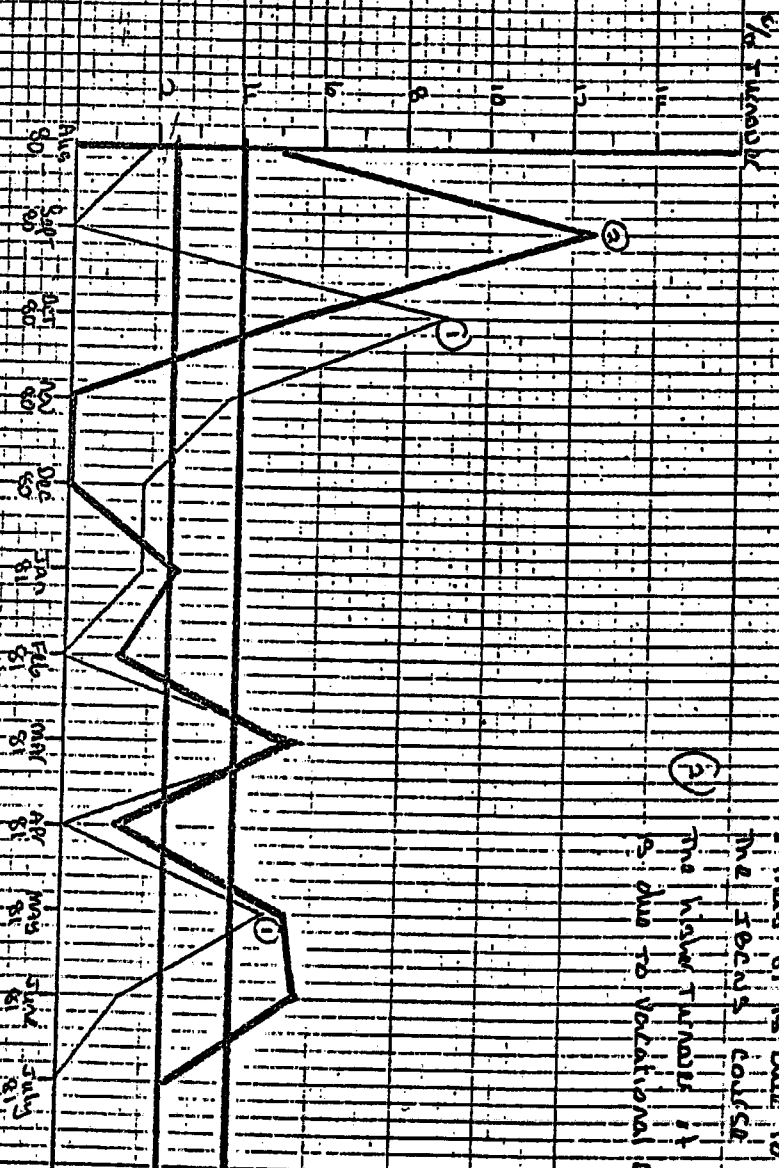
REBUILDING OF NSIC

12. A general note on the re-building of the NSIC is at flag C.

AMWEX

NSIC - Nurses Trained Staff		Fundl Estate	In Post	I - Vacancies	A	B	C	II Total 1980 Acc	I - II Over/Under
August	1980	58.73	50.80	7.93	-	0.62	0.09	0.71	7.32
September	1980	58.73	52.53	6.20	0.11	2.37	-	2.48	3.92
October	1980	58.73	49.99	8.74	0.94	2.56	0.02	3.52	5.82
November	1980	58.73	48.06	10.67	1.23	4.57	-	5.80	4.87
December	1980	58.73	47.06	11.67	4.02	3.31	0.81	8.14	3.53
January	1981	58.73	46.06	12.67	4.52	5.55	1.27	11.34	1.83
February	1981	58.73	48.06	10.67	1.44	3.95	0.64	6.03	4.84
March	1981	58.73	47.35	11.38	1.76	3.33	0.71	5.80	5.58
April	1981	58.73	51.35	7.38	2.76	2.78	0.98	6.52	0.86
May	1981	58.73	56.35	2.38	1.26	3.01	0.83	5.10	2.72
June	1981	58.73	55.35	3.38	0.98	3.46	1.39	5.83	2.15
July	1981	58.73	55.35	3.38	2.86	2.86	2.02	7.74	4.36
NSIC - Untrained Staff									
August	1980	72.5	72.5	-	-	-	16.92	16.92	- 16.92
September	1980	72.5	66.87	5.63	-	-	12.05	12.05	- 16.12
October	1980	72.5	63.87	8.63	-	-	12.55	12.55	- 3.92
November	1980	72.5	65.87	6.63	-	-	14.43	14.43	- 7.80
December	1980	72.5	68.76	3.74	-	-	10.55	10.55	- 6.81
January	1981	72.5	67.76	4.74	-	-	10.75	10.75	- 6.01
February	1981	73.03	68.67	4.36	-	-	11.11	11.11	- 6.75
March	1981	73.23	68.71	4.52	-	-	14.35	14.35	- 9.83
April	1981	73.23	71.23	2.00	-	-	10.89	10.89	- 9.89
May	1981	73.41	68.77	4.64	-	-	11.53	11.53	- 6.89
June	1981	73.41	66.24	7.17	-	-	7.39	7.39	- 0.22
July	1981	73.61	68.21	5.40	-	-	11.64	11.64	- 6.24

- overestablished



NSIC Staff Turnover

Trained Staff (Nursing & Untrained Staff (Nurses & 1950)

- (1) The higher turnover of trained staff in Oct 50 & May 51 is due to nurses competing for jobs outside the hospital.
- (2) The higher turnover in untrained staff in Oct 50 is due to vocational employees leaving.

Average (Avg. July 51)

Average

Nursing Staff

~~NSIC~~

NSIC

* (These Funded Estab. Figures were prior to 3 1/2 hrs/week)

Day Duty

	No of Beds	Meds Open	Funded Estab. Trained Staff	Funded Estab. Untrained Staff
May 1977	156	8	* 52-12 WTE	79.92 FTE
May 1978	148	7	* 55-21	78.95
May 1979	126	6	* 56-21	78.95
May 1980	134	6	* 55-75	72.00
May 1981	133	6	58-73	73.41

