

Charters Jimmy Jones / Patricia Jones 21.8.79	1A
Draft - Planning Dept and Vaughan's comm. to Service Industries	2A
Min Parra / Bob 10.9.79	3A
Charters Vaughan / Rosemary Graham + letter 4.8.80	4A + B
Min 14.9.80 Train / Train	5A
Min 17.9.80 Train / Bob	6A
Folder PAs and Papers 24.10.79 - 19.11.79	7A
Charters Grant / Norman O'Connell RHA 12.11.79	8A
Min Grant 12.11.79 + AHA consultation Document - ongoing meeting with M/S (H) 19.11.79	9A - B
Min Eds / Spencer 12.11.79	10A
Min Eds / Parra / Spencer 12.11.79	11A
Min Eds / Parra / Take 14.11.79	12A
Min Parra / Spencer 26.11.79	12B
Min Parra / Spencer 26.11.79	13A
Notes of meeting 30.11.79	14A
Notes local body consultation 4.12.79	15A
Min Parra / Spencer 4.12.79	16A
Min Spencer / Bob 4.12.79 + Min 5.11.79 DR agenda Vaughan	17A + B
Min Parra / Parra 5.12.79	18A
Min Spencer / Spencer 6.12.79	19A
Min Spencer / Spencer 11.12.79	20A
Min Spencer / Train 13.12.79	21A
Min Spencer / Spencer 14.12.79	22A
Min Spencer / Spencer 14.12.79	23A
Min Spencer / Spencer 14.12.79	24A
Min Spencer / Spencer 14.12.79	25A

min Tim / Deane 28.12.79 27A
 Note of mtg 12.79 28A
 Note of mtg 20.12.79 29A
 Booklet NSIC Stroke translation 30A
 min Petre / Temp - Tracy / Dr Rivett 31A
 min Beale / Petre 32A
 Extract from H. 55 Journal Nov 16 33A
 min Temp - Tracy / Beale 10.1.80 34A
 Paper - Rebuilding Appeal 35A
 Stroke translation - Press conference 23.1.80 36A
 min Beale / Cowler 16.1.80 + min 37A + B.C.
 Beale Knight + Rebuilding Appeal.
 Press Release 23.1.80 38A

Folder: B. Injuring - Visit hospital now + Stroke
 translation 20.11.79 39A
 min Tate / Hunt 30.1.80 40A
 min Petre / Cowler - Jimmy Smalls Appeal 41A
 min Petre / Woodcombe Adams 42A
 min Peter Smith / Brantshaw B.I. Assoc. 43A

FED Please close this Vol. & open a
 new one and return books to me.

P. Smith
 13.3.80

~~min 11.79. Smith & min 19.6.80~~

UNI 15/1

MR TIFFANY RISO'S AFH 04/3/86

SMD/7

File Office

This file is required for reference purposes and should be kept for 25 years from the date of the first paper.

L E MacFarlane

MRS L E MACFARLANE
OS30
Rm B1511
AFH
Ext 7717

25 Oct 1985

Ms Hails

LAYING OF FOUNDATION STONE OF THE NEW SPINAL INJURIES CENTRE AT STOKE MANDEVILLE HOSPITAL, AYLESBURY, ON 24 NOVEMBER 1981.

1. The Lord Elton has accepted an invitation from the Chairman of the Oxford Regional Health Authority and the Trustees of the Jimmy Savile Stoke Mandeville Hospital Trust to attend the laying of the foundation stone of the new National Spinal Injuries Centre at Stoke Mandeville on 24 November 1981. The ceremony will be performed by HRH, The Duke of Edinburgh.
2. The District Administrator of the Aylesbury and Milton Keynes Health District has sent details of the event direct to Lord Elton (dispatched on 18.11.81 by first class post!). Although the ceremony commences at 12 noon, guests are asked to arrive by 11.30 am. (Mr James Collier, Deputy Secretary at the Department and one of the Trustees of the Appeal, is also attending and will I believe be travelling there direct).
3. A short background note and copies of the Press Notices issued by the Department at the launching of the Appeal in January 1980 are attached opposite for Lord Elton's information.

P. G. Smith

P G Smith
RL2E
Room 1526 Ext 880
Buston Tower

20th November 1981

Copy: Mrs Fosh
Miss Davidson
Dr Smithies
✓ Mrs Arthur *DM 21/11*

1. Mr ~~Myers~~ *Alpinus 26-11.*

- this was prepared without reference to us.

I have phoned PO & asked them to make snopah

typ amendments to para 3 - nothing more is possible at this late stage.

2. Ms Maynard *RM*
to the OR

LORD ELTON'S VISIT TO STOKE MANDEVILLE HOSPITAL (LAYING OF FOUNDATION STONE FOR NEW NATIONAL SPINAL INJURIES CENTRE) 24 NOVEMBER 1981

BACKGROUND NOTE

1. THE RE-BUILDING OF THE NATIONAL SPINAL INJURIES CENTRE

The Jimmy Savile appeal was launched on 23 January 1980 with a public announcement by the Minister for Health - see press releases attached. 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 hutted accommodation and had suffered storm damage and maintenance problems resulting in national adverse publicity at the time. Jimmy Savile's avowed target was £10 million, and he is still quoting this as his ultimate objective. The help received so far has been both in cash and in offers of building materials at reduced rates and is in the region of £6 million. Building is expected to take about two years and the first patients should be admitted by 1984.

ROLE OF NHS

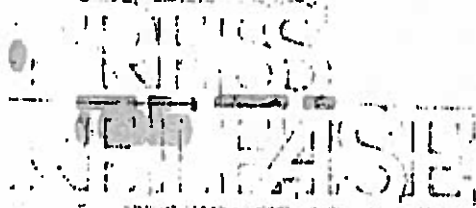
2. The replacement of the National Spinal Injuries Centre is the legitimate responsibility of the Oxford Regional Health Authority. However, although there were plans for its replacement within the Region's long term capital programme, other pressing Regional priorities (eg the provision of hospital facilities for the population of Milton Keynes) meant a new spinal unit could not have been provided until the end of the decade or even later. The Jimmy Savile initiative was warmly welcomed, therefore, by Ministers and the local health authorities and has had great public support.

3. OTHER DEVELOPMENTS FOR SPINAL INJURY PATIENTS

48 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 this month. 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.

STOKE MANDEVILLE DISTRICT GENERAL HOSPITAL

4. The Spinal Unit is part of the Stoke Mandeville District General Hospital (700+ beds) and there are, upon occasion, complaints from consultants in the main hospital that the nationally known Spinal Unit detracts attention from the work, and requirements, of the general hospital. Supporters of the NSIC have made the reverse criticism! However, it is unlikely that there will be any discordant note raised upon this happy occasion.



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?

DH Document 06. Page 9

It comes as quite a shock to realise that patients at the Stoke

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	196

There will be two further units by the mid 80s at Odstock Hospital, Chisbury, and the Royal National Orthopaedic Hospital at Stanmore.

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.

DAVID GOS
MINISTERS
NEWSPAPERS
INITIALS (S) E

Telephone 01-407 5522

80/11

23 January 1980

HEALTH MINISTER WELCOMES STOKE MANDEVILLE APPEAL

Jimmy Savile, OBE, today launched a multi-million pound campaign to rebuild the National Spinal Injury Centre at Stoke Mandeville. His initiative was welcomed by the Health Minister, Dr Gerard Vaughan, as an example of the sort of partnership between the Government and the public which has so much to offer.

Dr Vaughan said:

"Jimmy Savile, OBE, and Stoke Mandeville really need no introduction. Jimmy's zeal and enthusiasm for good causes and his long association with the Spinal Injury Centre are well known. If anyone can 'fix it' then I know he can. I wish him well in this task and I am sure that he will find a tremendous reservoir of public sympathy for Stoke Mandeville.

"What can one say about Stoke Mandeville? Nobody can visit Stoke Mandeville without realising that it is a very special place. You know it when you walk in and you know it when you talk to the patients. Stoke Mandeville's achievements in pioneering the treatment and rehabilitation of spinal injury patients are known to everyone, both at home and abroad. What is important now is to ensure its continued future as a centre of excellence.

"I believe that the British public will be anxious to know that when the new unit and its facilities rise at Stoke Mandeville, they will have supported it with their own voluntary help.

"Jimmy Savile will be giving information about his activities in the weeks and months to come. The minimum target is £6 million. In the meantime the public can start the ball rolling by sending their donations to:

The Jimmy Savile Spinal Building Appeal Fund, Address: Spinal
Injury Centre, Stoke Mandeville Hospital, Aylesbury, Bucks HP21 8AL

Miss Spencer

1. THE VOLUNTARY SECTOR: RESEARCH WITH US(1)

I attach briefing for US(1) interview with "Link" about the role of the voluntary sector concerned with ill people. Specific reference is made to Stoke Newington National Spinal Injuries Centre. The section concerned with recruiting volunteers contains a short passage on tapping the untapped resources of retired people. I am afraid that we have few examples readily to hand of local voluntary initiatives for elderly or disabled people but I hope that those which have been included will be sufficient for the interview.

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4 March 1980

cc Mr Kirkson
Mr Brown
Mr Clarke
Mr Wilson

C M BERS
HR20
3517 AMI
Ext 6132

} without Annexes B & C

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ARE VOLUNTARY ORGANISATIONS BEING USED TO PROVIDE SERVICES WHICH WOULD OTHERWISE BE PROVIDED BY STATUTORY AUTHORITIES?

3 In a time of financial constraint it is impossible for the statutory authorities to provide all the services which they would wish to. There is a long history of voluntary support for people who are ill, elderly or disabled and such contributions are always welcome whether they be financial,

THE ECONOMIC SITUATION

1 Severe economic difficulties. First priority is for the Government to put the economy right and, to do this, public expenditure cuts have been necessary. It would be wrong to pretend that social services, including those for elderly and disabled people will remain untouched. Yet, although it is not the Government's policy to interfere in local authority decisions, Ministers have urged that reductions should be achieved where possible without cuts in services directly concerned with the most vulnerable sections of the community.

ROLE OF VOLUNTARY SECTOR

2 The public have come to believe that the statutory authorities are the primary source of care and support for disabled people. But, the statutory authorities have never been able to provide for every disabled person's needs. Much of the help required by those who are disabled or ill is provided by family friends and neighbours in an informal way. The voluntary sector has always made a significant - although often unrecognized - contribution towards this help. But, this sector has now become better organized and larger (the number of voluntary organizations has almost doubled since 1970) and more recognizably able to shoulder a bigger share of the burden. It is right that greater emphasis should be placed on voluntary organisations as they have the ability to channel the type of informal voluntary care provided by families and friends into a wider area and can provide more innovative services on a more intimate and flexible basis than the statutory authorities. The Government wish to create an attitude where the statutory authorities are seen as the last, not first, resort and greater reliance is placed on the more independent and immediate support of the families and friends, and then the voluntary sector.

ARE VOLUNTARY ORGANISATIONS BEING USED TO PROVIDE SERVICES WHICH WOULD OTHERWISE BE PROVIDED BY STATUTORY AUTHORITIES?

3 In a time of financial constraint it is impossible for the statutory authorities to provide all the services which they would wish to. There is a long history of voluntary support for people who are ill, elderly or disabled and such contributions are always welcome whether they be financial,

as in the case of Stoke Mandeville [see separate briefing note] or more locally - and as examples - a Rotary or Lions club raising money to buy physiotherapy equipment, or services in kind, for example delivering meals on wheels.

4 The aim is to make the voluntary and statutory sectors complement rather than directly substitute for each other. By imaginative co-operation with the voluntary sector the statutory authorities should be able to make their resources go much further. This is already happening; for example voluntary organisations - particularly the WRVS - are taking on meals on wheels services - and other authorities are providing the meals but volunteers are undertaking the delivery.

EXAMPLES OF VOLUNTARY ACTIVITY

5 Volunteers are already active in many areas, particularly in the NHS, for example; providing a library trolley service, befriending long stay patients, running self or mutual help groups and entertaining patients. Particular examples of work in the community for elderly or disabled people are:

- (i) Local "Dial" (Disabled Information and Advice Lines) Services. A network of voluntary bodies providing information and advice to disabled people. In Derbyshire disabled people attending a day centre have organised and are running the service.
- (ii) At Preston Park (near Wembley) a local residents' association have organised a small medical loans service providing, for example, commodes to residents.
- (iii) Task Force. A London based organisation with mainly young volunteer workers who offer surrogate family services (shopping, gardening etc) and befriend elderly and disabled people. There are similar organisations throughout the UK.
- (iv) At Worle near Weston-super-Mare a neighbourhood scheme has been established with the community providing simple services (befriending, help with shopping etc) for elderly and disabled people.
- (v) At a higher level the Crossroads Care Attendants Scheme provides the type of help which a close relative might give to a disabled person and relieves some of the strain on a disabled person's family

and can delay or remove the need for a disabled person to enter residential accommodation. Last year over 400 people were helped in this way. All the care attendants are paid and the organisation is funded by grants from statutory authorities and donations. This year NHS has contributed approximately £15,000 to the trust's headquarters costs.

(vi) A separate detailed note on Stoke Mandeville is attached at Annex A.

IS THERE A POOL OF VOLUNTEERS?

6 Experience has shown that many people are willing to give freely of their time and energy to help the less fortunate. The number of voluntary organisations has almost doubled since 1970. In the NHS voluntary help organisations find that there is no shortage of volunteers but that there may be difficulties in fitting in everyone who wants to help. There has been an encouraging growth in self-help groups and this is to be welcomed particularly because of the way they foster the individual's independence.

7 There are a number of untapped areas of possible volunteers. In a speech to the Pre-Retirement Association last October PS(H) referred to the considerable numbers of retired people who have much knowledge and expertise to offer but who are seldom called upon to help. A successful self help group "Link Opportunity" has been established. Members trade skills in a community, for example a retired person might offer to do some teaching in return for help with shopping from a younger member.

8 An aim of local voluntary organisations should be to attract more volunteers and to make sure that they are given work commensurate with their ability and, if necessary, trained.

IS EXTENSIVE USE OF VOLUNTEERS LIKELY TO LEAD TO FRICTION WITH TRADES UNIONS?

9 The interviewer may refer to HC(79)20 issued in December which draw attention to the use of volunteers in industrial disputes and at other times. A copy of the circular is at Annex B. The role of the volunteer is to complement the paid worker not to replace him, undertaking the job which paid workers do not have the time to do. If volunteers work with paid staff it is vital that they should be acceptable to them and union interests must be consulted.

I believe that professional staff wish to do the best for their clients and are usually co-operative if they see that no-one is trying to take advantage of them.

FUNDING OF VOLUNTARY ORGANISATIONS

10 The statutory authorities have power to grant aid local voluntary schemes in their fields (an example is local funding of Crossroads Schemes). It is for them to determine what should be given according to their priorities. Grants are made centrally by DSS in support of voluntary effort that is not local in scope, and also towards headquarters expenses of national bodies which provide or promote voluntary services. Exceptionally central grants may be made for experimental pioneering projects which are initially local.

11 Up to 31 January (latest figures) of this financial year DSS had granted approximately £900,000 to over 40 voluntary organisations concerned with disabled people and grants of approximately £100,000 were being considered. A complete list is at Annex C.

12 Ministers have stated publicly that for 1980/81 the value of the Department's total allocation of grants to voluntary bodies will be maintained in real terms and that they hope that this level will be maintained in future years.

FUND RAISING

13 Following the appeal for funds for the National Spinal Injuries Centre at Stoke Mandeville (see Annex A) the interviewer may draw attention to fund raising for the NHS.

14 Health authorities have always been free to accept voluntary funds raised by other bodies - the level of voluntary cash contributions to the National Health Service in 1978/9 was about £14 million with a further £14 million from dividends on funds built up from past donations [NHS doesn't include value of donations in kind or value of voluntary work] but they have been unable to engage in such activities themselves. We believe this is an out-dated and unnecessary restriction on authorities, which the Bill removes.

15 Clause 4 of the Health Services Bill gives health authorities the power to initiate and engage in fund-raising activities. The Bill sets out the type of activities allowed - public appeals, collections and competitions, bazaars, fetes and similar activities.

16 It is not said this new fund raising power is an alternative method of financing the NHS; but as a source of useful supplementary money to help provide, maintain and improve local health services. The government has ever had adequate funds to finance all the demands made on the NHS. The new measure recognises this fact and also the reality that the NHS has always welcomed voluntary funds. Nationally voluntary funds represent only a relatively small part of NHS resources, but at local level and sometimes at national (eg Stoke Mandeville) they can make a significant impact in supplementing the facilities in local hospitals and the health services.

17 Such efforts can help forge closer links between the local health service and the community it serves - creating greater public understanding of the problems facing the NHS. Also the involvement of the health authority may help to direct such efforts towards areas of highest priority and avoid danger of well intentioned but misdirected appeals.

DISREGARD OF VOLUNTARY FUNDS

18 It has been clearly stated that voluntary funds will not be used as a means of reducing exchequer funds allocated to the NHS. Resources raised by local communities for their local services are supplementary to public funds; if it were otherwise there would be no incentive to raise voluntary funds.

STOKE MANDOVILLE APPEAL

The Appeal to raise funds to rebuild the National Spinal Injuries Centre at Stoke Mandeville, illustrates very well how voluntary support can operate at several levels for the benefit of the health service, in this case for severely disabled people.

The centre is nationally known and the Secretary of State was fortunate enough to be approached by a nationally known figure - Jimmy Saville, a tireless voluntary worker if there ever was one, who offered to try to raise what was necessary over a period of two-three years to rebuild the Unit; a task that simply would not be possible from limited public funds for a number of years yet. He and my colleague Mr. Vaughan, launched the Appeal jointly at the end of January, and already in the month since over £350,000 has been raised, the bulk of it in small but none the less welcome amounts. Thousands of letters have been received at Stoke Mandeville Hospital, and these are dealt with by volunteers, by NHS staff working in their own time, and by the patients themselves for whom the whole exercise has been a tremendous morale booster. So people can help by giving time or money.

In addition to the response from individual members of the public, a number of commercial and industrial organisations have promised their support. Then there have been offers of assistance in kind, for example, free publicity for the Appeal, help with professional services, and offers of building materials. An encouraging aspect in all this is that groups and individuals from very different walks of life have not waited to be approached; they have come forward asking how they can help.

In the case of Stoke Mandeville, this is a national appeal for a well known centre, but I believe that the public would respond in a similar fashion in different circumstances, particularly perhaps in support of small hospitals providing a valuable service to a local community. Most of us enjoy a challenge; I am convinced that the goodwill already exists.

247

5 Tavistock Way
Spinal Injuries
Association
5 Groundale Road
LONDON W21

27 February 1980

When we met last week you asked if the DSS wanted
to write a short article on the Stoke Mandeville
Daily Appeal for your newsletter. I hope this will
be a suitable contribution.

If there are any points you want to check out, please
ring me.

Yours sincerely

Mrs J Sutch

cc. Mrs Patrick
~~Mr Sutch~~ - ~~Mr Sutch~~ - ~~Mr Sutch~~ + M K H.H.
~~Mr Sutch~~
Mrs Hillman p. 30

9
437

SIA Newsletter Contribution

When the Minister for Health, Dr Gerard Vaughan, visited Stoke Mandeville hospital in November last year, he saw the effect that the hard winter of 1979 had had on the deteriorating hutted accommodation that housed the Spinal Unit there. He was told that the Unit could not continue to function as a national centre and to maintain the high standards which were expected of it in the present accommodation. With the health service being hit by cuts in public expenditure there was no immediate prospect of the cost of re-building being met from NHS funds, given the many competing claims on resources. Fortunately for the unit, Jimmy Savile OBE, who has been associated with Stoke Mandeville for many years offered to set up an appeal to raise funds to re-build it and Dr Vaughan welcomed this as an example of the sort of partnership between the Government and the public which he was trying to promote in the NHS.

The appeal was launched publicly on 23 January by Dr Vaughan and Jimmy Savile. The target to re-build the unit was set at £6 million. A further £4 million could also provide the necessary funds for a research centre on the same site. Many donations of cash and offers of help have been received already as a result of the press coverage of the launch: Jimmy Savile has also made use of his TV appearances to give wider publicity to the cause, and is planning to keep up the momentum of the campaign in the coming months.

