



Office of the  
**Trust Special Administrator**  
of MSFT

**Mid Staffordshire**

NHS Foundation Trust



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

**Trust Special Administrators'  
Final Report**

**Volume One**

**The main report**

December 2013



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Special Administrator of  
Mid Staffordshire NHS  
Foundation Trust**

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Final Report**

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Presented to Parliament pursuant to s.65I  
of the National Health Service Act 2006

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## Foreword

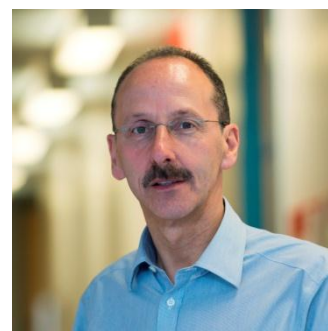
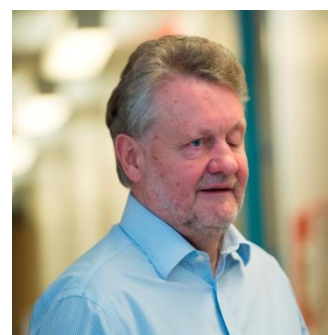
**By Professor Hugo Mascie-Taylor, Alan Bloom and Alan Hudson, Joint Trust Special Administrators, Mid Staffordshire NHS Foundation Trust (the TSAs).**

We were appointed, by Monitor, to be the first Trust Special Administrators for an NHS Foundation Trust. Our task has been to make a series of recommendations that will secure the sustainable provision of essential secondary care services for the local population for up to 10 years.

The decision by Monitor was not taken lightly and was in full knowledge and appreciation of the challenges faced by the Mid Staffordshire NHS Foundation Trust (MSFT or the Trust) and the Trust's continuing efforts over a number of years to address these challenges.

Changes to the way secondary care services are managed and delivered across Mid Staffordshire are not just essential, they are inevitable. The Trust has struggled for many years to find the right balance between delivering safe, high quality care and doing so within their available budget. These struggles have been well documented and to date no solution has been identified. Indeed, the work of our team, and the Contingency Planning Team before them, has demonstrated that there is no answer to these challenges available to the Trust in its current form.

We have therefore assessed clinical models based upon both Stafford and Cannock Chase Hospitals being integrated into separate clinical networks with larger hospitals which have a greater variety of specialties and sub-specialties. This is critical, because this opens up the possibility of retaining both hospitals; retaining a greater number of services in Stafford and Cannock than would have been possible if MSFT were to be retained as a separate entity; and ensuring those services clinically sustainable.



That is why MSFT, as the entity that runs the majority of secondary care services from Stafford and Cannock Chase Hospitals, cannot continue and should be dissolved as soon as is practically possible. We are making this recommendation to Monitor.

We have worked closely with the local Clinical Commissioning Groups (CCGs), run by local GPs, who purchase NHS services in the area. The CCGs decided the minimum range of services that must be provided in Stafford and Cannock to meet the needs of the local population (known as Location Specific Services or 'LSS'). By exploring clinical models based upon clinical networks and dissolving the Trust, we were able to put forward a series of draft recommendations for public consultation that safeguarded a wider range of services than the CCGs identified as LSS, ensuring 91% of the current patient attendances at Stafford and Cannock Chase Hospitals would still be able to take place at Stafford or Cannock Chase Hospitals.

We have been greatly encouraged by the response to the consultation from the staff, local population and key stakeholders of MSFT. The consultation has generated a robust debate about the future of secondary care services in Mid Staffordshire and our draft recommendations have been vigorously challenged. This is exactly what we had hoped for and we have listened to and reflected upon the views expressed.

Maintaining the status quo is not a viable option, but following our review of the response to the consultation we have made changes to our draft recommendations; in the areas of maternity services, paediatric services and provision of critical care. We have also identified a range of actions to address some of the issues raised through our continuing engagement with local CCGs; through the consultation process; and put to us by the Health and Equality Impact Assessment steering group – a group established to independently assess our draft recommendations.

