McBeag 157

DEPARTMENT OF HEALTH AND SOCIAL SECURITY
ALEXANDER FLEMING HOUSE
ELEPHANT AND CASTLE LONDON SE1 6BY
TELEPHONE 01-407 5522 Ext 7607

Lady R Mallalieu
Buckinghamshire AHA
Peverel Court
Portway
Stone
Aylesbury
Bucks HP17 8RP

4 December 1979

Many thanks for your letter of 29 November about Mr McMinn's generosity. I look forward to meeting him.

A J COLLIER

Savile – Trust to receive money
SM
Nothing on proper appeal officially launched until S/S happy that will.
? AHA antagonistic

D214

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY

Telephone:
AYLESBURY 748111
This matter is being dealt with by
Lady Mallalieu
extension 51

Area Headquarters:
PEVEREL COURT,
PORTWAY,
STONE, AYLESBURY,
BUCKS., HP17 8RP

Your ref.:
Our ref. HRM/EAK/H1/3

29th November, 1979

Mr. A. J. Collier,
Deputy Secretary,
Department of Health and Social Security,
Alexander Fleming House,
Elephant and Castle,
LONDON, SE1.

Dear Mr. Collier,

NATIONAL SPINAL INJURIES UNIT
STOKE MANDEVILLE HOSPITAL, AYLESBURY

I think the enclosed two papers speak for themselves. This is an exceptional offer which I am sure you will be very happy to receive.

I do not know when you intend to call the first meeting of the Steering Committee which Dr. Vaughan discussed with Mr. Roberts and myself but I would hope that you will be able to reply officially to Mr. McMinn and his Accountant accepting his offer on the terms which he has laid down.

Mr. Douglas McMinn is a well known Chesham resident who, having made an appreciable sum of money in business, is now disposing of it to projects which he deems to be worthy and the health services in Buckinghamshire already have cause to be extremely grateful to him.

If you would like more background information about Mr. McMinn we can provide it.

Yours sincerely,

Rita Mallalieu.

OAH 1020

(BUCKINGHAMSHIRE AREA HEALTH AUTHORITY)

MEMORANDUM FROM DISTRICT ADMINISTRATOR

To: Lady Mallalieu,
Chairman,
Bucks. A.H.A.,
Peverel Court.

Your Ref:

Our Ref: RET/PG

Date: 26th November, 1979

Offer of donation from Mr. Douglas McMinn for the rebuilding of the National Spinal Injuries Centre

I enclose a copy of a memorandum from Mr. Trimble to me together with a copy of my reply to Mr. McMinn's Accountant. This seems to be a matter which must be referred in the first instance to the steering committee which, I understand, you and Mr. Roberts are to serve on at national level, and in view of the second of Mr. McMinn's three provisos, may I please leave it to you to take up the matter with Mr. Collier at the Department as you think fit.

R.E. Titley
District Administrator.

C.c. Mr. K.G. Walker.

STOKE MANDEVILLE HOSPITAL

INTERNAL MEMORANDUM

TO Mr. R.E. Titley, District Administrator DATE 21st November, 197

FROM Mr. P.H.J. Trimble, Administrator - General Services

IN CONFIDENCE

OFFER OF DONATION FROM MR. DOUGLAS McMINN

Mr. Godwin, Accountant of Heal and Company acting on behalf of Mr. Douglas McMinn, telephoned me today to say that Mr. McMinn was prepared to give £150,000 towards starting an Appeal for the building of a new spinal injuries unit. He did give the following three provisos:-

1. That there must be a national appeal.

2. The offer must be accepted within a matter of a few weeks as he would not leave the matter open later than next month. The reason for this being that in view of the recent publicity through press, radio and television coverage, he felt that if any action is to be taken it should be taken whilst the public is aware of the situation.

3. The gift would, of course, be subject to the usual proviso as with the money donated to the Postgraduate Centre in that should Mr. McMinn die within twelve months of making the gift, the Authority would accept resonsibility for any capital transfer tax.

Mr. McMinn further felt that we ought to approach either Jimmy Savile or the Lord Mayor of London to be Patron of the Appeal.

Mr. Godwin has asked that I contact either himself or Mr. McMinn direct early next week to indicate whether the offer is likely to be accepted and to outline what proposals are being made for any Appeal.

ACTION INFO.

P. Trimble

P.H.J. Trimble
Administrator - General Services

PHJT/JG
GS.D6

RET/PG

IN CONFIDENCE.

Mr. A.E. Godwin,
Heal and Co.,
84, The Broadway,
Chesham.
Bucks.

26th November, 1979

Dear Mr. Godwin,

I have been informed by Mr. Trimble of Stoke Mandeville Hospital of Mr. McMinn's very generous offer to start an appeal for the building of a Spinal Injuries Unit at Stoke Mandeville Hospital, with a magnificant donation of £150,000. I also note the provisos attached to this offer.

I am immediately submitting your proposals to the Chairman of the Area Health Authority, Lady Mallalieu, as she together with the Chairman of the Oxford Regional Hospital Authority has agreed to sit on a steering committee at national level being set up by Dr. Vaughan, Minister of State (Health) with a view to a national appeal being launched. A senior official of the Department of Health and Social Security is to act as chairman of this group and I am sure that Mr. McMinn's generous offer will be greatly appreciated and you may expect to hear further from us on this matter in the near future.

Please convey, in the meantime, our very sincere thanks to Mr. McMinn for his continued interest in Stoke Mandeville Hospital.

Yours sincerely,

R.E. Titley,
District Administrator.

14A

NOTE OF OFFICE MEETING 30 NOVEMBER 1979 TO DISCUSS DEVELOPMENT OF THE NATIONAL SPINAL INJURIES CENTRE AT STOKE MANDEVILLE HOSPITAL

Present: Mrs Petrie
Mr Gant
Mr Bobb
Dr Tait
Miss Sweeney

1. Mrs Petrie had prepared a posit on paper for Mr Collier on 24 November setting out background, Ministerial commitment following his visit to Stoke Mandeville, matters requiring attention and suggestions for action and this paper was taken as the starting point for the discussion.

2. Particular points on paper.

a. Mr Bobb registered misgivings on "strategy for spinal injury centres" (pg. 3). DHSS involvement was not, and should not perhaps be, as full blown as Minister seemed to expect. A less grandiose term might be more appropriate "policy"?

b. The figure of £250,000 for 40 beds (pg. 4) seemed low to SB. Mrs Petrie explained it had been based on crude estimate of costs of current beds at Stoke Mandeville. Costs would obviously have to be more fully thought out as the project progresses.

c. The time table for new development at Stoke Mandeville seemed too tight (pg. 5). Mrs Petrie thought it might be achievable if Capricode procedures did not have to be involved and if outside designers and contractors could be used. It was pointed out that the RHA and AHA had already been asked to draw up a Development Control plan for Stoke Mandeville and to identify the location of a possible new NSIC and the association of the latter with parallel developments that would be required in the DGH.

3. Mrs Petrie reported briefly on Mr Collier's meetings (separately) on 28.11.79 with Jimmy Saville and Mr Davis (Seagrams). Mr Saville did not appear to want to be tied down as to his role at this time - he was known to prefer to act on his own and did not seem a "Committee" man. He had made no particular suggestion as to what the target of the appeal should be, possibly inclining to the view "see how much we raise and then decide what to do with it".
Mr Davis of Seagrams had now to discuss with his Managing Director their options -- not just Stoke Mandeville; they were also interested in heart transplants. They did appear however to be interested in any wider appeal for SM with an identifiable component within it on which to focus their efforts.

Mr Collier had asked for advice as to how Mr Borges could fit into the picture. Mr Bebb said that he was a very successful fund raiser for the RNOH (as a whole, not just the new SI unit being developed there) and could be useful. He had many City contacts. Mr Bebb could throw no light on where the figure of "£70,000" for SM, mentioned in Mr Borges' letter of 12.11.79 to Minister, came from or what it was intended to do.

4. On the whole, the meeting considered that Mr Collier should be advised that initially a defined target (say re-building SM NSIC with 100? beds), capable of being broken down into identifiable components, would be more likely to attract public support than proposals for temporary revenue support or maintenance of the existing Centre. These latter objectives might be brought within the main target as the project developed.

5. The meeting then considered possible membership of the Steering Committee (to be chaired by Mr Collier). This would be serviced and supported by a separate Working Group (or Groups) (mainly officials) working in parallel.

Mr Gordon Roberts (Chairman, Oxford RHA) and Lady Mallalieu (Chairman, Bucks AHA) had already been invited to serve. Others suggested were:-

Lady Masham - not too good for the job but would probably be impossible to keep out

The Duke of Buccleuch - also a spinal injury victim and very capable - already involved in services for the disabled in a wider context (RADAR)

Mr Borges - See note . above.

Mr Davis (Seagrams) if they maintain their interest in the SM project!

TUC (Mr Murray?) - to add the "common touch" and counteract the upper and middle class image of the other possible members.

/NB. The point was made that the whole exercise should be apolitical if possible/

Backbench MP (from All Party Disablement Group).

Medical representative. Retired SI consultant (Hardy or Glanville) or Dr Frankel.

Businessman - Lord Goodman to suggest a suitable one? (a Mr Buchanan, another spinal injury victim and senior official of Canadian Pacific Railway who was resident in this country was suggested).

Apart from the Working Group comprising officials in the main (DHSS, NHS, of various disciplines) there were others who might be fitted into the overall programme or might be called upon on a more ad hoc basis. Such might be Jimmy Saville (who may be disinclined to involve himself with committees) and people such as Michael Rodgers. Stephen Bradshaw, as Director of S1A, might appropriately be invited on the Working Group. When the Steering Group had handed over its task to the Trustees of a charity (the most probable outcome) the more illustrious members could perhaps be designated Vice Presidents of the Charity's Appeal Fund - perhaps a Royal Patron could be obtained to head the Appeal Fund?

6. Staffing of the Steering Group and Working Group was briefly considered. An AP to service the Steering Group might suffice initially but the whole project would seem to require staff resources outside the scope of RL or SR

divisions to provide at this time. The full Appeal under the aegis of a specially constituted charity would probably need administrative support equivalent at least to a Departmental section. RL were prepared to carry the proposals forward on a day to day basis but it would be necessary to make more satisfactory permanent arrangements in due course.

7. Possible functions of the Steering Group serviced by the Working Group(s) were identified as follows:-

i. to co-ordinate the fund raisers

ii. identify targets

iii. identify, for the benefit of the Working Group, what information they need to carry out their tasks

iv. determine administrative and supervisory structure for the appeal phase.

v. Consider the steps necessary to register the Appeal as a Charity and work within the limits of the Charity's Act. (The point was made that the wording of the appeal should be wide enough to allow disposal of excess income for the benefit of spinal injury patients generally if this becomes necessary).

vi. consider budget for project; use of professional fund raisers; costs of staff?

Generally, it was considered that the Steering Group would push quickly towards the creation of a registered charity with trustees to administer the finance and perhaps take over the role of the Steering Group which could not fall to the Working Group.

8. On the size of the new Unit at Stoke Mandeville, Ministers had made it clear that as there was such disagreement generally about this, DHSS should be prepared to say clearly the way in which it envisaged SI provision being developed for the South of England. As SI was a multi-regional speciality, it did seem that DHSS rightly had a co-ordinating function. (Mr Rae would take this over if DHSS did not.) Regional Strategic Plans were also arriving at the DHSS, some with SI developments, and it was necessary for DHSS to express a view on these matters. After discussion, Dr Tait agreed [illegible]

setting out the policy for development of spinal injury services in South of England (mention of Stanmore, Odstock and Sidcup) and pointing the way to c. 100+ bedded unit at Stoke Mandeville. (Anything less than this was known to be unacceptable to Ministers.). This paper might eventually be seen by all RMOs (by letter? and short-time table to avoid discussion at RMO meeting) before being passed to the Steering Group. It was not considered appropriate to clear this paper with the Spinal Injury consultants (they meet a few times each year) prior to it being seen by RMOs. The national meeting of the Spinal Injuries consultants was nevertheless a useful forum for developing and confirming unofficially DHSS initiated policy, and Dr Tait would if necessary convene a special meeting.

9. Mr Collier had indicated that he wanted a Medical Director to be appointed to the NSIC as soon as possible. Dr Tait expressed surprise at this; his view was that Dr Frankel would not wish to accept such a post which would not be welcomed by his colleagues or by the NHS authorities in Oxford. It might be better to have Dr Frankel appointed to the Steering Group and to have the title of "Medical Adviser etc". Mrs Petrie agreed to seek further information for Mr Collier on why a Medical Director was considered essential in view of the opposition this might generate in professional circles.

10. A further meeting of those present would be arranged late next week to carry discussions forward.

December 1979

RUA.

Mr Collier

VISIT BY MR DAVIE - SEAGRAM LTD - WEDNESDAY 28 NOVEMBER

I undertook to let you have a list of other possible good causes for independent finance if Seagrams do not like the ideas for Stoke Mandeville:

Heart (and other) Transplants.

Infertility : "Test Tube Babies" : Steptoe/Edwards work.

Perinatal and Infant Mortality (? via the Spastic Society).

Help the Aged (with fund-raising directed to specific targets).

Mental Handicap Units ———— ditto ————

Alcoholism Prevention.

Migraine Clinics.

Rheumatism Research (via Rheumatism Council).

Research into back pain.

I don't suppose there would be much support to raise funds to upgrade Rampton; is it worth a try?

I asked Dr Ford for some ideas, and am waiting to hear from her.

Pamela Petrie
RL1
ET.1532/Extn.884

26 November 1979

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12A

Mr Collier

STOKE MANDEVILLE - NATIONAL SPINAL INJURIES CENTRE

The attached position paper summarises (paras 1 and 2) the background to the NSIC situation at Stoke Mandeville and Ministerial commitments following Dr Vaughan's visit on 20 November (Para 3). It goes on to identify issues now requiring attention, and makes one or two suggestions for action (Paras 4-7).

With some editing the paper might be useful for your Steering Group and for the Officials Working Group; also as a brief for your meetings with Mr Saville and Mr Davis of Seagrams on Wednesday next if you wish.

Annexed to the paper are copies of two recent letters from Mr Borges, Deputy Secretary RHCH, to Ministers; and one from Dr Rue to Dr J M Forsythe.

Peter Gant and I are out of the office at RL:RTO meetings in Oxford and East Anglia on Monday 26 and Tuesday 27 November, but I shall be in early am and latein the evening on both days.

I have not circulated the attached paper widely because you no doubt wish to consider how to take the action on from here.

Pamela Petrie
RL1
Room 1532/Extn.884
Euston Tower

26 November 1979

Copies to:
Mr Babb
Dr Tait
Mr Gant
Mr Rayner - O/R (for information)

POSITION PAPER - 24 NOVEMBER 1979

STOKE MANDEVILLE SPINAL INJURIES CENTRE (SMSIC)

1. The centre is located on the site of Stoke Mandeville District General Hospital. It is one of a small number providing a multi-regional service, but it is the one with the largest catchment population, serving the whole of the south of England. By virtue of being the oldest established and best known centre of its kind, it also draws patients from the north of England and from overseas.

2. Over the years there have been no formal closures of beds at SMSIC, but the number of available beds has declined due to competition for limited financial resources in Oxford RHA and Bucks AHA; to intermittent staff shortages (mainly nurses) and to poor maintenance of what are, by any standards, poor (ex EMS) buildings. Within the past two years the number of staffed beds has fallen from approximately 150 to approximately 110.

Problems at SMSIC were brought into sharp focus very recently by proposals published by Bucks AHA in an effort to live within their cash limits this year. These included the closure of two wards for SMSIC purposes and the re-opening of one for geriatric patients transferred from elsewhere. The measures affecting the Spinal Injuries Centre were made as much for cosmetic reasons as for economic ones. Whilst the AHA needs to save money, other alternative accommodation was available for the elderly people, and the two NSIC wards mentioned were, already, force majoure, not in use, although not officially closed. The AHA took the view, with some justification, given their local responsibilities, that the Centre could not be the only unit exempt from necessary economies. They exceeded their responsibilities however in publishing proposals to close the wards without prior agreement with the RHA and DHSS in view of the multi-regional nature of the Spinal Injuries service.

Taking a medium term view, the AHA, in the same proposals undertook to restore SIC bed numbers, as soon as possible, from the present level of 110 to approximately 136. The measures put forward by the AHA however occasioned a great public outcry, first, because they were designed to formalise an existing reduction in service and second, because the medium term remedial measures failed to bring services back to the earlier level of approximately 150 beds.

3. Ministers and the health authorities have been under pressure for some time, from the National Spinal Injuries Association (NSIA) and from various MPs, ex-patients and others to alleviate SMNSIC's problems by identifying and protecting allocations reflecting the true costs of running the centre; to acknowledge it as a national and an international centre of excellence; and to give priority to the total reconstruction of the Centre. More recently, NSIA has expressed a wish to see an Institute associated with SMSIC and to have a Director appointed to run both institutions.

At the present time, on present resource assumptions for at least the next seven years, there is virtually no prospect of using public funds to secure marked improvements in the Centre.

In RAWP terms, Oxford is broadly on target. Bucks AHA is below target at present and it has a rapidly rising population; it can therefore expect to receive increasing capital and revenue allocations, but these (rightly) will be almost entirely mopped up by the new DGH at Milton Keynes. Thus, Oxford has no means of manoeuvering resources to Bucks or NSICs' advantage and Bucks priorities clearly lie elsewhere. Worse, recent (crude) estimates of NSIC costs suggest, if they are anywhere near accurate, that Bucks already receives adequate recompense for the service which NSIC provides. It follows that there would be no advantage in "top slicing" SMNSIC allocation, and the disadvantages, in terms of the effect on other multi-regional services are obvious.

4. It was against this background that the Minister for Health fulfilled a longstanding engagement to visit SM DGH on 20 November and, in view of the high level of public concern (evidenced by sit-ins and demonstrations), concentrated during his time there mainly on the Spinal Injuries Centre.

At the conclusion of his visit the Minister announced some measures to reduce public disquiet:

he gave assurances that NSIC services would fall no further; that the two wards presently out of use would be retained for spinal injury patients, one being brought back into use as soon as possible and the other being reserved for the NSIC. Dr Vaughan also acknowledged Stoke Mandeville as a world renowned centre, primus inter pares in the treatment and rehabilitation of patients with spinal injuries, and he undertook that the revenue target for NSIC would be clearly identified at succeeding levels of the service as allocations were made. The Minister then referred to the possibility of mobilising public interest in and good will towards the Centre to raise funds for aiding and replacing it. He mentioned Jimmy Saville's name in this context. Dr Vaughan also tested the idea on management and clinicians that a Director should be appointed. Management and two of the three clinicians at NSIC were opposed to the suggestion, a third consultant, a favoured candidate for such a post was not opposed.

The Minister also announced that he was setting up a small Steering Group, under Mr James Collier, to investigate and coordinate interest in private funding arrangements.

On the day prior to his visit to Stoke Mandeville, Dr Vaughan saw Gordon Roberts and Lady Mallalieu (the Chairmen of Oxford RHA and Bucks AHA respectively) and invited them to serve on a Group of this kind.

Dr Vaughan also referred to the need for a Departmental initiative to confirm a Strategy for spinal injury centres in the south of England (to complement that already developed in the north). He took the view that it would undoubtedly be necessary to involve the NHS in developing a strategy of this kind but that the Department should initiate it because of the multi-regional nature of the service and because of the possibility of both public and private funds being used in its development.

5. Looking at future action. Stoke Mandeville NSIC has an immediate, and a medium, as well as a longer term need for finance.

In the short term, the AHA has undertaken to restore one SI ward to full use as soon as resources permit. It is very difficult indeed to see how they could manage to do this next year, never mind in the current one. There is too, the question of when and how the second 'reserve' ward's service is to be restored.

One of the principles referred to in the context of private fund raising appeals concerns 'net benefit'. (ie that private money should not be off-set by a comparable reduction in NHS funds). If private funds were used to restore services in one or both of the reserved wards there would clearly be a breach of the net benefit principle. Nevertheless the benefits to patients would be both direct, and immediate, compared with the NHS's ability to restore the service. Not an unattractive goal for a fund-raising campaign and one capable of being realised in the relatively short term. The financial target might be around £250,000 p.a. for 40 beds, and if achieved for two years such help might see Bucks AHA through the very worst part of its difficulties.

A target of £0.5m might be feasible for Seagers and the project seems compatible with the firm's aims of raising funds for an identifiable good cause within a relatively short timescale. A target of this size might be feasible for a "bottle tops" campaign and, if the money was devoted to re-opening two wards there is the possibility of using the Company's name for them.

If Seagers are not interested in this approach they might be willing to contribute to a wider appeal fund for SMNSIC.

In the medium term there is the problem of maintaining and upgrading the Centre until it can be rebuilt. The target required for the NSIC alone might be of the order of £0.75m spread over 6-7 years. (There is an estimated maintenance backlog of £2m for the IMH as a whole).

Fund raising for a project of this kind however, would be beset by problems. On the positive side is the fact that contributions to this end would secure immediate tangible benefits - an important point given the alternative - a long interval between launching a re-development appeal and seeing a new building brought into use after a number of years. From Ministers' and the NHS' point of view it also has the advantage of removing some of the pressure for improvements in a situation where virtually no public money is available. Against the proposal however, the scheme could not show 'net benefit'; contributions to an "improvements" scheme might deflect money from a rebuilding scheme, and, most difficult of all to deal with would be the injustice of upgrading one centre within the DGH and ignoring the rest, and the infeasibility of apportioning voluntary NSIC money if common service departments were the top priority candidates for upgrading.

Nevertheless, Mr Thomas Borges, the Vice-Chairman of the Royal National Orthopaedic Hospital, and a good fund-raiser apparently, in his own right, has written to say that £70,000 p.a. for three to four years would help SMNSIC, and that he would be happy to be of assistance in this matter. (Rather disconcertingly he says that he is about to launch a £1m appeal for the new SIC at RNOH but perhaps he does not intend to tap the same sources twice over.) Copies of two recent letters from Mr Borges are attached for information - we are holding replies until after Mr Collier has spoken to Mr Saville on Wednesday of this week.