At the outset Jimmy Savile made a commitment that every penny received in donations would be spent directly on re-building. The staff at the hospital, and in the Spinal centre are giving their help free to receive the donations, bank and account for them and reply to questions and offers of help.

The patients themselves are also playing a part in dealing with the thousands of replies to the letters received. To avoid any administrative costs to the appeal fund, no publicity materials has been issued. Anyone who wants to help raise money and feels they need some official recognition of their work can write to Jimmy Savile at the hospital and he will do his best to reply to put them on an "official" basis.

Anyone who wants to make a donation or to ask for support for their own fund-raising venture can write to Jimmy at the Spinal Injury Centre, Stoke Mandeville Hospital, Aylesbury, Bucks HP21 8AL. Cheques and postal orders should be made payable to "The Jimmy Savile Spinal Building Appeal Fund". £50,000 will buy a bed and £250,000 will provide a ward!

TO Mrs. P. HALLOR



ST
+ 2A

Mr Woollocaba-Adams

"YOU AND YOURS" - FEB 18 FEBRUARY 1980

A speaking note for Secretary of State about the Stoke Mandeville Appeal is attached. A copy has gone simultaneously to Mr Collier.

P. Petrie

Pamela Petrie
RL1
Room 1532/Extn. 804
Bunton Tower

28 February 1980

Received 1.56

STOKE MANDEVILLE APPEAL.

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DONATIONS TO: SIMPLY SAVILE BUILDING APPEAL FUND
SPINAL INJURY CENTRE
STOKE MANDEVILLE HOSPITAL
AYLESBURY
BUICK

D21.17.145
New Information

12/7
7A

Mr. Jim H. White

no so ~~she~~ happening over Stoke
Mr. Williams - Mandeville

1. Mr. [unclear]
2. Mr. Woodward
3. Mr. [unclear]

Mrs. Anthony
Mr. [unclear] for Collier
18.2.

Bob's
his Belle
Mary Thanks.

Widow
9-2-80

For the file
18/2

SPONSOR: MANDEVILLE : JIMMY SAVILE APPEAL : PROGRESS W/C 4/2/80

1. Jimmy Savile collected £310,000 in cash during the first 10 days of the appeal, together with a further £2m worth of promises in kind, (of professional fees to the tune of £1m have been waived, and £1m may be knocked off construction costs by a contractor). In effect, if these promises are honoured, they reduce the target from £10 - £8m (as J.S. would say), or from £6 - £4m (according to the RIB/ARA's assessments of need).

2. Mr Savile received a letter from [redacted] last week:

" [redacted]

3. A draft letter has gone to MS(M) for possible use in approaching the big battalions. Lord Cullen advises a direct approach to the Bank of England and to top insurance companies. He will think about possible avenues to the City, and to major oil interests, and advise in due course. Regarding tactics, Lord Cullen suggests getting one bank (and insurance company) into the net and then quoting their support to the next institution on our list. Lord Cullen will try to identify a talent scout to act for us in the City, in a voluntary capacity. (Mrs Butch will follow this up).

4. Alasdair Milne of the BSC suggested that MS(M) approaches the BSC Appeals Committee to bid for an Appeals slot for Stoke Mandeville. If the proposal is accepted, Mr Savile will make the appeal a little later in the year.

5. Mr Savile intends to use Minister's room in the House for interviewing would-be major fund raisers. MS(M) felt that there were drawbacks to this idea, and we now hope to call on a suitable room in Admiralty House for the purpose. Department of Environment agree (B Beaumont MP is our contact), and we shall "inspect" the room next week.

J.S. wishes to meet big potential donors to talk things over; he intends to start with Mr Buchanan of Canadian Railways on 27 February (Wednesday) a.m. at Admiralty House, if this arrangement is mutually acceptable. Mr Savile would like to see other potential helpers on 27 February or on subsequent Wednesdays, and occasionally he hopes other fund raisers or potential fund raisers might be entertained to dinner (eg at the House of Lords) to discharge fees.

6. A meeting of the Stoke Mandeville Liaison Group, under the Chairmanship of [unclear], is being brought to the end of February or during the first week in March.

7. J.S.(H) has telephoned Jimmy Savile to say "well done; a good start"; the latter would like J.S.(H) to invite the "loyal volunteers" to London soon to meet the Minister and to have lunch afterwards in London. He suggested the House of Commons or the DHSS canteen! Mrs Sutch is looking at the possibilities of organising an event of this kind.

8. The question of how Ministers might approach possible donors has been considered, and Mrs Sutch is liaising with HS2 to draw on their earlier experience. Lord Cullen has strongly advised against approaching corporate bodies such as the CBI or smaller employer confederations. He suggests individual approaches to prosperous (preferably local) firms, but in the case of Stoke Mandeville this market may already have been given blanket cover by Sir Ludwig Gutman's Spinal Olympics Appeal.

9. We need to discuss approaches to individuals with MS(H) o/r. Mr Savile met Victor Matthews at Trafalgar House on 6 February 1960. The latter asked for a week to consider whether/how he might help.

10. On publicity, J.S. has done a deal with Holt Car Accessories and also with Ski Yoghurt. All products will carry the Appeal notice for several weeks starting in March. All Local BBC radio stations are carrying an Appeal announcement for the next 2-3 weeks.

11. John Laing & Company and the Platinum Guild are also interested in the Appeal. J.S. is following this up.

12. Mrs Sutch is contacting Mr Maylor of Nottingham, the man who claims to be able to raise a million pounds or more without too much trouble.

13. A Draft outline plan has arrived and is with the Minister. Region has a copy. (Jimmy Savile has met Dr Rue and the project team).

14. J.S. met the Prime Minister on 6 February. She urged that we lose no time in getting on to the major banks since they will shortly be announcing large profits. (The Minister has written to the Chairmen* (specimen attached). J.S. would like to be present when Minister sees them.

Patricia Petric
RL1
Room 1532/Extn.384
Euston Tower

6 February 1960

* Sir Patrick Madine was advised of intended approach to Lord Armstrong at Midland Bank.

Copied to: Mr Bayner Mrs Sutch
 Mr Bebb St N. & Confidential Files
 Dr Pitt

Mr J W Knight

STOKE MANDEVILLE APPEAL

alternative
I am attaching Drafts of the letter which Dr Vaughan might consider sending to a number of people, to seek their assistance with the Stoke Mandeville Appeal.

The first list of possible recipients identified in my minute of 1 February was prepared before Lord Cullen had advised on ways of approaching the big battalions. With the benefit of his advice, it does seem preferable to go for the big Banks and Insurance Companies first, leaving the City, Industry, wealthy individuals and sporting interests to the next stage.

If we take this line, the first letters might be despatched to:

Barclays	- Sir Anthony Tuke	Midland	- Rt Hon Lord Armstrong
Coutts	- D.B. Money-Coutts Esq	Nat Westminster	- Robin Leigh Pemberton
Lloyds	- Sir Jeremy Morse	Williams & Glyn	- Sir George Kenyon

The second approach might be to the people identified in my earlier minute with the addition of Sir Douglas Dunn, the Chairman of the All England Show Jumping Course at Hickstead. His likely interest in an appeal for Stoke Mandeville Spinal Injuries Unit is self-evident.

Perhaps the Minister would indicate please whether:

- a) he would like to tackle Banking and Insurance interests first, and the City, individuals and sporting interests later?
- b) he is happy with the individuals and organisations listed above and in my earlier minute of the 1 February.
- c) the revised Draft Letters are acceptable; one is a shorter version of the other.

Pamela Petrie
RL1
EP.1532/Extn.884

6 February 1980

Copied to: Mr Collier
Mrs Such

Mr J E Knight

JIMMY SAVILE'S MEETING WITH THE PRIME MINISTER

Jimmy Savile met the Prime Minister today (6 February). Mrs Thatcher advised him that the major banks will shortly be announcing substantial profits, and she would like them to divest themselves of some of these "in a nice way - like Stokes Mandeville."

My earlier minute of today's date suggested that the banks (and insurance companies) should be our first target in the approach to the "big battalions".

If Minister agrees we ought perhaps to aim to get letters to the Bank Chairmen by Friday of this week?

Mr Savile accepts that Ministers are in the lead here, but he would like to be invited along when Dr Vaughan meets the Bank Chairmen.

W. Blunt

Pamela Petric
RL1
ET.1532/Extn.884

6 February 1980

Copied to: Mr Collier
File

ALTERNATIVE DRAFT LETTER TO POTENTIAL DONORS

Dear

STOKE MANDEVILLE APPEAL

You may already know about the Appeal that I launched with Jimmy Savile last month to raise several million pounds for the re-building of the National Spinal Injuries Centre at Stoke Mandeville.

The early response to the Appeal has been most encouraging, and we have also received messages of support from HRH the Duke of Edinburgh and from the Prime Minister.

[Following a suggestion from Mrs Thatcher] I am writing to ask if you would care to assist the Appeal in any way. If so, I should be very happy to meet you to tell you more about it.

STOKE MANDEVILLE APPEALTO POTENTIAL DONORS

I am writing to ask whether you would feel able to participate in any way in the Appeal which I launched with Mr Jimmy Savile last week on behalf of the hospital for funds to rebuild the National Spinal Injuries Centre at Stoke Mandeville.

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

The centre has now reached a crisis. Patients are still cared for in the original prefabricated buildings provided when the unit opened in 1944 and, whilst a good deal of work has been done to provide a bright homely atmosphere, the buildings are in constant need of repair and are rapidly becoming obsolete. They must be replaced soon if the high standards of excellence are to continue. NHS funds are being used to develop more services for patients with Spinal Injuries; two new units are being built in London and in Wessex as part of the policy of providing some specialist accommodation closer to patients' homes, but given the many competing claims for limited resources, there is little prospect of being able to meet the cost of re-developing the national centre at Stoke Mandeville for some considerable time.

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

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

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

I very much hope that you might feel able to assist us in some way; if you would like to discuss this, or if you need more information, do please write to me.

Yours sincerely

GERARD VAUGHAN

(2A)
+ 01

Dr Tait

AOB MEETING: "STRATEGY" FOR SPINAL UNITS IN THE SOUTH

I agree with you and Mr Bebb that this is not the time to raise with AOBs. The "strategy" was precipitated for local reasons because of Secretary of State's involvement with Stoke Mandeville and Jimmy Saville's offer, and Dr Forsythe's proposal for SEI which backed Dr Rue's previous wish to reduce SM to some 50 beds. We don't want to provoke more difficulties (eg by our having discussed (however vaguely) SEI capital building so far ahead, or even re-opening the question of revenue for supra-regional specialties while it is being looked at in the Department. I have checked the latter with Dr Lees who agrees. I suggest that this should not go on the agenda. If Dr Evans feels that someone might raise the matter under AOB, he may wish to postpone discussion to another meeting, or you could perhaps brief him on the situation. But I hope we can let this particular dog lie quietly at present.

M. Tate

DR MARY TATE
MED CP1
B1117 AFH

30 January 1980

- cc Dr Evans
- Dr Melia
- Dr Lees
- Mrs Petrie
- Mr Bebb ✓

Mr. Meyers
Ann. H. H. H.
Jan.
1.2.
✓

PRESS RELEASE

Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone 01-407 5522

80/11

23 January 1980

HEALTH MINISTER WELCOMES STOKE MANDEVILLE APPEAL

Jimmy Savile, OBE, today launched a multi-million pound campaign to rebuild the National Spinal Injury Centre at Stoke Mandeville. His initiative was welcomed by the Health Minister, Dr Gerard Vaughan, as an example of the sort of partnership between the Government and the public which has so much to offer.

Dr Vaughan said:

"Jimmy Savile, OBE, and Stoke Mandeville really need no introduction. Jimmy's zeal and enthusiasm for good causes and his long association with the Spinal Injury Centre are well known. If anyone can 'fix it' then I know he can. I wish him well in this task and I am sure that he will find a tremendous reservoir of public sympathy for Stoke Mandeville.

"What can one say about Stoke Mandeville? Nobody can visit Stoke Mandeville without realising that it is a very special place. You know it when you walk in and you know it when you talk to the patients. Stoke Mandeville's achievements in pioneering the treatment and rehabilitation of spinal injury patients are known to everyone, both at home and abroad. What is important now is to ensure its continued future as a centre of excellence.

"I believe that the British public will be anxious to know that when the new unit and its facilities rise at Stoke Mandeville, they will have supported it with their own voluntary help.

"Jimmy Savile will be giving information about his activities in the weeks and months to come. The minimum target is £6 million. In the meantime the public can start the ball rolling by sending their donations to:

DH Document 06. Page 32
The Jimmy Savile Spinal Building Appeal Fund, Address: Spinal
Injury Centre, Stoke Mandeville Hospital, Aylesbury, Bucks HP21 8AL

Department of Health
and Social Security

**PRESS
RELEASE**

Alexander Fleming House
Elephant and Castle
London SE11 6BY

Telephone 01-407 5522
17 January 1980

80/9

JIMMY SAVILE TO HEAD PUBLIC APPEAL FOR STOKE MANDEVILLE

Dr Gerard Vaughan, Minister for Health, and Jimmy Savile, OBE, will next week announce plans for a national appeal to completely rebuild the Spinal Injury Unit at Stoke Mandeville.

The vital work carried out at the National Spinal Injury Centre is at risk unless money can be found to save it. The present accommodation is obsolete - still the original huts provided in 1944. It must be replaced for the centre to continue helping severely handicapped people, many of them still young, who are the victims of tragic accidents.

Jimmy Savile has a long association with Stoke Mandeville and he has generously agreed to spearhead the campaign.

Dr Vaughan and Jimmy Savile, joined by patients from Stoke Mandeville, would like to meet the press, television and radio at 11 am, Wednesday, 23 January, in Church House, Great Smith Street, Westminster (Hoare Memorial Room) to tell you all about this ambitious project.



With the Compliments of *Mrs Songkady*
Department of Health and Social Security *RLA*

x947 .

11/1/80

EUSTON TOWER
286 EUSTON ROAD
LONDON, NW1 3DN

*Miss Day Mrs Satter
Pl. file JRD 21.1.*

*The letter goes on
the file (I assume there
is no copy on already) JN*

BACKGROUND BRIEF ON OXFORD RHA FOR MINISTER OF HEALTH'S VISIT TO LITTLEMORE HOSPITAL AND STOKE MANDEVILLE HOSPITAL ON ~~26 SEPTEMBER 1979~~

20 November 1979

1. DESCRIPTION OF REGION

The Region comprises Berkshire, Buckinghamshire and Northamptonshire AHAs and Oxfordshire AHA(T). It has the most rapidly expanding population in the country and it is estimated that there will be a 11.6% increase in the number of people living in the Region in the period 1978-1988. There are four new towns in the Region: Milton Keynes and Northampton, both expanding rapidly, and Corby and Bracknell which have nearly completed their growth.

2. RHA CHAIRMAN

The Chairman of the RHA is Mr Gordon Roberts who was appointed from 1 8 78 on the retirement of previous chairman. Mr Roberts had been Chairman of Northamptonshire AHA prior to his appointment to the RHA.

3. FUNDING OF REGION

3.1 Revenue

Oxford RHA's revenue allocation for 1979/80 at November 1978 price levels is £180.7 million which means the Region is just above its "target", by 0.58%, according to Resource Allocation Working Party (RAWP) principles. Revalued, the final cash limit is £201 million. The Region's capital allocation, including joint finance monies, for 1979/80 is £15.37 million. The "growth" element within the revenue allocation is £3.1 million (1.75% increase).

Region's major criticism of RAWP

The Region has been critical of RAWP for two main reasons: it contends that the revenue formula works to the detriment of authorities with rapidly expanding populations because the population base used will be one or two years old; and it disputes the validity of Standardised Mortality Ratios (SMRs) as a measure of morbidity.

The Resource Allocation Working Party gave careful consideration to the possible indicators of morbidity and recommended the use of

composition of the population as being the best available indicator of relative health care need. The validity of the use of mortality statistics in resource allocation is being studied by a research team, which will report to the Department's Office of the Chief Scientist.

For the population base normally a figure one year old is used. For 1979/80 allocations, because of changes in OPCS operating procedures, revised mid-1977 estimates were used. The question whether projections rather than the latest available estimates of population should be used has been considered by the Department. Technical advice is that estimates are more reliable and more stable than projections. The fact of an increasing population of this region was taken into account in determining the rate of increase in the 1979/80 allocations. On the RAWP formula generally, the Advisory Group on Resource Allocation (AGRA), a working group of officers from the NHS and the Department, has been set up to consider the findings of relevant studies and to advise on possible modifications to the method of allocating resources for hospital and community health services.

3.2 Capital

The RHA is not satisfied that their capital allocations take sufficient account of the services which have to be developed for the Region's rapidly expanding population. Capital resources are required both for the development of completely new facilities eg the DGH at Milton Keynes due to be completed in 1983 and the maintenance and gradual replacement of older stock, eg Stoke Mandeville Hospital which has a severe maintenance problem both in the DGH itself and the National Spinal Injuries Unit.

As regards resources, Oxford will receive on its basic capital allocation small annual increases over the next few years, but should obtain considerably higher allocations towards the end of the decade. They have been advised that their average capital allocation for this period 1982/83 - 1988/89 will be "roughly 5-10% above the 1981/82 figure". In effect, Oxford Region can expect a level of capital allocation at the end of the decade some 10% higher than at the beginning as the effect of the projected increase in the region's population begins to be reflected in the

composition of the population as being the best available indicator of relative health care need. The validity of the use of mortality statistics in resource allocation is being studied by a research team, which will report to the Department's Office of the Chief Scientist.

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The fluctuation in notified figures of the next few years are a reflection of variations in the elements that contribute to the total capital resource other than the basic allocation (eg credits/debits for previous years, central contribution to teaching hospital schemes, special temporary allocations for energy conservation and Aid to the Construction Industry, etc).

4. JOINT FINANCING AND JOINT PLANNING

4.1 The Joint Finance allocation to Oxford RHA for 1979/80 is £1,730,000 (£770,000 capital and £960,000 revenue). Previous allocations (and expenditure) are as follows:-

	£000	£000
	Allocation	Expenditure
1976/77	340	113 Actual
1977/78	870	778 Actual
1978/79	1400	1601 Estimated

4.2 Jointly financed projects are to be found in various stages of development within the Region, Oxfordshire being notably less inclined to use joint finance than some authorities. The reasons for authorities' cautious approach include the now familiar anxieties about revenue consequences and of having subsequently to bear the full cost of schemes which do not necessarily coincide with the authorities' own priorities.

4.3 Regional examples of Joint Finance projects include a rural (farming) day care project for the mentally handicapped in Buckinghamshire and a Day Centre for Spastics at High Wycombe, Buckinghamshire.

4.4 Joint Planning arrangements exist in each authority but are uneven in their effectiveness. For instance, jointly financed projects are often not particularly good examples of joint planning.

5. THE REGION'S STRATEGIC PLAN FOR THE PERIOD 1979/88

The Oxford regional strategic plan has been received in the Department and preliminary analysis and discussions with the RHA are under way. The plan has been logically prepared and in methodology broadly conforms with Departmental planning recommendations. The Department has reservations some serious, about client group priorities. The RHA will receive detailed Departmental comments on its plan later this year.

6. THE PROBLEM OF MEETING CASH LIMITS

To comply with Secretary of State's instructions that all RHAs must plan on the basis of strict adherence to this year's cash limits the region now expects to have to cut back an/ ^{estimated} total overspending of approximately £7.3m this year. The RHA has agreed a plan of action in order to enable it to live "within its means": This involves freezing uncommitted Joint Finance, postponing some capital schemes, the use of central reserves, running down bank balances, and, locally, various forms of freeze on staff recruitment. Inevitably there will be some cuts in services to patients and protests will arise in consequence.

7. OTHER TOPICAL ISSUES INCLUDE .

- a. Regional secure unit for the mentally handicapped at Borocourt. /
- b. The Region's alternative proposals in regard to secure treatment for the mentally ill - ie: without recourse to an RSU. /
- c. The "Oxford Method" of building criticised by some; adopted for the high priority Milton Keynes dgh. /
- d. Psychiatr^{ic} services and especially services for the elderly severely mentally ill in Berkshire which depends on St Bernard's Hospital Southall, access to which is now being restricted. /
- e. Closure of Cowley Road Hospital. /
- f. Possible proposal to close Farnham Park Rehabilitation Centre /
- g. Stoke Mandeville Hospital and the NSIC. /

BACKGROUND BRIEF ON THE BUCKINGHAMSHIRE AHA FOR MINISTER OF STATE'S VISIT TO
STOKE MANDEVILLE HOSPITAL ON ~~26 SEPTEMBER 1979~~ 20 November 1979

CW

1. DESCRIPTION OF THE BUCKINGHAMSHIRE AHA

The Buckinghamshire AHA has 2 Districts, High Wycombe, and Aylesbury and Milton Keynes. The population of Buckinghamshire is about 483,000 and the new city of Milton Keynes, to the north of the county is one of the fastest growing communities in the county. The current population is about 80,000 and the population is planned to grow to 180,000 by the late 1980s and possibly to 200,000 thereafter.