SMH Night Duty Global Figure

Funded Estab. Trained Staff

Funded Estab. Untrained

May 1977

85.67 WTE

42.67 WTE

July 1981

105.44

51.27

D

GENERAL NOTE ON DEVELOPMENT OF NSIC AND OTHER FACILITIES FOR SPINAL INJURY PATIENTS

1. THE RE-BUILDING OF THE NSIC

The Jimmy Savile appeal was launched on 23 January 1980 with a public announcement by the Minister for Health. The primary purpose of the appeal was the re-building of the National Spinal Injuries Unit at Stoke Mandeville Hospital, Aylesbury (120 beds) to replace the existing unit which is still housed in wartime huttred accommodation. Jimmy Savile's avowed target was £10 million, and he is still quoting this as his ultimate objective. Latest estimates put the total cost of the 120 bedded unit at 7 million. To date about £5 million of the cash target has been received, together with offers of building materials and services at reduced rates which, while it is difficult to place a cash figure on them, should reduce the final cost of the unit considerably. The necessary enabling works have been completed and the re-building work has begun. Building is expected to take about two years. The new Centre should be completed in 1983.

2. OTHER DEVELOPMENTS FOR SPINAL INJURY PATIENTS

Work on building a new spinal unit at Odstock, Salisbury (which will provide some 50 places) has recently been started. It also should be completed by mid 1983. A temporary (16 bed) unit is expected to open at the Royal National Orthopaedic Hospital at Stanmore in November this year. The planned permanent unit of 25 beds at Stanmore is due to be completed in 1983. It is too early to say yet exactly when these new developments will come "on stream", but by 1984 it seems likely that they should be in a position to ease the burden falling upon the resources of the NSIC.

Miss Sweeney.

MS(H)'s meeting with representatives of the SIA - Sept 9.

1. I promised to let you have a short note on the little we know about those who will be meeting MS(H).

Lady Davy De Knayth - a baroness in her own right, she was married to John Ingrams (the brother of Richard Ingrams of "Private Eye") He was killed in the car crash that left her paralysed.