A medium term appeal to raise funds locally for upgrading Stoke Mandeville as a whole might be quite successful since the whole population, rather than NSIC patients only, would stand to benefit. Unfortunately within the past few weeks, Sir ~~Lionel~~ Ludwig Guttmann has launched an appeal for £0.25m for the Spinal Olympics Sports Village. There is considerable support for this locally; a number of people may be under the impression that they are contributing directly to the SMNSIC.

An appeal (longer term) target for the total redevelopment of SMNSIC would probably be of the order of £5-£6 million at present prices. One of the reasons for this imprecision is that the size of Unit required has not been established. The NSI Association and some NSIC interests want a unit of 150 beds. Oxford RHA and informed medical opinion inclines to something less, perhaps 120 beds.

In terms of time, left to its own resources, the NHS could not tackle the rebuilding of Stoke Mandeville DGH until the latter half of the 1980s, so that a new SMSNIC provided from public funds would be unlikely to materialise before 1990 at the earliest.

Private funding could considerably improve the outlook - if fund-raising commenced in 1980, planning and design work could be undertaken during 1980/81, contract and construction during 1981-83 and commissioning in late 1983 or early 1984 (but see (vii) below).

6. Several individuals and organisations have expressed an interest in fund-raising: Jimmy Saville, Seagrams Ltd, Mr Borges, and the ~~National~~ Spinal Injuries Association (which is already holding money for SMNSIC's benefit). Mr Collier's Steering Group is intended to be the "umbrella" group co-ordinating these several interests and ensuring that proposals for the Stoke Mandeville NSIC are compatible with a strategy for the whole of the south of England. It will also need to decide if, or at what point, Trustees might be required. An alternative might be for the NSI Association to act as bankers collecting, investing and disbursing funds.

7. To date, Mr Collier is the Chairman of the Steering Group and the Minister has invited Mr Roberts and Lady Mallalieu to serve as members. A number of issues remain to be dealt with:

(i) Who else should serve? If Seagrams proceed to raise money, should they nominate a member? Undoubtedly the NSI Association would wish Baroness Masham to participate (leaving the Association's Secretary to assist the Officials' Working Group). What about Mr Borges? And would Jimmy Saville wish to go it alone or to work with others? Certainly his public persona suggests that he is unlikely to agree to serve on a committee. What about a financier, or a banker?

(ii) Is money to be raised for SMNSIC only or for Spinal Injury services as a whole? The NSI Association may favour the latter, whilst the Oxford RHO (whose business it is not entirely) clearly does.

(iii) What targets should be aimed for? Restoring the service (0.5m)? Maintaining the fabric and upgrading (0.75m)? or rebuilding the whole £5-6m? If separate targets are pursued, how can they be dovetailed to avoid confusion and duplication?

(iv) What is the basis of the appeal? Is it to be entirely independent? Or can public funds be found to contribute on a pro rata basis (say £1 public for £3-5 private). What happens if the appeal fails to reach the target?

(v) Is professional fund-raising assistance needed? Mr Saville and Mr Borges will probably say 'no', although this may be the only thing they agree about. The latter seems, in his correspondence, to doubt the former's ability (and ? suitability) for a task of this kind.

(vi) Should V.I.P. Patrons be enlisted? The Duke of Edinburgh's name has been mentioned although he says that he has not been approached and would need to think about it.

(vii) Depending on the type of appeal (wholly independent finance or pro rata) how is the rebuilding project to be handled? Oxford RHA officers assume that they will assist in defining the need (see the letter from Dr Rue (Oxford RMO)) to Dr Forsythe (South East Thames RMO) attached) and will take the lead in the briefing, designing, and construction processes. Obviously, if public funds are involved the SMNSIC project cannot be exempt from the normal channels of control (Capricode) and accountability, but if they are not, it might well prove quicker (once the battle over principle has been won) to work through an independent (but representative) project team using private architects and project management. It would of course be essential to ensure that the SIC development was compatible with the overall SM DGH Development Control Plan, and to collaborate with the health authorities in planning supporting services.

8. Finally, there is the question of the function and membership of the Officials Working Group. The functions would presumably be to define (confirm) a strategy for SI services in southern England, and to identify a statement of need for Stoke Mandeville within it; to collect information for the Steering Group, for example to identify costs of restoring the service and upgrading existing facilities. And also to brief the appointed Project Team, or to be reconstituted (with appropriate membership) as the Project Team working directly to the Steering Group.

Initially, within the Department - HS2, RL, FD, OR, Medical, Nursing, and, at the appropriate time, Works representatives will be needed. The Working Group will also need to call on Physiotherapy and O.T. advisers in due course. From outside the Department, representatives may be needed from Oxford, North East and South East Thames, together with a clinician specialising in spinal injury treatment and rehabilitation. The Secretary of the Spinal Injuries Association should perhaps also be invited to serve.

9. MS(H) clearly attaches priority to Spinal Injuries services, and the commitments which he made during his visit to SMNSIC point to the need for urgent action by officials. In consultation with SH, RL undertook to prepare this report as a basis for further action by the appropriate Division.

Pamela Petrie
RL1

24 November 1979

DH Document 06. Page 172

Dr Tate

SPINAL INJURIES UNITS - STOKE MANDEVILLE

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

pp N P Halliday
Med OS1
1835 ET

14 November 1979

cc Mr Wormald
Dr Lees
Dr Sweeney
Dr Rivett

24B

South East Thames Regional Health Authority

Randolph House 46 48 Wellesley Road Croydon CR9 3QA
Telephone 01-686 8877 Telex SETRHA 947113

Your reference | Our reference JMF/SJF | Date 12th November 1979

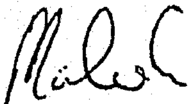
Dr. N.P. Halliday,
Senior Principal Medical Officer,
Department of Health and Social Security,
Euston Tower,
London,
NW1 3DN

Dear Norman,

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

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

Yours sincerely,



J.M. Forsythe,
Regional Medical Officer

cc Dr. T.K. Sweeney

CH

HA. 541
11A.

Mrs Petrie - if you agree
Miss Spencer

MS(H)'S VISIT TO STOKE MANDEVILLE, 20 NOVEMBER

Facing is a draft programme revised by the Area to take account of MS(H)'s wish to give good time to meeting with representative ex-patients of the NSIC. More time is also allocated for the visit to the NSIC itself.

The Area advise us that there could be a mass protest rally of paraplegics in the sports stadium coinciding with MS(H)'s visit. Does MS(H) wish to meet representatives only as the programme proposes, or to visit the larger demonstration? There would almost certainly be TV and radio coverage - on the whole it might be better for MS(H) to meet representatives so as to avoid a "shouting match" and then speak to TV if requested in the press conference after lunch.

Could we have urgent guidance/approved from MS(H) on the programme. The Area are waiting to make the arrangements.

Peter R Gant
RL1
Room 1504 Ext 816
Euston Tower

12 November 1979

cc Folder
Mr Bolitho
✓Mr Bebb
Dr Tate
Dr Melia
Miss Rowland-Jones
Mr Collingwood
Miss Sweeney/file
Miss Gwynn

DRAFT.

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY

Programme for the visit of Dr Gerard Vaughan, MP, Minister for Health to Stoke Mandeville Hospital on Tuesday, 20 November, 1979

10.00 am	Arrive at Hospital Main Entrance To be met by Lady Mallalieu - Chairman, Buckinghamshire Area Health Authority Mr R E Titley - District Administrator Coffee and brief discussion with - Mr R Catterson, Divisional Nursing Officer Miss E M V Denny, Senior Nursing Officer Mr D J Clay, Sector Administrator
10.15 am	Tour of part of Hospital - accompanied by Mr Titley North Corridor: 4 Wards - 1 Gynaecological Ward 8X 1 Geriatric Ward 10X 1 General Surgical Ward 10 1 General Medical Ward 11X
10.45 am	By car to New Wing - walking through Out-Patient Department to first floor, visiting: Ward 20 (Chest) Ward 22 (Female Fracture and Orthopaedic) Ward 21 (ENT)
11.15 am	By car to South Corridor, visiting: Regional Plastic Surgery and Burns Unit.
11.30 am	National Spinal Injuries Centre
12.00 noon	Meet representatives of ex-patients (who will be holding a mass-rally in the adjacent sports stadium).
12.30 - 1.45	Working lunch with chairmen of RHA, AHA and representatives of the Regional Team of Officers, the Area Team of Officers and the two DMTs. (Postgraduate Centre)
1.45 - 2.15	Meet staff representatives (Tutorial Room, NSIC)
2.15 - 2.45	Meet representatives of the consultant medical staff.
2.45	Press Conference (+ Radio and TV?) in committee Room
Approx 3.15	Depart from main entrance.

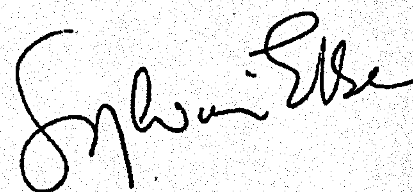
Miss Spencer

We have received a request for Dr Vaughan to give a radio interview on Stoke Mandeville as soon as possible following his visit there on 20 November. The request comes from the BBC Radio 4 Programme 'Does He Take Sugar'.

The programme would like to discuss with the Minister the case for central funding for a unit such as Stoke Mandeville.

A previous bid from the programme for the Minister to talk on this subject was turned down (it was then requested before the original date for Dr Vaughan's visit to Stoke Mandeville) in favour of a prepared statement.

In view of the considerable press and public interest in the future of Stoke Mandeville we recommended that the Minister should agree this request. It is quite likely that there will also be further broadcasting requests, around the time of the visit.



12 November 1979

SYLVIA ELSE

cc Mr Taylor
Mr Bebb
Mr Gant
Mr Williams

53/1
~~HA~~
9A

Mr Politho
Mrs Petrie
Mr R Smith
Mr Bebb and Dr Tate
Dr Lees
Miss Rowland-Jones

MS(H)'S VISIT TO STOKE MANDEVILLE 20 NOVEMBER 1979

BRIEFING MEETING WITH MS(H) 19 NOVEMBER, 3.15 PM AFH D614

Attached is a copy of the AHA's Consultative Document, the revised High Wycombe proposals and my letter of 12 November to Mr Norton preparing for the meeting of DHSS/ATO/RTO on this Friday 16 November 1979. These probably give more useful information at present than the visit brief, but I will circulate the revise when it is completed.

RCP and SH will obviously be concerned not so much about the specific decision at SM (though Mr Bebb would presumably not be happy at the permanent relinquishment of one 25 bedded ward by the NSIC) as for their own policies on central funding and on spinal units generally.

Peter R Gant
RL1
Room 1504 Ext 816
Euston Tower

12 November 1979

cc Mr Collingwood
Miss Sweeney/file
Miss Gwynn

98

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY

Telephone:
XXXXXXXXX AYLESBURY 748111
This matter is being dealt with by
Mr. Walker
extension 42
Your ref.:
Our ref. KGW/DL/F/1/10/79

Area Headquarters:
PEVEREL COURT,
PORTWAY,
STONE, AYLESBURY,
BUCKS., HP17 8RP

5th October, 1979

Dear Sir/Madam,

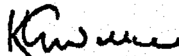
AREA OPERATIONAL PLAN 1979-81

I enclose copies of a consultative document which the Area Health Authority has agreed should be issued for consultation. The Area Health Authority will be considering the subject again at its meeting on the 7th November 1979, and will wish to receive comments upon the consultative document by that date. If possible could I please have any comments from you by 31st October 1979.

Should you require more copies of the document please let me know.

If you wish further information upon any of the proposals please get in touch with either Mr. R.E. Titley, District Administrator, Aylesbury & Milton Keynes Health District, 9 Bicester Road, Aylesbury, Bucks, Telephone: Aylesbury 84111; or Mr. R.S. Anson-Owen, District Administrator, High Wycombe Health District, Oakengrove, Shrubbery Road, High Wycombe, Bucks, Telephone: High Wycombe 24156, in respect of the papers of the respective District Management Teams. I myself will deal with enquiries concerning the Area managed services, or the consultative document generally.

Yours faithfully,



K.G.Walker,
Area Administrator.

Encs.

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY

Telephone:
AYLESBURY 748111
This matter is being dealt with by
....
extension ....
Your ref.:
Our ref.

Area Headquarters:
PEVEREL COURT,
PORTWAY,
STONE, AYLESBURY,
BUCKS., HP17 8RP

AREA OPERATIONAL PLAN 1979-1981

PREFACE TO THE CONSULTATIVE DOCUMENT - OCTOBER 1979

1. The Area Health Authority, faced with the requirement to contain expenditure within the cash limits notified to the Authority for the 1979/80 financial year, decided at its meeting on 29th August 1979 that there should speedily be prepared comprehensive and realistic plans matching the service which can be provided with the finance which is likely to be available. The three Management Teams were instructed to prepare such plans which would then form the basis for consultation.

2. The Authority at its meeting on 3rd October 1979 considered the proposals from the three Management Teams, and after lengthy discussion agreed that the proposals (with a few modifications) should be published as a consultative document. The modified proposals are attached.

3. The members of the AHA, in the course of considering the proposals, made a number of comments and decisions. The proposals of the Management Teams should therefore be read in the light of those comments and decisions.

4. They are:

   4.1 The requirement is for a reduction in expenditure so that expenditure does not exceed the financial allocations made to the Authority.

   4.2 Unless they are in accordance with previously agreed and published plans, the closures and reductions in service proposed are temporary and will be reviewed when the financial situation is easier.

   4.3 There are disparities in style of presentation and content of the papers from the three Management Teams. The AHA will not necessarily look for consistency of action throughout the Area, but it is recognised that some decisions concerning some parts of the Health Service in Buckinghamshire can have significant consequences for other parts.

   4.4 Reports have been called for from the senior staff concerned on the family planning services, and the school health service, to be considered alongside the proposals of the High Wycombe District Management Team for those services.

4.5 Special attention should be given to the proposed revised criteria for the use of the ambulance service, because of the inter-dependence of the ambulance service and many other sections of the Health Service.

4.6 Decisions by the Government arising from pay increases awarded very recently to Health Service ancillary staff and ambulancemen will mean that the figure for "pay increases not funded" will be greater than the £160,000 quoted on page 2 of the attached document.

4.7 The requirements of legislation on fire precautions, the use of drugs, safety regulations etc., are quoted on page 3 among the constraints upon the AHA not to reduce some services. In practice also financial stringency has constrained the AHA from doing as much as it would have wished with fire precautions, safety measures etc.

Area Administrator.
5th October 1979

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CONSULTATIVE DOCUMENT

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY

AREA OPERATIONAL PLAN 1979-1981

1. Introduction

This Authority, in common with all other Health Authorities, published annually a Plan indicating proposals for developments in the service over the ensuing three years. Such a Plan, covering the period 1980/81 to 1982/83 was in the course of preparation earlier this year when the Secretary of State announced that each Health Authority must contain expenditure within its allocation. Since the Plan then in preparation was based upon a five year financial programme which, in anticipation of increased funds in later years, involved deliberate overspending initially in order to maintain services, it was clear that the Plan was not consistent with the new Government's policy. Furthermore, since this Authority already had an inbuilt overspending on its budget which it had been carrying for some time but was now required to redeem by the end of the current financial year, it was also clear that immediate positive action would be required.

At its August 1979 meeting, the Authority determined that the first phase of this action would be an embargo on the filling of all but a few exceptional vacancies, and it has since been agreed that this embargo will continue until at least the beginning of November. The Authority also asked that a Plan detailing a second phase of action be prepared by that date.

This document is the one called for and covers the period from the present day to the end of the next financial year in March 1981. Inevitably the picture is an unhappy one, and despite all efforts to minimise the effect on services, the enforced reduction in the level of health service provision outlined in the document remains a matter of bitter disappointment to the members of the Area Health Authority.

2. The Financial Picture

For a number of years this Authority has carried an inbuilt overspending amounting to some £750,000 at November 1978 price levels. In terms of cash limits this overspending has been masked by a variety of circumstances until this year, when it was expected that the Authority would be overspent by the full £750,000. One solution to this problem would be to carry the overspending forward to the following year's allocation, but this would continue the problem from year to year until additional resources were made available to meet the overspending.

In June this year the Regional Health Authority published its revenue resource assumptions for the period 1980/81 to 1984/85, which gave Buckinghamshire Area Health Authority the following growth monies:

	£000s
1980/81	189
1981/82	800
1982/83	1720
1983/84	1100
1984/85	1570
	5379

These growth monies are quite significant after the first year and match the trend of the population of Buckinghamshire which has the fastest growth rate in the country.

In the light of these assumptions, therefore, a five year financial programme was drawn up to maintain the existing level of services and enable some small developments to take place at Milton Keynes where the population growth was greatest. The effect of this policy would be that by March 1982 the Authority would be overspent by £2.62m but that thereafter the expenditure would be contained within the increased allocation. By 1984/85 the deficit would have been recovered and sufficient revenue funds would be available to finance the revenue costs of the Milton Keynes District General Hospital.

This five year programme was adopted by the Area Health Authority at its July 1979 meeting as a basis for the next operational plan. However, on 17th July the Secretary of State for Social Services, speaking in the House of Commons, made it quite clear that each Health Authority would have to contain expenditure within its cash limits this year. At its August meeting, this Authority resolved to make all possible attempts to comply with the Secretary of State's requirements.

The difficulty of meeting these requirements was greatly increased when it was reported that the Authority would have to meet the full cost of the increases in VAT from 8% to 15%; the full effect of price increases over and above the 8½% per annum allowed for in the cash limit this year; and £160,000 of the cost of pay rises negotiated in the current round of talks. The Regional Health Authority has taken action to meet the deficit on the revenue allocation by stopping capital spending and transferring the unspent allocations to revenue, reducing cash balances and transferring earmarked reserves to general reserves. This should mean an additional non-recurring allocation of £467,000 will be made to Buckinghamshire Area Health Authority. In addition, the Area Health Authority's decision to stop minor capital spending should enable a further £300,000 to be made available on a non-recurring basis. A further £75,000 can be transferred from joint financing. The full effect of this is shown below:

	£000s	£000s
Inbuilt overspending		750
Payback last year's overspending		290
Pay increases not funded		160
Price increases not funded		990
		2190
Less: Additional non-recurring allocation from RHA	467	
Transfer from minor capital	300	
Transfer from Joint Financing	75	842
		1348

This figure represents some 3.8% of our allocation this year.

The size of this Authority's allocation in the next financial year (1980/1982) is difficult to predict. It is not yet known to what extent the effect of this year's inflation will be funded next year, nor indeed whether the pay and price increases element in next year's allocation will be sufficient to cope with the rate of inflation.

Furthermore, although there has been no retraction of the revenue resource assumptions listed on the previous page, it is possible that these will be reduced in line with Government policy. However, two elements that should not affect next year's allocation are the inbuilt overspending and the payback of the previous year's overspending, since it is hoped that these will be eliminated as a result of measures outlined in this document.

3. Objectives of the Plan

Although severely constrained by the financial situation, the overriding objective of this Plan is still the provision of the optimum level of service within the resources available.

In order to make savings of the magnitude required to contain expenditure within the allocation, it is inevitable that services will have to be reduced, but throughout the Plan, careful thought has been given to the means of achieving these savings with the minimum effect on patients.

The Secretary of State has said, and is supported by the members of the Authority in this, that he would not wish to see the permanent closure of any facilities as a result of this financial policy. Therefore, where complete closures, for example of wards or departments, have been proposed, these will be carried out in such a way as to enable them to be reinstated in a better financial climate. Obviously where services sustain only a reduction rather than complete shut down, these too will be more easily restored when sufficient resources become available.

Another prime objective is that emergency services will not be affected. Patients requiring urgent treatment as a result of accidental injury or sudden illness, as well as midwifery cases, will continue to receive the same high level of service from the Ambulance Service, Accident & Emergency Departments and Acute Wards as hitherto.

In addition to the emergency services, there are certain other services which will not be reduced because of constraints placed upon the Area Health Authority. These include:

i) Certain requirements arising from legislation on fire precautions, use of drugs, safety regulations etc.

ii) The policy of the Area Health Authority of no redundancy.

iii) The maintenance of a sufficient number of beds in various specialties to enable nurse training to continue.

iv) The maintenance of a sufficient number of beds in various specialties to enable training of junior medical staff to continue.

v) The maintenance of sufficient beds to enable the Joint Hospital/General Practitioner Medical Training Scheme to continue.

vi) Other standards imposed by professional bodies such as the General Medical Council, General Dental Council, General Nursing Council, Central Midwives Board and the Universities.

PLAN FOR AREA MANAGED SERVICES

The Area managed services fall into two groups:

1) Direct patient services and para-medical services managed on an Area-wide basis.
2) Support services provided for the whole of the Area.

The total budget for the Area managed services in the current financial year is £3,823,605 and the Area Team of Officers have discussed with individual budget holders proposals for providing their respective services within a reduced budget. Overall a reduction of the order of 10% is required if expenditure is to be contained within the allocation, but the same level of reduction will not necessarily apply to each individual budget. A summary of the proposals for Area managed services is as follows:

Service	Proposals	Consequences
1. Community Dental Services and Dental Administration	Appoint senior dental officers in Milton Keynes and Aylesbury, and reduce professional staff overall by 4.35. Maintain a 1 : 1 ratio of dental surgery assistants to professional staff.	Longer intervals between school inspections. Reduction in treatment levels.
2. Speech Therapy	One part-time post to be filled.* Other vacancies to remain unfilled. No student speech therapists taken on. Reduce staff levels by 2.5 Senior II speech therapists. * To be funded by Inner London Education Authority.	Closure of some clinics and less service to the educationally sub-normal schools.
3. Chiropody	Appoint Senior Chiropodist I in Milton Keynes. Other vacancies remain unfilled. Reduce proportion of private contractual work.	Reduction in level of service.
4. Contractual Hospitals and Homes	Reduce number of patients placed in private nursing homes. In current year no further patients to be placed.	Increased hardship for patients not placed. Increased load upon AHA services catering for these patients. Not possible to estimate saving.
5. Pharmacy Services, including Pharmaceutical Administration	Reduce staff levels. Introduce Quality Control service and reinstate manufacture of sterile products. Outpatient prescriptions limited to maximum of one month's supply of drugs. Appoint staff pharmacist at Milton Keynes Community Hospital, Pharmacist at Wycombe General Hospital & Technician for Quality Control Service. Other vacancies to remain unfilled	Difficult to evaluate effect. Area Headquarters pharmaceutical portion of the budget only £21,050 of a total budget of £248,160 and is unlikely to be reduced. Savings will be made from Districts' proportion of overall budget.