At the moment the population has to look to Northampton and Aylesbury, both some 15 or 20 miles away, for specialist hospital services, but a new 93 bed community hospital opened in Milton Keynes in February this year. The community hospital provides beds for geriatric and psychiatric patients and also for patients in the care of general practitioners. There is no accident and emergency service and no surgical work is undertaken at the community hospital.

2. AHA CHAIRMAN:- Lady Mallalieu who has recently been reappointed to serve as Chairman for a further two years ie: until 1981.

3. FUNDING OF THE AHA

3.1 Revenue

The AHA has been allocated revenue of £25.8m for 1979/80; this includes £721,000 growth money. The Area is below its revenue 'target' by 3.1%.

3.2 Capital

£340,000 has been allocated for minor capital works, and £114,000 for medical equipment for 1979/80.

3.2.1 Amersham General Hospital

The Regional Strategic Plan proposes that the main acute services for the High Wycombe District should be provided at Wycombe General and Amersham General Hospitals. There are outline plans to develop

services at Amersham General from its present 253 beds to a total of about 650 beds by the mid 1990s.

Departmental approval has recently been given to a scheme to build 3 operating theatres and a TSSU at an estimated cost of £978,000 - to start on site in 1980/81. A further phase, with a projected start date of 1983/84, is expected to provide a further 120 geriatric beds.

3.2.2 Milton Keynes District General Hospital

There is great local pressure for a start to be made on Phase I of the proposed new Milton Keynes District General Hospital. Work on Phase I is expected to start on site in October 1980 and will comprise a total of 265 beds. Construction of Phase I should be completed by March 1983 and the first patients admitted in mid-1984. In the Department's view these dates should be treated with caution; there are some indications that the Region's timetable may be over-optimistic. A start on site on Phase II is expected to take place between 1984 and 1985 while the construction of Phase II is expected to commence in the early 1990's.

4. JOINT FINANCING AND JOINT PLANNING

The Joint Finance allocation to Bucks AHA for 1979/80 is £387,000 (£215,000 revenue and £172,000 capital.)

Previous allocations (and expenditure) are as follows:-

	£000 Allocation	£000 Expenditure
1976/77	Figures not available	1
1977/78	193	104
1978/79	308	300

Joint planning is well advanced in Buckinghamshire and there are several interesting projects. For example, there is the Thrift Farm which to date has cost about £37,800 and which is run by a group of mentally handicapped adults.

There also are 3 specialist home helps who work with the community and liaise closely with the social work staff at Tindal Hospital.

This project is of particular importance because of the lack of psycho-geriatric hospital beds in the Area. Joint Finance was also used to open a wing in a residential home for the elderly where staff could focus on the needs of the severely confused. A day centre for the elderly has also been provided on this site.

Buckinghamshire recognises the value of voluntary services and Joint Finance has been used to assist projects such as activities at the George Mason Day Centre which was opened in conjunction with the Spastics Society for a group of multiply handicapped young people between 16-21 years of age. The Chesham Hostel for the mentally handicapped is another similar major venture this year receiving about £132,480 Joint Finance monies.

Money has also been used to recruit social work service staff who are vital to the health service.

5. FINANCIAL PROBLEMS OCCASIONED BY THE AHA'S NEED REMAIN WITHIN ITS

CASH LIMITS:-

5.1 The AHA expect to overspend its cash limits by about £1.75m during the current financial year ^{unless remedial action is taken}. The RHA hope to meet about £167,000 of this amount from its central reserve. ^{potential} To contain the balance of the over-expenditure, the AHA has resolved -

- To defer minor building schemes such as the upgrading of wards at Amersham Hospital and at St John's Hospital, and to postpone action on the backlog of Estate maintenance in the Area. The AHA is very concerned about this measure because the fabric of buildings in the Area is deteriorating rapidly. Amersham and Stoke Mandeville Hospitals, in particular, will be badly affected because maintenance work has been deferred pending rebuilding, and now funds for major rebuilding are not likely to be available for a while longer and refurbishing will cost a considerable sum. Conversion of the ethical pharmacy at Milton Keynes will also be postponed.

- to look into the possibility of releasing more land or property for sale.

- to use uncommitted Joint Finance money as acting revenue

- to continue for a further 2 months (until November 1979) the current freeze on filling vacancies, except in the case of junior medical staff, nurse learners, and night duty staff. However the District Management Team have freedom to deal with any exceptional situation that arises as necessary.

- to curtail certain other new developments.

6. CLOSURES -

6.1 THE CASUALTY DEPARTMENT AT AMERSHAM GENERAL HOSPITAL

In accordance with procedures for the closure or change of use of health service buildings the AHA has recently concluded preliminary consultations on its proposal to close this Department which has in fact been out of commission for some considerable time.

7. OTHER TOPICAL ISSUES

7.1 Manor House Hospital problems.

The low staffing at Manor House Hospital, ie:

- a. Nursing staff establishment at end of July - 190.76.
- b. Staff in post - 169.27 (on 3.8.79) with 3 more nurses due to leave in August.

This situation has evidently been exacerbated by holiday and disciplinary problems which arose at the hospital necessitating the dismissal of the sister of the Wing Unit. The overall result has been the temporary closure of the Day care unit since July and the inability of the health authority to open a further 8 beds at this hospital, for which money was made available during the last financial year. The closure of the Day Unit has concerned parents of children being cared for at the Unit.

However the health authority has confirmed that in association with the social services Department suitable alternative arrangements have been made to accommodate patients at Social Services Day Centres in the neighbourhood, and that at least one other patient has been admitted to the Hospital. The AHA hopes that the appointment of a new Sister to the Wing Unit will help to resolve the problem. Meanwhile the AHA intends to keep the staffing levels at the hospital under close review in order to try to maintain a satisfactory level of service to patients. At its meeting in August it was reported that publicity in the press had resulted in the management being able to recruit a number of untrained staff to the hospital.

7.2 THE ESTABLISHMENT OF A PREVENTIVE CARE SERVICE FOR ADOLESCENTS

The Oxford RHA has submitted for Departmental consideration, proposals put forward by the Bucks AHA to establish a residential unit (consisting of about 10 places initially) for severely disturbed adolescents.

MINISTER OF STATE'S DRAFT PRESS STATEMENT

First of all I must stress that I came here today to look not only at the National Spinal Injuries Centre, but also at the Stoke Mandeville Hospital as a whole.

Buckinghamshire AHA is having to share in the task of containing public expenditure in the fight against inflation. I should like to pay tribute to the way that all concerned are tackling this very difficult task. I have asked the Authority - as I have asked all Authorities - to look at every possible way of making savings without interfering with direct patient care, and I know that they are doing their best to meet this aim and that the heaviest cuts (in percentage terms) are being born by Area Managed Services and administration generally.

I want to pay tribute to the work of all the clinicians and staff of the hospital, and also to the work of the National Spinal Injuries Centre. Over many years, under Sir Ludwig Guttman and his successors, the Centre has pioneered methods of treatment and established a national and an international reputation as a centre of excellence.

Because the National Spinal Injuries Centre serves a catchment far wider than Buckinghamshire or the Oxford region it is natural that proposals for change in the level of service should give rise to some concern. I welcome, therefore this opportunity to clarify the position and to explain the level of service which will be provided in future by the National Spinal Injuries Centre.

First of all I endorse and welcome the Area Health Authority's decision not to seek to use National Spinal Injuries Centre accommodation for geriatric patients as was previously proposed. I can assure you that no National Spinal Injuries Centre wards will be used for purposes other than the care of spinal injuries.

What is the level of service to be? At present it is at its lowest for some time - only 110 beds are staffed and available. The Authority has undertaken to begin to restore beds in the National Spinal Injuries Centre from their

present low level to 130 as possible. The remaining ward will remain reserved for the future use of the National Spinal Injuries Centre.

One of the recurrent difficulties has been the problem of identifying the full cost of spinal injury services and ensuring that this vital multi-regional service is properly recognised in financial terms. I am aware of the difficulties and I have decided that new arrangements are necessary to identify the costs of providing the National Spinal Injuries Centre. I would like to ensure that right down to health district the cost of providing this service is separately identified within the health authorities' target allocations.

These are the actions which Government and the health service can take in the present circumstances. So far as further developments are concerned, money is tight, but I have been encouraged to believe that a real possibility exists to raise funds on a voluntary basis, first to upgrade the present National Spinal Injuries Centre buildings, and then to fund and build a completely new National Spinal Injuries Centre.

Such a scheme would have my own and the Secretary of State's enthusiastic endorsement and support.

I also know that the Health Authorities concerned would welcome such a proposal. Already some initial discussions have taken place with those who might play a leading role in a national campaign.

DR VAUGHAN GIVES ASSURANCES ON STOKE MANDEVILLE

Dr Gerard Vaughan, Minister of State for Health, today welcomed the decision of Buckinghamshire AHA to increase the number of beds currently available at the National Spinal Injuries Centre, Stoke Mandeville, and their assurances that no wards at the Centre will be used for any purpose other than the care of spinal injuries. Dr Vaughan said he was making arrangements to clarify the financing of this national Centre. He added that there was a real possibility of voluntary funds being raised to improve the existing Centre and possibly, ultimately, to provide a new Centre.

Dr Vaughan said:

STOKE MANDEVILLE AND THE NATIONAL

SPINAL INJURIES CENTRE/BUCKS AHA "CUTS"

Summary

1. Immediately behind this note is a short paper explaining the Buckinghamshire AHA's financial crisis and the measures they propose to adopt to "live within their means".

2. The Authority has reconsidered its proposals and DHSS Officials have met with Regional and Area Health Authority Officers. The outcome is -
 - (i) There is now no proposal that accommodation in the National Spinal Injuries Centre should be taken over for other patients (e.g. geriatric patients from Tindal Hospital) as previously suggested.
 - (ii) The general shortage of nursing staff exacerbated by the "freeze" on recruitment has led to a current situation where 2 wards in the NSIC are closed and only 110 staffed beds are available.
 - (iii) As soon as circumstances permit, the AHA will recruit/staff-up another ward in the NSIC and the remaining ward will be reserved to the use of the NSIC in whatever way resources permit and best serves the needs of patients.

3. There will, therefore, be no cut-back at all from the position to-day at the NSIC but on the contrary there will be a gradual increase in the number of staffed available beds as resources allow. The full facilities of the NSIC in terms of accommodation will remain reserved for the treatment of patients with spinal injuries. Throughout 1979 the average occupancy of the NSIC has been approximately 110 patients. The health authorities now expect this figure to rise as more beds are brought back into use. It could be said with justice that there is, therefore, now no cut in prospect, but that there should be an actual improvement in facilities available for spinal injuries - one would have, however, to add the rider that the pace of improvement will depend on the financial position of Bucks AHA.

The Problem

Likely breach of cash limits

£2,044,000

(Divides into two problems)

£1,279,000 overspend

and

£775,000 overspend

- This is a once only problem.
- It arises from previous year's overdrawing carried forward and the additional (unfunded) cost of pay and prices inflation.

- This is the permanent annual level of overspending which has to be eliminated.

- "cuts" or "savings" to this extent are inescapable.

Problem solved by -

- (1) Use of reserves and other non-recurring funds made available from region
(£467,000)
- (2) Use of Area reserves and other miscellaneous earmarked monies not immediately committed to service requirements
(£812,000)

- The Authority's proposals are detailed on the next sheet.

£1,279,000 met by £812,000 + £467,000

Proposals to eliminate the "built-in" overspending of £775,000 p.a.

The proposals are to reduce spending as follows :-

	£000's
- on Area Managed Services by	77
- on Ambulance Services by	97
- on Aylesbury & Milton Keynes District Services	262
- on High Wycombe District Services	<u>339</u>
	£775,000

The detailed proposals for each group of services are set out on pages 3 to 6 following. If implemented the strategy will, in the Authority's view, bring annual spending back under control and within cash limits from 1980-81 onwards.

The only doubt is whether this full saving can be achieved between now late (November) and the end of March 1980 (effectively, only four months). The Authority is hopeful because it believes that already the staffing "freeze" imposed since August, and other economies, have "pulled back" some £200,000. There is a small remaining reserve of £25,000 and, therefore, some £550,000 of revenue economies remain to be achieved. The "freeze" is operating in such a way that the rate of achieving economies is steadily accelerating and, when the "freeze" changes over into the planned economy measures, the cumulative effect will, it is hoped, lead to achievement of the target of zero overspend by 1 April 1980.

Area Managed Services

The total budgets for Area Managed Services will be reduced overall by some 8.5% although the same level of reduction will not apply to each individual service. In general, the budgets for direct patient services such as Speech Therapy and Chiropody will suffer less reduction, around 5%, than the budgets for administration and other supporting services where in some cases the reductions exceed 10%.

The full effect of these budget reductions on the service is specified in the Consultative Document.

The financial effect of these measures will be to reduce expenditure on the Area Managed Services by some £100,000.

The Ambulance Service

In order to reduce expenditure on the Ambulance Service, the Authority proposes to adopt the following revised criteria for non-emergency requests for the use of the ambulance service.

- a) All requests for ambulance transport must satisfy the test of medical need.
 - b) All ambulance requests must be authorised by a Doctor, Dentist or Midwife (for patients of their particular speciality) and it is emphasised that there must be a genuine need for transport because the patient is medically unfit to travel by other means and not because it is cheaper or more convenient to travel by ambulance. This decision must not be delegated.
 - c) Requests for ambulance transport should be made only as a last resort after all other possibilities have been examined and found unsuitable.
 - *d) Not less than 24 hours notice should be given of all non-emergency inter-hospital transfers and discharges. It is highly desirable that such requests are timed for morning journeys.
 - e) Not less than 48 hours notice should be given of all out-patient and day patient requests.
 - f) The majority of appointments for out-patients using ambulance transport should be confined to the hours between 0930 and 1530 hours.
 - *g) Essential requests only should be made for Saturday or Sunday and no hospital discharges should be programmed for the week-end unless by agreement with Ambulance Control.
- * The Authority have asked that further consideration be given to these criteria.

In addition to these measures, the Area Chief Ambulance Officer is continuing negotiations with the staff and Trade Unions with a view to making changes in working arrangements etc., which will result in improved efficiency of the service.

DH Document 06. Page 51

These negotiations are being held with the objective, in due course, of a reduction of the order of £20,000 in the expenditure on the

Aylesbury & Milton Keynes District

The proposals from the Aylesbury & Milton Keynes District are as follows:-

* a) Stoke Mandeville Hospital

Temporary closure of four wards

e.g. 1 ward in the National Spinal Injuries Centre
and 3 General Acute Wards

or Temporary general reduction of beds in each
specialty to achieve the same financial effect.

Temporary general reduction of beds in each specialty equivalent to a total of 4 wards in total

b) Renny Lodge Hospital

Rationalisation of beds at Renny Lodge Hospital by closure of two small wards (17 beds in total) and transfer of patients elsewhere. Reduction of geriatric bed complement from 87 to 60 (following opening of Community Hospital).

Vacated space to be used at a later stage when funds permit.

c) Drug Rationalisation

District Drug and Therapeutic Committee to draw up suitable lists for the rational use of drugs and seek co-operation of hospital medical staff to restrict their prescribing to such lists as far as possible. Prescriptions generally to be limited to two weeks' supply but with discretion to extend the period in certain circumstances.

* The detail of the temporary closures is subject to consultation with the medical staff and other interested parties.

The anticipated effect of the above measures will be to reduce the expenditure of the District by a figure approaching £300,000.

High Wycombe District

Proposals from the High Wycombe District fall into two parts:-

a) Savings which will not immediately affect the patient:

	Estimated Annual Savings £000's	£000's
Occupational Health Service (closure)	12	
Closure of Creche - Wycombe General Hospital	10	
Closure of Creche - Amersham General Hospital	11	
Reduction in the Family Planning Services	30	
Economies in respect of Drug prescribing	25	
Reduction in the Child Health Service	<u>10</u>	98

b) Savings which will directly affect patient care:

<u>Amersham General Hospital</u>		
Temporary closure of "G" Ward (day ward)	35	
* Temporary closure of 25 beds and also the reduction of beds in the Paediatric Ward to 10	123	
<u>The Chalfonts & Gerrards Cross Hospital</u>		
Reduction in patient services	15	
<u>Wycombe General Hospital</u>		
* Temporary closure of 1 ward (20 beds)	<u>98</u>	<u>271</u>
		<u>369</u>

ESTIMATED SAVING - £369,000

* The detail of these temporary closures is subject to consultation with the medical staff and other interested parties.

BRIEF FOR MINISTER OF HEALTH'S VISIT TO STOKE MANDEVILLE HOSPITAL -
MANDEVILLE ROAD, AYLESBURY BUCKS

1. OBJECTIVES OF VISIT:-

The objectives are for Minister to familiarise himself with the general environment within the hospital and the hospital's relationship with the community it serves; to gain an impression of the scope and quality of services provided, staff morale and attitudes and current problems, and to hear something of the way in which the services may develop in the future.

2. STOKE MANDEVILLE HOSPITAL

2.1 A large general hospital, housed mostly in wartime huttet accommodation. There are approximately 758 beds.

The hospital has a supra-regional spinal injuries unit (The National Spinal Injuries Centre), a regional plastic surgery and burns unit, and a regional rheumatism unit.

2.2 The National Spinal Injuries Centre -

The Centre was established during the Second World War to provide a service for wounded military personnel. Much of the pioneering work was undertaken by Sir Ludwig Guttman whose drive and reputation helped the centre to achieve international recognition.

The Centre has a total of 150 beds, and a 30 place younger disabled unit. The Centre also has a large physiotherapy department, a large hydrotherapy pool, a large hall used for archery, table tennis etc - and other sporting facilities. A fuller note on the work of Spinal Units throughout the country and Stoke Mandeville NSIC is included in the brief

2.2.1 Problems concerning funding of the NSIC -

The funding of the Centre attracts continuing interest and public concern because of the importance of its functions and its international standing as a centre of excellence. The publication

of an AHA report last Autumn, which indicated that there was a backlog of maintenance work at Stoke Mandeville Hospital as a whole totalling about £2m, led to major public outcry, and this was further aggravated when in January 1979, due to the severe winter weather water pipes burst, ceilings were damaged and 4 wards (3 in the NSIC) had to be evacuated. Repairs have, however, now been completed and the wards are back in use.

At present the hospital and the unit are both funded by the Buckinghamshire AHA which in turn is funded by the Oxford RHA from its normal revenue allocation. The AHA does not separate out the costs of running the NSIC but, in establishing the Region's annual revenue allocations (The RAWP target), account is taken of the patients from outside the region who are treated at the NSIC, and other such units.

The possibility of a voluntary fund-raising campaign for the NSIC has been mooted. Lady Masham and the Spinal Injuries Association have raised this question and have been advised to discuss any proposals initially with the Oxford RHA, and the AHA prior to meeting Minister in the Autumn

3. STAFFING PROBLEMS AND WARD CLOSURES

Nurse staffing level (wte) funded establishment (excluding learners) 621.7. Numbers in post on 21 September 1979 (i) trained staff - 315.3 (ii) untrained staff 250.5. Number of vacancies (wte) 55. Current ratio of trained to untrained staff (excluding learners) 1 trained-.79 untrained. Nurse staffing level (1 to 1.8 beds) has led to the closure of 80 beds at the hospital - (ie: 2 spinal injuries wards, 1 general medical ward, 12 beds in the plastic surgery and burns unit, 2 beds in ITU) and restrictions in the general operating theatre.

Recruitment is a continuous problem because the hospital is remotely situated and Aylesbury itself is a town which offers a wide range of competing employment. Learner nurse intake has been maintained, but there has been difficulty in recruiting nurses to the rheumatology unit, the spinal injuries unit, the plastic surgery and burns unit and for night duty throughout the hospital. There also have been problems with recruiting adequate support and ancillary staff.