Michael Rogers - married to Liz Rogers, the Senior Nursing Officer at Stoke Mandeville, whom he met whilst a patient there. He is the author of two of the SIA's best selling publications - "So you're paralysed" and "Able to Work".

I'm sorry that we have no information about Philip Lewis and Ivor Elms - apart from the fact that both are presumably ex-patients of NSIC.

We spoke about the necessity of ensuring that access and arrangements for the meeting are worked out, since all 4 people are bound to be in wheel-chairs.

2. I have told Dr Tait about the meeting. DA Document 67. Page 143
Whilst we do not wish to send a representative,

you may wish to bear in mind that the SIA has mentioned their anxiety and concern over various aspects of service provision at NSK. However, they have never spoken directly to those staff concerned who could possibly ameliorate the situation.

3. Finally, there is nothing we wish to contribute to your brief at this stage - it seems a purely local matter. However, please let us see a copy of it.

Paula Ashier

AFH 81511 X7713

cc: Dr Tait

7:9.81

Mr Myers (O/R)

Mrs Arthur

I checked the SIA file and the Stoke
Haverhill file and cannot find any
reference to any of the individuals
mentioned in Miss Sweeney's minute.
They are not, apparently, National
Officers, nor have they attended recent
AGMs. If they are members of the
SIA their involvement would appear
to be at purely local level. There seems
to be no reference to any of these people
in papers relating to MS(H)'s visit to
SM in 11/79.
I have spoken with Miss Sweeney
and told her that these characters do
not feature in our files, but promised
that you would speak with her
tomorrow (4/9/81) to confirm / clarify
the position.

John
3/9/81

Mr Arthur,

MS(H) MEETING WITH REPRESENTATIVES OF THE
SANAL INJURIES ASSOCIATION ON 9th SEPTEMBER 1981
 (at 2 pm in D616 AFH)

You will see from the attached letter from Mr Michael Rogers that MS(H) has agreed to meet him to discuss problems at the NSIC at Stoke Mandeville. With the help of the Bucks AHA and Aylesbury DHA, we are preparing a brief for MS(H) by 7th September.

I should be grateful if, from your knowledge of the ~~Health~~ Spinal Injuries Association you could provide information on those who will be meeting Minister. They are Lady Davina Daisy De Knight, Philip Lewis, Jim Clark and Mr Michael Rogers who issued the invitation.

I shall let you see a copy of the draft brief later this week. The issues to be raised (at least as far as we know to date) all concern the NSIC directly so it has been taken the lead in coordinating the brief. If however there is anything you feel we should be aware of, on the national picture perhaps you could let us know in advance.

Telephone:
Stoke Mandeville 3642
(STL Code 029-661)

PCA/2763/484

CONFIDENTIAL

RECEIVED
18 JUL 1981
PRIVATE OFFICE
SW

"TROODOS"
23 IRVINE DRIVE
STOKE MANDEVILLE
AYLESBURY
BUCKS. HP22 5XA

15th July 1981

Dr. G. Vaughan,
Minister for Health,
Department of Health and Social Security,
Alexander Fleming House,
Elephant & Castle,
London SE1 6BY

Dear Dr. Vaughan,

Thank you so much for your letter dated 29th June, 1981, we are delighted that you are in agreement to meet with us, to discuss our fears about the future of The National Spinal Injuries Centre at Stoke Mandeville Hospital.

May I suggest that we meet, should it be convenient to yourself, at any time after 11.00 a.m., during the week commencing 7th September. If one of these days is suitable, would you be good enough to let us know where and at what time.

At the moment we have not had the opportunity to meet and draw up a detailed list of our fears concerning the Centre, this we plan to do before we meet you and as requested I will send you this in advance.

The areas of concern are as follows:-

1. The overall lack of Medical leadership and enthusiasm
2. Attitudes of senior medical staff towards patients
3. The decreasing time Consultants (who are already part-time) are giving to their patients.
4. The totally inadequate staffing levels, with particular reference to night cover.
5. The overall expansion and development of Private Patient services

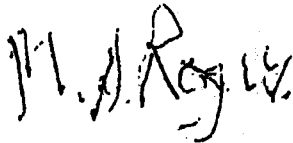
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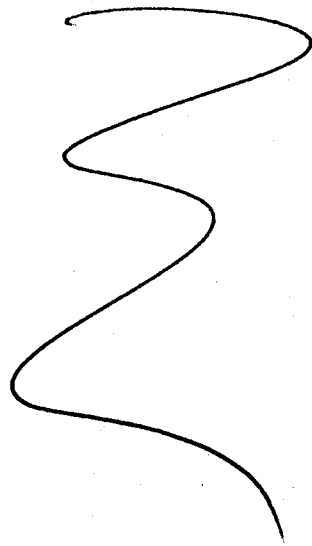
6. The huge turnover of all grades of staff
7. The problems of check-up care
8. The failure to keep patients statistical records
9. The general deterioration in administration.