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Service	Proposals	Consequences
6. Health Education	Reduction in staff numbers as vacancies occur, and cutback in expenditure on educational material and training courses.	General reduction in the level of health education activities. Suspension of advanced staff training.
7. Ambulance Service	Adoption of revised criteria for the use of the ambulance service (Appendix 1), with consequential reduction in demand on the service. Area Chief Ambulance Officer to review urgently the operation of the service with the objective of producing firm proposals on manning level and procedures designed to respond economically to demand in the light of possible future developments.	Ambulance service will be less available than hitherto for non-emergency patients.
8. Family Practitioner Committee Administration	Reduction of 7 staff, including 3 temporary by non-filling of vacancies. Withdraw participation from the Cervical Cytology National Recall Scheme. Cessation of all overtime working.	Some F.P.C. work will not be carried out, but registration of patients, patients medical records and payments to independent contractors will be priority tasks for continuation.
9. Area Treasurer's Department	Reduction in staff numbers sufficient to effect reductions in expenditure but allowing limited number of vacancies to be filled including one HCO post in Salaries and Wages. Reduction in security services arising from changeover from cash to cheque payments for weekly wages.	Audit services withdrawn with consequential risks. Reduction in budgeting information from Treasurer's Department. Payment of salaries and wages and payment of accounts will rate as priority services for continuation.
10. Area Supplies Department and Supplies Transport	Filling of small number of vacancies associated with ordering and delivering services, but overall reduction in staff numbers. Increased rationalisation of items and reduction in frequency of deliveries. Close scrutiny of orders and requisitions.	Difficult to predict. Perhaps some inconvenience to users.
11. Personnel Administration and Training	Reduction in staff numbers as vacancies arise. Continuing tight control on training budget. Reduction in advertising expenditure.	Possible reduction in the service provided by the Area Personnel Department (which AHA members have stated is insufficient already). Further reduction in training activities (which is already at a level far below what is desirable).

Service	Proposals	Consequences
12. Management Services	Reduction in staffing when vacancies occur. More flexible use of existing staff.	Monitoring of bonus schemes and activities connected with high cost areas to remain as priority services.
13. Administration - Area H.Q. Peverel Court and Area Child Health Records	One post to be filled. 3½ vacancies to remain unfilled. Further reduction of staff as further vacancies arise. Work of Child Health records to be maintained. Action taken to curtail expenditure on postages, telephones, stationery, furniture & equipment. More flexible use of existing staff.	Work of the Planning & Information Section in general, and Land and Property Transaction work in particular will be very seriously affected. Some other work may not be carried out.
14. Medical Administration	Reduction in staff numbers as vacancies arise. Some curtailment of training activity.	Reduction in the collaboration work undertaken with Local Authority.
15. Nursing Administration	Area Nurse (Service Planning) post to remain unfilled. Further reduction of staff numbers as vacancies arise.	Less contribution from nursing administration to the activities of the Area Health Authority.
16. Nurse Training	Cancelling the District Nurse Training School plan for January 1980. Reduction in number of student health visitors by 2.	A reduction in the number of trained health visitors available in the Area.
17. Works Administration	Cessation of payments to apprentice who has completed training. Less use of professional consultant staff. Reduction in staff numbers if appropriate through vacancies. More flexible use of staff.	Reduction in the contribution of the small number of professional works officers in the Area H.Q. on works schemes throughout the Area.
18. Maintenance Budget for Area H.Q. Properties (4)	Maintenance to be confined to "breakdown" work and repairs arising from terms of leases. A substantial proportion of this budget is accounted for by rent and rates.	Continuing deterioration in the premises and no improvements.
19. Losses and Compensations, Members' Expenses and Area Medical Services	These three very small budgets not susceptible to control.	

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The proposal anticipated from the Government in the autumn of 1979 for charges in the management arrangements for the NHS c[illegible] have direct bearing upon some of the functions and posts in the Area Headquarters. Any decisions concerning the filling of vacancies should be taken in the light of the Government proposals, and until those proposals are available vacancies in the more senior managerial posts should not be filled.

A summary of the financial effects of all the above proposals is given below:

Service	Pay Budget	Non-Pay Budget	Total Budget	Savings 1979/80	Savings 1980/81
1. Community Dental Services and Dental Administration	237,680	31,340	269,020	36,000	37,000
2. Speech Therapy	110,300	11,950	122,250	10,000	12,000
3. Chiropody	199,080	15,940	215,020	8,000	22,000
4. Contractual hospitals and homes	-	34,400	34,400	-	-
5. Pharmacy Services & Pharmacy Administration	20,350	700	21,050	-	-
6. Health Education	59,350	14,855	74,205	7,000	7,500
7. Ambulance Service	1,141,760	389,930	1,531,690	20,000	120,000 *
8. F.P.C. Administration	200,110	37,220	237,330	20,000	24,000
9. Area Treasurer's Department	334,580	101,650	436,230	15,000	43,000
10. Area Supplies Department and transport	175,030	43,725	218,755	10,000	15,000
11. Personnel Administration and training	32,400	13,600	46,000	1,000	2,000
12. Management Services	39,910	3,815	43,725	200	500
13. Administration - Area Headquarters and	92,990	30,915	123,905	} 11,000	20,000
Area Child Health Records	37,750	32,000	69,750	}	
14. Medical Administration	62,750	3,600	66,350	5,000	7,000
15. Nursing Administration	47,870	2,700	50,570	5,000	8,000
16. Nurse Training	62,440	16,000	78,440	7,000	10,000
17. Works Administration	50,350	2,100	52,450	2,000	5,000
18. Maintenance budgets for Area H.Q. Properties	5,000	106,620	111,620	7,000	10,000
19. Losses and Compensations and	-	6,500	6,500	-	-
Members' Expenses and	2,270	4,875	7,145	-	-
Area Medical Services	7,000	200	7,200	-	-
TOTAL BUDGETS	2,918,970	904,635	3,823,605		
TOTAL ALLOCATION	-	-	3,407,901		
INBUILT OVERSPENDING			415,704		
TOTAL SAVINGS ANTICIPATED IN EACH YEAR				164,200	343,000

* This is a target figure but it is difficult to assess to what extent this will be achieved

Area Team of Officers
September 1979

CONSULTATIVE DOCUMENT

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY

APPENDIX I

CRITERIA FOR THE USE OF THE AMBULANCE SERVICE

REVISED SEPTEMBER 1979

The demands for transport placed upon the Ambulance Service must be related to the ability of the Service to meet these demands in such a manner as to satisfy the reasonable expectations of legitimate users. When demand exceeds resources standards fall, patients experience delays and Doctors, Hospital Staff and others are inconvenienced.

The present financial position has high-lighted the dilemma of the Ambulance Service and it is recognised that uncontrolled demand and demand patterns result in over-spending. Proper use of the Service, maximum co-operation from users and the application of criteria are necessary to enable the Service to fulfil its obligations within cash limits. The use of criteria is essential to spread demand in the non-emergency field as this permits all proper demand to be met in the most cost effective manner without detracting from the ability to respond effectively to emergency requests.

Advice on the use of the Ambulance Service, together with the observation that use of the Service should be restricted to patients with a medical need, previously approved by the Authority, should form a preamble to the non-emergency ordering criteria which should be:-

CRITERIA FOR NON-EMERGENCY REQUESTS

(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 Chief Controller and/or Ambulance Liaison Officers will provide every assistance in any case of special difficulty but the criteria must be adhered to if the Authority is to provide an efficient Ambulance Service.

Ambulance Headquarters

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY

AYLESBURY AND MILTON KEYNES DISTRICT

FINANCIAL SITUATION - Revised Operational Plans

1. INTRODUCTION

Previous plans have drawn attention to the continued overspending of the District's financial allocation, although in previous years this has, to a large extent, been "cushioned" in various ways.

It has now been made clear that in the future the level of services provided must not exceed the financial allocation.

In this District, with the most rapid population growth in the whole of the country, particular difficulties arise in trying to plan services within the available resources. Not only do we have to provide extra staff in the Community to meet the primary care needs of the new population, but we find that all of our acute services are under considerable pressure in trying to cope with the additional demands made upon them.

It is estimated that on current levels, we are exceeding our allocation of approx. £18m per annum by some £500,000 per annum - i.e. just over 2½%.

Until the financial allocation is based on current or projected population figures rather than retrospective figures, the District will continue to be in an overspending position and therefore the District Management Team has had to look at all of its services to see what proposals can be put forward to live within its means.

It must be borne in mind that we have "trimmed" many of our services (some quite severely) over the last three years, and therefore any further savings can only be made to the detriment of patient care.

We find it wholly unrealistic and distasteful to have to submit proposals for restricting services when in fact we should be putting forward plans for development of services to meet the needs of the ever growing population.

2. GROWTH OF DISTRICT

a) Population

The following table illustrates the population growth since 1974 and the projected growth to 1991.

		Aylesbury Vale '000's	Milton Keynes '000's	Total '000's
Actual	(1974	117.60	78.00	195.60
	(1977	120.80	100.60	221.40
	(1978			230.01 *
Projection	(1981	129.00	128.00	257.00
	(1988	145.40	190.50	335.90
	(1991	149.19	218.81	368.00

* total District figure - breakdown: Aylesbury Vale 123.1; Milton Keynes 107.0.

During this period the number of acute beds has remained virtually the same, apart from a small increase in orthopaedic beds when Phase I of the new development at Stoke Mandeville Hospital opened in 1976.

b) Workload

Totals for all Units

	1974	1977	1978
Average available beds	1831.2	1921.8	1854
Average occupied beds	1514	1584.6	1543
Discharges & Deaths	23119	25474	24064
Day Cases	4841	5262	6635
Waiting List at 31 Dec.	2859	4310	5279
Day Case Waiting List at 31 December	612	697	1233
New Out Patients	30518	32315	37179
Total Out-patient attendances	122926	125982	137282
New Accident & Emergency Cases	19661	19256	20154
Total A & E attendances	25285	23624	21933
X-Ray units	900682	1144256	1160909
Path. Lab. requests	206812	249658	262820
weighted requests	584526	713755	747209

Notes: 1974 does not include Westbury Maternity Home, Renny Lodge Hospital or Stony Stratford Health Centre.
Winslow Hospital excluded from January 1978.

c) Revenue Allocations

Whilst the allocation has increased significantly over recent years, the bulk of the extra money was for meeting inflation and wage award costs. Very little has been made available for development of services, in fact whilst the total allocation has increased from £6.725m in 1974/75 to £18m in the current year, only £3m of this is in respect of developments of service.

d) It is against this backcloth that the implications of the following plans must be assessed.

3. PROPOSED OPERATIONAL PLANS

Previously agreed plans for the foreseeable future were based on the following objectives:

a) Acute services in Aylesbury to be concentrated on two sites, i.e. Stoke Mandeville Hospital and the Royal Buckinghamshire Hospital, leading to the eventual closure of Tindal Hospital, probably when a District General Hospital is established in Milton Keynes.

b) An amount of revenue in the early 1980's to be conserved to allow for sufficient funds to open Phase I of the Milton Keynes District General Hospital.in 1984/85. (i.e. this amount of revenue to be spent each year on a non-recurring basis.)

c) Mental illness services to continue to be based at St. John's Hospital with some facilities at Milton Keynes.

d) Mental Handicap facilities for the whole of the County to be based at Manor House Hospital.

e) Community services to expand in relation to population growth.

In looking at the position in the immediate future, the District Management Team has tried to formulate its proposals in line with the foregoing objectives.

i) General Sector

a) Stoke Mandeville Hospital

It is proposed to transfer geriatric services from Tindal to Stoke Mandeville Hospital so that a large part of Tindal Hospital can be taken out of use.

It will be recalled that when the closure proposals for Tindal were put forward two years ago, these had a considerable impact on the services provided at Stoke Mandeville Hospital, and this will still be the case under the present proposals.

Briefly, to achieve this transfer and to run services within financial resources will entail a loss of some 100 beds. Detailed proposals as to how reductions can be made in the acute services will be the subject of discussion with all concerned during October, but in general terms it will mean the loss of either a ward or a part ward in the following specialties:

General Medicine
General Surgery
Spinal Injuries
Geriatrics
Plastic Surgery & Burns, and Dental.

Support services would also be expected to achieve a saving of up to 10% of their current annual expenditure.

b) Tindal Hospital

If geriatric services (including the day unit) are transferred to Stoke Mandeville Hospital, the following services will remain at Tindal:

Psycho-geriatric
Paediatric Assessment Unit (planned to transfer to Royal Bucks. Hospital but delayed because of embargo on Capital Schemes)

In addition, some residential accommodation will be required and the Area Management Services Unit and the accommodation used by the Oxford Diocesan Council for the Deaf will also be retained.

Catering services are already being provided from Manor House Hospital, and it is planned to base other support services such as portering at Manor House.

It is therefore recommended that the remaining services at Tindal (which can be concentrated into about half of the existing buildings) should be regarded as an annexe of Manor House and administered by that Hospital.

The vacation of certain buildings will enable a considerable part of the Tindal site to be sold, although the details are still to be worked out.

c) Community Services - Aylesbury

In view of the additional burden which will fall on primary care and Community services, it is not recommended that existing levels of service should be reduced. On the other hand, there will be little opportunity for any development of service or staffing levels despite the increasing population in Aylesbury.

ii) Psychiatric Sector

a) Mental Illness

i) Although the planned opening of psychiatric beds in the Community Hospital at Milton Keynes has had to be postponed, the District Management Team is anxious that these facilities are brought into use as soon as possible.

It is therefore proposed that Crouch Ward at St. John's Hospital (23 bed admission ward) be closed and that approx. 15 beds are opened in Milton Keynes, thus reducing the total number of admission beds by eight. (Crouch Ward already admits male patients from North Bucks. and is one of the less attractive wards in the hospital, as well as being very expensive to heat.)

ii) The transfer of the Psychiatric Day Unit from its present location in Byron House, Wendover Road, Aylesbury, to either Tindal or Manor House Hospitals would enable Byron House to be closed and the property could then be sold.

iii) Because of staffing difficulties the Occupational Therapy Department at St. John's Hospital is under-utilised at present, and it is proposed that for a temporary period, say for 6 months in the first instance, the Main Department could be closed. Some work currently carried out in this building could be transferred elsewhere.

iv) Support services to aim to achieve a saving of up to 10% on current expenditure.

b) Mental Handicap

i) The level of service has been substantially reduced in recent months due to the serious shortage of both trained and untrained nursing staff. It is important that staffing levels are improved as soon as possible to provide an adequate standard of care for patients within the hospital and to enable the Day Care Unit and the Assessment Unit to be re-opened.

Some accommodation in the hospital could be utilised for other purposes (e.g. transfer of psychiatric day unit as mentioned earlier).

ii) The co-ordination of certain support services to provide cover for Tindal Hospital will achieve significant reductions in expenditure.

iii) Milton Keynes

A) Hospital services

i) With the proposed opening of psychiatric beds in the Community Hospital, no further developments of services are planned for this unit.

ii) At Renny Lodge Hospital, Newport Pagnell, the closure of two small wards (17 beds in total) and the transfer of patients to other wards will produce savings in the order of £20,000 per annum.

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iii) The possibility of closing the Day Unit at Renny Lodge and concentrating services in Wolverton Day Hospital is being examined, and savings of some £7,000 per annum could be achieved.

b) Community services

There is little or no opportunity of reducing expenditure in this area, in fact it is necessary each year to provide extra community staff to meet the requirements of the ever increasing population.

iv) Other Services

The aim of the District Management Team is to achieve a reduction of up to 10% in as many other services as possible, and all items of expenditure are under investigation - e.g. telephones, postages, estate management administration generally. Certain suggestions from staff have been particularly helpful in this respect.

v) Options

The District Management Team would have preferred to present various options to the Authority as to how expenditure can be reduced. However, it has been difficult enough to put forward many realistic proposals, bearing in mind the points made at the beginning of this report.

The closure of small units, e.g. Buckingham Hospital, Bletchley Maternity Unit, Westbury Maternity Home, would not achieve any significant savings unless the staff at these units were either redeployed into vacancies elsewhere in the District or made redundant. Furthermore, the services provided at these units could not be easily provided elsewhere.

There is room in our proposals for discussion on the detailed aspects of in-patient facilities at Stoke Mandeville Hospital, but unless the number of beds in the General Sector are reduced by about 100 (with consequent staff reductions and with some beds remaining empty) we cannot achieve the necessary savings.

vi) Summary of proposals and estimate of financial savings

A) General Sector

Reduction of approx. 100 beds some of which will remain empty.

Reduction of up to 10% in all other services.

Providing Tindal support services from Manor House.

Estimated savings £460,000 per annum.

B) Psychiatric Sector

Closure of 23 admission beds at St. John's Hospital and opening of 15 beds at Milton Keynes Community Hospital.

Transfer of Psychiatric Day Unit from Byron House.

Reduction of up to 10% in all other services.

Estimated savings £50,000 per annum.

C) Milton Keynes

Closure of 17 beds at Renny Lodge Hospital.

Closure of Day Unit at Renny Lodge Hospital and centralising facilities at Wolverton.

Reduction of up to 10% in all other services.

Estimated savings £30,000 per annum

D) Other Services (including District Headquarters)

Reduction of up to 10%

Estimated savings £10,000 per annum

TOTAL ESTIMATED SAVINGS £550,000 per annum

To achieve savings of this magnitude will require the full co-operation of all concerned. We are encouraged by the responsible attitude being taken generally by staff, but we must repeat what has been said earlier, that the detriment to the clinical services which will result from these proposals is something which we find wholly distasteful.

If the Authority agrees, we would propose to undertake consultations with all concerned during October and come back to the November meeting with a more detailed account as to how the proposals will be applied, and the consequential financial effect.

eptember 1979

Aylesbury and Milton Keynes
District Management Team.

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY

HIGH WYCOMBE DISTRICT

THE DISTRICT MANAGEMENT TEAM'S REPORT ON THE FINANCIAL SITUATION 1978/80 & 1980/81

1 EXPENDITURE 1979/80

Based on the present information available it is estimated that the High Wycombe District, unless economy measures are instigated, will overspend the current year's financial allocation by at least £600,000. The Consultative Document prepared by the Area Team of Officers for the Authority estimated approx £800,000 of Capital Monies (Region and Area) not yet committed would be available for transfer to Revenue in the current year. It is estimated that if this transfer is made approx £260,000 would be available to be set against the overspending of the High Wycombe District and therefore a saving of approx £340,000 has to be made this year. Even this figure may be substantially increased subject to the level of inflation.

2 EXPENDITURE 1980/81

The High Wycombe District cannot expect any new money to be available in 1980/81 and therefore the Area Health Authority have requested an operational plan to be prepared for the October meeting of the Authority which will bring the cost of the service operating in the District in line with the predicted Allocation for 1980/81. This means in effect that if services etc in the District are to be reduced to produce a saving of at least £600,000 per annum by 1 April 1980 a reduction of approx 5% of the present expenditure is required and this will mean a reduction of the number of staff employed in the District by 100 to 120 full time equivalent staff.

3 CONSTRAINTS

The District Management Team when submitting their recommendations have had to operate within the following constraints:-

a) The Secretary of State's comment that cuts should be made in a way which does not result in permanent closures particularly of much loved small hospitals. Temporary closures of wards may in some places be right.

b) The policy of the Area Health Authority of no redundancy.

c) To ensure that there are the relevant number of beds of various specialties available to continue nurse training.

d) To ensure that there are the relevant number of beds in the appropriate specialty available to obtain recognition for training of Junior Medical Staff.

e) To ensure that there are sufficient beds to continue the Joint Hospital/ General Practioner Medical Trainee Scheme.

4 STATISTICS

Prior to considering the recommendations of the District Management Team the Authority members are requested to study the Comparative Table showing BEDS AVAILABLE AND THE NUMBER OF BEDS PER 1000 POPULATION MANAGED IN EACH DISTRICT IN THE OXFORD REGION IN 1978.

These statistics clearly indicate the enormous problems facing the District Management Team when putting forward recommendations to reduce the cost of the Health Service in the Wycombe District. The statistics confirm the fact that the High Wycombe District, in nearly all the major specialties, is desperately short of beds per 1000 managed population compared with other Districts in the Region. It should be emphasised that because of the low level of Hospital Services provided in the District up to 30% of patients in some specialties go outside the District for treatment. However, this is to some extent true of other Districts (eg half the population of Milton Keynes look to Northampton District) and the exercise is therefore intended to highlight a comparison of the facilities provided for the population within each District of the Oxford Region.