Social Work Unit - Headed by Mrs J Russell. There are 6.5 social workers in post of whom 3 are qualified. At present there are 2.5 full time vacancies.

3.1 Staff morale -

The cumulative effect of the deteriorating condition of the buildings and low staff levels is said to have had a harmful effect on staff morale. Problems have also been experienced by community nurses as pressures have increased with the rapid hospital throughput and rapid population growth particularly in Milton Keynes.

4. INDUSTRIAL RELATIONS

Staff at the hospital belong to all the major unions ie: COHSE, NUPE, RCN. Industrial relations between management and staff are satisfactory. There are consultative committees at Area and District level. There is currently a move to set up separate negotiating machinery between the management and TUC and non-affiliated TUC unions.

5. VOLUNTARY HELPERS

There is a full time voluntary organiser based at Stoke Mandeville Hospital. Besides about 200 volunteers who visit the hospital regularly, among whom is Mr Jimmy Saville, the hospital has a very active League of Friends who run a comprehensive shop and a canteen for patients, staff, and visitors.

6. FUTURE OF THE HOSPITAL:-

It has been the health authority's intention to rebuild Stoke Mandeville, which will continue to serve as Aylesbury's District General Hospital after the completion of Milton Keynes dgh. Until Milton Keynes dgh opens, Stoke Mandeville and Northampton will have to continue to provide all major hospital facilities for Milton Keynes as well as providing for their local catchments.

To date, however, only one new wing consisting of 100 beds and support facilities has been completed and brought into use. A new 40 bed geriatric unit

(which will include a day hospital) is currently under construction and is expected to be brought into use in 1980. Together with another vacated ward it is hoped that all geriatric patients (other than long stay patients) will be treated at Stoke Mandeville and that this will coincide with the closure of the day hospital at Tindal Hospital in Aylesbury.

In its District Plan for 1979 the AHA indicates that it does not propose to undertake any major capital development work at the hospital during the next 3 years except to upgrade and repair those parts of the premises which need refurbishing eg - the X-ray department (in S corridor) and operating theatre (in north corridor).

According to the Draft Regional Capital Programme, the next major development will be the construction of a further 200 acute, and 40 geriatric bed units, and support facilities. The start on site date for this work has been fixed for 1984/85, and the estimated cost will be over £8m. The DMT hopes that the new developments will provide gynaecology and general surgery replacement beds and be linked to the existing new wing. The vacated space it is hoped, will be utilised for the remaining geriatric and psychogeriatric patients from Tindal Hospital.

The next major rebuilding project will not commence until 1990 when it is hoped that replacement beds for obstetrics and paediatrics will be provided. New kitchen facilities may also be required at this stage.

If new spinal unit buildings and staff residential accommodation can be provided through non-NHS funds this will enable a more rapid re-development of the whole hospital. If the NSIC is included in the general rebuilding programme through the 1980s and early 1990s the question of relative priority to be accorded to the NSIC and the other part of the hospital remains to be resolved. The AHA will have 2 meetings in October to further consider developments at Stoke Mandeville.

**PRESS
RELEASE**

Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone 01-407 5522

23 January 1980

CIAL ABOUT STOKE MANDEVILLE

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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 Stoke Mandeville
Mandeville unit are still being cared for in the original hutted accommodation

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- 1 Mr Bobb ✓
- 2 ~~Mr Fair~~

Have you seen
the attached?

3 Mr Arthur PMA
for the S.M. file
pl.
R. Myers.
23.1.

4. Mr Williams
to see

5. Mrs Saxon
please get file up to date
return in 1521 PMA 25/1.

PRESS RELEASE

Alexander Fleming House
Elephant and Castle
London SE1 6BY

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 huttled 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	<u>196</u>

There will be two further units by the mid 20s at Odstock Hospital, Salisbury, and the Royal National Orthopaedic Hospital at Stanmore.

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.

Department of Health
and Social Security

**PRESS
RELEASE**

Alexander Fleming House
Elephant and Castle
London SE1 6BY

Telephone 01-407 5522

80/11

23 January 1980

HEALTH MINISTER WELCOMES STOKE MANDEVILLE APPEAL

Jimmy Savile, OBE, today launched a multi-million pound campaign to rebuild the National Spinal Injury Centre at Stoke Mandeville. His initiative was welcomed by the Health Minister, Dr Gerard Vaughan, as an example of the sort of partnership between the Government and the public which has so much to offer.

Dr Vaughan said:

"Jimmy Savile, OBE, and Stoke Mandeville really need no introduction. Jimmy's zeal and enthusiasm for good causes and his long association with the Spinal Injury Centre are well known. If anyone can 'fix it' then I know he can. I wish him well in this task and I am sure that he will find a tremendous reservoir of public sympathy for Stoke Mandeville.

"What can one say about Stoke Mandeville? Nobody can visit Stoke Mandeville without realising that it is a very special place. You know it when you walk in and you know it when you talk to the patients. Stoke Mandeville's achievements in pioneering the treatment and rehabilitation of spinal injury patients are known to everyone, both at home and abroad. What is important now is to ensure its continued future as a centre of excellence.

"I believe that the British public will be anxious to know that when the new unit and its facilities rise at Stoke Mandeville, they will have supported it with their own voluntary help.

"Jimmy Savile will be giving information about his activities in the weeks and months to come. The minimum target is £6 million. In the meantime the public can start the ball rolling by sending their donations to:

The Jimmy Savile Spinal Building Appeal Fund, Address: Spinal
Injury Centre, Stoke Mandeville Hospital, Aylesbury, Bucks HP18 3AL

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Mr Collier

REAL

STOKES MANDEVILLE

Emergency

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 me to let you have a copy of the amended draft as early as possible this morning. A copy is attached.

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

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.

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G M BEBB
SH2C
B517 AFH
Ext 6132

16 January 1980

cc Mrs Petrie
Dr Tait
Mr Scott Whyte

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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

Mr Knight

S.S.
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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.

PEAL

Emergency

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.

In the hospital
in World War II,
ent of the Centre,
a result of the
return to live

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.

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16 January 1980

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	<u>Number of beds</u>
Midlands SIU, Oswestry	46
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Pinderfield SIU, Wakefield	31
Hexham SIU, Hexham	20

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	45
Lodge Moor SIU, Sheffield	64
Southport SIU	35
Pinderfield SIU, Wakefield	31
Hexham SIU, Hexham	20

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 ~~from 25 other countries~~ ^{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~~ 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 ~~and~~ 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.

304 931
~~RPA~~

STOKE MANDEVILLE SPINAL UNIT APPEAL

1. PRESS CONFERENCE

A press conference to launch this Appeal is to be held on Wednesday (23) January (10.30 hours) in the Bishop Partridge Hall at Church House, Westminster.

Following coffee on arrival,¹ the Minister of State for Health will formally open the proceedings at 11.00 hours. He will introduce Mr Jimmy Saville OBE, who will explain what the Appeal hopes to achieve in terms of target facilities and timing. A hand out will be available for the Press² and a Press Notice will be issued.³

Approximately 30 people representing local Stoke Mandeville interests will be among those present. The number includes 8 paraplegic patients, two of their children accompanied by their parents. Arrangements for local representation are being handled by Mr Saville in collaboration with Stoke Mandeville Spinal Unit managers. Admission is by invitation from the Minister of State; a batch of 36 invitations will be sent to Mr Saville⁴ and each card will carry instructions on how to find Church House and Bishop Partridge Hall.⁵

With the Minister, Mr Collier, Dr Tait, Miss Else (Press Office), Miss Davidson (Nurse) and Mrs Petrie will attend from the Department.⁶

The Minister intends writing to the Editors of national (and local) newspapers, and to major TV companies to invite them to the Press Conference.⁷

Mr Collier intends discussing conference details including the press hand out and statement with Mr Saville in Room D904 APE on Wednesday 16 January at 10am.⁸ Mr Collier has also agreed to telephone the Oxford RHA and Bucks AHA Chairmen to invite them to attend the press conference.⁹

2. APPEAL MECHANISM

At the moment odd financial contributions are being handled by Bucks AHA, the money being credited to an identified section of the

Authority's general endowment fund. Action is in hand to establish an independent Bank Account for the Appeal Fund, and to establish Trustees to administer it.¹⁰ As a first step there will be three trustees: Mr Saville, Mr Collier and one other. Mr George Russell-Fry, an Accountant, has agreed to advise on establishing both the Trust and the banking arrangements. He hopes to meet Mr Collier to discuss these at the beginning of next week.¹¹

3. FUND RAISERS MEETING - HOUSE OF LORDS

A meeting of fund raisers, sponsored by the Duke of Buccleuch, is planned at the House of Lords on 20 February.¹² Mr Collier intends to invite Mr Borges (RNOH), Seagrams,? Sir Charles Abrahams, and Mr Buchanan (Canadian Railways).¹³

4. LIAISON GROUP

A liaison Group is to be established¹⁴ to provide a link between project planners and fund raisers. At present the potential membership is Mr Roberts RHA, Lady Mallalieu AHA, (Chairmen), and Dr H Frankel Chairman of the Spinal Injuries Review Committee. Mr Collier intends to Chair the Group, and will be writing to potential members, outlining their functions and suggesting an invited meeting towards the end of February.¹⁵

5. At the instigation of the National Spinal Injuries Association, the MPs' all party Disablement Group plan to visit Stoke Mandeville Spinal Injuries Unit on [Wednesday 13 February]. It would be helpful, prior to the visit, if Mr Rathbone would tell the Chairman of the Group [Jack Ashley MP]? what is happening in relation to the Stoke Mandeville Unit.¹⁶ And, in advance of the Appeal Press Conference on 23 January, MS(H) may wish to brief Mr Prentice along similar lines.¹⁷ Mrs Petrie to maintain links with NSI Association to keep them up-to-date.

6. A Mr K Nayler has written to Lord Cullen offering to raise more than £1m for the Stoke Mandeville Appeal. This may or may not be a serious proposal, but officials are committed to meeting Mr Nayler to discuss prospects after the Appeal has been launched on 23 January.

7. ACTION

RL1 will continue to coordinate action and prepare briefing material.

Details on who is doing what. References
1-17 above will be tabled at the
office meeting to be held on Friday am 11th Jan.
in Mr. Wilson's office.

Wheeler

Pamela Petrie
RL1
ET.1532/Extn.884

10 January 1980

copy: Mrs Else
D. Taylor } By Hand
Mr Belton }
Miss Davidson
file

~~358~~
358
X

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

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.

~~Mr. B~~
Mrs. Salter
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Mr. [unclear] [unclear] [unclear]
For the file. [unclear] 16/11
L: 16 SW 11/1
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~~Mr. Bebb~~
~~Mrs. Petrie~~

STOKE MANDEVILLE APPEAL : SPINAL INJURIES UNIT

I cannot agree to Mr Bebb's suggestion that SET RHA should take up direct with MOD the use of Army facilities. We are already engaged in discussions with MOD on the use of Army hospitals in the Thames Regions. Moreover the question of NHS use of QEMH is highly contentious and I do not believe that at this stage it would help to let SET RHA get into bilateral discussions without RL3 preparing the ground and being closely involved. I must insist that RL3 take this on.

SF Thorpe-Tracey

S F Thorpe-Tracey
RL3
1506 x899
Euston Tower

10 January 1980

Copies to:

- Dr Rivett
- Dr Tait
- Mr Suckling
- Mr Collingwood

Note.

Spoke to Mr. Thorpe-Tracey, and outlined our view on MOD involvement. It is not part of our strategy and the relevant minute in the note of the meeting will make the clear. He will sound out those concerned himself.

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V"

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Mrs. Salter ~~for~~
for the Stoke Mandeville
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Disabled living

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Fighting to save the future

Last week, 70 wheelchair-bound ex-patients occupied Stoke Mandeville Hospital in protest against proposed cuts which would further restrict the work of its famous Spinal Injuries Unit. Although the unit's achievements in treatment and rehabilitation are considerable, lack of funds have caused it to fall behind in the last ten years. The staff are distressed because they can no longer offer help to enough patients, as Alison Hyde found when she visited the unit

SPECIALISTS automatically seek perfection and wish to do more for their patients, perhaps more than is possible. This is true of the National Spinal Injuries Unit at Stoke Mandeville Hospital where, amid tightening financial restrictions and in housing that one consultant described as 'rotting', hordes of visitors — media, doctors and the public alike — continue to visit.

The unit has achieved its unique position in the public and professional mind because it was the birthplace of modern treatment of spinal injuries. In 1942, when Stoke Mandeville was created to deal with horrific wounds, treatment of spinal injuries was in its infancy and the future for most victims was poor.

Over the years the hospital has been developed as a general hospital, although the original buildings were only intended to have a useful life of 25 years. New facilities have been added but successive squeezes have made expansion plans

largely redundant, and the overall impression remains of a line of Nissen huts.

The unit provides treatment for spinal injuries, including paraplegia and tetraplegia, for the whole of southern England. It caters for men, women, young and old. The majority of patients are, however, young men between the ages of 16 and 25, after industrial, sporting or auto accidents.

As Edith Heycock, the unit's senior physiotherapist commented, this fact makes for an active and lively atmosphere. But it does sadden her that some patients come to the hospital expecting to be cured. This is still impossible although the unit has performed near miracles at times.

All disciplines are working for rehabilitation, and a return to the community where it is hoped the patient can lead as normal a life as possible. Patients spend between eight and 12 weeks in bed when admitted and during that time a rapport is built up between the physiotherapist and the patient. A good relationship is vital, said Miss Heycock, otherwise rehabilitation is just not possible.

The length of time spent in bed and the gradual establishment of a relationship is necessary if the patient is to have the confidence to learn to cope with the disability.

Developing skills

The physiotherapy department, although it has built up a unique fund of experience, does not resort to anything mysterious. However, the use of sport has become intimately associated with the hospital and is an integral part of therapy. The use of games such as basket-ball, conducted from the wheelchair at a furious pace, would put many able-bodied athletes to shame. It also highlights the unit's maxim: it is not the disability that counts but the ability.

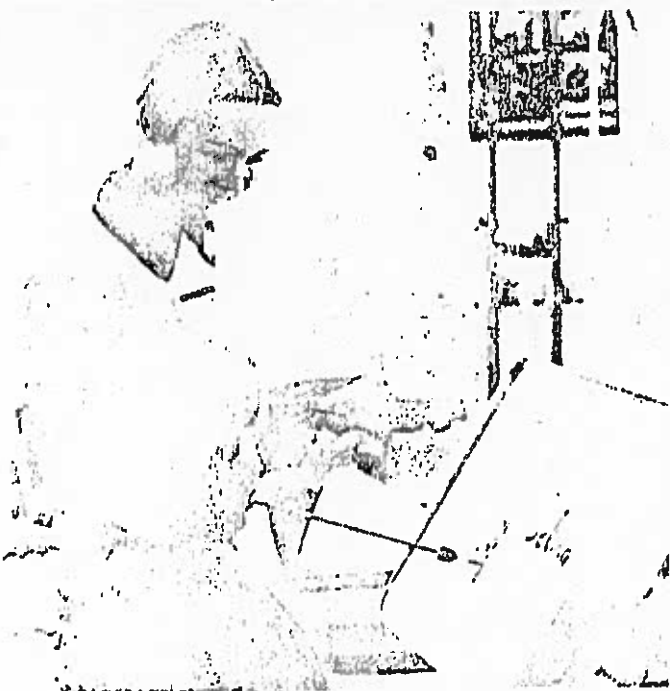
The patients are also encouraged to take up archery which develops all sorts of extra skills and is a wonderful muscle builder. The concentration needed to cope with the bow and hit the target is immense and shows its rewards in the rehabilitation process.

Joan Simonsson, head occupational therapist, is well aware of the age group differences. She does not necessarily agree with the philosophy but she knows that the lion's share of the attention goes to the young with the rest of their lives ahead of them, rather than the elderly. This is particularly true when she says that her establishment is not high enough.

Quality of life

She has seven and a half occupational therapists for the 725-bed hospital 'and that's not nearly enough', she says. The specialist type of work carried out by the renowned burns unit and the spinal injuries unit makes far more demands on the OT's time than a 'normal' hospital. She feels that the establishment really ought to be 12.

Mrs Simonsson says her department is concerned with the quality rather than the quantity of life, which is up to the medical side to determine. The department has a new kitchen with adjustable work surfaces donated by a Mothers' Union which greatly aids a patient in getting in and out of a car for patients to learn the art of getting in and out of a vehicle



More DTs are needed for these patients

Doc Document 06 Page 35

of the Mandeville miracle



What are the chances of this rather special unit being extracted from its cramped housing?

unaided. The OT department, which is also responsible for all splinting within the hospital, is at present working on a splint for tetraplegic patients which will improve the mobility of the neck.

Eirlys Barr, senior social worker, counsels both patients and relatives. She admits that it is probably not possible to provide adequate counselling to prepare the handicapped person for his return to life outside the hospital walls where life is almost entirely geared to the able-bodied.

Mrs Barr said that she sees the patient soon after admission and often before the full extent of the disability is known. She also sees relatives who need a range of advice to help cope with the new situation. Her main problems are the allowances available, housing and employment.

She also copes with a wide variety of reactions to disability. Some people are very philosophical, others become aggressive or depressed and some do not experience depression until they return home.

As part of the unit's attempt to rehabilitate patients and prepare them for a return to as normal a life as possible, they are allowed to go home at weekends. This can be traumatic at first but it helps to highlight problems which might arise and also what physical adaptations to the house might be necessary.

Mrs Barr also feels that her work suffers through lack of time and she would like to spend more time with relatives.

The cry that the various departments are under-staffed is a common one, especially since an embargo has been placed on all recruitment and special cases have to be made to the



Good Relationships in DH Document 66, Page 76

Praise and bitterness from a patient

At 1.30pm on Sunday, January 14 this year, Tony Stokell was driving home from a public house in Cheltenham with his girlfriend — sober, he hastens to add. It was in the middle of the bad spell of weather and the roads were covered in slush. He was travelling at 35mph because of road conditions. Suddenly the car just turned over and landed on its roof.

The accident left Tony Stokell, at 26, with a broken back and the prospect of long months in hospital. Although he was living in Cheltenham, he had originally come from Leeds and had a choice of returning north to Pinderfields Hospital or Lodge Moor. Instead he chose to go to Stoke Mandeville. Naturally he had heard about Stoke Mandeville and the service it provides for paraplegics and tetraplegics. He also was not surprised at the fabric of the place, although he admits that he did not expect it to be quite as 'tatty' as it is.

He came to the hospital with a determination to leave it 'on his feet'. His success in reaching this goal he puts down to 75 per cent perseverance and 25 per cent tuition.

'When I started they just taught me to be able to use a wheelchair, then I started walking, bit by bit. Most of it's a matter of confidence — if you feel confident, if you

feel safe, then you can cope.'

But he also pointed out what a massive strain re-learning the everyday skills are for paraplegics. For example, when he was first faced with a four-inch curb it appeared mountainous and he was 'terrified'.

Tony Stokell feels that the hospital is simply starved of money and the basic equipment to do things. He feels bitter that many of the allowances for the disabled, such as mobility, are taxed and said: 'As far as I'm concerned, I'm here through no fault of my own, and I'm entitled to everything that's going. If there is a choice between money and the patients, then the patients should come first.'

His feelings about the treatment he has received at the hospital are mixed. He praised the physiotherapists who he says are 'the best' at teaching paraplegics to walk again, but he complained bitterly about the inadequacy of the counselling available. He feels strongly that there is insufficient reality about the advice given on how to cope with life outside such as the allowances that are available, sex counselling and getting back to work.

Tony Stokell is returning to Cheltenham as soon as a purpose-built bungalow is ready for him and he is also returning to his old firm.

district management team. But the complaints go deeper than a lack of staff.

Isaac Nuseibeh, chairman of the spinal division, complains bitterly that the unit's international reputation has not been matched by upgrading, and claims that it has been starved financially for the last ten years or so. He can also see the unit losing its primacy, especially as far as overseas units are concerned, because of lack of confidence.

He is also concerned that a further reduction in the number of beds in the unit, part of the Aylesbury and Milton Keynes

district's plan to meet the Government's demand for savings, will mean a regression in the treatment of spinal injuries.