Yours sincerely,



Michael A. Rogers

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

POA/2763/484

Mr Michael A Rogers
"Troodos"
23 Irvine Drive
Stoke Mandeville
Aylesbury
Bucks
HP22 5XA

29/6 June 1981

Dear Mr Rogers

Thank you for your letter of 25 May asking that I should meet with Lady Davina Darcy De Knayth, Philip Lewis, Ivor Elms and yourself to discuss your fears about the future of the National Spinal Injuries Centre at Stoke Mandeville Hospital.

I share your determination to ensure that the future of Stoke Mandeville is safeguarded, and I shall be very happy to meet you all to listen to your views and discuss the matter; perhaps you would contact my Private Office to arrange a mutually convenient date. It would be helpful if you could in the meanwhile give me some idea of what you are concerned about. This will be treated in the strictest confidence if you so wish, but it would enable us to keep you properly informed.

Yours sincerely

DR GERARD VAUGHAN

Phone:
Stoke Mandeville 3642
(Code 029-661)

RECEIVED IN THE
OFFICE OF
27 MAY 1981
MINISTER FOR
HEALTH

"TROODOS" *SW*
23 IRVINE DRIVE
STOKE MANDEVILLE
AYLESBURY
BUCKS. HP22 5XA

25th May 1981

Dr. Gerard Vaughan, DPM, FRCP, MP,
Minister of Health,
House of Commons,
Westminster,
LONDON

ack R.O. 16/6

CONFIDENTIAL

Dear Dr. Vaughan,

Eighteen months have now passed since you personally responded to the proposed cuts in beds within the National Spinal Injuries Centre at Stoke Mandeville Hospital.

A short while ago, Lady Davina Darcy De Knayth, Philip Lewis Ivor Elms and myself met to discuss the present and future development of the Centre. Through our discussion, considerable factors have emerged causing us great anxiety and concern. I understand that Philip Lewis mentioned the situation to you, when you met recently at Downing Street.

We would Minister, welcome the opportunity to have a frank but confidential meeting with you, to discuss our fears. As Philip Lewis is being admitted for surgery next month and I will also be away until the 19th June, perhaps we could meet later in the year say September or October, should you be agreeable.

I shall look forward to hearing from you.

Yours sincerely,

Yes SW
M.A. Rogers

Michael A. Rogers

MW ~~Wattman~~

Mm Salke
For the SM
file
8W
30/6

22A

£12,000 a day puts Savile's helpers in a happy fix

By DAVID FLETCHER Health Service Correspondent

THE Jimmy Savile appeal for rebuilding the spinal injury centre at Stoke Mandeville Hospital, Bucks, is in danger of being strangled by its own success.

Donations of nearly £12,000 a day are still pouring in more than 17 months after the appeal was launched.

A total of £6 million has been raised so far but the deluge of letters, donations and inquiries is a problem for the hospital which has no special staff available.

The clerical side is dealt with by eight medical secretaries in their spare time and they take a mass of paperwork home.

One, Mrs Silvia Nicol, said: "We get about 10 letters each day containing cash, cheques and postal orders and send a 'thank you' to each one. On top of that we often get 600 visitors on Saturdays and Sundays."

It was marvellous that so much money was being raised but there was a backlog of replies.

Donation not gifts

"We get daily examples of people's generosity," said Mrs Nicol. "We had a couple celebrating their ruby wedding who asked friends not to give them presents but to send a donation to Stoke Mandeville instead."

But despite the administrative difficulties of coping with such a huge inflow of money the hospital is still keen to encourage donations and has high hopes that the total will reach as much as £10 million.