COMPARATIVE TABLE SHOWING
BEDS AVAILABLE AND THE NUMBER OF BEDS PER 1000 POPULATION MANAGED
IN EACH DISTRICT IN THE OXFORD REGION IN 1978

District		Oxford	East Berks	West Berks	North-ampton	Kette-ring	Ayles-bury	Wycombe
Population (thousands managed)		506.3	335.7	399.3	264.9	248.9	221.4	260.6
General Surgery	Beds	222.8	206.1	216.5	243.9	111.5	95.3	84.9
	Ratio	0.44	0.61	0.54	0.92	0.45	0.43	0.33
Gynaecology	Beds	90.6	76.2	94.0	80.7	31.4	29.6	40.6
	Ratio	0.18	0.23	0.24	0.30	0.13	0.13	0.16
ENT	Beds	37.1	29.6	35.3	55.4	20.1	21.0	29.4
	Ratio	0.07	0.09	0.09	0.21	0.08	0.09	0.11
Paediatrics	Beds	59.0	31.9	68.9	68.3	34.7	17.0	31.1
	Ratio	0.12	0.10	0.17	0.26	0.14	0.08	0.12
T & O	Beds	311.5	132.8	123.3	261.4	92.8	68.3	66.1
	Ratio	0.62	0.40	0.31	0.99	0.37	0.31	0.25
General Medicine	Beds	272.6	217.3	164.1	186.8	60.8	60.8	84.9
	Ratio	0.54	0.65	0.41	0.71	0.24	0.27	0.33
Dermatology	Beds	10.5	3.3	9.5	15.3	11.0	4.9	14.1
	Ratio	0.02	0.01	0.02	0.06	0.04	0.02	0.05
Mental Illness	Beds	583.8	760.4	701.1	583.6 (Northampton and Kettering)		568 (Aylesbury and Wycombe)	
	Ratio	1.15	2.26	1.75	1.13		1.17 (only 20 beds in Wycombe)	
Mental Handicap	Beds	361.4	369.2	750.0	326.4	20.0	220.2	-
	Ratio	0.70	1.10	1.90	1.20	0.10	0.50	-
Geriatrics (Pop over 65)		60.8	38.4	44.5	34.5	33.3	23.0	28.0
	Beds	398.3	278.6	327.2	343.6	280.3	224.3	185.7
	Ratio	6.55	7.25	7.35	9.96	8.42	9.75	6.60

The District Management Team have shown in the above statistics the number of beds available in the District for the population managed. The same criteria has been applied to all Districts in the Region and the exercise is therefore one of comparability of studies for the population of each District and as such is entirely valid.

5 SCHEMES

The District Management Team as instructed by the Area Health Authority have not discussed any proposals with the Medical or any other staff concerned. The Team submit for the Area Health Authority's consideration various schemes under three headings with appropriate comments. The total of the schemes listed is in excess of the savings required, but here again this was the requirement of the Authority.

a) <u>Schemes where it is considered savings could be made, subject to consultation</u>

Proposal	Hospital/ Community	Estimated Annual Saving £	Comment
Closure of Creche	Wycombe General	10,750	This will cause serious recruitment problems.
Closure of Brooks Ward (10 beds) and withdrawal of Theatre facilities	Chalfonts & Gerrards Cross	72,000 (incl. 21,000 Theatre)	Some patients would have to go to Amersham Hospital. Some would go outside the District for treatment. The surgical waiting list will increase.
Closure of X-Ray and Physiotherapy Depts	Chesham	15,000	Waiting list would be longer at Amersham Hospital.
Restriction in Family Planning Service	Wycombe, Amersham and The Chalfonts	14,000	This is a 50% reduction in the item of service payments made to Surgeons, Anaethetists, etc and will result in a reduced service.
Reduction in Family Planning Service	Community	47,000	The aim is that only "special groups" would be dealt with under the National Health Service.
Closure of G Ward	Amersham General	35,000	Used for day cases. This will drastically reduce the day case facilities available in the District.

b) Schemes where savings are possible but undesirable (again subject to consultation)

		£	
Closure of Wards 1A/B Mental Illness (20 beds)	Wycombe General	112,000	This would mean that there will be no "In Patient" Psychiatric Service in the Wycombe District. (The General Nursing Council require the trainee nurses to have Psychiatric training and the ward is used for a part of the General Practitioner trainee scheme.)
Conversion into a 5 day Ward Ward 3A/ENT & other (22 beds)	Wycombe General	10,000	The unoccupied beds, if any, in this ward are nearly always occupied by T & O cases.
Closure of Occupational Therapy Unit (Day Unit)	Chesham	11,000	This would also effect the Social Services Dept of the Bucks County Council. The Community Occupational Therapist would be based on Amersham Hospital.
Volunteer Stroke Scheme	Community	3,000	As the Area Health Authority had the foresight to finance National Health Service support for this important scheme which is now operating nationwide, it would be a tragedy to abandon the service provided.
Closure of Creche	Amersham General	11,500	Certain key staff would have to resign.
Closure of Paediatric Ward	Amersham General	88,500	It might be possible to concentrate the Paediatric services on Wycombe General Hospital but some extra beds and capital involvement will be required and this will reduce the estimated savings considerably.

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c) <u>Schemes where savings are possible but highly undesirable</u>

		£	
Closure of Intensive Therapy Unit (3-4 beds)	Wycombe General	113,000	This unit would have to be replaced by at least two "High Dependancy Beds" in a ward. This would reduce the estimated savings to approx £57,000.
Closure of In Patient facilities (12 beds)	Marlow	65,000	Only Out Patient facilities would be left at the hospital. In view of the Geriatric content such patients would have to be retained in the Acute Geriatric Dept at Amersham General Hospital thereby blocking Acute Geriatric admissions which could result in the death of patients concerned.
Closure of In Patient facilities (23 beds)	Chesham	100,000	
Closure of the Occupational Health Service	All	12,000	All medical examinations would have to be carried out by General Practitioners.

[illegible]) <u>Other Schemes the District Management Team have considered but discarded as not practicable because of one or more constraints</u>

		£	
School Health Services complete closure	Community	114,300	Invaluable service - certain responsibilities are statutory and some obligatory.
Closure of Ward 1C, Gynaecological (12 beds)	Wycombe General	75,000	Not sufficient beds available at present - see para 4.
Closure of Ward 5A, Surgical (20 beds)	Wycombe General	98,000	As above
Closure of One Theatre	Wycombe General	49,000	Unless Surgical/Orthopaedic or Gynaecological beds are closed the Theatre is needed.
Closure of D Ward Surgical 22, ENT 2, Orthopaedic 10 beds	Amersham General	109,000	Not sufficient beds available at present.
Closure of F Ward, Medical (25 beds)	Amersham General	105,000	The occupancy of this Ward during approx 3 months of the year is low but it is essential to have the beds available for the overflow from the Geriatric Unit.
Closure of Occupational Therapy	High Wycombe	?	Approx 30% of the cost of running the unit is met by Social Services.
Preventive Services	Community	?	The possibility of reducing the number of Health Visitors, District Nursing Sisters, etc working in the Community was examined but the numbers at present employed are well below the suggested "norms". Furthermore if beds are reduced in the hospitals then more work must fall upon the Community Staff.
General Community Care	Community	?	

6 HEADQUARTERS ST...

In view of the substantial savings previously made it is unlikely that further large inroads in the present staffing will occur. Thirteen and a half posts have been left unfilled to date. The possibility of not filling any vacant post will however be considered as and when it occurs.

7 VOLUNTARY REDUNDANCY/EARLY RETIREMENT

The District Management Team consider that staff should be offered voluntary redundancy or early retirement as this may ease the problem of the reorganisation of the service within the District.

8 CONCLUSION

The District Management Team are not prepared to recommend such drastic reductions as will decimate the service to the population served for years to come. They can see no possibility of making such savings as are required without cutting clinical services to a level which is unacceptable. Whilst the District Management Team realise the instructions the Area and the Region have been given by the Secretary of State they feel that it could not possibly be his intention to be the architect of the ruination of the Health Service in this District.

The District Management Team in making their recommendations however unpalatable they may be have endeavoured to maintain the majority of the Acute Services at the Wycombe and Amersham Hospitals. If the amount required to reduce the running cost of the Health Service in the District to the funds available is not forthcoming from the District Management Team's recommendations, then inevitably there will have to be closures of Acute Wards at the two main Hospitals.

The proposals in this paper have not been discussed with the interested parties. It is presumed these discussions will take place during October 1979. To effect the reductions required in the service will need the complete co-operation of all staff as many staff will have to transfer to alternative posts either in the same hospital or another hospital in the District. In many cases the savings will not be immediate but they will gradually accrue as the service runs down. The estimated total savings will only be possible if many posts are eliminated and regrettably this may entail redundancies of staff.

HIGH WYCOMBE DISTRICT MANAGEMENT TEAM — 4 October 1979

RBJ/JD

Tabled 7.11.79

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BUCKINGHAMSHIRE AREA HEALTH AUTHORITY
High Wycombe District

HIGH WYCOMBE DISTRICT OPERATIONAL PLAN - SECOND DRAFT

Since the publication of the first draft plan, as a result of comments received by the Area Administrator and discussions with the Chairman and A.T.O. the room for manoeuvrability to run services within cash limits has been reduced. The DMT is conscious of the need to maintain acute services to provide emergency and urgent treatment and it was our aim to keep such services intact. However, we are instructed to maintain all hospitals in the district and as a consequence we will be forced to reduce services in the district general hospitals. Reductions in the family planning services were also considered too severe and these have been modified.

It appears inevitable, therefore, that our in-patient services will be reduced below those shown in the table on page 19 of the original plan. If the DMT is instructed to take these measures our new position in the Region is indicated on the attached table. Apart from the obvious immediate effects of the reduction in beds, the DMT will be concerned about the implications for the future. The reduction in the number of patients treated will lead to a smaller "catchment" population which will attract a reduced revenue income in the years to come.

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY
High Wycombe District

Proposal	Unit	Effects	Cost Saving
Acute Services			
Reduction in patient services.	Chalfont & Gerrards Cross Hospital.	Surgical W.L. increase. Some patients would go outside district for treatment and more pressure on Amersham General Hospital.	£25,000
Closure of X-ray Dept.	Chesham Hospital	Extend W.L. at Amersham General Hospital.)	£15,000
Closure of Physiotherapy Department.	" "	Patients will have to travel to Amersham General Hospital where W.L. will increase.)	
Closure of G ward	Amersham General Hospital.	Drastic reduction in day case work in the district.	£35,000
Closure of Paediatric ward (17 beds)	Amersham General Hospital.	Less accommodation for mothers, increased pressure on Wycombe paediatric beds, inadequate isolation facilities, increased pressure on other departments which use paediatric beds.	£88,500
Closure of 20 surgical beds (ward 5A)	Wycombe General Hospital.	Increase W.L. in a specialty already under bedded.	£98,000

continued.......

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Proposal	Unit	Effects	Cost Saving
<u>Acute Services (continued)</u>			
Closure of 25 medical beds (F ward)	Amersham General Hospital.	This will have severe repercussions on the care of the elderly and reduce available medical beds by almost 50%.	£105,000
<u>Preventive Services</u>			
Restriction in family planning Services.	Wycombe, Amersham and Chalfont Hospital and community.	Majority of patients will have to seek alternative sources. Increase in obstetric and gynaecology work (and social problems) in the future. Costs will be largely transferred to F.P.C.	£30,000
Reduction in School Health Service.	Community	Reduced availability of service to schools as a result of reduction in staff.	£10,000
<u>Occupational Therapy</u>			
Closure of Day Unit.	Chesham	Patients will receive inadequate rehabilitation. Increase relapse rates. Increased workload on other departments particularly orthoptic, rheumatology, G.P.s etc. and Social Services Dept.	£11,000

continued......

Proposal	Unit	Effects	Cost Saving
Occupational Health Service			
Closure of service.	All	Increase loss of work by staff, increase legal liability to the Authority. Some of the work would have to be carried out by G.P.s.	£12,000
Others			
Closure of Creche	Wycombe General Hospital.	Recruitment of certain key staff might be difficult.	£10,750
Closure of Creche	Amersham General Hospital.	Recruitment of certain key staff might be difficult.	£11,500

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY
High Wycombe District

C[illegible]ARATIVE TABLE SHOWING BEDS AVAILABLE AND THE NUMBER OF BEDS PER 1000 POPULATION MANAGED IN EACH DISTRICT IN THE OXFORD REGION IN 1978

District		Oxford	East Berks	West Berks	North-ampton	Kette-ring	Ayles-bury	Wycombe 1	Wycombe 2
Population (thousands managed)		506.3	335.7	399.3	264.9	248.9	221.4	260.6	
General Surgery	Beds	222.8	206.1	216.5	132.4	111.5	95.3	84.9	64.9
	Ratio	0.44	0.61	0.54	0.50	0.45	0.43	0.33	0.24
Gynaecology	Beds	90.6	76.2	94.0	49.3	31.4	29.6	40.6	
	Ratio	0.18	0.23	0.24	0.19	0.13	0.13	0.16	
ENT	Beds	37.1	29.6	35.3	35.3	20.1	21.0	29.4	
	Ratio	0.07	0.09	0.09	0.13	0.08	0.09	0.11	
Paediatrics	Beds	59.0	32.9	68.9	33.6	34.7	17.0	37.0	20
	Ratio	0.12	0.10	0.17	0.13	0.14	0.08	0.14	0.07
T & O	Beds	311.5	132.8	123.3	168.6	92.8	68.3	66.1	
	Ratio	0.62	0.40	0.31	0.64	0.37	0.31	0.25	
General Medicine	Beds	272.6	217.3	164.1	126.0	60.8	60.8	84.9	59.9
	Ratio	0.54	0.65	0.41	0.48	0.24	0.27	0.33	0.23
Dermatology	Beds	10.5	3.3	9.5	15.3	11.0	4.9	14.1	
	Ratio	0.02	0.01	0.02	0.06	0.04	0.02	0.05	
Mental Illness	Beds	583.8	760.4	701.1	583.6 (Northampton and Kettering)		568 (Aylesbury and Wycombe)		
	Ratio	1.15	2.26	1.75	1.13		1.17 (only 20 beds in Wycombe)		

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District	Oxford	East Berks	West Berks	North-ampton	Kette-ring	Ayles-bury	Wycombe 1	Wycombe 2
Mental Handicap Beds	361.4	369.2	750.0	326.4	20.0	220.2	-	
Ratio	0.70	1.10	1.90	1.23	0.10	0.50	-	
Geriatrics(Pop over 65)	60.8	38.4	44.5	34.5	33.3	23.0	28.0	
Beds	398.3	278.6	327.2	343.6	280.3	224.3	185.7	
Ratio	6.55	7.25	7.35	9.96	8.42	9.75	6.60	

The District Management Team have shown in the above statistics the number of beds available in the District for the population managed. The same criteria has been applied to all District in the Region and the exercise is therefore one of comparability of studies for the population of each District and as such is entirely valid.

Note: - Wycombe Columns:

(1) Existing level.

(2) Level if plan adopted.

~~10A~~ 8A

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

Telephone 01-388 1188 ext

D Morton Esq
Regional Administrator
Oxford Regional Health Authority

Your reference

Our reference

Date
12 November 1979

Dear Don

CUTS IN BUCKINGHAMSHIRE/NATIONAL SPINAL INJURIES CENTRE

I wrote to you the other day to ask if you could be a little more explicit about your recent observation that all the areas were taking reasonable and realistic measures to live within their means with the exception of Bucks AHA which was, by inference, proposing a measure of "overkill" in its cuts.

Subsequently I attended the AHA on 7 November and saw tabled there your letter of 5 November recording the outcome of Area and Region discussions on the nature of the problem and the extent to which permanent reductions in service level are required. The Region's view was an ongoing reduction of £[illegible],000 pa against the Area's figure of an ongoing £[illegible],000.

In preparation for our tripartite officer discussion on Friday, it might be helpful if I spell out the grounds for our concern. These are:-

1. The matter of principle. The NSIC provides a service for the whole of the South of England and there is a significant shortage of spinal beds. The service is supra-regional or quasi-national in character and it is not therefore appropriate, in our view, that it should be significantly reduced without agreement between Area, Region and the Department.

2. The scale of the cut proposed. Bucks figure of £720,000 on a cash limit of £36 million is a cut "over the board" of some 2[illegible]%. A reduction in the complement of spinal beds from 156 to 131 is about 16% and must be seen as quite disproportionate. I know that, when account is taken of recent levels of staffed available beds in the NSIC and probable occupancy rates, the figures can be presented in a more palatable light, but it remains a fact that the proposal is to cut the NSIC by a greater percentage than the level of reduction in service applied generally in Bucks.

3. Next there is the question of the legality of the Bucks AHA's [illegible] vis a vis the HC([illegible])207 closure or change of use procedures and the [illegible] (CHCs) Regulations 1973, SI 1973 No 2217. Our view is that [illegible] closure is involved the full process of consultation with the CHC [illegible] up to the RHA and DHSS [illegible] page (i) paragraph [illegible]

carefully worded, but the first two lines of page 14 make it clear that what is being proposed is a permanent closure of part of Tindal Hospital and by implication, therefore, at least a part of the relocations of services from Tindal are permanent moves. The use of the 25 bedded NSIC Ward for geriatric patients in particular would probably be held to be a permanent change of use because of the permanent closure of a part of Tindal which occasioned the change of use. Colleagues responsible for policy in this area are very conscious of the recent proceedings against the Commissioners at Lambeth, Southwark and Lewisham and the Court's ruling. In a nutshell, only temporary closures and then temporary closures based on the urgency of the need to make savings to remain within cash limits can by-pass the standing procedures. We shall have to discuss, therefore, whether the proposals of the Bucks AHA must not be recast to be "temporary" over the board, dropping the reference to disposal of Tindal. Later, of course, at an opportune time the temporary closure can be proposed to become permanent.

4. One central practical point we shall have to consider is the possible unwillingness of the Minister to sanction the cut in NSIC beds and the moving in of geriatrics to the ward concerned. If he does take this decision, what is the saving foregone? This must be quantified if at all possible and, in costing, it must be allowed that one possibility is that the NSIC ward could remain "mothballed" until the AHA was able to afford fully to staff its 156 spinal unit beds. In this case the saving foregone will reduce to the excess cost of caring for one ward of geriatrics (left behind at Tindal?) as compared, for example, with caring for the same patients in Stoke Mandeville. The Minister may well "home in" on this point. My own view is that the saving foregone (in the short-term) may be slight especially if the patients selected not to go to Stoke Mandeville are a group without significant needs for the full facilities of the dgh.

5. We shall also need to consider the question of the rebuilding of the NSIC and the priority currently assigned to this project within the overall re-development proposals for SM. The site of the unit also arises, but on this there will be (probably) little problem. Are you at the position, or could you quickly come to the position where there is a development control plan for the site? - this would be essential if rebuilding were to be accelerated as a result of any Ministerial initiative or, eg as a result of capital becoming available from non-exchequer sources. The Minister will be probed on this (indeed he already has been) and we shall have to give some indication of what may be possible.

6. There is finally the question of "dishonoured pledges" which some of the ex-servicemen paraplegics have already raised with the Minister. We are researching the background - I am not familiar with the points at issue here - but I mention them because we shall want to check that we have a common understanding of the history on Friday because this will form a part of the Minister's briefing.

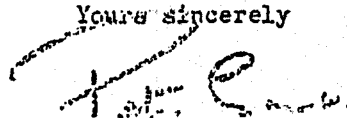
In the points I have listed at 1-6 above I have concentrated on SM and the NSIC because my impression is that the Minister will say on 20 November that it is for the Authority to decide on how other necessary savings are achieved and that his interest is limited to SM and the NSIC. For the AHA this could be, I know, unsatisfactory because the Aylesbury and [illegible] District proposals are interlinked and have been costed to some extent as an "interdependent package". So far as High Wycombe District is concerned, we shall I think

DH Document 06. Page 211

re only marginally concerned (if at all), although we should be interested to hear the views of AIO and RTO on the High Wycombe DMT proposals which, in the form presented to the Authority on 7 November, were more of a list of unpalatable possibilities than a specific plan. Have these proposals been further refined in the interim? We shall be interested to know the outcome of the Special Authority meeting this Wednesday 14 November.

I am copying this letter to Ken Walker.

Yours sincerely



Peter R Gant

7A.

Papers 24.10.79 – 19.11.79
Spinal Injury Unit Stoke Mandeville

PQ's 1537/1979/80.
1531
1534
1535 } copies
1948
1983

Reference ....

PQ 1537/1979/80. 25.10.79 — 1A.

Draft Briefing material - DR Vaughan's Visit to Stoke Mandeville — 2A.

PQ 1531/1979/80
PQ 1534/1979/80
PQ 1535/1979/80
PQ 1536/1979/8. — 3A

Min 31.10.79 Taylor/Spencer — 4A

Letter 2.11.79 Bradshaw Spinal Injuries Asso. + copies of letters Min Health/Chairman RHA — 5A - D.

Min 6.11.79 / Gaunt re Jimmy Savile's meeting SofS. — 6A

8.11.79 C/letter Cook/Tait - Wakefield AHA.

PQ 1948/1979/80 — 7A
PQ 1983/1979/80. — 8A

Min 12.11.79. Barston/Spencer — 9A

Min 12.11.79. Sweeney/Myers + C/letter 26.10.79 Borges British Postgraduate Med Federation U/London to SofS — 10A

Min 13.11.79 Myers/Sweeney — 11A.

Note of meeting 14.11.79. — 12A.

Min 15.11.79 Halliday/DR de Pyer — 13A

Min 16.11.79 DR Tait/Collier — 14A

Min 19.11.79 Pierce/Scott-Whyte + C/letter DR Rue (RMO Oxford) to DR Forsyth (RMO SE Thames) — 15A

16A

Meeting ... 16.11.79

DH Document 06 Page 214

CODE 18-77

HA. 109/79

MEETING: 19 November 1979

PRESENT: Secretary of State
MS(H)
Mr Collier
Mr Scott-Moncrieff
Dr Tait
Mrs Petrie
Mr Longfield
Mr Grant

SUBJECT: STOKE MANDEVILLE

1. Secretary of State said that in looking at the options the essential point was that Ministers were determined that Stoke Mandeville should be allowed to preserve its special place as a national centre for the treatment of spinal injuries. Jimmy Saville had made it clear that he was confident that money could be raised not only to help with revenue costs but for the rebuilding of the entire unit. Ministers would want to give such an initiative their total support.

2. The discussion covered the following points:

1. The question of 'earmarking' funds needed to be looked at in a broader context. One of the most difficult questions was how to limit the demands on 'earmarked' funds.

2. The immediate need at Stoke Mandeville was to provide assurances that the unit was recognised as a special centre and would be treated as such. With this assurance there would be support from voluntary funds.

3. The health authority had dropped the idea of putting geriatric beds into the spinal injuries unit but the numbers of beds available to the unit would depend on the general pressures on resources.

4. Special treatment for Stoke Mandeville would not be regarded as being justified in some quarters as there were a number of spinal units which could claim to be providing specialist services which were not routinely available. The future of Stoke Mandeville might be considered in the context of an overall strategy for dealing with spinal injuries.

5. The consultants at Stoke Mandeville appeared to specifically reject the possibility of restoring the post of Director.