'There should not be a waiting list. Some admissions have had to be postponed for ten weeks, which cancels out completely the modern method of treating spinal injuries,' says Mr Nuseibeh.

Fighting hard

'This is not the standard of care that we would like to give because we like to admit someone immediately or as soon as their injury allows them to be moved, not when an empty bed is available. But that's what's happening now. We are fighting, we are fighting hard, but it's very sad.'

Mr Nuseibeh says that the fabric of the hospital is rotting and remembers vividly last winter when the ceilings of some of the wards collapsed. But despite the fact that Stoke Mandeville catches the headlines, is considered at ministerial level and in the House of Lords, nothing is done to help.

The problem revolves around whether or not the National Spinal Injuries Unit is special in terms of local health provision and whether it has any right to be treated differently to other parts of the hospital. The administrators do not think so; the view seems to be that it must take its chance along with the rest.

It is Mr Nuseibeh's contention that the unit provides a regional, if not national service, and should be funded accordingly.

The feeling that the spinal injuries unit at Stoke Mandeville is rather special will probably hit many people who visit it for the first time. And yet there seems little likelihood of it being extracted from its cramped conditions. Although staff seem depressed about physical conditions, they continue to provide what is still regarded by many as 'simply the best' treatment of its kind.



Most of the patients are under 25

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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).

G M BEBB
SH20
B517 AFH
Ext 6132

9 January 1980

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

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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 }

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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 Team
 - Dr Rue - RMO Oxford Region
- Committee*

DHSS

- Mr James Collier (Chairman)
- Mr G Bebb
- Mrs P Patrie
- 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, Stanmore (24 beds due for completion by mid-1982), and Clacknock (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 the Royal National Hospital, subject to suitable financial arrangements being made. It is suggested that such a unit should be available for the region within 5 years.

iii. Pattern of Provision 1980-1990

	1980	1983	1985	1990 _a
Stoke Mandeville	National 150 Operational 136	136	110) New Bldg 26) Old Ward	110
Odstock	-	50	50	50
RNOH	-	24	24	24
New Unit SE Thames (T 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 recent has been taken on 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 units at Stoke Mandeville so that there is no diminution of bed availability following the completion of the new 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 (RH3) to the Region conveying agreement to the principle 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 consultation on behalf of the Region or the Authority as wished.

? with whom
re draft

6. Dr Roe reported that a Joint Regional/Army/RAF task group had been established to look at the requirements of Stoke Mandeville Hospital and other units. The first meeting was held on 11th July 1971.

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 specialty 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. DRSS to confirm agreement in principle to North East Thames RHA for the creation of a 50-bed unit in the North East Thames region with the RHA's proposals as requested by the RHA and other groups. (1/8) (para 4 subject)

- X
- ii. DHSS 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.

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4 January 1980

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OXFORD REGIONAL HEALTH AUTHORITY

THE NATIONAL SPINAL INJURIES CENTRE

STOKE MANDEVILLE HOSPITAL

THE NATIONAL SPINAL INJURIES CENTRE

STOKE MANDEVILLE HOSPITAL

INTRODUCTION

The Centre, situated at Stoke Mandeville Hospital, Aylesbury, is administered by the Buckinghamshire Area Health Authority. It was set up in 1944 by Sir Ludwig Guttmann, who pioneered the treatment of spinal cord injuries in servicemen injured during World War II. Until then, the outlook for these patients was regarded as fairly hopeless.

Originally the Centre was run by the Ministry of Pensions and at one stage reached a maximum of about 200 beds. In the early 1950s, the Centre was taken over by the National Health Service and at the present time there are 156 inpatient beds and 30 hostel beds. The Centre treats on average about 700 inpatients and 2,000 outpatients per annum.

SPINAL CORD INJURY

"Spinal Cord Injury" is the term which refers to complete or partial transection of the spinal cord, either as a result of trauma (when it is often associated with fractures of the spinal vertebrae) or when other disease processes affect the spinal cord, e.g. tumour.

This results in patients being paralysed from the level of the injury downwards, with an accompanying impairment of sensation. Patients are also usually incontinent of urine and faeces. Patients with spinal cord injury with an associated head injury are not admitted to the Stoke Mandeville Centre until the head injury has been stabilised. Separation from the Regional Neurosurgical service

does present problems in the management of patients with accompanying head injury.

The main problems in the treatment of spinal cord injury are :

- (1) the management of the spinal vertebrae injuries and of associated injuries
- (2) the management of long periods of immobilisation on traction to stabilise fractures
- (3) the provision of early rehabilitation
- (4) the prevention and treatment of kidney damage due to inactivity and infection
- (5) the prevention and management of pressure sores
- (6) the prevention and treatment of contractures
- (7) the prevention and treatment of psychiatric problems
- and (8) the provision of supportive after-care.

Treatment includes both medical and surgical treatment.

The work of identifying and managing these problems was pioneered at the Stoke Mandeville Centre.

THE INCIDENCE OF SPINAL CORD INJURY

Most of the internationally published work has been descriptive and usually on the work of a particular spinal cord injury unit. A few surveys have been conducted to establish the incidence of traumatic spinal cord injury but only one or two have been comprehensive and with a defined population base Table 1.

Surveys in Switzerland¹ and Norway², which both covered the whole country, give an annual incidence of 13.4 traumatic cases/million population and 16.6 traumatic cases/million population in 1968 and 1975 respectively. Other surveys have given incidences of traumatic spinal cord injury ranging from 12.7 to 33.2 million³⁻⁸ Table 1. It has been generally accepted that the incidence of traumatic spinal cord injury, in Western Countries, is of the order of 15-20/million population per year.

BED PROVISION

Provision of inpatient hospital beds varies in Western Countries from 7 per million population to 13 per million population Table 2.

INCIDENCE AND BED PROVISION IN ENGLAND AND WALES

No recent surveys can be found which give estimates of the incidence rates of spinal cord injury in the United Kingdom. Generally an incidence rate for traumatic spinal cord injuries of 15-20 million/per year has been used for planning purposes. However, this survey based on inpatients at the Spinal Injury Centre at Stoke Mandeville Hospital and described later in this report suggests an annual incidence based on the population of the Oxford Regional Health Authority of 8.1 traumatic cases/million population per year.

Bed provision in England and Wales is shown in Map 1 and Table 3. In England, although regionally, bed provision varies considerably, the present position is that there is a fairly equal division between the North and South of the country, with 8.5 and 6.6 beds/million population respectively. When the new Unit at Odstock in the Wessex Region, consisting of about 50 beds, is opened, the South of England will have a slightly higher provision of 8.7 beds per million population. The main problems, of course, in the South, are distance and transport for both patients and relatives especially for people living in the South West and for those having to cross London from the South East.

THE NATIONAL SPINAL INJURY CENTRE
STOKE MANDEVILLE HOSPITAL, AYLESBURY

Report of a study carried out on all new admissions during the years 1976/77 and 1977/78 and a sample of all readmissions during those two years.

A description of the work of the Unit is given in the following form :

- 1 Introduction
- 2 Workload - a description of the patients treated at the Centre
- 3 Manpower involved in provision of the service
- 4 An assessment of future bed requirement
- 5 Summary.

INTRODUCTION

SURVEY

To obtain a complete and factual picture of the work of the Centre, a case-note survey was carried out. Hospital Activity Analysis data is not collected at hospitals in the Aylesbury Health District. The survey covered :

1. ALL NEW ADMISSIONS, for the two years 1976/77 and 1977/78.

The actual periods covered were :

1 April 1976 - 31 March 1977

and 1 April 1977 - 31 March 1978.

2. A SAMPLE OF ALL READMISSIONS during the same period. The sample months were May and October 1976 and 1977.

Readmissions during these months were thought to be representative of the cases admitted throughout the year.

3. ALL PRIVATE PATIENTS admitted during the same two year period. All these were first admissions.

POPULATION SERVED

At present the Stoke Mandeville Centre serves the whole of the South of England. For the purposes of this report, the South of England is defined as the area covered by the following Regional Health Authorities; South Western, Wessex, Oxford, East Anglia and the four Thames Regions.

INCIDENCE OF SPINAL CORD INJURY

It is most probable that all patients following spinal cord injury are admitted to hospital and a number of alternative courses of action are possible :

1. Admission to a local district general hospital under the care of traumatic and orthopaedic surgeons, neurologists or neurosurgeons, for the whole period of treatment and rehabilitation.
2. Admission to a local district general hospital followed some time later by transfer to the Spinal Injuries Centre at Stoke Mandeville (or to other Spinal Injury Units).
3. Direct admission to the Spinal Injury Centre at Stoke Mandeville (or to other Spinal Injury Unit) for the whole period of treatment and rehabilitation.

At present it is assumed that (2) and (3) occur more frequently than (1). However no definite information on this is available. The number of admissions of new traumatic cases of spinal cord injury to Stoke Mandeville is used to estimate the incidence of traumatic

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At present it is assumed that (2) and (3) occur more frequently than (1). However no definite information on this is available. The number of admissions of new traumatic cases of spinal cord injury to Stoke Mandeville is used to estimate the incidence of traumatic

spinal cord injury. No information is available on patients with traumatic spinal cord injury who never get to the Stoke Mandeville Centre and who reside in the South of England. Average number of first admissions per million population to the Stoke Mandeville Centre by Region of Residence is shown on Table 4. The overall admission rate of 4.67 per million population for new traumatic cases from the South of England is well below the expected 15-20 million referred to previously. The admission rate for Oxford Region residents is much higher at 8.05 per million. It could be assumed that all cases of traumatic spinal cord injury occurring to residents of the Buckinghamshire Area would be admitted to the Stoke Mandeville Centre. During the two years of the study there were, on average, five new traumatic admissions per year from the Area giving an admission rate of 10.4 per million population. As the number of admissions is small the reliability of this admission rate is dubious. It should be pointed out that Buckinghamshire like the Oxford Region does not have any major centres of heavy industry or a coastline - both important factors in the incidence of spinal cord injury. It seems likely therefore that some patients mostly from outside the Oxford Region are being treated wholly in their local hospitals and are not being transferred to Stoke Mandeville for rehabilitation. This seems especially true the further away the patient's home is from the Stoke Mandeville Centre and points to the difficulty in providing a service for patients from the South West.

During the period of the study the Spinal Injury Centre was under considerable pressure because of shortage of nurses thus a portion of the beds were continually out of use. This resulted in a policy of selective admissions and a considerable number of first admissions had to be refused or delayed. During the calendar years 1976-1978

about 11 patients, on average, died whilst waiting for admission to the Stoke Mandeville Centre. Delay and refusal to admit patients with traumatic spinal cord injury did inhibit doctors from seeking admission of their further patients. This may help to explain the lower admission rates from outside the Oxford Region.

It must also be pointed out that because of the workload on the Centre a proper system of review and check-up of patients has not been carried out. If this were instituted it would eventually lead to more readmissions - thus making a requirement for additional beds. One other factor which is of importance is the fact that with better rehabilitation patients with traumatic spinal cord injury are living much longer and have a life span almost approaching that of normal people. The older these patients become the greater the need for services and especially for short periods of readmission - this has been evident in recent years with the cohort of ex-servicemen with spinal cord injury who are now in age range 55 to 70.

It is considered that admission rates for pathological spinal cord injury patients depends mostly on clinical practice. The lower admission rate for both traumatic and pathological patients from the North of England is as one would expect - the North of England having its own Spinal Injury Units and a higher bed provision than the South

WORKLOAD OF THE CENTRE

CASE-NOTE SURVEY

There were 170 and 147 new National Health Service admissions in 1976/77 and 1977/78 respectively, the two study years. All the 1976/77 notes were examined, but 5 of the case-notes of the 147 admissions in 1977/78 were lost (96% ascertainment) Tables 5a and 5b.

Statistics from the Centre show that there were 521 and 540 readmissions during the two study years. All the notes from the two sample months, May and October in each year, were examined (100% ascertainment) and these amounted to 94 notes in 1976/77 and 102 in 1977/78. Of the 45 and 47 private patients admitted during the two study years, 41 and 43 case-notes respectively were examined.

Table 5b shows the distribution of all first admissions by type of spinal cord injury and age and sex. This shows that the number of females admitted in each year (36 and 35) is small when compared to male admissions. As the number of females is small data on females are only included in tabular form when useful details or trends can be identified.

FIRST ADMISSIONS

Age/Sex Structure/Place of Residence

The distribution of first admissions by age and sex is shown in Table 6. First admissions accounted for about 22% of all admissions. Just over one-fifth of first admissions were females. In both sexes, just about half the patients were under 30 years of age. About 15%

of patients came from the Oxford Region, 50% from the four Thames Regions, about 29% from the rest of England, and 6% from abroad Table 7.

Cause of Injury Table 8

44 (33%) and 55 (48%) of male admissions during the two years respectively were from road traffic accidents and of these over 60% were under 30 years of age. This means that of all new male admissions, between one-quarter and one-third were due to road traffic accidents in the under 30 age group. Four and 7 male admissions in the respective years were from accidents at home. Accidents at work accounted for 23 and 9 male admissions respectively while sports injuries, including motor sports injuries, accounted for 9 and 12 male admissions. 25 (19%) and 18 (16%) of male admissions respectively were the result of pathological causes. Female admissions followed a similar pattern, except that there were no admissions resulting from accidents at work, and admissions resulting from pathological causes were a higher proportion of the total. Generally "falls" accounted for most of the accidents at work, at home, and "other" in both sexes.

Latent Period Between Onset and Admission to Stoke Mandeville Centre

Following a traumatic spinal cord injury, there may follow a considerable period of time before transfer to the Spinal Injuries Centre at Stoke Mandeville from the hospital of first admission. Although in 1977/78 over 40% of male admissions waited less than one week (some were admitted directly), 30% had to wait one month or more. These figures show a considerable improvement on the previous year's figures Table 9. The most striking feature of this

table is that it shows that very few patients resident in the Oxford Region had to wait more than a month before admission to Stoke Mandeville Spinal Injuries Centre.

Associated Injuries

Spinal cord injury resulting from trauma can be expected to be accompanied by other injuries, and this is so for about half the patients Table 10. The table shows that those aged under 30 do not appear to have more associated injuries than the other age groups. Table 8 shows that about half the males in the under 30 age group were suffering from road traffic accidents.

Additional Relevant Conditions

Patients were given a score for each additional condition - pressure sore, indwelling catheter, tracheostomy, use of respirator, psychiatric history - present on admission. Table 11 shows the longer the time taken to transfer the patient whose spinal cord injury resulted from trauma the greater the chance of an additional complication being present. Those patients whose spinal cord lesion resulted from pathological conditions had fewer complicating conditions. Of the total of 69 patients with a pathological spinal cord injury admitted over the two years nearly 60% had only one complicating condition on admission (this was mostly an indwelling catheter) and there were no patients with three or more complicating conditions.

Length of Stay

The mean length of stay for traumatic cases was 190 days for both sexes - 193 days for males and 177 days for females. The mean length of stay for pathological cases was 126 for both sexes which is considerably shorter than for traumatic cases Tables 12a and 12b.

Complications developing whilst in Spinal Injury Centre

Data were collected as to whether pressure sores, contractures, or psychiatric conditions requiring psychiatric consultation, developed during the period of stay at Stoke Mandeville as shown in Table 13. Five patients in 1976/77 and 4 in 1977/78 developed pressure sores whilst in the Centre. Twenty-one patients in 1976/77 and 22 patients in 1977/78 received psychiatric consultation.

Operations

Some of the major problems in the care of spinal cord injury patients are the prevention of pressure sores, and care of the urinary system. These problems are reflected in the number of operations performed. Nineteen and 24 patients respectively had operations for pressure sores in the two years (most patients having developed the sores before admission). Operations on the urogenital system were performed on 64 and 56 patients in the two years respectively Table 14. In all 44% and 49% of patients required an operation in the two years Table

Disposal

Most patients are settled at home following treatment and rehabilitation although often the home has to be adapted, sometimes considerably. 120 and 22 patients who were transferred in the two respective years to their original admitting hospitals were generally fully rehabilitated but awaiting appropriate accommodation in the community Table 16.

READMISSIONS

Introduction

There were 94 and 102 readmissions during May and October combined in 1976/77 and 1977/78 respectively. Readmissions account for over 70% of all admissions Table 5a.

Age/Sex Structure

12% and 25% of readmissions were female in the two study years. There is a marked contrast in the age of the readmissions of both sexes compared with first admissions in that more than 50% of the readmissions were in the 30-59 age group Table 17. 9-13% of readmissions live in the Oxford Region, 38-50% live in the four Thames Regions, and up to 6% abroad Table 18.

The general pattern of reasons for readmission is shown for the two years by age and sex in Tables 19a and 19b. Tables 20a and 20b show the reasons for readmission by length of stay. These tables show that :

1. I.V.P. and check-up with overnight stay was the reason in about 50% of cases and for the bulk of the one and two-day lengths of stay
2. Treatment and surgery for pressure sores accounted for 20% of readmissions, and for the bulk of more than one week stay.

28-31% of readmissions have an operation performed on them. Just over half the operations are on the urogenital system, and 26% are for pressure sores Table 21.

Almost all patients return home Table 22.

PRIVATE PATIENTS

Forty-five and 47 private patients were admitted in 1976/77 and 1977/78 respectively. These patients accounted for 6% of all admissions. Patients were admitted from Europe, Africa, Asia and South America. Saudi Arabia accounted for the highest proportion (19%). 62% of patients were admitted following a road traffic accident, although admission was often only after many months had elapsed since the accident. Generally these patients were in poor condition following inadequate rehabilitation. The Arab Countries sent mostly road traffic accidents Table 23.

MANPOWER

These figures are as at 1.9.79

- MEDICAL
- 3 Consultants 3 whole-time equivalents
- 1 Consultant vacancy
- Visiting Consultants - 5 sessions
- 1 Senior Registrar
- 1 Medical Assistant
- 1 Registrar full-time
- 1 Registrar part-time - 6 sessions
- 3 Senior House Officers
- 1 Locum Senior House Officer
- 1 Senior House Officer part-time - 6 sessions

NURSING DAY-TIME	Establishment	In post
Nursing Officer	1	1
Sister/Charge Nurse	13	12.9
Clinical Teacher	1	1
Staff Nurse	11.4	8.9
Post Basic	12	6
Sen. Enrolled Nurse	2.8	1.8
Enrolled Nurse	14	8
Nursing Auxilliary	15.9	17.1
Orderly	63	59
NURSING NIGHT-TIME	12.5	6 at 5.12.79

PHYSIOTHERAPY

	Hosp. Dept. Establishment wte.	Hosp. Dept. In Post wte.
Superintendent Grade I	1	1
Grade III	1	0
Senior I	3	3
Senior II	6	6
Basic	15	13.7
Remedial Gymnast Senior I	1	1
Aides	2	2
Typist	0.5	0.5
Totals	29.5	27.2 whole-time equivalents

Proportion of staff working on Spinal Injuries Centre = 50% 14 whole-time equivalents

OCCUPATIONAL THERAPY

	Dept. Establishment wte.	Dept. In Post wte.	Total Hours in Spinal Centre
Head Grade III	1	1	36
Senior	1	1	36
Senior II	2.5	2.5	162
Basic	3	2	
Helper	2.5	2.5	90
Technical Instructor	1.5	0.5	18
Totals	11.5	9.5	342

Proportion of staff working on Spinal Injuries Centre = 4.7 whole-time equivalents

ADMINISTRATIVE AND CLERICAL - The Centre's Medical Records Department is separate from the Hospital's Medical Records Department and is run by the Centre's administrative and clerical staff.

	Establishment	In Post
G.A.	1	1
H.C.O.	1	1
Personal Secretary	2.7	2.7
Clerical Officer	1	1

DOMESTICS

All grades 12 whole-time equivalents on wards

SWIMMING POOL ATTENDANT 1.25 1

MEDICAL SOCIAL WORKER 2 1.5

FUTURE REQUIREMENTS FOR SPINAL CORD INJURY BEDS
FOR THE SOUTH EAST OF ENGLAND AND BASED ON THE
ADMISSION RATES TO STOKE MANDEVILLE HOSPITAL

An estimate of the total bed requirement is shown below given that (1) the present rate of admissions remains the same and (2) there is a bed occupancy of 90% - this is considered reasonable in view of the length of stay.