The appeal was launched by Jimmy Savile in January last year when he promised to "fix it" for the hospital to get a new building. Part of the spinal injuries unit is still housed in wartime huts.

UNI 15 - 21A

Reference

DITAL

E
01-864 5311

^{AMK}
Mr Myers.

Please see the attached list of questions from the Northside Park staff side to S&F.

Q.10 is about Stoke Mandeville. I want to send a reply to private office by Tuesday 16 if possible but would like to discuss the content with you first. Could you give me a ring on Monday, please?

Julie Sutan

RLZE

11/15/67

8247

12.9.67

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average wages and above average good-will and dedication to work without any noticeable effect on the private sector.?

- 10. A D.H.S.S. circular recently published, outlined the ways in which voluntary workers could be used in the event of protracted industrial action. Can you tell us how you propose to indemnify both patients and public in the event of legal action for damages.?
- 11. In order to save money in the long term, why isn't more money being ploughed into prevention of disease and health education? In this way, the public health would improve, saving a lot of money in the long term.
- 12. We have heard that the government does not intend to impose cuts or close down any hospitals. How then can the recent reduction in beds at Stoke Mandeville Hospital be justified? Surely such an important unit as a National Spinal Injuries centre is worth keeping?

Draft to Jenny Middleton

**NORTHWICK PARK HOSPITAL
AND CLINICAL RESEARCH CENTRE**

Watford Road Harrow Middlesex HA1 3UJ 01-864 6311

extension

**FORMAT OF MEETING BETWEEN J.S.C.C. STAFF SIDE
AND SECRETARY OF STATE FOR HEALTH & SOCIAL
SERVICES**

INTRODUCTION BY CHAIRMAN

QUESTIONS

1. What particular qualifications, qualities or expertise do you think it is important for a Secretary of State for Health and Social Services to have?
2. There is a lot of unrest in the Health Service about consultation procedures. The feeling is that staff organisations are invited to comment on documents or procedures about which decisions have already been made. In our eyes this is NOT consultation and we would like your views on how this state of affairs can be improved.?
3. How much are you influenced by what staff bodies say about documents and procedures in the N.H.S. - in particular with reference to 'Patients First'.?
4. The Civil Service, policemen, teachers and N.H.S. staff all get different levels of London Weighting. When the cost of living and travel is the same for everyone, why can't we have a standard London Weighting for all the public services.?
5. Is the government making a determined effort to exclude the N.H.S. from cuts which other public departments are experiencing.?
6. How can the N.H.S. be protected from 'hidden cuts' like inflation, V.A.T. increases, staff vacancies not been able to be replaced because of poor wages etc.?
7. Part of your party policy states that people cannot be paid more unless they produce more. In our professions, we cannot define 'productivity', many of us work beyond our contracted time in order to complete our work. How can our pay settlements be adjusted to reflect our essential role and service to the community?
8. How can pay settlements in the public sector be used as an example to the private sector when historically our service has been characterised by below average wages and above average good-will and dedication to work without any noticeable effect on the private sector.?
9. A D.H.S.'s circular recently published, outlined the ways in which voluntary workers could be used in the event of protracted industrial action. Can you tell us how you propose to indemnify both patients and public in the event of legal action for damages.?
10. In order to save money in the long term, why isn't more money being ploughed into prevention of disease and health education? In this way, the public health would improve, saving a lot of money in the long term.
11. We have heard that the government does not intend to impose cuts or close down any hospitals. How then can the recent reduction in beds at Stoke Mandeville Hospital be justified? Surely such an important unit as a National Spinal Injuries centre is worth keeping?

DH Document 07. Page 154

Draft to Jenny Middleton

Secretary of State

SECRETARY OF STATE'S MEETING WITH JSCG STAFF SIDE
AT WINDSOR PARK

I attach a written reply to the question about
the National Spinal Injuries Centre, Stoke Mandeville
which was brought up at the Staff Side raised with the
Secretary of State. I have discussed the reply with



John G. ...
15/10/72
15/10/72

15/10/72

MRS

SECRETARY OF STATE

to impose cuts
in beds at
important unit

with 150 until
the fabric of the
is repaired. It had
of 150 beds in
as agreed to
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those patients

National Spinal
Injuries Centre
rebuild the
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of providing a high
level of care for
overall increase
will not have

MEETING BETWEEN NORTHWICK PARK JSCG STAFF SIDE AND SECRETARY OF STATE

Q 10 We have heard that the Government does not intend to impose cuts or close down any hospitals. How then can the recent reduction in beds at Stoke Mandeville Hospital be justified? Surely such an important unit as a National Spinal Injuries Centres worth keeping?