3. CONCLUSIONS

A. The Minister of State would make it clear on his visit to Stoke Mandeville that:

1. Ministers recognise the importance and special nature of the unit as a national centre and are determined to preserve it.

2. The proposal to include geriatric accommodation had been dropped.

3. The scope for extending the present work was limited because of pressure on public funds but Ministers hope that the voluntary agencies concerned will be willing to help raise additional funds.

B. The Department should ensure that the authority had reserved the land required for rebuilding the unit with voluntary funds.

ACTION: Mr Gant

D BRERETON
Rm D704
Extn 7666

21 November 1979

Copies to:

Those Present

Mr Phillips
Dr Shore
Mr Nodder
Mr Wormald
Mr Bebb
Dr Lees
Miss White

Mr Scott-Whyte
Mr Wormold

SPINAL INJURY UNITS

You may like to see a copy of a recent letter sent by Dr Rue (RMO Oxford) to Dr Forysthe (RMO SE Thames). It deals with three issues:

- The potential scale and distribution of spinal units in the SE sector of England

- The Departments response to spinal injury proposals contained in SE Thames' and Oxford's plans.

- The possibility of spreading any "Jimmy Saville Funds" over all spinal units rather than Stoke Mandeville

Although SDG is adopting a lowish profile with regard to regional strategies at present I doubt if Ministers ideas on minimum intervention extend to non involvement by the Department in the planning of multi-regional services. Certainly RLI needs your advice on how to respond to Oxford Spinal Injury proposals and (unless they have already received it) RL do also. If we do not become involved Dr Rue will fill the void and this opens up the possibility that the whole spinal injuries unit policy will be manipulated to suit Oxford's views. Is this desirable? One option is to suggest that MSH says tomorrow when he visits Stoke Mandeville, "I have asked my officials urgently to consult with appropriate health authorities to firm up plans for future shape of spinal injury services. "Would you agree?

On the third issue, Dr Rue is determined to press the case for independent financial assistance to all Spinal Injury Units. This is not, I think what Jimmy Saville has in mind but you should be aware of this situation before we meet the Secretary of State today.

Whilst on the subject and again before our meeting with Secretary of State could SH confirm whether or not it is policy to care for spinal injury children in the childrens department of "host" hospitals or in the spinal injuries centre? This question is likely to be raised when Dr Rue attends the Ministers briefing meeting at 3.15 pm today prior to his visit to Stoke Mandeville tomorrow.

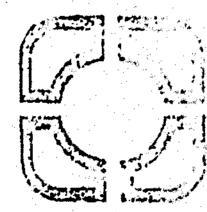
I am sorry for the short notice. We could not meet the health authorities until last Friday pm to obtain their views and Rosemary Rue handed me the attached letter then.

19 November 1979

P Petrie

cc Mr Bebb
Dr Tate
Dr Lees
Dr Melie
Miss Rowland Jones
Mr Thorpe-Tracey
Mr Gant
Mr Suckling
RL file/float

168.



Oxford Regional Health Authority

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

your reference our reference ERR/VD 11/38/6/SIC

15 November 1979

Dr J M Forsythe
South East Thames Regional Health Authority
Randolph House
46/48 Wellesley Road
Croydon
Surrey

Dear Dr Forsythe

PLANNING SERVICES FOR SPINAL INJURIES

Following discussions at RMOs meetings with the DHSS concerning the planning of Supra-Regional Specialties you will remember that it seemed to us that the question of spinal injuries appears to be a planning matter now between our two Regions.

I shall soon be in a position to send you a paper which we have prepared which sets our services at Stoke Mandeville in the national context and substantiates the proposals in our Strategic Plan that to meet its future responsibilities Stoke Mandeville needs a unit of at least 120 beds with the various supporting departments and services. This figure assumes the functioning of the units at Odstock and Stanmore and would be increased to 150 beds if the facilities were to be provided in two units rather than at Stoke Mandeville alone. You will be aware from the warnings and progress reports that I have given over many years that the level of services at Stoke Mandeville has in fact dropped below this figure on several occasions and we are having great difficulty at the present time, both for financial and staffing reasons, in maintaining 120 active beds. We have asked the DHSS, in submitting to them our Strategic Plan, urgently to confirm whether this level of service is approved since our buildings are in a very bad state and we are beginning to plan replacement accommodation in the hope that capital will somehow be available.

X Meanwhile you have told me that your Regional Strategic Plan submits proposals to the DHSS for a 60 bedded unit at Sidcup, and you also are awaiting a response from the DHSS. If that proposal were to be approved the size of the Stoke Mandeville unit could be reduced apparently to 60-90 beds, but as we briefly discussed there may be arguments for the Stoke Mandeville unit being rather larger and yours being rather smaller depending on the way catchment from the North East Thames Region might alter.

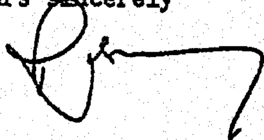
X Table 6A of 79-88 Regional Strategic Plan shows 50 bedded Regional Spinal unit operational from 1991-92 at Q.M. Hospital, Sidcup. Capital spending £1,000 between 1982-3 – 1988-89. P.56 of the Plan refers to the DHSS having cut little possible of central money being available for this in the near future

/Over

Chairman G. J. Roberts, CBE JP
Regional Medical Officer E. Rosemary Rue, CBE MB FRCP FFCM MRCPsych
Regional Nursing Officer Miss M. Davis, SRN SCM
Regional Treasurer
Regional Works Officer A L. Arschavir, Dip Arch RIBA DipTP
Regional Administrator Donald Norton, LLB DFA FHA

It seems that we both need early planning decisions, and I am writing in the hope that we can both obtain a DHSS view. I feel fairly optimistic that if we were able to obtain a place in our Capital programme for a "basic" Stoke Mandeville unit there is much goodwill which might be translated into some additional financial support. It is very important that any organisations offering such support should have a clear picture of the scale of the Stoke Mandeville unit in the future, and the opportunity perhaps to extend their interest to other developments in the spinal injuries field, particularly the unit you propose. I am therefore copying this letter to Dr Walker of the North East Thames Region to keep that Region fully informed, and to the DHSS in the hope that they will speedily give their view, if necessary by convening a meeting between us all. In any event, as soon as we have heard from the DHSS I would suggest that planning teams from our two Regions should meet and consult with Dr Walker to work out the likely catchment and functional content of our two Units.

Yours sincerely



Regional Medical Officer

Mr Collier

NATIONAL SPINAL INJURIES CENTRE, STOKE MANDEVILLE HOSPITAL

1. I was talking to Dr Frankel yesterday and, inter alia, explored the abolition of the designation "Director". He made it very clear that this designation had been very unpopular, and that neither he, nor the other two consultants at the NISC would wish this position to be re-instated. This is obviously a very sensitive proposal and should be discussed with S of S on Monday as I am sure it would also be opposed by the RMO who played a major role in its abolition (ref. last sentence at paragraph 5 of note of the meeting in your office 14 November).

2. We may be able to meet Mr Saville's request by suggesting that a named doctor should be "Medical Adviser to the Appeal Committee". This would provide the necessary focus and allow for the more complex issues to be resolved as plans unfold.

Frank Tait

FRANK TAIT
Med CP1
B1111 AFH

16 November 1979

cc
Dr Shore D908
Dr Evans D916
Dr Tate B1117
Dr Lees R Sq.
Mr Scott-Moncrieff 622 Fr.Hse
Mr de Peyer D319
Mrs Petrie 1532 ET
Mr Gant 1504 ET
Mr Bebb B517

h. Meyer
N

CODE 18 77
MF 13174

Dr de Peyer

STOKE MANDEVILLE

Reference your minute of 15 November regarding the funding of multi-regional services and the units providing this service. I am content with the two paragraphs you suggest, but I trust we will not be identifying the Stoke Mandeville Unit as a national unit. Rather that the six spinal units collectively provide what might be termed a national service, as you suggest in your paragraph. If we identify any of the units who at present provide the multi-regional services then I think we will be in danger of suggesting that their "national" role warrants them relating directly to the Department. I certainly have heard many of the clinicians who work in units who would like to have such "national" recognition, expressing the view that they should not have to go through Areas or even Regions but should deal with the Department directly. The JCC accept that the term multi-regional service includes those services where we may only require one or two units for the country as a whole. It is my impression that the profession generally would not favour the title "national" being applied to any of the units.

With regard to your paragraph 2(c) I think it is true to say that the present round of discussions with the JCC are complete. The paper presently being prepared within the Department which reflects the state of play reached at the last meeting is in fact a completion of the present round of discussions. The JCC and the Department have agreed that four multi-regional services should be identified for consideration in a pilot scheme of financing during 1980/81. Amongst the services agreed by the JCC as warranting recognition as multi-regional services is that of spinal units and of course amongst the spinal units is the Stoke Mandeville Unit. I do not believe that there is anything provisional about the list agreed between the Department and the JCC with regard to multi-regional services.

N D Halliday
Med OS1
1835 ET

15 November 1979

cc Mr Collier
Dr Evans
Mr Wormald
Mr R Smith
Dr A M S Mason
Mr Gant
Dr Sweeney

Mr Smith

STOKE MANDEVILLE

At the meeting which Mr Collier took yesterday it was agreed that Mr Gant would put together some briefing for the Minister of State's visit to Stoke Mandeville on Tuesday (20 November). There is to be a briefing meeting on 19 November (3.15pm in D614 at AFH). I think you have already seen the attached papers. I undertook to contribute a couple of paragraphs of speaking notes aimed at reassuring the Health Authority, Jimmy Saville (who is raising funds for Stoke Mandeville if he gets the necessary assurances), and of course the Minister that the hospital's position would be protected and its national role recognised.

2. There are several difficulties about giving specific assurances at present:-

a) the Department allocates to RHAs, not to AHAs, so that we cannot readily earmark funds for SM;

b) AGRA has not yet reported;

c) the JCC/DHSS discussions about the selection of units/services for special treatment are not complete, though I think we are in no doubt that the spinal injuries units are pretty well certain for special treatment;

d) central funding by the Department (as for Odstock and Stanmore) would be highly repercussive.

In addition, we do not know quite what the outcome of the costing of the cross-boundary flows for the spinal injury units will produce.

3. With all these points in mind I have drafted the attached paragraphs. Perhaps you would be kind enough to consider them and discuss with Mr Gant. It seems to me we should keep off the extremely complicated question of the mechanism for adjustments to cross-boundary flows (and the alternative to them). Equally, Ministers should be strongly advised against central funding.

15 November 1979

D de Peyer
RCP/PPU

cc: Mr Collier
Dr Evans
Mr Gant

STOKE MANDEVILLE - FUNDING

PRESENT POSITION

The Department allocates funds to RHAs, and RHAs determine allocations to AHAs. The formula on which national allocations are based takes account of cross-boundary flows of patients, so that the Oxford RHA allocation already recognises the fact that Stoke Mandeville treats many patients from outside the region, though this is not separately identified.

FUTURE PROTECTION

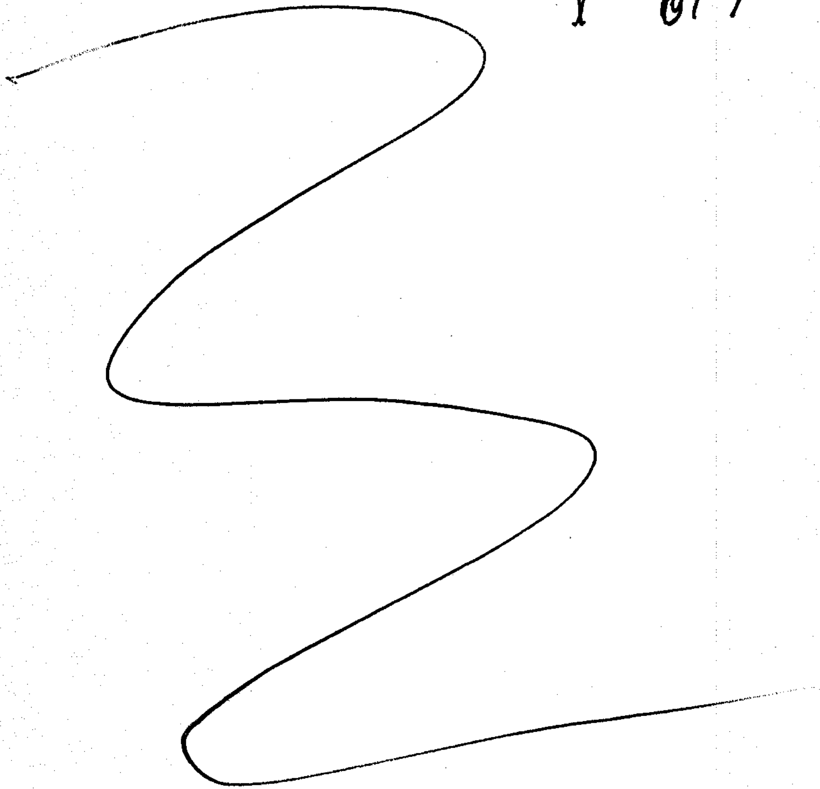
The Department accepts that the 6 spinal injuries units provide between them a national service. The Advisory Group on Resource Allocation (AGRA) which advises the S of S on resource allocation matters, has been considering the best way of funding national services, and will be reporting soon. I know they are hoping that some adjustments can be made for the 1980/81 financial year. We will make sure that the letter to Oxford RHA announcing its revenue allocation will identify the element for Stoke Mandeville.

[illegible]

26th [illegible] [illegible] [illegible] [illegible]

3pm –
Dr [illegible]

[illegible] 617



KJ

NOTE OF A MEETING

DATE 1[illegible] November 1979

TIME 4.30 pm

PLACE AFH Room 904

PRESENT Mr Collier
Dr Evans
Dr Lees
Dr Tait
Mr Scott Moncrieff
Mr De Poyer
Mrs Petrie
Mr Gant

NATIONAL SPINAL INJURIES CENTRE, STOKE MANDEVILLE/JIMMY SAVILLE'S MEETING WITH SECRETARY OF STATE

1. The implications of the suggested central funding of the NSIC were discussed, as was also the suggestion that the Centre might be rebuilt using in whole or part non-exchequer funds - funds which might be raised by public subscription led by Jimmy Saville. The question of the lapsed designation of the senior consultant as "Director" of the Centre was also considered.

2. The Department and AGRA were developing initial proposals for central funding by amending the cross-boundary flow weighting more accurately to reflect the actual cost of treating patients, approximately 90% of whom in the case of the NSIC came from outside the Oxford Region.

3. The Department, the JCC [and AGRA] had provisionally identified four groups of supra-regional services which appeared to be sufficiently distinct and distinguishable for them justifiably to be centrally funded as to revenue - or to have their funding protected by "a pipe within a pipe" - and fortuitously the six Spinal Units, including the NSIC, were one of the groups so identified.

4. After discussion it was agreed:-

i. That independent fund-raising had to offer to the organisers the evident prospect of "net benefit". Voluntary monies had to be seen not to be simply reducing the NHS - exchequer component of provision for the service in question. In the case of the NSIC, if "AGRA - pipe within a pipe" revenue protection proposals were associated with a voluntary scheme to raise capital to rebuild the NSIC, this objective would be secured. (The ORHA could not rebuild the NSIC before 1985-1992 at the earliest). [If revenue were raised on a voluntary basis it would be necessary to ensure the protection of the full present level of funding of the NSIC (and inflation increases? PRC) if "net benefit" were to be demonstrable.]

ii. That revenue could be protected to the point of service delivery. It was considered, as explained above, that the "AGRA - pipe within a pipe" proposals could secure protection, but it was less clear whether the proposals as at present enunciated would protect the full cross-boundary recompense, ie the present historic in-built recompense and any additional cross-boundary recompense arising from new weightings and amended RAWP targets, or only the latter. In any case, the suasion Sub-Regionally would be moral rather than mechanical.

iii. That the AHA's current proposal to close 25 beds in the NSIC and to introduce geriatric patients into one of the empty wards was unacceptable and that MS(H) could appropriately make such an announcement.

iv. That the designation of a Director of the clinical unit could be revived if this were an advantage to any voluntary fund-raising effort. The designation had been dropped in favour of a rotating "Chairmanship of Division" but Dr Musiebeh, the present Chairman, was not a potential "Director". Dr Frankel was the only likely candidate locally or nationally. (This matter would need to be agreed with the ORHA and the Bucks AHA - the abolition of the "Directorship" was not a DHSS decision and likewise it would be for the authorities, not the Department, to reinstate the designation.)

v. That any capital contribution towards rebuilding the NSIC - which was housed in absolescent wartime EMS accommodation - could not be at the expense of the ORHA's minimal present capital programme and whatever its basis (£1 for £1 or £3 for £1, exchequer: voluntary) it would have to be "top-sliced" from NHS capital allocations.

vi. That any capital development using entiraly non-exchequer funds controlled eg by Trustees could by-pass Capricode and other accounting procedures and might be more flexible and rapidly implemented (though liaison with AHA and RHA would be necessary to integrate with the general hospital development plan) Any involvement of exchequer monies would, however, mean that normal procedures must apply. This did not rule out the ORHA sub-contracting design etc away from its own troubled Works Department.

Conclusion

5. All these issues (i-vi), subject to a measure of clarification on specific points, present no insuperable difficulties and Ministers' wishes appear to be attainable. It will, however, be necessary to secure the full and willing co-operation of the Region and Area without which there is considerable scope for misunderstanding and difficulty. It was proposed that the 3.15 Monday 19 November meeting with MS(H) be reallocated for a meeting between MS(H) and the Regional and Area Chairmen.

D2/H1/145

Mr Williams to see O/R. 5/12.
Mr Myers/Mrs Hutton [illegible] 4.12
Mrs Salter For the file
Pl. file 7/1

[illegible] date

1. I attach a paper prepared by FL and tabled at the meeting with Mr Collier yesterday.

2. The section relating to revenue will be altered. [illegible] vans said that JC[illegible] had agreed that Spinal Units (along with paediatric haemodialysis, and some others) fulfilled a role beyond the Region and an alternative formula for their revenue allocation was being considered.

3. It was agreed that there should be no difficulty in ensuring that any monies collected would be for the benefit of the [illegible] Spinal Unit. If the charitable funds for the capital project were a part rather than the whole of the sum needed there is no possibility of the Region contributing the difference. This would have to come from top slicing of NHS allocation. (I pointed out the possibility of other units unsatisfactorily housed (eg Southport) making similar demands, either sponteneously or with the help of the SI/).

4. There was general acceptance of the need to see [illegible] as a part of a national pattern of services and the danger of over-emphasising its national role.

5. Mr Saville, or the SIA, had mentioned the possibility of a Research Institute but it is not felt that the question of the Directorship is connected to this notion. The Units planned at [illegible]stock and RNOH have a research component (the former association with Southampton University) and if this was to be developed at S[illegible] it should be connected with an academic department. The question of a director is one for local decision and has no policy implications.

6. [illegible] are satisfied that the bed numbers can be maintained, and some charitable monies might be deflected to revenue for this purpose in the short term. This for further discussion.

7. There seems to be no obstacles to proceeding; the meeting with Secretary of State is at 12 noon on 19 November.

Frank Ta[illegible]

FRANK [illegible]
Hea[illegible]
[illegible]

1[illegible] November 1979

cc
Dr [illegible]
Mr [illegible] 2517 ✓

STOKE MANDEVILLE HOSPITAL

NATIONAL SPINAL INJURIES CENTRE

1. BACKGROUND

1.1. Stoke Mandeville Hospital was established in 1940 as an EMS Hospital under the aegis of the then Ministry of Pensions. The Spinal Injuries Unit was opened in 1944 as the result of Government initiative, with the object of studying and treating spinal injuries. In 1953 when the Ministry of Pensions handed the unit over to the Ministry of Health there were approximately 150 available beds, and initially central funding was preserved. Two years later the central funding was abolished and the unit was funded via the normal revenue allocation made to the Oxford RHB; there were no special arrangements for protecting funds for the unit.

1.2. Over the years the number of beds has fluctuated and stands now at 156, of which 110 are currently staffed and available. There are however now five other units in England, viz:

	Number of beds
Midlands SIU, Oswestry (established 1963)	46
Lodge Moor SIU, Sheffield (established 1954)	64
Southport Paraplegic Unit (established c.1950)	35
Pinderfield SIU, Wakefield (established 1954)	31
Hexham SIU, Hexham (established 20-25 years ago)	20
Total:	196

There is also a proposal to increase the number of beds at Hexham SIU by 12 to 32.

1.3. The best available estimate of need is that some 100 beds are required in addition to existing provision to provide adequate treatment and follow-up for all traumatic cases. Some further provision

may be necessary for cases of non-traumatic spinal cord lesions. The greatest need is in the South of England; the NSIC's catchment area, South of a line from the Bristol Channel to the Wash, covers 75% of the population, while the Unit has only 33% of England's beds.

1.4. New Spinal Units are proposed for the Royal National Orthopaedic Hospital, Stanmore (24 beds) and Odstock Hospital, Salisbury (50 beds) and planning for both is at an advanced stage. The opening of the new units in 1981 and 1983-85 respectively should help relieve pressure on Stoke Mandeville.

1.5. The status of the NSIC is thus one of a network of supra-regional units providing a national service. By virtue of its size, history and reputation it stands "primus inter pares", but in some respects more advanced treatment and research is carried out in other units. It is not necessarily the most "excellent" in all respects; yet it remains a special case. Paraplegics and tetraplegics who have returned to the community, need from time to time to be re-admitted for further treatment and by virtue of its size and long establishment the Centre has built up a large "family" of dependent patients for whom it represents home. The proximity of the British Paraplegic Sports Society's Stoke Mandeville Sports Centre reinforces the affection and esteem in which Stoke Mandeville is held, both in the United Kingdom and further afield.

1.6. There have been a number of complaints in recent years that the NSIC's accommodation does not match up to its reputation. The NSIC is still housed in Wartime EMS hutted accommodation which is in poor repair. The whole hospital of which the NSIC is part, has maintenance arrears of over £2 million and a rebuilding programme is proposed, but will not commence even on a phased basis before the period 1985-1990.