1. NHS, FIRST ADMISSIONS, TRAUMATIC, SOUTH EAST ENGLAND

If the Wessex and South Western Regions (for convenience, here called South West England) are served by the proposed new unit at Odstock, then the Stoke Mandeville Centre will have a primary responsibility to the rest of the South of England, i.e. the Oxford, the four Thames and East Anglia Region (called here South East England).

Table 4 shows that the average annual

number of patients admitted from here is

92 cases per year

If the mean length of stay is

190 days this will produce 17,480 bed days

At 90% bed occupancy a total of 19,422 bed days

which will require a total of

53 beds

2. NHS, FIRST ADMISSIONS, TRAUMATIC, REST OF ENGLAND

Although there are spinal units in the North of England it is assumed that Stoke Mandeville will continue to admit a small proportion of patients at the same rate from the North of England as it does at present. It is also assumed that patients will be admitted from the Wessex and South Western Regions at the same rate as from the North, after the Odstock Unit is opened.

Admission rate of new traumatic patients from the North of England

0.39 cases per million population

Population of South West England and North of England

28,602,000

Average annual number of admissions from this Area will be

11 cases per year

If the mean length of stay is

190 days this will produce 2,090 bed days

At 90% bed occupancy a total of

2,322 bed days

which will require a total of

6 beds

3. NHS, FIRST ADMISSIONS, TRAUMATIC, RESIDENT ABROAD

There are 6 such cases per year.

If the mean length of stay is

190 days this will produce 1,140 bed days

At 90% occupancy a total of

1,267 bed days

which will require a total of

4 beds

4. NHS, FIRST ADMISSIONS, PATHOLOGICAL, SOUTH EAST ENGLAND

It is assumed that pathological cases will continue to be admitted at the same rate as at present.

Average annual admissions from this

Area amount to

26.5 cases per year

If the mean length of stay is

126 days this will produce 3,339 bed days

At 90% bed occupancy a total of

3,710 bed days

which will require a total of

10 beds

5. NHS, FIRST ADMISSIONS, PATHOLOGICAL, REST OF ENGLAND

It is assumed that following the completion of the Odstock Unit, admissions to Stoke Mandeville from South West England will occur at the same rate as from the North of England.

Admission rate from North of England 0.07 cases per million

population per year

Population of South West England and

North of England 28,602,000

Average annual number of admissions

from this Area will amount to 2 cases per year

If the mean length of stay is

126 days this will produce 252 bed days

At 90% bed occupancy a total of 280 bed days

which will require a total of 1 bed

6. NHS, FIRST ADMISSIONS, PATHOLOGICAL, RESIDENT ABROAD

There were 3.5 cases per year admitted.

If the mean length of stay is

126 days this will produce 441 bed days

At 90% bed occupancy a total of 490 bed days

which will require a total of 1 bed

7. NHS, READMISSIONS, SOUTH EAST ENGLAND

Again, it is assumed that readmissions will continue at the same rate as present

Average annual number of readmissions

is 336 cases per year

If the mean length of stay is

20.9 days this will produce 7,022 bed days

At 90% bed occupancy a total of 7,803 bed days

8. NHS, READMISSIONS, REST OF ENGLAND

It is assumed that Stoke Mandeville will readmit patients from South West England at the same rate as from the North of England.

Readmission rate from North of

England

5.2 cases per million

population per year

Population of South West England

and North of England 28,602,000

Therefore the number of readmissions

will be 150 cases per year

If the mean length of stay is

20.9 days this will produce 3,135 bed days

At 90% bed occupancy a total of 3,483 bed days

which will require a total of 10 beds

9. NHS, READMISSIONS RESIDENT ABROAD

It is assumed that Stoke Mandeville will continue to readmit patients from abroad at the same rate as at present

Average annual number of

readmissions from abroad 18 cases per year

If the mean length of stay is

20.9 days then this will produce 376 bed days

At 90% bed occupancy a total of 418 bed days

which will require a total of 1 bed

10. PRIVATE PATIENTS

It is assumed that these patients will continue to be admitted at the same rate as present.

Average annual number of admissions	46 cases per year
If the mean length of stay is	
111 days this will produce	5,160 bed days
At 90% bed occupancy a total of	5,733 bed days

which will require a total of 16 beds

Total Bed Requirement = 123 beds approximately.

Following the building of the Unit at Odstock, the number of beds required to serve the catchment population of the South East of England will be 123 beds approximately.

A review of the world literature shows an incidence rate of traumatic spinal cord injury of 15-20 per million population per annum. This case-note study of two years new admissions to Stoke Mandeville Hospital shows an admission rate for Oxford Regional Health Authority residents of 8.1 traumatic cases per million per year and an admission rate of 5.2 per million per annum based on the population of the South East of England. This would indicate that the further patients reside from the centre of treatment the less likely they are to be referred for rehabilitation. Using the present admission rates and readmission rates of both traumatic and non-traumatic spinal cord injury patients to the Stoke Mandeville Centre and the admission rates of private patients it would seem that the future bed requirement to serve the envisaged catchment population of the Stoke Mandeville Centre is in the order of 123 beds, i.e. 107 National Health Service and 16 Private beds.

This does not account, as stated previously, for an increasing population or an increasing incidence of traumatic spinal cord injury. The latter is likely as the trend for all accidents and especially for road traffic accidents is rising. It also seems likely that new forms of rehabilitation will not significantly reduce the length of stay. Thus 123 beds is considered to be a minimum estimate and based on these admission rates 140 beds would seem more appropriate.

The other factor which must be considered is the large geographical variation in admission rates to Stoke Mandeville Hospital Table 4. It has been shown that the Regions furthest from the Centre but within the catchment area have the lowest admission rates. It is considered that this represents an 'unmet need' for spinal cord injury rehabilitation and points to the need for more local services. If more local services were to be provided then it would be expected that the present Oxford Region admission rate for traumatic cases of 8.1 per million/annum would apply to the future total catchment population of Stoke Mandeville Centre namely Oxford, East Anglia and the four Thames Regions (17,610,000). The total annual number of admissions would then be in the order of 143 traumatic cases which with average length of stay of 190 days and with a 90% bed occupancy would require 83 beds (not 53). If this were to happen then the total bed requirement for the population of the South East of England would be in the order of 170 beds approximately, i.e. 140 plus 30.

Bed requirement is also dependent on an adequate supply of hostel or 'half-way' places sited near the patients' places of residence.

Thirty hostel places are provided at Stoke Mandeville and are reserved mainly for patients resident in the Buckinghamshire Area. Blockage of spinal cord injury beds does frequently occur due to inadequate hostel accommodation throughout the South of England.

SUMMARY

A review of the literature shows an annual incidence rate for traumatic spinal cord injury of 13-33 cases per million population. This survey of all new traumatic cases to the Spinal Injuries Centre at Stoke Mandeville Hospital gives an incidence rate of 8.1 per million population for Oxford Region's residents and an incidence of 5.2 per million for the population of the South East of England. These incidence rates are based on the number of first admissions of traumatic spinal cord injury during a two year period 1976-1978. The data show wide geographic variation in admission rates of new cases and clearly indicates that the further patients reside from the Spinal Injury Centre the less likely they are to be admitted there. There is obviously an 'unmet need' for spinal cord injury rehabilitation in the South East of England and patients are either being rehabilitated elsewhere or not being rehabilitated at all. Using the present admission rates for traumatic and pathological spinal cord injury cases and the present readmissions rates for both types of patient and the mean length of stay an estimate of future inpatient bed requirement for the population of the South East of England is calculated to be in the order of 170 beds. Some of these beds should be provided South of the Thames as there is evidence from the present referral rates that patients from there are not being referred to the Stoke Mandeville Centre. Analysis of the first admissions and readmissions shows that first admissions accounted for about 22% of all admissions and about one-fifth of first admissions were female. About 50% of all first admissions were aged under 30, 15% were resident in the Oxford Document 06. Page 101

Region and about 50% were resident in the four Thames Regions.

Between one-third and one-half of all male first admissions resulted from road traffic accidents and more than half of these were under 30 years of age. Female admissions followed a similar pattern.

The latent period between onset of injury and admission to the Stoke Mandeville Centre varies considerably but in 1977/78 30% of males had to wait more than one month before admission. Patients resident in the Oxford Region were admitted more promptly on the whole. It is evident that the longer the interval before admission to Stoke Mandeville the greater the chance of additional complications being present on admission.

The mean length of stay for all traumatic cases was 190 days - 193 days in men and 177 days in women. In patients with pathological spinal cord injury the mean length of stay was shorter at 120 days. Few complications developed after admission to Stoke Mandeville but a considerable proportion of patients had to have operations performed on them for pressure sores (present on admission) and for urological reasons. Most first admissions were discharged home.

Readmissions accounted for about 70% of all admissions and were different from first admissions in age structure in that more than 50% were in the 30-59 age group. The main reasons for readmission were check-up and urological investigation. Treatment of pressure sores accounted for 20% of readmissions. The median length of stay of readmissions was 8.6 days.

Private patients accounted for about 6% of all admissions - almost one-fifth of them coming from Saudi Arabia. These patients were generally in poor condition and many months had elapsed since their injury. The mean length of stay of these patients was 111 days.

TABLE 1

INCIDENCE RATES OF TRAUMATIC SPINAL CORD INJURY
AND REFERENCES

		Country	Incidence rate/ million population
1.	Gehrig, R and Michaelis, L S Paraplegia 5, 93-95	1968 Switzerland	13.4
2.	Gjone, R and Nordie, L Paraplegia 16, 88-93	1978 Norway	16.5
3.	Minaire, P., Castanier, M., Gerard, R., Berard, E., Deidier, C and Bourret, J Paraplegia 16, 76-87	1978 France	12.7 - 19.2
4.	Kraus, J F., Franti, C E., Riggins, R S., Richards, D and Bormani, N O J. Chron. Dis. 28, 471-492	1975 USA	33.2
5.	Tusji, S and Fujishama, H referred to in Paraplegia 16, 76-86	1975 Japan	27.1
6.	Key, A G and Retief, P J M Paraplegia 7, 243-249	1970 S. Africa	16.7
7.	Sutton, N G Injuries of the Spinal Cord - the management of Paraplegia and Tetraplegia, Butterworth, London	1973 Brisbane, Australia	14.4
8.	Cheshire, D J E Proc. 16th Annual Clinical S.C.I. Conf., V.A. Hosp., Long Beach, California, Sept. 27-29, pp. 39-49	1967 Victoria, Australia	17.1

TABLE 2

INTERNATIONAL COMPARATIVE BED PROVISION

COUNTRY	POPULATION	BEDS	BEDS/MILLION
Switzerland	3 million	30	10
France: Lyon	7 million	90	13
Toulouse	6 million	40	7
England	50 million	349	7
Wales	2.8 million	48	17
South of England	23½ million	154	7

TABLE 3

BED PROVISION IN SPINAL UNITS IN ENGLAND AND WALES 1979
(also see map)

	BEDS		BEDS/MILLION POP.	
	PRESENT	FUTURE	PRESENT	FUTURE
HEXHAM	20		6.4	
WAKEFIELD	31		8.7	
SOUTHPORT	35		5.5****	
SHEFFIELD	64		14.2	
OSWESTRY	45		8.7	
NORTH OF ENGLAND	195		7.6	
STOKE MANDEVILLE ODSTOCK	156	50 (projected)	6.6*	8.7** 8.8****
SOUTH OF ENGLAND	154	204	6.5	8.7
STANMORE		20 proposed (? mainly research)		
WALES	48		17.3	
ENGLAND AND WALES	397	467	8.1	9.5

NOTES: Beds/million population has been calculated assuming that each unit serves its own region, except where stated below.

* Stoke Mandeville Hospital. This figure has been calculated on the assumption that the Centre serves the South of England, i.e. Oxford, the Thames, East Anglia, Wessex and South Western Regions

** Stoke Mandeville Hospital. This figure has been calculated on the assumption that the Centre will in future serve the South East of England, i.e. Oxford, the Thames and East Anglia Regions

*** Odstock. This figure has been calculated on the assumption that the Unit will serve the South West of England, i.e. Wessex and South Western Regions

**** Southport. This figure has been calculated on the assumption that the Unit serves the North Western and Mersey Regions

Region	Population (000's)	Average number of patients per year		Admission rates per million population per year			
		Traumatic	Pathological	All	Admission rates per million population per year		
					Traumatic	Pathological	All
ORHA	2,237	18.0	5.5	23.5	8.05	2.45	10.5
Thames Regions	13,685	66.0	20.0	86.0	4.80	1.48	6.28
East Anglia	1,827	8.0	1.0	9.0	4.38	0.55	4.93
South East England	17,749	92	26.5	118.5	5.22	1.50	6.72
Wessex	2,698	8.0	1.0	9	3.00	0.38	3.38
South Western	3,006	9.5	1.0	10.5	3.16	0.33	3.49
Total South of England	23,453	109.5	28.5	138.0	4.67	1.22	5.89
West Midland	5,154	2.5	0.5	3.0	0.49	0.10	0.59
Trent	4,509	1.5	0.5	2.0	0.33	0.11	0.44
Mersey	2,476	-	-	-	-	-	-
North Western	4,071	1.5	0.5	2.0	0.37	0.12	0.49
Yorkshire	3,572	2.5	-	2.5	0.70	-	0.70
Northern	3,116	1.0	-	1.0	0.32	-	0.32
Total North of England	22,898	9.0	1.5	10.5	0.39	0.07	0.46
Wales	2,762	-	1.0	1.0	-	0.36	0.36

Total Population 49,113
 Population for survey mid-1977 estimate taken
 from OPCS PPI/79/6

TABLE 5a

SPINAL INJURIES - ALL ADMISSIONS
NUMBER OF ADMISSIONS

	1976/77	1977/78
FIRST ADMISSIONS	170	153
READMISSIONS	521	540
PRIVATE	45	47
TOTAL ADMISSION	736	740

NUMBER OF CASENOTES EXAMINED

FIRST ADMISSIONS

	M	F	T	% Ascertainment
Full Year 1976/77	134	36	170	100
Full Year 1977/78	112	35	147	96
TOTAL	246	71	317	

READMISSIONS - Sample Survey May and October

	M	F	T	% Ascertainment
1976/77	83	11	94	100
1977/78	76	26	102	100
TOTAL	159	37	196	

TABLE 5a (contd.)

PRIVATE PATIENTS - All new admissions

	M	F	T	% Ascertainment
1976/77	32	9	41	91
1977/78	35	8	43	92
TOTAL	67	17	84	

TABLE 5b

SPINAL INJURIES - ALL FIRST ADMISSIONS
 Traumatic and Pathological Patients by Age and Sex

1976/77		AGE GROUPS			TOTAL
		0-29	30-49	50+	
Traumatic	M	56	37	16	109
	F	9	3	11	23
	T	65	40	27	132
Pathological	M	7	9	9	25
	F	4	4	5	13
	T	11	13	14	38
TOTAL		76	53	41	170

1977/78		AGE GROUPS				TOTAL
		0-29	30-49	50+	N/S	
Traumatic	M	58	20	16	-	94
	F	10	4	8	-	22
	T	68	24	24	-	116
Pathological	M	4	7	6	1	18
	F	2	8	3	-	13
	T	6	15	9	1	31
TOTAL		74	39	33	1	147

TABLE 6

SPINAL INJURIES - ALL FIRST ADMISSIONS

Age, sex breakdown (%)

AGE GROUPS	1976/77			1977/78		
	M	F	T	M	F	T
0-19	29 (22)	8 (22)	37 (22)	28 (25)	8 (23.5)	36 (24)
20-29	34 (26)	5 (14)	39 (23)	34 (30)	4 (11)	38 (26)
30-39	28 (21)	4 (11)	32 (19)	14 (12)	4 (11)	18 (12)
40-49	18 (13)	3 (8)	21 (12)	13 (12)	8 (23.5)	21 (14)
50-59	14 (10)	6 (17)	20 (12)	13 (12)	7 (20)	20 (14)
60-64	3 (2)	4 (11)	7 (4)	3 (3)	-	3 (2)
65+	8 (6)	6 (17)	14 (8)	6 (5)	4 (11)	10 (7)
N/S	-	-	-	1 (1)	-	1 (1)
TOTAL	134 (%)	36 (%)	170 (%)	112 (%)	35 (%)	147 (%)

Figures in () are percentages

TABLE 7

SPINAL INJURIES - FIRST ADMISSIONS

Place of Residence

Region of Residence	1976/77			1977/78		
	Male	Female	Total	Male	Female	Total
Oxford	19 (14.2)	6 (16.7)	25 (14.7)	18 (16.0)	4 (11.4)	22 (15.0)
N E Thames	14 (10.4)	2 (5.6)	16 (9.4)	17 (15.1)	6 (17.2)	23 (15.6)
S E Thames	19 (14.2)	7 (19.4)	26 (15.3)	16 (14.3)	4 (11.4)	20 (13.6)
N W Thames	17 (12.7)	8 (22.1)	25 (14.7)	13 (11.6)	7 (20.0)	20 (13.6)
S W Thames	12 (9.0)	5 (13.9)	17 (10.0)	16 (14.3)	5 (14.3)	21 (14.3)
London (not stated)	3 (2.2)	1 (2.8)	4 (2.4)	-	-	-
Wessex	9 (6.7)	- (0.0)	9 (5.3)	7 (6.3)	-	7 (4.8)
East Anglia	9 (6.7)	1 (2.8)	10 (5.9)	8 (7.1)	-	8 (5.4)
South Western	11 (8.2)	3 (8.3)	14 (8.2)	5 (4.5)	2 (5.7)	7 (4.8)
Other Regions	12 (9.0)	2 (5.6)	14 (8.2)	7 (6.3)	3 (8.6)	10 (6.8)
Abroad	9 (6.7)	1 (2.8)	10 (5.9)	5 (4.5)	4 (11.4)	9 (6.1)
Total	134	36	170	112	35	147

Figures in () are percentages

TABLE 8

SPINAL INJURIES - FIRST ADMISSIONS

Cause of Admission by Age

MALES

AGE CAUSE	1976/77				1977/78				
	0-29	30-	50+	TOTAL	0-29	30-	50+N/	STOTAL	
R.T.A.	29	10	5	44	40	9	6	-	55
Accident at home		2	2	4		2	5	-	7
Accident at work	9	10	4	23	4	4	1	-	9
Sports Injury	5	4		9	11	1		-	12
Pathological	7	9	9	25	4	7	6	1	18
Other	13	11	5	29	3	4	4	1	11
TOTAL	63	46	25	134	62	27	22	1	112*

FEMALES

Of the 71 patients admitted during the two years, 29 cases resulted from R.T.A., 26 from Pathological Conditions, 9 from other causes and 5 Sport Accidents, 2 Accidents at Home.

SPINAL INJURIES - FIRST ADMISSIONS
(TRAUMATIC MALES ONLY)

Region of Initial Hospitalisation by Latent Period and Year

REGION OF FIRST ADMISSION	1976/77				1977/78				TOTAL
	< 1 week	1-3 weeks	1-3 months	> 3 months	< 1 week	1-3 weeks	1-3 months	> 3 months	
Oxford	10	1	2	2	9	5			14
N W Thames	1	2	4	1	5	1	2		8
N E Thames	1	8	6	1	4	1	3		8
S E Thames	4	3	4	4	8	5	2	3	18
S W Thames	2	1	2	3	4	2	3	4	13
(Not Stated)				1	1	1			1
Wessex	2	3	1	1	5	1	1	1	8
South Western	1	3	2	1	1	3	2	2	7
East Anglia	4	1	2	3	3	4	1		8
All Other Regions	1	1	1	2	1			1	1
Outside England	2	8	5	3	2	3	3		8
TOTAL	28	30	29	22	40	26	17	11	94
%	26	28	27	19	42	28	18	12	100

Notes:

1. Latent Period = Date of Onset to Date Admitted to S.M.H.
2. Traumatic patients are all those whose injuries follow an accident - i.e. excluding those with pathological spinal lesions.

TABLE 10

SPINAL INJURIES - FIRST ADMISSIONS

Associated Injuries by Age and Year

TRAUMATIC MALES ONLY

	AGE GROUPS 1976/77				AGE GROUPS 1977/78			
	0-29	30-49	50+	TOTAL	0-29	30-49	50+	TOTAL
Spinal Injury only	32	18	9	59	32	11	10	53
Spinal plus Head Injury	8	4	2	14	9	2	2	13
Spinal plus Chest Injury	9	3	3	15	8	3	3	14
Spinal plus Head and Chest Injury	2	7	1	10	2	2	-	4
Spinal plus other Injury (Limbs etc.)	5	5	1	11	7	2	1	10
TOTAL	56	37	16	109	58	20	16	94

- NOTES: 1. Traumatic patients - those whose injury is following an accident - i.e. excluding pathological spinal lesions.
2. Associated injuries - injuries sustained at time of accident.