Answer

The Spinal Injuries Unit at Stoke Mandeville was operating with 150 until about 18 months ago. As a result of the deterioration in the fabric of the Unit during the winter of 1976-77, two wards were closed for repair. It had been proving difficult to staff a single local unit of 150 beds in Aylesbury, and so, when the two wards became unusable, it was agreed to keep the bed numbers down to 120 and provide a ~~good~~ ^{reasonable} service at this level. This presented no problems of availability of places for those patients requiring admission to Stoke Mandeville.

The Government's commitment to see the continuation of the National Spinal Injuries Centre was made clear earlier this year with the launch of the campaign with Jimmy Savile OBE to raise voluntary funds to rebuild the unit completely. I am pleased to say that the public response to the campaign has been most encouraging.

The new NSIC will have 120 beds as at present. The policy of providing a much more localised network of spinal injuries units in the South of England (one at Stanmore and one at Odstock) means that there will be an overall increase in available beds when the units are completed, and patients will not have so far to travel for treatment.

M. Ann Arthur
M. J. Meyer 13/7 19/9
+ to file 1 20A
mcw
20/6

Mrs Petrie

NSIC. APPLICATION FOR EEC FUNDS

1. I have discussed your minute of 13 June with Miss Winterton who has agreed this response.
2. The Department's concern is with the service function of the NSIC and only if there is a surplus of funds should the Institute notion be carried forward. If there is not, then it will have to be fostered and funds requested when a specific proposal has been made. This seems to have been in the minds of whoever wrote the operational policy for SM I read this morning.
3. Institutes are academic bodies and matters for a University. Neither RL or SDG can take the lead. In the case of SM there would be advantages in linking the proposed Institute with an organisation that is involved in a closely related area of work. The Institute of Neurology would be the obvious link as there is almost universal agreement that the main advances in the treatment of patients with spinal cord lesions (traumatic or non-traumatic) will lie within the field of neurophysiology; and there is a Chair of Neurophysiology and the Institute of Neurology. I think the rehabilitative aspects are of secondary importance as to a large extent they are shared with a number of other conditions.
4. Geographically a link with the University of Oxford would be the obvious choice; I think SM made an approach to Oxford some years ago and were rejected, but I am not sure of that.
5. I suggest that Dr Frankel is advised to consider the Institutes idea more fully; at the moment it is just a gleam in the SM eyes and we are in no position to request funding for it, and certainly not from the EEC.
6. The operational policy included neurophysiological laboratories, and I am sure that is right; they are included at Oustock and RNOH. The centre as described in that document will certainly provide facilities for some research, but again I do not see how we can ask for research funds until there is a more specific proposal.

Frank Tait

FRANK TAIT
Med CP1
BL111 AFH

20 June 1980

cc
Miss Winterton ✓

UNI 15.

Reference ~~Mr Salter~~ BA-
~~Mr Winstanley~~
- to see & file
PWA 1/6

Mr Salter - 211

STONE MANSFIELD: DESIGN BRIEF.

Your recent note to Mrs Winstanley &
Dr Tait refers.

In general, we feel that this is a well-
prepared brief and we were particularly
impressed by Patrick Cave's plan.

I am attaching a copy of Dr. Tait's
more detailed comments on the brief.

Please keep us in touch with developments.