2. PREVIOUS UNDERTAKINGS RELEVANT TO THE NSIC

2.1. The principal undertakings to have been quoted by the NSIC and its supporters relate to Government pledges that war pensioners should be accorded priority in hospital care relating to their accepted disablement.

2.2. When the Ministry of Pensions was amalgamated with the Ministry of National Insurance in 1953 and the medical treatment it provided was transferred to the Ministry of Health, the then Prime Minister, Mr Winston Churchill said in announcing the amalgamation on 26 February 1953,

> " 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".

2.3. The principle of giving priority of hospital treatment to war pensioners in respect of their accepted disablement was reiterated in HM(72)75:

"In 1953 the Government of the day gave a clear undertaking for priority to be given to war pensioners needing examination or treatment for their accepted disablement at all hospitals in the National Health Service." Mr Prentice re-affirmed the Government's commitment to this principle in reply to a PQ on 23 October 1979.

2.4. There is no record of specific undertakings made in the past the RHB at the time of the transfer. Concern was, however, expressed in 1977 when proposals were advanced to reduce the number of beds at the NSIC by up to 12 and the then Secretary of State stated on 17 October 1977 that :

"In view of the importance of the contribution made by the Spinal Injuries Centre at Aylesbury to the national provision of services for patients suffering from injuries to the spine, I am telling the Regional and Area Health Authorities that my prior approval is required before any decision is made about reducing services there."

BUCKINGHAMSHIRE AHA AND OXFORD RHA : THE FINANCIAL BACKGROUND

3.1. Because Oxford is on target and Bucks AHA within Oxford below target, Bucks services are on a low "base". The need to live within cash limits means that Bucks AHA has to pull back £1.75m on a cash limit of £36m before April 1980 (The Region has to pull back £7m or more) and the actual cuts to be imposed on services (after all other devices have been exhausted) are approximately £750,000 pa recurring. Imposing cuts of this severity has given rise to considerable concern - staffing levels are being reduced, wards closed, rationalisation plans advanced - but they all add up to a very visible diminution in the AHA's health service provision - a diminution which is thrown into sharper relief by Bucks relatively low base-level of provision.

3.2. There is also the fact that Bucks AHA has the fastest growing population of any AHA in the Oxford Region which itself is one of the two fastest growing Regions in the country. Because RAWP is based on population estimates up to 18 months in arrears, the Region complains with some justice that it has to make provision for health care for newly arrived population without adequate funding. Negotiations are in train to accelerate the position slightly by taking population growth into account in the 'pace of change' decisions on revenue allocation.

3.3. Regionally revenue is very tight indeed because in addition to the population growth problem there are problems generated by the coming "on stream" of developments like Northampton Phase I, JR2 and Royal Berkshire Phase V1, and others in the pepeline which are both politically and service-wise almost untouchable - especially Milton Keynes and services in East Berkshire. There is no scope for the region diverting revenue from the other areas towards Buckinghamshire. They all are in a "cutback" position and diversion of revenue is simply exporting the problem from one AHA to another. There is scope for diverting growth money, but the tiny amount of growth money in prospect will be more than mopped up by demographic change.

3.4. While it must be for the AHA and the RHA to decide on the local measures necessary to restrain expenditure and live within cash limits, the NSIC provides a service of value to the whole of the South of England, and beyond, and any proposals for cuts in that service must be expected to be a matter of concern to Ministers.

3.5. It is generally accepted that Regional and Supra-Regional services should not be exempt from the need for restraint, but should bear the same proportion of cuts as do local services. In this instance, however, Buckinghamshire AHA is proposing to reduce the 156 bed NSIC by 25 beds, a 16% cut in services whereas the Area requirement for service cuts (in financial terms) is only 2.5% (in practice problems with staffing the NSIC beds mean that the actual reduction in service would be unlikely to approach this level, but the principle remains unaffected). The comparison is even less favourable when made with service cuts across the NSIC's South of England catchment area. There are a number of Areas where no, or only minimal service cuts are planned; where significant cuts are to be made these are taking place in the main in 'above target' Areas where at least some reductions in service, however painful, can be justified as the advancement of rationalisations which would have been introduced in due course. Parallels with the cuts proposed for the NSIC are few and far between. Although it has not been possible to quantify precisely the level of service reduction proposed across the South of England, all the evidence suggests that a proportionate cut at the NSIC would involve the loss of no more than a very few beds, - a measure which could hardly avoid the appearance of meanness and would do little to help with the cash limits problem. If services at Stoke Mandeville are to be preserved and placed on a secure basis, some means of protecting the Unit from Buckinghamshire's local problems need to be found.

4. THE CASE FOR CENTRAL FUNDING

4.1. Revenue. The case for central funding is based on both equity and practical need. The unit is extremely expensive and costs approximately £1.9million per annum for 156 staffed beds. This figure includes the cost of support services from the main hospital. In 1974 the unit drew 3% of its patients from the Buckinghamshire and Oxfordshire Areas, a further 5% from the rest of the Region, and 82% from elsewhere in the United Kingdom. The remaining 10% of patients were from overseas. Their treatment is paid for privately, although inevitably there are occasional difficulties in securing this payment.

4.2. Recompense by cross-boundary flow calculations is very little consolation because cross-boundary flows react on RAWP populations and hence on targets. They in turn affect revenue growth money allocated

to Regions. Oxford region is "on-target" for RAWP and with little prospect of any significant growth, the "cross-boundary" recompense effectively disappears. Proposals at present to revalue upwards the weighting for the cross-boundary flow suffer from the flaw that no "real money" gets to the Region, let alone the AHA or the Unit.

4.3. Present recognition of the burden imposed by the NSIC can thus be argued to be inadequate and Section 3 above sets out the case against embroiling the Centre in Buckinghamshire's current cash limits/overspending problems. The solution would seem to be to provide more adequate protection of/the Centre's revenue funding and this proposal is developed below.

4.4. Capital

Capital allocations under RAWP are determined on the basis of resident population and existing stock. The Oxford Region is deemed to be "above target", and therefore cannot expect to do well in the competition for funds, although its rapid population growth should ease the position in a few years time. The Region's supposedly favourable position conceals the fact that its more recent stock includes a significant proportion of EMS buildings (including Stoke Mandeville) which are now coming towards the end of their useful life. Capital RAWP does not take account of cross-boundary flows, so Oxford receives no special help in respect of the NSIC, despite the fact that some 90 % of its patients come from outside the Region.

4.5. The new Spinal Injuries Units at Odstock and Stanmore, both the result of Government initiatives, are to receive central funding to the order of £4.2 million and £1.2 million (?) respectively. In the circumstances it would seem reasonable for Oxford to receive help from voluntary support, central funding, or a combination of the two, to meet a similar need for capital investment in a service which could not otherwise be accorded priority over Regional and Area services, also in urgent need of capital provision.

5. A POSSIBLE WAY FORWARD

5.1. There is known to be considerable enthusiasm - Lady Masham, Jimmy Saville, the Duke of Edinburgh - for a major fund raising initiative, and Ministers have already expressed their support in principle. An offer to discuss the possibilities after the Minister's visit has been made.

The supporters are confident that they could raise a sizeable proportion, if not all the capital required for a new unit; should an offer of help from central funds be made eg to match the voluntary contribution, to make good any shortfall, or on some other basis?

5.2. ~~It seems advisable to channel voluntary interest into the capital project, leaving revenue funding for the Department to control.~~ Demands for the protection of revenue to unit level - the 'tube within a tube' approach - will be difficult to resist, although RCP will no doubt wish to consider the implications of such a decision for the Odstock and Stanmore Units when they come on stream. RCP has requested information on the cost of spinal units by 30 November and will presumably wish to study this before making detailed commitments, but a decision on the principle of protection could/should come earlier?

5.3. If the basic proposals outlined above are accepted, consideration will need to be given in the forthcoming discussions with the health authorities and interested parties to the nature of the appeal and the size of the unit. On the former, the formulation of a Charitable Trust to mount the appeal is likely to be the most attractive approach, although the enactment of the Miscellaneous Provisions Bill should enable health authorities to raise money on their own account, if this method were preferred.

5.4. Size may present a more difficult problem. Stanmore and Odstock should be coming on stream by the time the Unit is built, and the demand for beds at the NSIC should accordingly decrease. It is important that patients should be able to attend a unit close to their home so that coordination between inpatient, community health and social services can evolve, and the opportunity should therefore be taken to move away from the concept of a very large "national" unit. The indications are that the SIA would be content with a 120 bed unit [but it might perhaps be advisable to suggest a further reduction to about beds if there is any realistic possibility of a further unit being created to serve South England.] There is some evidence that when bed numbers have been reduced in the past, occupancy rates have increased; a similar increase in efficiency might result if the size of the unit were deliberately controlled.

5.5. An appeal will, however, need to emphasise the prestige of the Centre. Jimmy Saville saw this as centring on the Director, and suggested that the "Directorship" might be reinstated (it was previously discontinued with the agreement of the health authorities, the consultants and junior doctors staff & the Attends [illegible].

DH Document 06. Page 234

6. <u>SUMMARY</u>

i) There is considerable pressures on Ministers to intervene and prevent the cuts of the NSIC proposed by Buckinghamshire AHA and they will clearly wish to make a positive response. Intervention should be limited to the Supra-Regional specialty - in other respects responsibility for service cuts should remain the responsibility of the AHA/RHA. Immediate measures to prevent cuts will need to be followed by positive plans for the future.

ii) This paper outlines the case for capital funding to be provided by voluntary or central funding, or both. It is proposed that revenue funding should be protected to unit level.

iii) If i) and ii) are accepted as a basis for future activity, discussions with the health authorities and with NCIC supporters will need to explore fund-raising mechanisms and the requirements for the new unit.

iv) A caveat : great care will need to be taken not to offend the other spinal units, who already resent the popular view of Stoke Mandeville as the "national" centre and feel that their own work is disregarded. The NSIC is only a <u>part</u> - albeit a large and valuable one - of the national service.

~~[illegible]~~ PQ 4/1/() 28 02/23

Thank you for your minute of 12.11

So far as we in SH2C are concerned, any efforts to raise money for Stoke Mandeville are to be welcomed. As you know officials are meeting ~~Mr Bargess~~ Dr Vaughan on Monday 19 November and Mr Bargess' proposal could be discussed then. ~~We suggest that this should be [illegible] in your draft~~ reply (We suggest Dr Vaughan should reply — as you know he is visiting Stoke Mandeville on 20 November)

We know nothing of a/c of the

Borges' letter except that we are aware that in his capacity as Chairman of the League of Friends he has taken a leading part in raising substantial sums of money for the RNOH.

We hope that there isn't going to be any friction between Jimmy Savile and Mr Borges!

R Hughes
SH2C
BSIO APA
x6411

13 November 1979.

cc. Mr B.L.G.

10A.

Reference

...RSITY OF LONDON

Hospital 01-357 ....
Institute 01-357 7740

Mr Myers,

Po(s of S) 2802/23 — THOMAS BORGES

(Deputy Chairman, Institute of Orthopaedics RNOH)

31/10

Please see attached letter to S of S — for answer by 14/11/79. Unless you have objection, we intend to draft a welcoming reply to his offer of help and perhaps invite him to any exploratory meeting. Do you know anything of the organisation of X/- of his letter? Were SH2 involved.

Any comments welcomed. [signature] 12/11/79

(MISS M. T. SWEENEY)
RLIA Rm 1533 C.T. X833

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... the planning and
... R.N.O.H. Stanmore.

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... Mandeville.

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... this Hospital and
the Central Middlesex Hospital to provide rehabilitation and research facilities, (both capital and running expenses), which could not have been provided by your Department. The benefits to patients and staff is widely known. All these developments were planned in co-operation with the respective authorities and your department.

X/

I believe that ... support from the ... sector might be ... to help alleviate the situation at ... Mandeville. However, we ... rather the facts ... by a ... effect. I am aware ... ...

BRITISH POSTGRADUATE MEDICAL FEDERATION, UNIVERSITY OF LONDON

THE INSTITUTE OF ORTHOPAEDICS

Royal National Orthopaedic Hospital
234 Gt. Portland St. London W1N 6AD

Hospital 01-387 5070
Institute 01-387 7740

26th October, 1979

21/10

The Rt. Hon. Patrick Jenkin, MP
Secretary of State for Social Services,
Department of Health and Social Security,
Alexander Fleming House,
Elephant and Castle,
London SE1 6BY.

Dear Secretary of State,

You are, I believe, aware that Lady Masham is a Member of this Hospital's Board of Governors, and its Sub-Committee concerned with the planning and building of a twenty-four bedded Spinal Injuries Unit at R.N.O.H. Stanmore.

Based on the latest advice received from your Department, we believe that this unit may now be operational towards the end of 1981; therefore, it is unlikely to provide a timely solution to some of the problems which may arise if the proposed cut-back in facilities at the Stoke Mandeville Spinal Injuries Centre is carried out.

Financial disciplines contribute to a more effective management style and this is bound to have considerable long term benefits. However, society in general, and patients in particular, invariably react emotionally, and change is seen as a threat. I believe, therefore, that in the present climate, Health Authorities might find their task less onerous if new plans were communicated in a sympathetic way so as to lessen the anxiety to patients and members of staff.

Stoke Mandeville provides comprehensive treatment and rehabilitation facilities on a national basis, and the issue therefore appears to be a particularly emotive one. It is accepted that the Health Authority in adhering to their budget may not be able to consider the very special nature of this case.

You are aware that substantial private funds have helped this Hospital and the Central Middlesex Hospital to provide rehabilitation and research facilities, (both capital and running expenses), which could not have been provided by your Department. The benefits to patients and staff are widely known. All these developments were planned in co-operation with the respective authorities and your department.

X

I believe [illegible] support from [illegible] might be [illegible] to help alleviate the situation at Stoke Mandeville. However, we [illegible] [illegible] can only be done by a comprehensive [illegible] effort. [illegible] Stoke [illegible] [illegible] and Dr. [illegible]

The Rt. Hon. Patrick Jenkin, MP   20th October 1979

Past experience encourages me to believe that a mutually acceptable solution to this important matter may again be possible and I would be grateful, therefore, if your Department, or the appropriate Health Authority could consider setting up an exploratory meeting. Adverse press publicity and questions in the House are certainly not going to help your cause.

Kind regards
Sincerely

Thomas [signature]
THOMAS BORGES
(Deputy Chairman)

PS. Jimmy Savile is a regular visitor to Stoke Mandeville, however, I doubt whether his willingness to 'Mix It' is the answer to the problem!

cc. Lady Macher
Mrs. J.H. [illegible] - DHSS - [illegible] Tower
Mr. S.P.J. [illegible] - [illegible] & Secretary

PQ. 13 - 1/111/100

Reference .... 9A.

Miss Spencer

STOKE MANDEVILLE

1. Secretary of State has commented on the suggested reply to Mr Alfred Morris' PQ:

> "I want a proper discussion on the National Spinal Injuries Centre with the Minister for Health and officials before he goes there (in the light of my discussion with Jimmy Saville)".

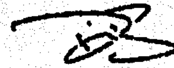
2. I am arranging a meeting and meantime summarise below the discussion with Jimmy Saville on Thursday 8 November.

3. The main point which Jimmy Saville put to the Secretary of State was that, in his view, the difficulty at Stoke Mandeville was not finding extra money but persuading the health authorities concerned that it still had a role as a national and, indeed, international centre of excellence. Jimmy Saville was entirely confident that sufficient funds could be raised to meet both Stoke Mandeville's immediate revenue needs and the larger part of its capital redevelopment providing that it was accepted that it was more than just a local hospital. Jimmy Saville argued that the fundamental requirement to secure the future of the hospital and its ability to attract charitable monies was the acceptance by Ministers, the Department and the Health Authorities of its national role. In his view two decisions were required to demonstrate a commitment to Stoke Mandeville as more than just a local hospital:

1. a reversal of the decision to break up the physical integrity of the unit by including geriatric wards in the same buildings;

2. to reinstate the post of Director.

Secretary of State made it clear that he would have to take advice on the points which had been put to him by Jimmy Saville but that in general he was entirely in agreement with the view that individual merit and centres of excellence should be encouraged and would want to do all he could to secure the continuance of the reputation and stature of the Stoke Mandeville unit.



12 November 1979

D BRERETON

cc
Mrs Fosh
Mr T Phillips
Mrs Brennan
Mr Collier
Mr Nodder
Mr Wormald
Dr Lees
Mrs Petrie
Mr Gant
Dr F G Tait

ED OR
ORISED

SEO or above 8A

ON

Parliamentary
A712 AFH
7687 or 6904

154015/301675 250M 4/73 JT&S/L

Mr Bebb
Thatcher

FT
12/11/79

Mr Myers

13/11

Oral

PRIORITY

WRITTEN

NOTICE PAPER	
DATE	PAGE
8/11/79	734.

1979

Chairman Dr. Fortunato fellow MP (H)? have back pl

Bebb 12/11

I have warned Peter Bore(?) the Commons Question & suggested the form of the reply (Treasurer of the AHA)

give an
or beds

... Hospital.

RTY: La.

FINAL No.

mentary Branch Action	Referred to	Date	Referred to	Date
	Mrs Petrie	12/11/79.		
ION COPIED TO:- Mr Bebb.				

SIGNED OR AUTHORISED

SEO or above 8A

DIVISION Parliamentary
ROOM A712 AFH
EXT. 7687 or 6904

1540151/301675 250M 4/73 FT&SL

DEPARTMENT OF HEALTH AND SOC

Registered Number 1983 1979/80

PRIORITY

ARLIAMENTARY QUESTION

Oral ~~WRITTEN~~

NOTICE PAPER	
DATE	PAGE
8/11/79	734.

ANSWER ON: WEDNESDAY 5th DECEMBER 1979

LORDS ORAL

AFT REPLY to reach
liamentary Branch not
er than

Dr. Tait.
You should see this. It is fortunate that it will follow MS(H)'s visit. May I have back pl

[illegible] Bebb 12/11

BJECT: STOKE MANDEVILLE HOSPITAL. P.S. I have warned Peter Smith about the Commons question + suggested the form of the reply (business of the AHA)

TION:

†*The Lord Davies of Leek — To ask Her Majesty's Government whether they can now give an assurance that they have no intention of cutting services available to paraplegics or beds available in Stoke Mandeville Hospital.

TY: La. FINAL No.

mentary Branch Action	Referred to	Date	Referred to	Date
	Mrs Petrie	12/11/79.		

ON COPIED TO:-
Mr Bebb.

DEPARTMENT OF HEALTH AND ...

DIVISION	Parliamentary
ROOM	A710 AFH
EXT.	7687 or 5504

7A

Registered Number

1984

10/1/30.

PARLIAMENTARY QUESTION

PRIORITY

WRITTEN

NOTICE PAPER	
DATE	PAGE
12/11/79.	1972.

FOR ANSWER ON: TUESDAY 13/11/1979

DRAFT REPLY to reach Parliamentary Branch not later than TODAY 12th NOVEMBER 1979 1600.

SUBJECT: STOKE MANDEVILLE HOSPITAL.

QUESTION:

70 Mr Nicholas Winterton (Macclesfield): To ask the Secretary of State for Social Services, what effects Her Majesty's Government's public expenditure policy will have upon the Stoke Mandeville Hospital; and if he will make a statement.

PRIORITY: C.

FINAL No.

Parliamentary Branch Action	Referred to	Date	Referred to	Date
	MB Colne	12/11/79.		
ACTION COPIED TO:- Bebb.				

7A.

WAKEFIELD AREA HEALTH AUTHORITY - Western District (Wakefield)

Department
NEUROLOGY

PINDERFIELDS GENERAL HOSPITAL
ABERFORD ROAD
WAKEFIELD
WEST YORKSHIRE
WF1 4DG
Telephone WAKEFIELD 75217

Our Ref. JBC/JeV

Your Ref.

Verbal enquiries on this matter should be made to

.... Ext............

8 November 1979

Mr. F. Tait
Department of Health and Social Security,
Alexander Fleming House,
Elephant and Castle,
London,
SE1 6BY.

Dear Frank,

It is of interest and possibly significant that the article by Marshall should have been submitted to you for comment after steps had been taken for its publication. I will look at it again and take appropriate action.

Andrew Burt and I saw the television programme on Tuesday on Nationwide, emanating from Stoke Mandeville and we share the view that we do not think that that is really the way of setting about things. There were a number of points to which we would take exception. The first is the repeated mention of a national spinal injuries unit which it never really was even in the days of the great man himself and which it most certainly is not now. Many of the facilities which they showed were not really directly to do with the management of spinal injuries but with the promotion of sports for paraplegia.

We hold the view that in general Stoke Mandeville is over-blown and is proving to be something of a drag upon development and possibly standards in other existing units. I refer particularly to their training programme where without proper consideration they are appointing people who would not be acceptable to appointments committees in general and who would certainly not be acceptable to the major spinal injuries units.

We feel that it is high time that the situation should be rationalised and money diverted to the development of other centres in the South of England and we find it difficult to understand why there should be the delay which seems to be caused by the requirement for a fullyequipped centre. Both here and at Sheffield the units started in very poor quality wards with no special facilities and indeed we are only now after 25 years undergoing our first building modification.

We feel that providing the staff is available spinal injuries should be managed in accommodation with minimal adaptation and with routine services. Indeed it could be said that that is all part of the exercise aimed at improving their care in general and demonstrating that spinal injuries can be managed and should be managed without very expensive equipment and staff.

Yours sincerely,

John B. Cook MD FRCP

6A.

MV

Mrs Petrie - if you agree
Miss J Middleton

JIMMY SAVILLE'S MEETING WITH SECRETARY OF STATE RE. STOKE MANDEVILLE HOSPITAL THURSDAY 8 NOVEMBER

Facing is a note setting the problems of the National Spinal Injuries Centre at Stoke Mandeville in the context of the hospital's and the Buckinghamshire AHA's problems generally. The note is agreed with RCP and SH.

Buckinghamshire AHA meets tomorrow, Wednesday 7 November. Among the major proposals for service reductions will be the proposal to close temporarily 25 beds in the NSIC. I will be attending the meeting of the AHA and will let you have a note on the outcome either tomorrow evening or on Thursday morning.