TABLE 11

SPINAL INJURIES - FIRST ADMISSIONS
(TRAUMATIC MALES ONLY)

Latent Period by Points Scale for Condition on
Arrival

SCORE

LATENT PERIOD	Score 0	1	2	3	4	5	TOTAL
<u>1976/77</u>							
< 1 week	4	24					28
1-3 weeks	5	16	9				30
1-3 months	12	9	8				29
3+	9	8	3	1	1		22
TOTAL	30	57	20	1	1		109
<u>1977/78</u>							
< 1 week	4	33	3				40
1-3 weeks	2	15	7	2	1		27
1-3 months	2	5	6		1	2	16
3+	6	2	2		1		11
TOTAL	14	55	18	2	3	2	94

Notes

1. Latent period = Date of onset to Date of Admission to S.M.H.
2. Points Scale. Each patient is given one point for any and each of the following conditions present on arrival to S.M.H.

Pressure Sore - present or developing

Catheter - Indwelling

Tracheostomy - Open or healed, but performed between
accident and admission S.M.H.

Respirator - Needed at any time between injury and
admission S.M.H.

Psychiatric - giving a history of contact with psychiatric
Consultation services before injury

TABLE 12a

SPINAL INJURIES

Traumatic cases length of stay by sex

Length of Stay	MALES		FEMALES		TOTAL	
	1976/77	1977/78	1976/77	1977/78	1976/77	1977/78
30 days	4	4	-	1	4	5
30 - 119 days	19	12	5	5	24	17
120 - 209 days	47	47	12	9	59	56
210 - 299 days	24	19	5	4	29	23
300 - 365 days	7	8	1	1	8	9
1 year +	7	3	-	2	7	5
Not stated	1	1	-	-	1	1
TOTAL	109	94	23	22	132	116
Median length of stay in days	180	179	171	173	177	
Mean length of stay in days	198	186	170	184	190	

TABLE 12b

SPINAL INJURIES

Pathological cases length of stay by sex

Length of Stay	MALES		FEMALES		TOTAL	
	1976/77	1977/78	1976/77	1977/78	1976/77	1977/78
< 30 days	3	3	2	1	5	4
30 - 119 days	14	7	4	7	18	14
120 - 209 days	5	4	4	2	9	6
210 - 299 days	3	4	-	2	3	6
300 - 365 days	-	-	1	-	1	-
1 year +	-	-	2	1	2	1
TOTAL	25	18	13	13	38	31
Median length of stay in days	93	112	141	105	101	
Mean length of stay in days	100	118	172	140	126	

TABLE 13

SPINAL INJURIES - ALL FIRST ADMISSIONS

Conditions Developing During Inpatient Stay

AGE	1976/77			1977/78		
	0-29	30-49	50+	0-29	30-49	50+
CONDITION						
Sores	3(4)	1(2)	1(2)	1(1)	1(3)	2(6)
Contractures			1(2)			
Psychiatric Consultation	7(9)	7(13)	7(17)	7(10)	9(23)	6(18)
NUMBER OF PATIENTS	76(100)	53(100)	41(100)	74(100)	39(100)	33(100)

Figures in () are percentages

TABLE 14

SPINAL INJURIES - ALL FIRST ADMISSIONS

Types of Operations

OPERATION	NUMBER OF OPERATIONS		NUMBER OF PATIENTS HAVING OPERATION	
	1976/77	1977/78	1976/77	1977/78
SKIN - Deslough/ Excision	42	25	19	24
TUR and/or DES	31	22	29	21
DILATATION	8	2	8	2
CYSTOSCOPY	16	23	15	20
LITHOLAPAXY	14	9	11	7
CIRCUMCISION	1	6	1	6
OTHER	21	27	17	24
TOTAL	133	114	100	104

SPINAL INJURIES - FIRST ADMISSIONS
 Number of operations carried out by sex and type of Spinal Injury

MALES

	1976/77			1977/78		
	Traumatic	Pathological	Total	Traumatic	Pathological	Total
Patients having no op.	64 (59)	12 (48)	76 (57)	46 (49)	9 (50)	55 (49)
" " 1 "	21 (19)	5 (20)	26 (19)	25 (26)	5 (28)	30 (27)
" " 2 "	14 (13)	7 (28)	21 (16)	13 (14)	2 (11)	15 (13)
" " 3+ "	10 (9)	1 (4)	11 (8)	10 (11)	2 (11)	12 (11)
MALE TOTAL	109	25	134	94	18	112
		<u>FEMALES</u>				
Patients having no op.	13 (57)	6 (47)	19 (53)	15 (68)	5 (38)	20 (57)
" " 1 "	9 (39)	3 (23)	12 (33)	7 (32)	3 (23)	10 (29)
" " 2 "	1 (4)	2 (15)	3 (8)	-	4 (31)	4 (11)
" " 3+ "	-	2 (15)	2 (6)	-	1 (8)	1 (3)
FEMALE TOTAL	23	13	36	22	13	35
GRAND TOTAL	132	38	170	116	31	147

BOTH SEXES

Patients having no operation	95	75
Patients having 1 or more operation	75	72
% having an operation	44%	49%

TABLE 16

SPINAL INJURIES - FIRST ADMISSIONS

Disposal by Age and Year

MALES

DISPOSAL	1976/77				1977/78				
	0-29	30-49	50+	TOTAL	0-29	30-49	50+	N/S	TOTAL
Home	55	37	18	110	46	20	16	1	83
Transferred back to hospital of first admission	6	9	5	20	11	5	6	-	22
Hostel	2	-	2	4	2	1	-	-	3
Died	-	-	-	-	1	1	-	-	2
N/K	-	-	-	-	2	-	-	-	2
TOTAL	63	46	25	134	62	27	22	1	112

TABLE 17

SPINAL INJURIES - READMISSIONS

Age and sex breakdown

AGE GROUPS	1976/77			1977/78		
	M	F	T	M	F	T
0-19	2 (2)	0 (0)	2 (2)	1 (1)	1 (4)	2 (2)
20-29	13 (15)	1 (9)	14 (15)	9 (12)	4 (15)	13 (13)
30-39	20 (24)	4 (37)	24 (26)	26 (34)	10 (39)	36 (35)
40-49	18 (22)	2 (18)	20 (21)	23 (30)	4 (15)	27 (26)
50-59	18 (22)	3 (27)	21 (22)	11 (15)	4 (15)	15 (15)
60-69	8 (10)	1 (9)	9 (10)	5 (7)	3 (12)	8 (8)
70+	4 (5)	0 (0)	4 (4)	1 (1)		1 (1)
TOTAL	83 (%) (88%)	11 (%) (12%)	94 (%) (%)	76 (%) (75%)	26 (%) (25%)	102 (%) (%)

Two months' sample figures

Figures in () are percentages

TABLE 18

SPINAL INJURIES - READMISSIONS BY REGION OF RESIDENCE
AND SEX

Two months' sample each year

REGION	1976/77			1977/78		
	M	F	T	M	F	T
Oxford Region	8	4	12	5	4	9
Thames Region	30	6	36	37	11	48
East Anglia	3	-	3	2	2	4
South East England	41	10	51	44	17	61
Wessex	11	-	11	8	-	8
South Western	6	1	7	10	2	12
Total South of England	58	11	69	62	19	81
West Midlands	9	-	9	6	1	7
Trent	2	-	2	2	4	6
Mersey	3	-	3	3	1	4
North Western	4	-	4	1	-	1
Yorkshire	-	-	-	-	-	-
Northern	2	-	2	2	-	2
Wales	-	-	-	-	-	-
Other Countries	5	-	5	-	1	1
TOTAL PATIENTS	83	11	94	76	26	102

Reason for Re-admission by Age and Sex

AGE GROUPS	MALES													TOTAL			
	1	2	3	4	5	6	7	8	1+6	3+6	8+6	2+4+5	8+2		1+6+8	6+2	6+7
0-19							1			1							2
20-29		1	2			5		1		1							13
30-39	1	1	3	1		4	3	2		2		1					20
40-49			4			2	3			4				1			18
50-59		1	2	1		4	1	3		5						1	18
60-69	1	2	1			1	1	1		1							8
70+							1	3									4
TOTAL	2	5	12	2		16	10	10	14	1	7	1		1	1	1	83
FEMALES																	
0-19																	
20-29									1								1
30-39		1					1	1	1								4
40-49					1				1								2
50-59		1	1											1			3
60-69								1									1
70+																	
TOTAL		2	1		1		1	2	3					1			11

1. I.V.P.
 2. Sores
 3. Surgery
 4. Re-hab.
 5. Re-assessment
 6. Check-up
 7. Establish diagnosis
 8. Other
- Two months' sample figures

Reason for Re-admission by Age and Sex

AGE GROUPS	MALES													TOTAL			
	1	2	3	4	5	6	7	8	1+6	3+6	8+6	2+7	3+2		1+6+8	1+6+2	TOTAL
0-19							1										1
20-29		3			4		4				1	1					9
30-39	1		4	1	8	1	4		4		2	2			1		26
40-49	1	1	2	3	3	3	7		2	2							23
50-59	1			5	5	1	1		2		1						11
60-69			1		1		1			2							5
70+							1										1
TOTAL	3	4	7	1	21	5	15	8	2	8	1				1		76
AGE GROUPS	FEMALES													TOTAL			
	1	2	3	4	5	6	7	8	1+6	3+6	8+6	2+7	3+2		1+6+8	1+6+2	TOTAL
0-19																	
20-29		1					2										1
30-39	1		1		2		1		1		2		1				4
40-49			2		2		2							1			10
50-59				1	1						1	1					4
60-69			2		1		2			1							4
70+																	3
TOTAL		2	6		4		7		1	3	1	1	1	1			26

- 1. I.V.P. 2. Sores 3. Surgery 4. Re-hab. 5. Re-assessment 6. Check-up
- 7. Establish diagnosis 8. Other

Two months' sample figures

1. I.V.P. 2. Sores 3. Surgery 4. Re-hab. 5. Re-assessment 6. Check-up
 7. Establish diagnosis 8. Other

Reason for Readmission

Length of stay	1	2	3	4	5	6	7	8	1+6	3+8	8+6	2+4+5	8+2	1+6+8	2+6	6+7	TOTAL
1 day	1					4			4						1		10
2 days	1					6	1	1	6		1						16
3 days						1			1								2
4 days		1				1											2
5 days						1			3								4
6 days			1					1									2
1+ weeks			2		1	3	6	2	2		2						18
2+ weeks			4	1				4			4			1		1	15
3+ weeks			1				1	2	1								5
1+ months		1	3	1			1	2		1							8
2+ months		2	2				1	2				1	1				8
> 3 months		3					1										4
TOTAL	2	7	13	2	1	16	11	12	17	1	7	1	1	1	1	1	94

Median length of stay males and females = 11.1 days - 1976/77

Mean length of stay males and females = 17.5 days

Two months' sample figures

SPINAL INJURIES - RE-ADMISSIONS

TABLE 20b

Length of Stay by Reason for Re-admission 1977/78
 1. I.V.P. 2. Sores 3. Surgery 4. Re-hab. 5. Re-assessment 6. Check-up
 7. Establish diagnosis 8. Other

Length of stay	Reason for Re-admission													TOTAL		
	1	2	3	4	5	6	7	8	1+6	3+6	8+6	2+7	3+2		1+6+8	1+6+2
1 day	1	1	1			9	4						1			17
2 days	1					8	1	2	1	1	1					13
3 days	1		1			1	2	2	1	1						5
4 days			2			3	1	1	1							9
5 days						1	1	1	1							5
6 days						1										1
7 days																3
1+ weeks		1	3		1	1	2	1	2	1	4					17
2+ weeks			2				1	4	2	1				1		9
3+ weeks		1	1				3	3	1	3						8
1+ months			2				1	3	1	1		1			1	3
2+ months																5
> 3 months		3	1	1		1	3	1							1	7
TOTAL	3	6	13	1	-	25	5	22	8	3	11	2	1	1	1	102

Median length of stay males and females combined 6.5 days - 1977/78

Mean length of stay males and females combined is 24.1 days

Mean length of stay males and females combined over the two years period is 20.9 days

Two months' sample figures

TABLE 21

SPINAL INJURIES - READMISSIONS

Number of patients having operations by sex

OPERATIONS	1976/77			1977/78		
	M	F	T	M	F	T
None	61	7	68	55	14	69
1	22	4	26	21	11	32
2	-	-	-	-	1	1
TOTAL	83	11	94	76	26	102

Operations by sex

OPERATIONS	1976/77			1977/78		
	M	F	T	M	F	T
1. Bladder Neck	13	-	13	11	3	14
2. Litholapaxy	2	-	2	2	1	3
3. Sores - Excis./ Deslough.	5	2	7	6	3	9
4. Sores - Grafting	-	-	-	-	-	-
5. Orthopaedic	2	-	2	1	4	5
6. Other	-	2	2	1	2	3
TOTAL	22	4	26	21	13	34

Two months' sample figures
each year

TABLE 22

SPINAL INJURIES - RE-ADMISSIONS

Disposal by sex

	1976/77			1977/78		
	M	F	T	M	F	T
1. Home	81	11	92	72	23	95
2. Hostel				2		2
3. Transfer					1	1
4. Died	2		2			
5. S.M. Hostel				2	2	4
TOTAL	83	11	94	76	26	102

Two months' sample figures
each year

TABLE 23

STOKE MANDEVILLE HOSPITAL SPINAL INJURIES CENTRE
PRIVATE PATIENTS

1976/77 and 1977/78 combined

COUNTRY OF ORIGIN BY CAUSE: MALE AND FEMALE

COUNTRY OF ORIGIN	1		2		3		4		5		6		N/S		TOTAL
	M	F	M	F	M	F	M	F	M	F	M	F	M	F	
ENGLAND		1													1
SWEDEN											1				1
PORTUGAL	1										1	1			3
ITALY	3	1				1			1	1					7
GERMANY			1										1		1
GREECE	3							1					1		5
YUGOSLAVIA	1	1													2
SPAIN		1													1
TURKEY		1													1
CYPRUS	1														1
NIGERIA											1				1
KENYA	1										1				2
ZAMBIA	1														1
GUYANA	1				1						1				3
BRAZIL	1														1
ARGENTINA						1									1
LIBYA	5	1							1						7
EGYPT	1										3				4
SUDAN	1				1				1						3
IRAQ											1	1			2
IRAN	4	2									1				7
JORDAN	1								1						2
KUWAIT	2														2
QATAR	1														1
SAUDI ARABIA	13	1							1						15
U.A.E.	2					1									3
N/K	1											1			2
N/S													3	1	4
TOTAL	44	9	1		1	1	3		5	3	10	3	3	1	84

1. Road Traffic Accident 2. Accident at Home 3. Accident at Work
4. Sports Injury 5. Pathological 6. Other

11

D2/H1/145 29A
~~10A~~

STOKE MANDEVILLE APPEAL

NOTE OF MEETING 20/12/79

1. Mr Collier said that the Appeal was likely to be launched in the House of Lords, possibly on 23 January 1980. No pictures or exhibits were required; a number of Stoke Mandeville patients would be present to demonstrate the need for and the results of treatment. The Duke of Buccleuch as President of RADAR might be involved, and possibly Princess Michael of Kent if arrangements can be made in time.

2. Trustees were likely to be appointed from among the major fund raisers - the position of the SI Association would also need to be considered.

3. A parallel Group would be needed to act as advisers to the Trustees, their functions to include the resolution of planning problems if these arose. Two members, the Chairmen of Oxford RHA and Bucks AHA, had already been invited to serve on the Group; Dr Frankel would also be offered membership, and other individuals might also serve.

4. It is understood that Oxford RHA and Bucks AHA had already established a project team. The Department would be seeking ways of maximising the NHS contribution to the Design Brief (with continuity for DHSS provided perhaps by Departmental officers). The question of project management during the construction stage was left open, as was consideration of the contribution to be expected of the RHA Works Department

5. Arrangements for the meeting with Doctors Rue, Forsythe and Frankel were confirmed - Wednesday 2 January 1980, in Room 1532 Euston Tower at 11 am.

RP

Pamela Petrie
RL1
ET.1532/Extn.884

December 1979

Copied to: Mr Collier - with a copy of Dr Tait's strategy paper
Mr Bebb
Dr Tait
Stoke Mandeville File

D2/H.1/145 - 23A
SJA.
Miss Satter
-Jw Stoke Mandeville
Jlc Amx4/1/80.

NOTE OF A MEETING TO DISCUSS THE PD RLG STRATEGY DOCUMENT
HELD ON 4 DECEMBER 1979 AT MANHIBAL HOUSE

- PRESENT: Mr Bebb Mr Myers
 Mrs Arthur Mr Nye
 Miss Baddiley Mr Perry
 Miss Browning Dr Rawson
 Miss Cawson Dr Rothman
 Miss Dyer Dr Tait
 Mr Godfrey Mr Thompson
 Mrs Holden Miss Day

1. Dr Rothman was welcomed on her appointment as Research Manager for the PD RLG.

2. THE PD RLG STRATEGY DOCUMENT AND REVISED RLG ARRANGEMENTS

(i) It was agreed that the strategy document did not require any major changes of content, but that its structure could be improved; it would be a mistake to give more support to short-term as distinct from long-term projects: the likely value of the research should be the determinant in every case. It was agreed that the PD RLG should give more emphasis to projects in which the work was done in stages and which gave results at regular intervals. This would make project management simple and more effective, whilst providing policy branches with more up-to-date information.

(ii) It was suggested that in its present form the paper was difficult for researchers to work from, too long, and unclear in setting out priorities and fields of possible research. It was agreed that the paper should be restructured by the Secretariat, with the help of SR5. Sub-group chairmen were asked to review their priorities for inclusion in the revised paper.

(iii) It was intended to publish all the RLG strategy documents together as a DHSS document for researchers. The present document would be included in the next edition, but the revised paper could be sent to individual researchers and units.

(iv) The revised RLG and Small Grants Committee arrangements were discussed. All grant applications below £40,000 would be considered by the Small Grants Committee. Project Liaison Officers would bring proposals for SGC support to the attention of the relevant RLG Chairman who would also receive a list of applications approved, and be given an opportunity (in the rare cases when circumstances justified it) to take on a project and/or suggest modifications to it to make it more useful to the Department. The new arrangements which were being introduced for a trial period of 12 months, were intended to reduce the workload of OCS; consultation time should also be reduced, and the procedure speeded up for the researchers.

(v) The question of sub-groups meeting before the main RLG meeting was raised. It was agreed that it was for the individual sub-group chairman to decide whether he had enough business to call a meeting.

3. PUBLICATION OF DR DUCKWORTH'S RESEARCH PAPERS

(i) Dr Duckworth's research papers were now ready for publication, and the form publication should take was discussed. It was agreed that the best way was to issue the papers in the DHSS research series published by HMSO. As part of an existing series librarians were more likely to buy the publication. The alternative was a free issue through the Department, but this would have the disadvantages of possibly inadequate publicity and that all distribution would have to be done by the sponsoring branch.

(ii) The publication of Dr Duckworth's abridgement of Mr Philp's research was also considered. Mr Philp was content with the abridgement, and it was agreed that he should be asked whether he had any objections to the paper being distributed to interested research workers. Meanwhile, it was a useful internal document, and might be published in the future in the DHSS research series. It was agreed that publication should not go ahead until Mr Philp had decided whether or not to publish his complete paper.

4. STOKE MANDEVILLE

(i) The Spinal Unit had only 110 beds in use at present, rather than 150 because of staff shortages and the poor state of the buildings, problems exacerbated by lack of money. The area had agreed to increase the number of beds in use to 125.

(ii) Proposals for a national collection to rebuild the Unit had been put forward. A number of people were involved, including Jimmy Saville and Mr Borges of the RNOH. A departmental working group, chaired by Mr Collier, had been set up to look at this suggestion.

(iii) It was hoped that any money raised would be used to rebuild the unit. An acceptable number of beds in the rebuilt unit would be 100-110, rather than 150, although the unit would have to retain 136 beds, by keeping open an old ward, until the new units planned at Odstock and Starnmore became operational.