Paula Arthur
Stics
ASH 8516 x 7842
10.6.50.

cc Mrs Winstanley 2 ~~Miss B...~~ to see
later please 3 ~~Mr Duper~~ + circulate
4 Mrs Arthur please
1 ~~Mr...~~ 10/6/50
2 ~~Mr...~~ 10/6/50
3 ~~Mr...~~ 10/6/50
4 ~~Mr...~~ 10/6/50
on ALL 10/6/50
19-6

COBB 12/15

Dr. Williams

PROPOSAL FOR A SPINAL UNIT

1. General Remarks: Page 4. The first paragraph is a little over optimistic. "Complications" is the first in the following paragraph at the middle of page 3 and an inevitable consequence of spinal cord lesions. "Prevention of unnecessary complications" would be a better definition of the concept. But none of this affects the design and it would be pedantic to quibble at this stage.
2. The Size of the Unit. Page 7. What is the evidence for the "increasing incidence of spinal cord injury". And I miss any reference to the 64 beds to be provided at the RNOH Stearns. If 120 beds are needed for Oxford, North West Thames, North East Thames, and East Anglia and another 50 for the South East Thames and South West Thames Regions we will be 24 beds in excess of that. Furthermore as the plans for a Unit in the South East Thames Region are not yet clearly formulated I think it would be more accurate to say, "It was therefore decided to build a new Unit at Stoke Mandeville Hospital of 120 beds to serve Oxford, and with the 24 beds at the RNOH Stearns, the North Thames Regions and East Anglia. It is understood that it has been agreed in principle to establish a unit in the South East Thames Region at some later date".
3. I think the patient care policy is splendid and has very clearly been drawn up by a group of people who have experience in the treatment of patients with spinal cord lesions. The stress laid on heated corridors is particularly pleasing (I think we might well run into problems at Odstock on this score) as is the generous (but necessary) provision of lavatories.
4. I find some ambiguities in the section on physiotherapy. We will need to watch closely to see that there is adequate provision for:-
 - i. individual treatments
 - ii. general activities.

On page 35 the existing facilities are listed as two separate physiotherapy areas, an OT area, archery and indoor games area and pool. However in the middle of page 36 it says "As most of the existing facilities (ie OT, hydrotherapy and archery) are to continue in use for a number of years" This suggests that the physiotherapy areas will not be maintained and that the only provision will be in the area designated "gymnasium" in favour of "activities".
5. The request for physiological laboratories is reasonable, even if the proposed Institute is not realised. We have agreed the inclusion of neurophysiology laboratories at both Odstock and RNOH.

Reference

6. I do not believe there is a clear differentiation between "acute nursing care" and "long term care"; page 9 - 2nd paragraph.

7. The one possible over-provision is in the number of offices for medical staff, although within District, it is agreed that this will not be required as an extension here. The present establishment is 3 consultants, but there is one vacancy. They ask for 5. And is it necessary for the doctors to have a separate office.

Frank Tait

17 June 1990

FRANK TAIT
MED CP1
B1111/AFH
Ext 7409

Reference.....

16A.236

Dr Tait

STOKE MANDEVILLE : DESIGN BRIEF

1. As Mr Arthur has been unavoidably called away from the office today could you take a look at this Brief, and comment upon it, if you consider necessary.
2. I have looked at it quickly, but do not consider myself sufficiently knowledgeable to be able to make worthwhile comments!
3. When you have finished with it, could you please return it to Mr Arthur.

S. Williams

16 June 1980

SH2C1
A527
X615E

Mr Myers-Matthews
Reference Any comment?
pucus

12/6

ISA

1. Miss ~~Monterton~~
2. Dr Jait

STOKE MANDEVILLE : DESIGN BRIEF

I attach a copy of the design brief for the spinal injuries unit at Stoke Mandeville which arrived on 9 June.

The brief will be discussed at a SM Liaison Group meeting, chaired by Mr Collier, on 19 June.

Julie Sutch

RH1
1815 ET
x347

CODE 18-78

Mr. [unclear]
Mrs. [unclear]
19A
Jan 31

Mr Lillywhite

NATIONAL SPINAL INJURIES CENTRE: POSSIBLE APPLICATION FOR EEC FUNDS

You should see the attached minute of 13 June from Mrs Petrie to Miss Winterton and Dr Tait. I have not seen papers, but I have a nasty feeling that we shall find Treasury holding the same line as they have in the past on EEC matters ie the grant goes to Treasury; DHSS is left to fund the project by top-slicing of existing RHA allocations.

2. The reference to an exchequer grant is very mystifying.

Jan 31

16 June 1980

Mrs J M Firth

- cc Mrs Petrie
- Miss Winterton ✓
- Dr Tait
- Mrs Sutch
- Mr Seabourn
- Mr J Sharpe