Peter R Gant
RL1
Room 1504 Ext 816
Euston Tower

6 November 1979

cc. ✓ Mr Myers
Mr Longfield
Miss Sweeney
Miss Gwynn
Dr Melia
Miss Rowland-Jones
(PRG personal)

STOKE MANDEVILLE HOSPITAL/THE NATIONAL SPINAL INJURIES CENTRE (NSIC)/BUCKINGHAMSHIRE AHA'S FINANCIAL PROBLEMS AND PROPOSED CUTS

<u>Visit of Mr Jimmy Saville OBE to Secretary of State</u>

STOKE MANDEVILLE HOSPITAL

1. Stoke Mandeville Hospital near Aylesbury, is managed by Buckinghamshire AHA. It is a major district general hospital with approximately 758 beds. It also houses the Regional Plastic Surgery and Burns unit, the National Spinal Injuries Centre (156 beds) and the National Sports Stadium for Paralysed and other Disabled.

2. Stoke Mandeville dgh serves the whole of the Aylesbury area and, until the new proposed new Milton Keynes dgh is built, has additionally to provide (with Northampton) hospital facilities for the rapidly growing population of Milton Keynes new town. This imposes severe additional pressures which will not be relieved until the mid 1980s.

3. The greater part of Stoke Mandeville Hospital including the NSIC is housed in wartime hutted accommodation which is rapidly deteriorating; there are major maintenance problems and in severe weather last winter ceilings collapsed, and several wards (including part of the NSIC) had to be evacuated. Recruitment of nursing and non-nursing staff has been a problem and has led to the closure of beds and/or wards from time to time in recent years. General rebuilding of Stoke Mandeville hospital is proposed in the Oxford Regional Strategic Plan in stages between the mid 1980s and the early 1990s. The likely date for the rebuilding of the NSIC within this general programme has not yet been determined.

THE NSIC AND OTHER SPINAL UNITS

4. The National Spinal Injuries Centre is much the largest of the national network of six Spinal Units. It pioneered under Sir Ludwig Guttman the special skills and treatment which have resulted in a considerable improvement in the quality of life and life expectancy of paraplegics and tetraplegics. The NSIC is the only centre of its kind in the South of England and until new Spinal Units proposed for Odstock and (Salisbury) the Royal National Orthopaedic Hospital (Stanmore) are opened in the early 1980s. Until these two new Units become operational, provision in the South of England will be insufficient. Provision in the North is generally adequate. This is the background to the present public concern at the Bucks AHA's proposal to close temporarily 25 beds in the NSIC (in fact staff shortages and other factors have currently reduced the complement at the NSIC to 12[illegible]

CUTS IN BUCKINGHAMSHIRE

5. Buckinghamshire AHA's current financial allocation is approximately £36million for the current year and the present position is that unless economy measures are introduced as a matter of urgency it is estimated that cash limits will be exceeded by approximately £1.75 million.

6. Since August the AHA and Oxford RHA have taken a number of steps to reduce the potential overexpenditure including in Buckinghamshire an almost total embargo on the recruitment of staff and an urgent revision of the Area Operational Plan. This was received by the Authority in September, has subsequently been out for public consultation during September/October and will be submitted to the Authority for decision on 7 November. The revised Operational plan proposes wide-ranging economies including a reduction of beds in the general sector (including 25 at the NSIC), cuts in the psychiatric sector, a reduction of expenditure in the mental handicap sector, reduction in geriatric beds and many miscellaneous proposals for temporary closures and changes of use.

OPPOSITION TO CUTS AFFECTING THE NSIC

7. The proposed cuts at the NSIC and the temporary closures of beds in recent montl have given rise to a major "lobby" of Ministers by the National Spinal Injuries Association, Lady Masham, Lady Darcy de Knayth, MPs, clinicians and concerned members of the public. There is a common theme in that almost all correspondents argue for protection of the NSIC beds against cuts, if necessary by direct central funding. The SIA argue forcefully, as do others, that it is particularly important to maintair the full 156 beds at the NSIC pending the opening of the units at Stanmore and Odst- in view of the acknowledged shortage of beds for treatment of Spinal injuries in the South of England.

AGRA PROPOSALS

8. The question of central funding has been examined by the joint NHS - DHSS Advisory Group on Resource Allocation (AGRA). While rejecting central funding as such AGRA is expected to recommend shortly to the Secretary of State that special treatmer should be accorded to certain multi-regional services, including Spinal Units. The mechanism would be a more realistic costing of cross-boundary flows, which would react on "RAWP- targets" and therefore, indirectly, on actual allocations to Regions.

DH Document 06. Page 248

6

A POSSIBLE CASE FOR A NATIONAL APPEAL

9. It has been suggested that the rebuilding of the NSIC could be accelerated if there were to be a major public fund-raising appeal, possibly under the aegis of the Spinal Injuries Association. The Duke of Edinburgh has expressed a general interest and concern about Stoke Mandeville and Mr Jimmy Saville is exceptionally well-placed to advise and assist in any such campaign. There is a general fund of good-will towards paraplegics and tetraplegics and a major campaign properly organised could be very successful indeed and might accord well with the Government's wish to promote initiatives of this kind.

MS(H)'S PROPOSED VISIT 20 NOVEMBER

10. As a first step in dealing with the problems of Buckinghamshire and the NSIC, MS(H) will be visiting Stoke Mandeville on 20 November to discuss the problems with clinicians and senior management at first hand. Shortly afterwards he will be meeting Lady Masham and this would be a good opportunity to explore the idea of a national appeal . for the rebuilding of the NSIC.

115
5A.

Spinal Injuries Association

126 Albert Street London NW1 7NF 01-267 6111

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

Dr F Tait
Department of Health & Social Security
Alexander Fleming House
Elephant & Castle
LONDON SE1

2nd November 1979

Dear Frank

Please find enclosed copies of letters to the Minister of Health and the Chairman of the Oxford RHA for your records.

Any advice you can give on how the Association can help towards solving the worsening position of the treatment and care for paraplegics and tetraplegics in the South of the country would be very much appreciated.

Best wishes,

Yours
Stephen

Stephen Bradshaw
Director

Mr B[illegible]
Stephen has sent these copies — the one to MS(H) is practically illegible but the message comes out. I would be interested to see the reply if there has been one
5/11/79 Frank Tait

Mr Myers
Can you find out if the 12 Oct letter [illegible] dealt with [illegible] [illegible] [illegible] they know what the RHA is saying about this letter?

SIA — The charity that helps paraplegics and tetraplegics
Registered charity number 267935

5B

Spinal Injuries Association

126 Albert Street London NW1 7NF 01-267 6111

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

Dr Gerard Vaughan MP
Minister of State for Health
Department of Health & Social Security
Alexander Fleming House
Elephant & Castle
London SE1 6BY

12th October 1979

Dear Dr Vaughan

The National Spinal Injuries Centre will lose a further 25 beds forthwith if immediate action is not taken to avert this disastrous proposal. The DHSS recognises the need for a further 100 beds in the South of England to treat newly injured and check up old patients. Yet well before the proposed Odstock and Stanmore Spinal Units are on stream, the Aylesbury District Management Team has announced that a spinal ward and annexe must be allocated to geriatric patients due to the closure of Tindall Hospital.

Newly injured people are suffering irreversible damage in general hospitals because the National Spinal Injuries Centre is unable to admit them before complications develop: eg, a patient from a London hospital injured only eight weeks ago is to be admitted with packed pressure sores - pressure sores do not develop if spinal cord injured people receive the internationally recognised correct treatment.

Due to the fact that money has not been put into the National Spinal Injuries Centre for equipment, or to provide the necessary staff, or to replace the fourth consultant when he left, our members cannot be checked up to catch problems before they develop to the stage where prolonged hospitalisation is required. Preventive medicine cannot be practised because of the iniquitous treatment metered out to the National Centre. Patients are suffering wrong or dangerously delayed treatment under the NHS.

It is imperative that the National Spinal Injuries Centre receives national funds to prevent a further crumbling of inadequate services for spinal cord injured in the South. This Association is all too willing to help raise public funds for the rebuilding of the Centre, but right now the situation is desperate. Whether or not the Centre is receiving its rightful share of regional funds is debatable, but the fact that it has been systematically changed is a matter of fact. The Area Health Authority meets on November 7, 1979, to finalise the cuts in spinal beds. Please visit the Centre to assess the situation for yourself before it is too late.

A local decision to move geriatric patients to Stoke Mandeville simply cannot be allowed to decimate the woefully inadequate provision for spinal cord injured for the whole of the South of the country.

Yours faithfully

Stephen Bradshaw, Director

GT/L

5C

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

Telephone 01-388 1188 ext

The Secretary
The Spinal Injuries Association
126 Albert Street
LONDON
NW1 7NK

Your reference

Our reference
U/H3/SIA/2
Date
16 October 1979

Dear Sir

I have been asked to thank you and to reply to your telegram of 26 August to Dr Vaughan about the National Spinal Injury Centre at Stoke Mandeville Hospital. I am sorry that we were unable to give you an earlier reply.

The Buckinghamshire Area Health Authority informs me that the decision to ban the filling of staff vacancies was reached with great reluctance only after full and reasoned discussions had taken place. The health authority's view was that the temporary freeze on recruitment should apply 'across the board' and that no units, not even the NSIC, should be exempt. The health authority was anxious however to minimise disruption to direct patient care as far as possible as a result of the major economies which they must achieve if they are to remain within their cash limits, and have therefore given the District Management Team discretionary powers to fill vacancies in certain instances. I trust that this move would enable some relief for Stoke Mandeville and the NSIC.

On the question of national funds for the Centre there are certainly at present no central funds which can be earmarked for this purpose, but in the light of criticism, regarding the funding of units of national importance like the NSIC, this matter is now being looked at most carefully with a view to ensuring that such units are fairly treated in future within the general framework of the current funding arrangements for health authorities.

Finally, while I wish to assure you that Ministers and this Department share your Association's concern about the care and treatment of Spinal Injuries patients, we do not think it right to interfere in the difficult decisions which many health authorities are having to make about the economies to be adopted locally, so that their budgets are not overspent in this financial year. We feel sure that all authorities will act most responsibly in these matters and seek to make the maintenance of services to patients their first priority.

The Minister for Health, Dr Vaughan, hopes to visit the NSIC at Stoke Mandeville Hospital within the next few weeks. He was most disappointed that he had to defer this visit, originally arranged for 26 September 1979.

Yours sincerely

E. L Jayakody.

Mrs E L Jayakody

TREAT OFFICIALLY

RECEIVED IN THE OFFICE OF 24 AUG 1979 MINISTER OF STATE (H)

T
889189 PO SE G
889256 PO PK G

17 RETRANS 1723 LONDON T 106

DOCTOR GERARD VAUGHAN MINISTER OF STATE FOR HEALTH DHSS ALEXANDER
FLEMING HOUSE ELEPHANT AND CASTLE
LONDONSE1

NATIONAL SPINAL INJURIES CENTRE NEEDS NATIONAL FUNDS . THE SPINAL
INJURIES ASSOCIATION IS ALARMED THAT STAFF FREEZE (46 UNSTAFFED
BEDS) HAS RESULTED IN 15 NEWLY INJURED PATIENTS AND 21 OTHER URGENT
CASES BEING REFUSED ADMISSION AT STOKE MANDERVILLE HOSPITAL .
IRREVERSABLE DAMAGE CAN BE CAUSED IN GENERAL HOSPITALS RESULTING
IN LONG REHABILATION AT THE VERY BEST . PEOPLE ARE SUFFERING.
SPINAL INJURY IS SO CRUEL A BLOW THAT THE PROBLEM SHOULD NOT BE
EXACERBATED BY GOVERNMENT ACTION - HELP NOT CUTS NOT NEEDED .
SPINAL INJURIES ASSI OCIATION

COL SE1 15 (46 UNSTAFFED BEDS) . 21 . . . . - .

889256 PO PK G
889189 PO SE G

126, Albert Street
London NW1 7NK

JJJJJJ

Spinal
Injuries
Association

51

126 Albert Street London NW1 7NF 01-267 6111

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

Gordon Roberts Esq, CBE, JP
Chairman
Oxford Regional Health Authority
Old Road
Headington
Oxford OX3 7LF

1st November 1979

Dear Mr Roberts

National Spinal Injuries Centre

The SIA is shocked to hear of plans to further decimate the already inadequate provision for spinal cord injured people in the South by chopping twenty-five beds at the NSIC. The DHSS recognises the need for a further one hundred beds in the South of the country to treat newly injured and check up old patients, yet well before the proposed Odstock and Stanmore Spinal Units are on stream, a spinal ward and annexe (built by voluntary support for paralysed children) are proposed to be allocated to geriatric patients on the closure of Tindal Hospital.

Newly injured people are suffering irreversible damage in general hospitals because the NSIC is unable to admit them before complications develop, eg pressure sores do not develop if spinal cord injured people receive the internationally recognised correct treatment. Patients are being subjected to wrong treatment under the NHS at untold cost in human and financial terms because the NSIC has been systematically starved of money over the years.

Due to the fact that over recent years money has not been put into the NSIC to replace old or provide new equipment, or to attract the necessary staff (can we really expect staff to live in what has been referred to as a 'slum'), or to attract a fourth Consultant to fill the vacancy, our members cannot be checked up to catch problems before they develop to the stage where prolonged hospitalisation is required. Increasingly SIA members in need of a check-up have been turned away and increasingly surgical cases, even urgent ones, are refused admission when delays for paralysed people are far more critical than normal and can lead to irreversible damage within a dangerously short space of time. Preventive medicine cannot be practised because of the iniquitous treatment meted out to the NSIC. Patients are suffering unnecessarily under the NHS.

It would appear that the Oxford RHA is not receiving its rightful share of funds, especially as it has the fastest growing population in Europe. Whether or not the NSIC is receiving its rightful share of Area funds is debatable, but the fact that it has been systematically starved of funds is a matter of fact.

Should a local decision to move geriatric patients to Stoke Mandeville be allowed to decimate the woefully inadequate provision for spinal cord injured people for the whole of the South of the country?

Obviously SIA wants to help the Oxford RHA provide proper facilities for the treatment and care of spinal cord injured people. How can we work together to obtain central funds to rescue the NSIC? What would you like us to do? Our members in the South have suffered enough.

Yours sincerely

Stephen Bradshaw
Director

cc: Lady Mallalieu JP
P Grant Esq

114

4A-. 13/11

2 Feet

For information. This is below my talk with Dr Myers ID last night

For the file.

Miss Spencer
AFH D617

The Minister will recall that in mid-September the BBC radio programme "Does He Take Sugar?" was asking for a Ministerial comment on the financial problems of the Stoke Mandeville spinal injuries unit. We subsequently gave the programme a very short quotation from the Minister in which he indicated that he would be discussing the financial position of the area during a forthcoming visit.

The subject has again been raised with Press Office, this time by BBC "Nationwide". They are requesting a 3 minute interview with Dr Vaughan to discuss the "risk to Stoke Mandeville over current plans for cuts. Is it a case for central funding? What about the poor provision for spinal injuries cases in the whole of the south of England"?

"Nationwide" are currently filming at Stoke Mandeville Hospital, talking to patients, Dr Frankel (at the Unit), to the Spinal Injury Association - all, presumably, putting the case for the Unit being provided for by central funding.

Press Office also understand that "Nationwide" are intending to interview the Chairman of Bucks AHA. BBC are intending to question her about the general need to make cuts in services to achieve savings of something like £1¾ million out of their £35 million budget.

As we understand Dr Vaughan is going to visit Stoke Mandeville on 20 November, we would recommend that Dr Vaughan should not agree to take part in the programme at this stage. We would explain, if the Minister agreed, that he was wishing to visit the hospital, the Unit and the AHA, to discuss the particular problems of the Authority's expenditure plans and that he did not wish to make any comment on the particular difficulties of the spinal injuries unit ahead of his discussions with the AHA.

NEVILLE TAYLOR

31 October 1979

cc	Mr Collier	D904
	Mrs Petrie	ET 1532
	Mr Gant	ET 1504
	Mr Bebb	B517
	Miss Else	D508

Mr Arthy PN...
24/9.

D2/H1/145
H1/11176/1

3A.

PQ 1531/1979/80
PQ 1534/1979/80
PQ 1535/1979/80
PQ 1536/1979/80

168. Mr Alfred Morris (Manchester, Wythenshawe): To ask the Secretary of State for Social Services, how many patients in the past 12 months from the South of England have had to be treated in spinal injuries units in the North because of the inadequacy of Stoke Mandeville Hospital and the absence of alternative facilities in the South; and if he will make a statement.

171. Mr Alfred Morris (Manchester, Wythenshawe): To ask the Secretary of State for Social Services, if he is satisfied with the number of beds in spinal injuries units and their distribution throughout the country.

172. Mr Alfred Morris (Manchester, Wythenshawe): To ask the Secretary of State for Social Services, what is his policy towards annual check-ups for spinal injury patients at the unit where they were originally treated; which spinal injuries units are currently unable to provide this service; and if he will make a statement.

173. Mr Alfred Morris (Manchester, Wythenshawe): To ask the Secretary of State for Social Services, if he will list the spinal injuries units in England with the number of beds in each (a) currently in use, and (b) temporarily closed; what is the reason for the bed closure in each case; and if he will make a statement.

SUGGESTED REPLY

As there is no spinal injuries unit south of Stoke Mandeville, provision in the South of England is not sufficient, but the position will improve when the Stanmore and Odstock units come into operation. I have no information about numbers of patients treated in northern units because of lack of provision in the South, but the evidence I have suggests that provision in the North is generally adequate.

Any decision on the frequency of reviews of patients is a matter for the individual consultant, and it is for him to decide whether to carry out the review himself or to refer the patient to a colleague. I am aware that the consultants at Stoke Mandeville experience problems because of their wide catchment area.

I will write to the hon. Gentleman giving him up-to-date information about bed occupancy and availability in each unit. The position changes frequently because of staff recruitment and other factors.

DEPARTMENT OF HEALTH AND S

EXT.

Registered Number

P.Q. 1533 1979/80

PARLIAMENTARY QUESTION

~~Oral~~ PRIORITY WRITTEN

NOTICE PAPER	
DATE	PAGE
22 OCT 1979	12

FOR ANSWER ON: THURSDAY 25 OCT 1979

Mr Aitken

DRAFT REPLY to reach Parliamentary Branch not later than Wednesday 24th October 1979 1600

SUBJECT: SPINAL INJURIES UNIT - ODSTOCK HOSPITAL

QUESTION:

170 W Mr Alfred Morris (Manchester, Wythenshawe): To ask the Secretary of State for Social Services, when he expects the spinal injuries unit at Odstock Hospital, Salisbury, to become operational; and if he will make a statement.

PARTY: LA.

FINAL No.

Parliamentary Branch Action	Referred to	Date	Referred to	Date
	MB Pebrie	23/10		
QUESTION COPIED TO:-				
Mr Bebb				

SIGNED OR AUTHORISED — SEO or above: Parliament
DIVISION
ROOM
EXT.

(429) 577032 110m (8) 3/78 WP

DEPARTMENT OF HEALTH AND SOCIAL

Registered Number
P.Q. 1532 1979/80

PARLIAMENTARY QUESTION

PRIORITY
WRITTEN

NOTICE PAPER	
DATE	PAGE
23 OCT 1979	/2

FOR ANSWER ON: THURSDAY 25 OCT 1979

Mr Arthur.
(This should of course go to Mr Lingwood)

DRAFT REPLY to reach Parliamentary Branch not later than Wednesday 24th October 1979 1600

SUBJECT: SPINAL INJURIES UNIT AT STANMORE HOSPITAL

QUESTION:

169 W Mr Alfred Morris (Manchester, Wythenshawe): To ask the Secretary of State for Social Services, what stage the proposal to build a new spinal injuries unit at Stanmore Hospital has reached: and if he will make a statement.

PARTY: La.

FINAL No.

Parliamentary Branch Action	Referred to	Date	Referred to	Date
	Mr Thorpe-Tracey	23/10/79.		

QUESTION COPIED TO:-
Mr Bebb

Crr

97/13

WRITTEN ANSWER
THURSDAY 25 OCTOBER 1979

PQ 1532/1979/80

Mr Alfred Morris (Lab. Manchester, Wythenshawe):
To ask the Secretary of State for Social Services, what stage the proposal to build a new spinal injuries unit at Stanmore Hospital has reached: and if he will make a statement.

SUGGESTED REPLY

The functional content and operational policies of the unit have been agreed and I am very glad to say that approval has been given for the Board of Governors to proceed as quickly as possible to detailed design of the Unit.

Mrs Arthur [illegible]
[illegible] 26/10.

Mr Bebb,
Copied at Mrs Goldsworthy's request - I understand you have discussed this reply with her.
K Foster. 24.10.79
1718

Mr Bebb
Thanks. Good news
with Scott Whyte
[illegible] 25/10

You may like to be aware of this. It follows a meeting at the Royal National Orthopaedic Hospital yesterday at which we reached agreement with the Board on all the outstanding points. The project is a 24 bedded unit costing £1.24 M. It should significantly relieve pressure on Stoke Mandeville when operational — hopefully by end 1982.

25.

27.

DRAFT BRIEFING MATERIAL FOR DR GERARD VAUGHAN'S VISIT TO STOKE MANDEVILLE

1 Introduction

Spinal units came into being to treat people who had suffered spinal cord injury. But gradually the special skills and techniques developed in the units have been applied to patients with non-traumatic spinal cord ~~injury~~ lesions. The number of non-traumatic cases treated in the individual units is determined by the interests of the consultant in charge. Although industrial accidents are no longer the main cause (road accidents have become increasingly important), the number of new cases occurring each year remains at about 12 per million population and a similar figure applies to all Western industrialised countries. Advances in treatment have resulted in an increase in the life expectancy of paraplegics and particularly tetraplegics. It is estimated that at least 100 beds, in addition to the existing 348, are needed to treat and provide adequate follow-up for all traumatic cases and some provision must be made for the non-traumatic cases eg severe spina bifida.