5. ACTION

(i) Sub-group chairman to review research priorities for inclusion in revised RLG strategy document and to inform the RLG Secretariat of the outcome of their deliberations;

(ii) Secretariat and SR5 to restructure the strategy document.

Mr Bebb B517

OXFORD RHA. PAPER ON THE NSIC STOKE MANDEVILLE

1. I have sent you a copy of a minute I sent to Mrs Petrie which considered this paper in the light of the meeting with the RMO's on 2 January. But it also raises some general points which are of some importance to the Policy Division.

2. The first of these relates to Designation. I have been a stout supporter of the name "Spinal Unit" and had to defend this again the last time we met Professor Lipmann Kessel at the RNOH. I note that the Oxford RHA document says "a "Spinal cord injury" is the term which refers to complete or partial transection of the spinal cord, either as a result of trauma (when it is often associated with fractures of the spinal vertebrae) or when other disease processes affect the spinal cord, eg tumour." Later throughout the paper reference is frequently made to "traumatic spinal cord injury". If this could be a generally accepted definition I would be very ready to revert to the earlier designation "Spinal Injury Service" and Professor Kessel, and many others, would be happier.

3. I would, however, need to be convinced that the SIA would accept this definition. As you know they will only allow "traumatic cases" to be full members; the others (including those with spina bifida) are limited to associate membership (I think Michael Rogers is an exception). The advantage of our suggested term "Spinal Unit" did not accord any higher or differential status to traumatic cases and that is what the argument has been about.

4. One other point. You know ~~they~~¹ have been unhappy at Wessex' request for regular psychiatric consultations. We have no reason to believe that SM is particularly insensitive to psychiatric problems; indeed as two of the consultants are physicians and only one a surgeon they are likely to be more aware than some, and they are employing a non-medical psychotherapist to do some research. For the year 1976/77 21 patients were referred for psychiatric consultation and for the year 1977/78, 22 patients were referred. For the same periods the numbers of patients in the Unit were 170 and 146. As the numbers treated at Odstock will be below these figures (for the first years considerably so) we might estimate that some 10 patients a year will be referred for psychiatric consultation. This would not warrant any fixed sessions and could easily be coped within the session allotted to Odstock Hospital as a whole.

5. The data on number and type of operations will also be useful in estimating need for theatre sessions (Table 14, first admissions and Table 21, re-admissions).

6. I think it would be worthwhile circulating a copy of this report to the CGT (including Miss Dyer and Mrs Grove) and you may think we should pass on some observations to the Odstock and RNOH project teams

Frank Tait

28 December 1979

FRANK TAIT
Med CPL

cc Mr Myers B510
Miss Baddiley C202 Mrs Grove } 1116 HH
Miss Browning C310 Miss Dyer }

DH Dbl Line AF66. Page 136

Mrs Petrie 1532 ET

OXFORD RHA, NATIONAL SPINAL INJURIES CENTRE, STOKE MANDEVILLE

1. I have read this paper thoroughly and in view of the number of variables which determine the number of beds required for the spinal injury service it is surprising that our two separate estimates are so close.
2. The paper divides the South of England (8 Regions) into the South West (South Western and Wessex Regions) and the South East (East Anglia, Oxford and the four Thames Regions). It is assumed that the new Unit at Odstock will serve the South West. On page 22 you will read (second paragraph) "the number of beds required to serve the catchment population of the South West of England will be 123 beds approximately.
3. However this figure is adjusted in the second paragraph of page 23 and for reasons (some of which are implicit in our paper) the conclusion is that "the total bed requirement for the population of the South East of England would be in the order of 170 beds". Our figure for the South East was 184; that is 50 beds (Odstock) lopped off our grand total of 234. For all practical purposes and bearing in mind what statisticians call the "dirtiness" of the data these figures are identical, and the only point of issue between us is likely to be the distribution of the beds; how many in Oxford and how many in South East Thames.
4. Our view is that the answer to this question must be determined by history (SM exists) and the fact that there is no likelihood of central funds being available to develop a service in the SE Thames Region for a considerable time; furthermore, experience with Odstock has shown us that there is a long period (five years plus) between the monies being available and the Unit being operational. We cannot allow the number of beds available for this service to be reduced while we await the next development which at best is unlikely to occur before another ten years.
5. Our suggestion that the new building should reduce the number of beds at SM to some 110 is a compromise. This would provide 134 beds in the South East (24 at Stanmore) and this is only 26 short of their total estimate of 170. (Better here to use their figure than ours). It is for this reason that we will argue that the total complement must be maintained by keeping some of the old beds operational. I expect that Dr Frankel (representing the Spinal Injuries Review Committee) will strenuously support this view and it will be a matter of considerable importance to the Spinal Injuries Association. The total will be increased as a part of a longer term strategy when we can proceed with the SE Thames proposal.
6. If any possible areas of disagreement occur to you before the 2 January would you let me know so that I can be sure that we are well prepared for what should be a very important meeting.

27 December 1979

cc Dr M Tate
Mr Collier
Mr Bebb ✓
Mr Gant

Frank Tait
FRANK TAIT
Med CP1
Bl111 AFH



Your reference
Our reference

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

TELEPHONE 01-380 1188 EXT 884

17 December 1979

*Copy Mr Collier
Mr Bebb ✓
Dr Tait*
For info
35A
(No papers)

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 RTDGS have withdrawn to Sheffield.

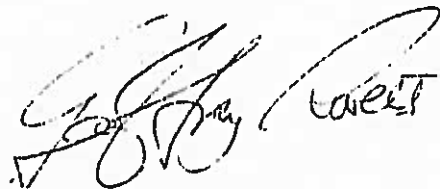
Mrs Delrie

cc. Mr Webb
Dr Tait
Mr Thorpe-Thorpe
Mr Gent
Dr Melia
Mr Collier

SPINAL UNIT BUILDING APPEAL

Thank you for your minute of 14 December and for the personal word you had with me.

I will hold the date on 2 January, although I will not attend automatically but only at your further request. You will of course know that among the liaison responsibilities of Medical OSI are liaison with the Board of Governors at the Royal National Orthopaedic Hospital Stanmore, as well as with the Thames regions.



17 December 1979

G C Rivett
Med OSI
Room 1B38 BT ext 891

Mr Collier

SPINAL UNIT REBUILDING APPEAL

Your meeting to discuss the draft strategy for Stoke Mandeville (size, location and timing) has been fixed for Wednesday 2 January 1980 at 11 am. As a concession to outside participants who were pressed to accept the date and time at very short notice, I have organised the meeting in my room, 1532 Euston Tower since this is said to be more convenient for our NHS colleagues. I hope you wont' mind.

Drs Rue and Forsythe are attending, so is Dr Frankel. I have not told the RMOs that Dr Frankel will be there - it will be rather tricky to do so, but perhaps a "right" time to do it will become apparent in due course.

Mr Thorpe-Tracey cannot be present at the meeting on 2 January. At his suggestion I have spoken to Dr Rivett, who is content that we keep in touch and call for his help if we need it.

Pamela Petrie
RL1
Room 1532/Extn.884
Euston Tower

14 December 1979

Copied to:

Mr Bebb
Dr Tait
Mr Thorpe-Tracey
S.M. File
Mr Gant
Dr Rivett
Dr Melia -- Shall we have a word?

80/8
37A
227

Mr Collier

STOKE MANDEVILLE - REBUILDING APPEAL - TARGET

1. Taking Mr Goodman's estimate (which includes a 50% on-cost allowance and which covers equipment), and arbitrarily assuming an annual uprating of 15% over each of three years*, the potential cost of rebuilding the SI Unit comes out somewhere near the following:

	<u>Present Prices</u>	<u>Uprated</u>
Expenditure in 1981/2	£0.5m + .075m	£0.575m
" " 1982/3	£2.5m + .375m	£2.875m
" " 1983/4	£1.0m + .5m	£1.500m
	<hr/>	<hr/>
Present Estimate	£4 million	£4.95 million
	<hr/>	<hr/>
		Uprated total

* Our economist adviser in Euston Tower says that the 15% figure is as good as any and, of course, the faster we get on with the project the less the element of inflation.

2. If staff accommodation is included (for which we might be looking at a figure of about £1m), the total cost could come out at around £6m.

say
£7m.

Pamela Petrie

Pamela Petrie
RL1
ET.1532/Extn.884

14 December 1979

Copied to:

Mr Bebb ✓
Dr Tait
S.M. File

Reference.....

321 7/14
219

Dr Tait

STOKE MANDEVILLE. MINUTE FROM DR HALLIDAY
WITH ATTACHED LETTER FROM DR FORSYTHE

Your minute to me of 11 December refers.

I am sure that we must keep our heads well down
over this tricky business at present, with regard
to both Dr Forsythe and Dr Rosemary Rue.
Mrs Petrie spoke to me the other day about this
and we agreed that silence is essential while
current complexities are being sorted out.

Since events appear to be moving with some speed
I am sure that a reply to Dr Forsythe's letter
should be held up for the time being. As you say,
it may well be possible to reply after
Mr Collier's meeting, which I understand is likely to
take place within the next week or two.

Mary Tate.

DR MARY TATE
MED CP1
B1117 AFH

13 December 1979

cc Dr Halliday
Mr Bebb
Mr Thorpe-Tracey
Mrs Petrie

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

Dr. Tate

STOKE MANDEVILLE. MINUTE FROM DR HALLIDAY WITH ATTACHED
LETTER FROM DR FORSYTHE

1. Dr Halliday's minute of 14 November indicates that Dr Forsythe will be expecting a reply. It is difficult at this stage in the negotiations about Stoke Mandeville, and the simple fact is that while it may be preferable to have 60 beds on each site there are no monies available for the Sidcup Development and the SM appeal could not be used to build a new unit in Kent. It is to be focussed on SM and its historical, international and emotional appeal; it is not possible to engender the same feeling about a "project".
2. You have a copy of the "strategy paper" and it is intended to discuss this with the two RMO's and Dr Frankel representing the SM at a meeting chaired by Mr Collier.
3. Mr Bebb and Mr Thorpe Tracey will need to be aware of Dr Forsythe's letter. I am sure the Region will not wish to fund the Unit themselves and so it may be necessary to make some firm statement as to the likely availability of central funds. The ~~strategy~~ paper makes it clear that expedience and history are both important factors in the formulation of strategy.
4. I do not know when Mr Collier will be arranging the meeting but I assume it will be in the next weeks as it has been made clear that we must maintain a strong momentum. Notification of that meeting may be the best reply.

Frank Tait

FRANK TAIT
Med CPL
B1111 AFH

11 December 1979

cc
Dr Halliday
Mr Bebb
Mr Thorpe Tracey
Mrs Petrie

IN CONFIDENCE

Mr J Collier
Room D904
AFH

cc-pl to
Mr Peter
Mr Bell -
Dr Tait

STOKE MANDEVILLE PARAPLEGIC UNIT

Based on a 112-bed unit, including accommodation for social activities and occupational/physiotherapy, I assessed the costs to be a fraction over £2m basic cost. To that we should add on-costs, which can vary between 30% and 50% (so say 50%) ie £1m, giving a total work cost of £3m. To that we should add, equipment at 12½% £450,000 and fees at 15% £375,000, giving the total cost of £3.8m (say £4m) for building, including fees and equipment.

These figures presume the normal NHS standards and are based on an extrapolation of our cost limits and the expected level of on-costs; these and equipment costs are the percentages which we normally allow. I understand that the architect already appointed for the project is Richard Seifert, whose only experience of hospitals is in the private sector and these were considerably more expensive than NHS hospitals. It might be, therefore, that if this project is to be a "showpiece" we should make some additions to these costs; assuming that we can defend a showpiece project, albeit one financed from voluntary contributions.

I have to say that I suspect the motives of the promoters of this project. I am sure that paraplegics have considerable visual appeal to the media, but if one is concerned with the greatest good to the National Health Service, then senile old ladies in Ashton-under-Lyne might come somewhat higher up the list.


Howard Goodman
Director of Works Development

6th December 1979

74/4

~~26A~~

~~18A~~ 18A

A. Division

For the file

✓

MRS PETRIE

STOKE MANDEVILLE

We don't need minutes of the discussions we have - let's make history and not bother about recording it! But to make sure that we know who is going to do what it may be helpful to list the decisions which I think we took -

a. We need to establish a firm Departmental/RHA/SMH view of the size of the unit needed. Frank Tait's paper will be the basis of a meeting which I would chair. I think we need to try to have this before Christmas (I will tell Chairmen that we are doing this and I will also tell Jimmy Saville. In talking to the Chairmen I will explain that we are not yet setting up a steering committee because we want to make sure the undergrowth is clear before we invite such great people to sit round a table with us - I can keep Dr Vaughan content on this one).

b. In our relationship with the fund raisers, I confirmed that it is on my plate to talk to Thomas Borges (incidentally I have steered the draft letter for the Minister to reply to Borges). I am also in touch with Grandmet.

c. We noted that the appeal might be announced on January 16. When that happens there will be a lot of questions asked of Ministers as well as of the fund raisers. You are kindly going to identify the questions which will need to be answered at some time - this will be very helpful.

d. Just to confirm that I would be very grateful if you would talk to Howard Goodman about the potential cost of a new unit - but not revealing to Oxford RHA that you are doing this.

5 December 1979

A J COLLIER
D904 AFH
Ext 7607

Copies to:

Mr Bebb ✓
Dr Tait

17A
~~23A~~

17B

ence ~~23A~~

MRS PETRIE
DR TAIT
MR BEBB

I attach a copy of a minute which I have received from the Minister.

4 December 1979

AJ
A J COLLIER
D904 AFH
Ext 7607

p the momentum going.
pushing ahead fast,
lp him to succeed in
in touch. When you
i being, I would natural
use I will then want to
e. In the meantime I
Saville could let me
th, the progress you
e are any obstacles
p remove, let me know

DR GERARD VAUGHAN

3 to 800 for info

VE 18-78

30.11.79.

Please show to SGS for information only
Dr

MG

7B. 3/2

Reference

~~278~~

Mr Collier

STOKE MANDEVILLE

I am extremely anxious to keep the momentum going. I know that Jimmy Saville is pushing ahead fast, and I am looking to you to help him to succeed in this. I want you to keep me in touch. When you have the Steering Committee in being, I would naturally like to meet it, but in any case I will then want to have reports from the committee. In the meantime I would like it if you and Jimmy Saville could let me know regularly, say once a month, the progress you are making. If of course there are any obstacles which arise, which I could help remove, let me know at once.

30/11 November 1979

DR GERARD VAUGHAN

cc Mr Bretton - for SGS to see for information

30.11.79.

ME 18-78

Please show to SGS for information only
EW

Copied to: Mr Bebb ✓
Dr Tait
Mr Gant
File

7/12
21A
16A

Mr Collier

STROKE MANDEVILLE NSIC APPEAL

Following our discussion yesterday, I have tried to identify what the implications are likely to be for the (Department) in terms of input and workload. Obviously, planning and fund raising will proceed in parallel, and you are concerned with both aspects. Other officials, mainly with the former only.

On the (fund raising side, Jimmy Saville wishes the appeal to be largely a two-man show with subsidiary contributions from other fund raisers if they wish to join in. This can quite easily be accomplished as the diagram at Appendix A shows, but we need to establish Charitable Status and to execute a deed as quickly as possible (See Appendix B) if momentum is to be sustained. You will see that I have suggested that Dr Frankel should be one of the Trustees; this position combined with the prospect of getting him elected as permanent chairman of the SIC cogwheel at the end of the present incumbent's term of office, seems to me to get round the difficulties associated with appointing him as Director of SMESIC. The arrangement outlined meets most people's wishes about what they want to do or to be.

With regard (to the Steering Group. Perhaps their function is (a) to establish a Trust, and (b) to coordinate planning, as opposed to the financial activities.

On the Planning front we quickly need to:

- a) confirm a national SI Centre strategy (Dr Tait).
- b) Define S.M.'s place within it in terms of role and functional content.
- c) Obtain agreement to a) and b).
- d) Ensure the feasibility and compatibility of (b) with RHA and AHA plans, service and site arrangements.
- e) Appoint a project team.
- f) Appoint architects and a project Manager (Siefert - Architect).
- g) Appoint a Commissioning Team.

I see the Steering Group as an endorsing and problem resolving body with the detailed project and planning work being done in Working Groups but working to a tight programme laid down by the Steering Committee. Interested individuals like Michael Rogers (the tetraplegic husband of the SM Div. W.O.) could be involved at Working Group level rather than at Steering Group. (I believe Jimmy Saville wants him to have a role). An incomplete chart showing Steering/Working Groups is at Appendix C.

On a separate point it would be helpful to have your views as to what sort of a secretariat you require. There will be at least three groups to serve if the job is done totally in house, and it would be helpful if all three could share a common secretariat at least in the early days. To this end, because Mr Gant's section is under great pressure, I have bid for an AT, although it may turn out that an HEO(A) will be needed instead (or as well).

Meantime, existing RL1 staff will continue to provide support.

Handwritten signature

DH Document 06. Page 148
Patricia Petrie

4 December 1979

RB1

NATIONAL SPINAL INJURIES CENTRE : STONE DANDEVILLE

REBUILDING APPEAL

Fund Raising Organisation

POSSIBLE PATRON: PRINCESS MICHAEL OF KENT

PRESIDENT ? YES/NO
VICE PRESIDENTS /NO

FUNDRAISERS
J. SAVILLE
(Mr. Bridges)
(SEAGRAYS)

Ad hoc
Contributors
(eg Bucks
man)

REGISTERED
CHARITY TRUSTEES
Members:
McCollier
Dr Frankel
Lady DASHAM
Duke of Buccleuch
BANKER/ACCOUNTANT
? H. Authority Chairman
(5 or 7 members)

? Common Secretariat provided by DHSS

Mr Collier

STOKE MANDEVILLE NSIC

ESTABLISHING A TRUST FOR THE REBUILDING OF THE CENTRE

1. The Legal Position

There are no provisions under NHS legislation for the establishment of special trustees for SMNSIC, nor can a special health authority be established for this purpose.

The options are:

- a) for donations to be made to the AHA solely for the benefit of SMNSIC, these donations to be held and managed in trust by the AHA;
- b) for a Trust to be established and registered with the Charity Commissioners by supporters of SMNSIC;
- c) to invite NBI Association to act as custodians of donations and possibly to act as Trustees.

Option (a) will find no favour with the principal fund raiser, Jimmy Saville. Similarly, Option (c) may be unacceptable on the grounds that the Association would like an appeal to be directed to the benefit of all the SICS in the country.


Option (b) seems to be the most appropriate to Stoke Mandeville's need.

2. Points to Watch

- a) The relationship between the Trust and the AHA/RHA would need to be formalised. Cross representation is not absolutely essential; it might be appropriate for the Department, rather than an individual authority to be represented.
- b) Under Section 91 of the 1977 NHS Act, health authorities can use monies paid them by Trustees, for any health services purpose if they do not consider it practicable to apply them for the purpose specified by the Trust. In this event the Trustees have recourse to the Courts or they might approach the Secretary of State.
- c) Once constructed on NHS property, health facilities become the property of the Secretary of State and, health authorities rather more than Trustees perhaps, have a say in their use and management.

Next Steps

- i) Consider the aims and membership of the proposed Trust.
- ii) Invite interested parties to join.
- iii) Instruct solicitors to prepare a Trust Deed. The Charity Commissioners would then need to be consulted on the granting of Charitable status before the Deed could be executed. The Charity Commissioners advise that there should be an odd number of Trustees; perhaps five or seven.



Pamela Petrie
KL1
Room 1532/Extn.884
Easton Tower

4 December 1979

Copied to:

Mr Babb
Dr Tait
Mr Gant
File

APP.

NATIONAL SPINAL INJURIES CENTRE: STORR HANDEVILLE

Planning Organisation

Steering
GROUP -

Chairmen: James Collier

Members: Gordon Roberts
 Lady Naldwin
 Dr Frankel
 Dr Tait
 Mr Petrie
 Mr Rebb

secretariat:

Working Group(s)

Planning Dr Tait
 Mr Petrie

Project Team Dr Tait
 Dr Frankel
 Mr Petrie
 Michael Rogers
~~Stephen Bradshaw~~
 SIEFERT-JACOBET

DHSS Secretariat.