2 Distribution of units

There are six units in England:-

Spinal unit	Number of beds
National Spinal Injuries Centre, Stoke Mandeville	150
Midlands Spinal Injuries Unit, Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry	46
Lodge Moor Spinal Injuries Unit, Sheffield	64
Southport Paraplegic Unit, Southport	37
Pinderfield General Hospital, Spinal Injuries Unit, Wakefield	31
Hexham Spinal Injuries Unit, Hexham	20
Total	348

The first unit was the National Spinal Injuries Centre at Stoke Mandeville, set up during the Second World War to provide a service for military personnel. The other units were developed after the war and Stoke Mandeville is now a part of a network of units.

The major problem lies in the uneven distribution of the units throughout the country and particularly the shortage of beds in the south. Although 75 of the population lives south of a line from the Bristol Channel to the Wash, Stoke Mandeville is the only unit in the area and this provides less than 50 of the total beds available.

3 <u>National Spinal Injuries Centre: Stoke Mandeville</u>

This is an integral part of Stoke Mandeville Hospital. Because it was the first to specialise in this field and because of the pioneering work of Sir Ludwig Guttman whose drive and reputation achieved international recognition, it has acquired a unique status. This reputation has been maintained but the service it provides is no different in kind from that provided by the smaller units. The Department views the Centre as the first amongst equals. Since 1969, the Centre has attempted to restrict its catchment area to cases arising south of a line from the Bristol Channel to the Wash and approximately 75 of patients do come from there. On average, there are around 80 people on the waiting list (mostly follow-up cases). Waiting periods vary. In urgent cases, the period can be anything from twenty-four hours to six weeks, with an average of four weeks. For less urgent cases the period can vary from eight weeks to two years.

The average length of stay for the newly injured varies from 6 months to a year for paraplegics, and from 9 months to 13 months for tetraplegics. Discharge is dependent on satisfactory arrangements being made in the patient's home area for housing adaptations, the provision of aids and the necessary components of health care and social services. This poses particular problems or Stoke Mandeville as it serves so wide a catchment area, making relations ith health and local authorities particularly complex. The wide catchment ea also results in more patients having to stay overnight when they have attend for their routine follow-up review.

4 Proposed units

As Stoke Mandeville is the only unit in the south, the establishment of another unit in the area has long been one of the Department's priorities. Planning is well advanced for a 50 bedded unit at Odstock Hospital, Salisbury (Wessex RHA) and this should be operational before 1985. Further provision is still required in the south and the Department has been considering the establishment of a small 24 bedded unit at the Royal National Orthopaedic Hospital, Stanmore. There is some doubt whether this can be afforded. Departmental representatives are to visit the RNOH next week, and will report to the Minister about this on 25 September.

Reference PQ 1537/1979/80

1A

Mr Scott Whyte

There was no time to transfer this to RL but the reply has been agreed with them. If Mr Prentice is to answer the Question it should be made clear that it is the Secretary of State who will be visiting. I have dealt with this Question separately in view of its specific nature.

Min Sweeney
Copy for file and send on to
Mr Myers P.R. [illegible] 1/11

Mr Grant
All well!
[illegible] 31/10

G M BEBB
SH2C
B517 AFH
Ext 6132

24 October 1979

Parliamentary Branch
[illegible] 24/10

CODE 18-78

(HMSO 12/76)

Thursday 25 October 1979
W-A-

PQ 1537/1979/80

Mr Alfred Morris (Manchester, Wythenshawe): To ask the Secretary of State for Social Services, what representations he has received from the Spinal Injuries Association concerning Stoke Mandeville Hospital; what reply he has sent; and if he will make a statement.

DR GERARD VAUGHAN

R.J.

~~SUGGESTED REPLY~~

~~I~~ We have received representations recently from the Spinal Injuries Association concerning the availability of beds and funding arrangements at the National Spinal Injuries Centre at Stoke Mandeville. ~~My right hon Friend~~ I intend to visit Stoke Mandeville next month to see the situation for ~~myself.~~ ~~himself~~ myself.

Dr Vaughan to visit Stoke Mandeville 20 November

Dr Vaughan

Secretary of State is to visit Stoke Mandeville next month.

Julie Brand

24.10

Thursday 25 October 1979
Written Answer

PQ 1537/1979/80
Han Ref Vol
Col

SPINAL INJURIES ASSOCIATION - STOKE MANDEVILLE HOSPITAL

W34 Mr Alfred Morris (La. Manchester, Wythenshawe)

To ask the Secretary of State for Social Servoces, what representations he has received from the Spinal Injuries Association concerning Stoke Mandeville Hospital; what reply he has sent; and if he will make a statement.

DR GERARD VAUGHAN

We have received representations recently from the Spinal Injuries Association concerning the availability of beds and funding arrangements at the National Spinal Injuries Centre at Stoke Mandeville. I intend to visit Stoke Mandeville next month to see the situation for myself.

Mr [illegible] Mr Will
For the file Mrs Sa[illegible]
7
6

V. [illegible]

18/9

Stike mandeville

Here is the information
for the Region SMO.
The "difficulties in
recruiting" matter
loses its bite
when there are other
reasons for reduction
which is a pity for
the Depts point of view

Frank.
17/9/[illegible]

~~6A.~~ 5A

Mr Tait
Room L1111
Alexander Fleming House

RE: NATIONAL SPINAL INJURY CENTRE - STOKE MANDEVILLE HOSPITAL

Thank you for your note of 10 September.

For some considerable time the number of available staffed beds in the Centre (excluding the hostel) has been running at about 130 (ie one ward has remained empty out of a nominal total of 161) - the reason for this is a combination of difficulties in recruiting nurses and difficulties with the fabric of the building (ceilings etc).

The current "freeze" on staff recruitment which was introduced on 1 August has resulted in a further reduction to 122 beds.

I hope this is of some help.

N P MELIA
1822, Euston Tower
Ext 657

14 September 1979

cc Miss I Rowland-Jones
Mr E Collingwood

4A

HEALTH & SOCIAL SECURITY

, Elephant & Castle, London SE1 6BY.

hone 01-407 5522

inister of State (Health)

Mr Bebb
We will no doubt be called upon to contribute towards briefing. I've made a start on this as I knew it was imminent

Paula Asher
13.9.79.

Mr Higgins
You may wish to be aware of the attached correspondence. MS(H) has not yet signed the letter (copy attached) to Lady Masham.

Dr will be setting up a meeting with Lady Masham in due course but this is unlikely to take place before the second half of October.

[signature] H Angus (?) (Ms)
(D) 616 x6907
13-9-79

September 1979

ıst about the National Spinal Injuries Centre
ry you have not had an earlier reply. I am
sworth and there is therefore some delay
from my office in London.

e for a day's shooting and it is with deep
gramme when I return to the office on Monday

s soon as possible after my visit to Stoke
ough I know my diary is already heavily
ange a date for a meeting as soon as I

DR GERARD VAUGHAN

4 A

DEPARTMENT OF HEALTH & SOCIAL SECURITY

Alexander Fleming House, Elephant & Castle, London SE1 6BY.

Telephone 01-407 5522

From the Minister of State (Health)

Baroness Masham of Ilton

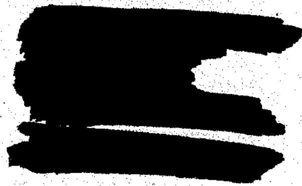
September 1979

Thank you for your letter of 9 August about the National Spinal Injuries Centre at Stoke Mandeville. I am very sorry you have not had an earlier reply. I am presently on 'leave' at home in Blisworth and there is therefore some delay in correspondence travelling to and from my office in London.

It was very kind of you to invite me for a day's shooting and it is with deep regret that due to my very busy programme when I return to the office on Monday that I must decline at present.

It is most important that we meet as soon as possible after my visit to Stoke Mandeville on 26 September and although I know my diary is already heavily committed for the Autumn I will arrange a date for a meeting as soon as I return to London.

DR GERARD VAUGHAN



4B

RECEIVED IN THE OFFICE OF
20 AUG 1979
MINISTER OF STATE (H)

9th August, 1979.

The Rt. Hon. Dr. G. Vaughan, M.P.,
Minister of State for Health,
House of Commons,
Westminster,
London. S.W.1.

Dear Dr. Vaughan,

Patrick Jenkin has written suggesting that we meet sometime during the autumn to discuss the rebuilding of the National Spinal Injuries Centre at Stoke Mandeville Hospital. Because of its past reputation, I am sure a national appeal launched on a large scale would bring in at least half the funds needed.

I hope we will be able to discuss some of the other problems involving the unit, such as rehabilitation, after-care, including the hugh backlog of patients who need check-ups and on-going treatment. There is a desperate shortage of social work support and this is most worrying. So many patients have manifest home problems to cope with and come from long distances apart.

Enclosed for your information is a letter from Roger Titley, who is the District Administrator, and he is a first class person and obviously very concerned. Many members of the Spinal Injuries Association have discussed their problems with us, and they are concerned at the deteriorating services at Stoke Mandeville.

I hope also, you will be able to tell me when the two future units at Odstock and Stanmore Hospitals will be operational. It is of great concern that neither of these units are yet treating patients.

If you are visiting Yorkshire, perhaps you would like a day's shooting, and come here for the discussion? You met David when he stayed with Lord Crewshaw.

If ever you have time to visit the Hospital at Odstock to look at the work they are doing on Tissue Viability, I know it would give them immense encouragmont.

I look forward to hearing from you.

My best wishes,

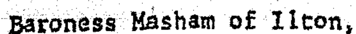
Baroness Masham of Ilton.

AYLESBURY AND MILTON KEYNES HEALTH DISTRICT
BUCKINGHAMSHIRE AREA HEALTH AUTHORITY

9 Bicester Road,
Aylesbury,
Bucks. HP19 3AB

Telephone : AYLESBURY (0296) 84111

District Administrator : R. E. Titley, D.S.A., F.H.A.
Your Ref. :
Our Ref. : RET/PG


Baroness Masham of Ilton,

3rd August, 1979

Dear Lady Masham,

I must apologise for not having written to you since your letter of 29th May, but taking your suggestion, I have tried on several occasions to telephone you without success.

Our overall financial situation is extremely serious and for your information I enclose a copy of a statement from the Area Health Authority outlining the current position. I am just about to depart on holiday (thank goodness) and will be happy to communicate with you again in September, but as things stand at the minute, I can see no improvement in the position.

With best wishes,

Yours sincerely,

Roger Titley

BUCKINGHAMSHIRE AREA HEALTH AUTHORITY

FINANCIAL SITUATION

1. Since its inception in 1974 the Buckinghamshire Area Health Authority has endeavoured to provide the people of Buckinghamshire with the best health service possible within the financial resources made available to it. The economic situation of the country has meant that those resources have been less than the Authority would have wished, but nevertheless, with the understanding co-operation of all members of the staff a service has been maintained and some development has taken place.

2. Earlier this year the Area Health Authority prepared a plan covering the next five years, based on assumptions of increased revenue finance to meet the needs of the rapidly increasing population in the County, and the general progress and improvement of the service.

The plan aimed to eliminate the present overspending, recover the deficit being incurred and provide for sufficient funds for planned future developments.

A main feature of the plan, however, was that the Area Health Authority would be permitted to overspend its cash allocation for the first three years, the position being recovered in the final two years of the plan.

3. Now the Area Health Authority, in common with all other Health Authorities in the country, has been told by Mr. Patrick Jenkin, the Secretary of State for Social Services, that there will not be extra money this year to meet the full cost of wage awards, and price increases; Health Authorities will have to manage within the cash limits they have been given.

4. The Secretary of State in a speech in the House of Commons on 17th July 1979 conceded that some Health Authorities were faced with the need to make real cuts this year in order to remain within their cash limits. He anticipated that the total amount to be squeezed in the whole country would be of the order of £90 million to £100 million in this year.

5. In Buckinghamshire a reduction of £1,750,000 in a total budget of £36 million is required. Faced with that situation the Area Health Authority has accepted that cuts in service will be the inevitable consequences of the current financial situation.

6. The Area Health Authority has decided that immediate action must be taken to cope with the problem in the current financial year, and, in due course, it will take a more considered look at means of dealing with the situation from next year onwards.

7. The immediate decisions which the AHA have taken include the transfer of uncommitted funds from the Minor Capital Account to the Revenue Account, and the curtailment of some new developments.

8. The Authority has asked its officers to look very closely again at the possibility of more land or buildings being declared surplus to requirements and sold; and it looks to all staff to continue the attack on 'waste' wherever it is seen.

9. The Area Health Authority is not proposing the total closure of any hospital, nor contemplating redundancy amongst existing staff.

10. The AHA recognises that savings of the order required can only be achieved by a further reduction of expenditure on salaries and wages. It is aware that the full co-operation of all concerned is essential and that reduction must be planned in full consultation with the managers of services in the Area and with staff-side interests. The consultation will be with the Joint Staff Consultative Committees and with the Trade Unions representing staff, and will be against the background of the Area Health Authority's job security policy.

11. The Secretary of State, in his speech in the House of Commons, referred to the possibility of posts which fall vacant being left unfilled temporarily and the AHA has agreed as a basis for consultation with managers and staff a procedure for delay in the filling of posts as they fall vacant, the length of the delay being related to the nature of the work undertaken and its closeness to direct patient care.

12. The members of the Authority have asked that these consultations take place during the month of August and have decided that during this month no vacancies shall be filled, except for junior medical staff (registrar and below); nurse learners; and staff for night duty.

13. The members of the Area Health Authority have reached these decisions with extreme reluctance and will be making strong protests about the unenviable task facing them.

14. The members accept that if there are delays in filling posts, some work will not be done and standards of service will fall. Some work may have to be re-allocated and that is provided for in the job security policy. The members know that the staff, and the people we serve, will share their bitter disappointment at this enforced reduction in standards of service.

K. G. WALKER,
Area Administrator

3rd August 1979

Mr Bebb

~~Mr Fletcher~~

STOKE MANDEVILLE SPINAL INJURIES CENTRE

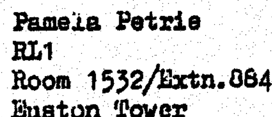
A number of current, and to some extent inter-connected, activities concerning Stoke Mandeville Spinal Injuries Centre are about to be brought to Ministers' attention mainly by outside interests, viz:

- the forthcoming visit by Dr Vaughan to Stoke Mandeville;
- an approach by Baroness Masham to new Ministers;
- a hint of royal interest in the development of the Centre;
- Oxford RHA's decision to cut back on services at Stoke Mandeville as part of the Region's general retrenchment in expenditure this year;
- a letter from Jimmy Saville OBE inviting himself to tea with Patrick Jenkin to discuss (presumably) fund-raising for Stoke Mandeville.

The outcome is likely to be that a considerable sum of non-exchequer money will be raised to develop Stoke Mandeville, and relatively soon. If that happens, does the Department have a plan for the development of spinal injury services nationally? I know about Odstock and RNOH but leaving those aside, how big would we wish Stoke Mandeville to be if money was not a problem. Apart from offering an international service, how extensively should it serve NHS patients? Regionally? Supra-regionally or what? Oxford RHA want to know this (a) because they see themselves as the probable building agents in any development, and (b) because they want to know for strategic plan and programming purposes how much money they are likely to be expected to find (or how much NHS money might be released, if a voluntary fund is successful, and how this might be used to deal with other Regional priorities.)

The foregoing is all rather nebulous, but if we are to provide a reasonable brief to Secretary of State for the various deputations we ought to have some idea of where we want to go and how we might get there. Oxford want to know too.

I do not think it is premature to think about having a small, informal, HS; SH; RL get together soon to consider whether anything or what needs to be done. Your advice would be welcome; Peter Gant and I would gladly come to AFH to see you, if that is the most convenient thing to do.



for Pamela Petrie
RL1
Room 1532/Extn.884
Euston Tower

10 September 1979

cc: Mr Gant

DRAFT BRIEFING MATERIAL FOR DR GERARD VAUGHAN'S VISIT TO STOKE MANDEVILLE

1 Introduction

Spinal units came into being to treat people who had suffered spinal cord injury. But gradually the special skills and techniques developed in the unit have been applied to patients with non-traumatic spinal cord injury. The number of non-traumatic cases treated in the individual units is determined by the interests of the consultant in charge. Although industrial accidents are no longer the main cause (road accidents have become increasingly important), the number of new cases occurring each year remains at about 12 per million population and a similar figure applies to all Western industrialised countries. Advances in treatment have resulted in an increase in the life expectancy of paraplegics and particularly tetraplegics. It is estimated that at least 100 beds, in addition to the existing 348, are needed to treat and provide adequate follow-up for all traumatic cases and some provision must be made for the non-traumatic cases eg severe spina bifida.

2 Distribution of units

There are six units in England:-

Spinal unit	Number of beds
National Spinal Injuries Centre, Stoke Mandeville	150
Midlands Spinal Injuries Unit, Robert Jones and Agnes Hunt Orthopaedic Hospital, Oswestry	46
Lodge Moor Spinal Injuries Unit, Sheffield	64
Southport Paraplegic Unit, Southport	37
Pinderfield General Hospital, Spinal Injuries Unit, Wakefield	31
Hexham Spinal Injuries Unit, Hexham	20
Total	348

The first unit was the National Spinal Injuries Centre at Stoke Mandeville, set up during the Second World War to provide a service for military personnel. The other units were developed after the war and Stoke Mandeville is now a part of a network of units.

The major problem lies in the uneven distribution of the units throughout the country and particularly the shortage of beds in the south. Although 75 of the population lives south of a line from the Bristol Channel to the Wash, Stoke Mandeville is the only unit in the area and this provides less than 50 of the total beds available.

3 National Spinal Injuries Centre: Stoke Mandeville

This is an integral part of Stoke Mandeville Hospital. Because it was the first to specialise in this field and because of the pioneering work of Sir Ludwig Guttman whose drive and reputation achieved international recognition, it has acquired a unique status. This reputation has been maintained but the service it provides is no different in kind from that provided by the smaller units. The Department views the Centre as the first amongst equals. Since 1969, the Centre has attempted to restrict its catchment area to cases arising south of a line from the Bristol Channel to the Wash and approximately 75 of patients do come from there. On average, there are around 80 people on the waiting list (mostly follow-up cases). Waiting periods vary. In urgent cases, the period can be anything from twenty-four hours to six weeks, with an average of four weeks. For less urgent cases the period can vary from eight weeks to two years.

The average length of stay for the newly injured varies from 6 months to a year for paraplegics, and from 9 months to 13 months for tetraplegics. Discharge is dependent on satisfactory arrangements being made in the patient's home area for housing adaptations, the provision of aids and the necessary components of health care and social services. This poses particular problems for Stoke Mandeville as it serves so wide a catchment area, making relations with health and local authorities particularly complex. The wide catchment area also results in more patients having to stay overnight when they have to attend for their routine follow-up review.

4 Proposed units

As Stoke Mandeville is the only unit in the south, the establishment of another unit in the area has long been one of the Department's priorities. Planning is well advanced for a 50 bedded unit at Odstock Hospital, Salisbury (Wessex RHA) and this should be operational before 1985. Further provision is still required in the south and the Department has been considering the establishment of a small 24 bedded unit at the Royal National Orthopaedic Hospital, Stanmore. There is some doubt whether this can be afforded. Departmental representatives are to visit the RNOH next week, and will report to the Minister about this on 25 September.

With the Compliments of
Department of Health and Social Security

MRS JAYAKODY
RL1

EUSTON TOWER
286 EUSTON ROAD
LONDON, NW1 3DN

MANDEVILLE [illegible]
AYLESBURY
BUCKS

21st August 1979

[illegible] of July 13th. The hospital have [illegible] but they [illegible] their big [illegible] our [illegible]

the [illegible] yet, should I ring [illegible] take [illegible] of an afternoon and maybe I [illegible] quick [illegible] minutes

0702
27/8

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[illegible] AREA HEALTH AUTHORITY.

MANDEVILLE ROAD
AYLESBURY
BUCKS
[illegible]

21st August 1979

Mr Grant

S/S would like to see Jimmy Savile. Perhaps you could ask him there? [illegible]

[illegible]

I would be grateful for [illegible] by 5 September.

[illegible]

[illegible] 23/8

[illegible]

[illegible] of July 13th. The hospital here [illegible] but they [illegible] our [illegible] coffers,

[illegible], should I [illegible] take [illegible] off an afternoon and maybe I [illegible]

[illegible] to [illegible]

[illegible] MANDEVILLE [illegible]

[illegible]

(BUCKINGHAMSHIRE AREA HEALTH AUTHORITY)

TEL: AYLESBURY [illegible] Ext. 3026

[illegible] 05/07

YOUR REF.

MANDEVILLE [illegible]
AYLESBURY
BUCKS
[illegible]

21st [illegible] 1979

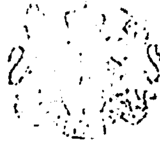
The Right Honourable Patrick Jenkin, M.P.,
Alexander Fleming House,
Elephant & Castle,
London S.[illegible]

[illegible]

Thank you for your letter [illegible] July 19[illegible]. The hospital [illegible] think that the [illegible]0,000 was well [illegible] but [illegible] Big [illegible] and we managed to blow it back into our coffers.

Having never been to the [illegible] yet, should I ring your Secretary to find out what time you take [illegible] of an afternoon and maybe I might be invited to join you for a quick [illegible] minutes[illegible]

[illegible]



DEPARTMENT OF HEALTH & SOCIAL SECURITY

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

Telephone 01-407 552[illegible]

From the Secretary of State for Social Services

13 July 1979

Jimmy Saville Esq OBE
c/o British Broadcasting Corporation
Broadcasting House
LONDON
W1A 1AA

Dear Jimmy Saville,

I have been told that you were kind enough to play a key role in obtaining for the Stoke Mandeville Hospital Postgraduate Society, a very generous gift of £50,000 from Mr Douglas McMinn of Chesham. I know that you have a long and distinguished record of support for our hospital services, but it seemed to me that this latest piece of good work on your part deserved recognition. There is no doubt that at a time when public resources are under severe constraint, the value of private gifts to the National Health Service is greatly enhanced.

I would like to thank you most warmly, not only for your intervention in this particular case, but also for your continuing concern and interest in the problems of our hospitals.

Yours ever