Although there is widespread support for many of our recommendations, we are aware that some people will not agree with all of our recommendations. The support that the hospitals' staff has seen from their local populations has been manifest, and we have admiration for the efforts that local people have made to support their hospitals. We understand how unsettling our work has been and how worried some people are about what our proposed changes would mean for them individually and as a community.

We are confident that our recommendations, set out in this report, will ensure services can be delivered in a safe and sustainable manner and will significantly reduce the cost of secondary care delivery in the Local Health Economy by over £27m per annum. However, our recommendations do not fully address the financial deficit of MSFT, which is forecast to exceed £40m in 2017 if no changes are made.



The scope of our work extends to MSFT and the services it provides. We are clear that there is no solution, within our scope, that fully addresses the forecast deficit and we are putting forward our recommendations on the basis that they represent the best solution to address the challenges faced by the Trust. This will provide local CCGs with the right foundation to ensure the long term delivery of high quality, safe and affordable services within the region. This does mean that more work will have to be undertaken, by local CCGs with the wider local health system, to ensure the clinically sustainable services we are proposing are affordable in the long term.

There are many challenges ahead, but it is essential that decisive action is taken in the very near future. The Trust has made significant improvements over the last 2-3 years and is currently clinically safe, but the Trust is highly fragile. Within the last six months, the majority of the former executive team have announced they are leaving; staff from the University Hospital of North Staffordshire have been deployed at Stafford Hospital to adequately resource its A&E department; and staff vacancy levels have increased significantly over the last few months.

Any prolonged debate about making changes to the Trust and its services will only serve to undermine the ability to continue delivering the high quality and safe care that the local population rightly expect. For this reason, we believe that MSFT should be dissolved as soon as practically possible and we have proposed, for consideration by the Secretary of State, that the University Hospitals of North Staffordshire NHS Trust and the Royal Wolverhampton NHS Trust are, respectively, best placed to run the services at Stafford and Cannock Chase Hospitals.

We want to conclude by expressing our thanks to many people. First of all, we would like to thank all the members of the public, stakeholders and individuals who have provided us support, information and their feedback during the consultation. We would like to specifically thank the chairs and members of the clinical advisory groups and the independent chairs of the public meetings we held.

Finally we want to thank all of the staff at MSFT. They have remained dignified and committed throughout the TSA process. Fixing the problems faced by MSFT will not be easy, but we are confident that over the coming months the staff will continue to provide the care and compassion that the local population have come to expect.

**Professor Hugo Mascie-Taylor**

**Alan Bloom**

**Alan Hudson**





## 1 Introduction

1. On Monday 15 April 2013, the parliamentary order '*The Mid Staffordshire NHS Foundation Trust (Appointment of Trust Special Administrators) Order 2013 (SI 2013/838)*' was made by Monitor under section 65D(2) of the National Health Service Act 2006.
2. This order was accompanied by the document '*Mid Staffordshire NHS Foundation Trust: The Case for Appointing a Trust Special Administrator*' which was presented to Parliament under section 65D(6) of the National Health Service Act 2006. This document confirmed Monitor's decision to appoint TSAs for MSFT with effect from 00:01 on Tuesday 16 April 2013. The Trust Board and the Board of Governors of MSFT were both suspended from this point forwards with the TSAs assuming immediate accountability for MSFT.
3. In addition to taking on accountability for the day to day running of the Trust, the TSAs were required to develop a plan for ensuring that clinically and financially sustainable services can be delivered for the local population currently served by MSFT over a period of up to ten years. In doing so, the TSAs had to ensure that this plan does not undermine the delivery of healthcare services to any other part of the Local Health Economy. Those proposals would then be submitted by Monitor to the Secretary of State.
4. On Wednesday 31 July 2013, the draft report of the TSAs<sup>1</sup> was laid before Parliament and published alongside a consultation document based upon the contents of the draft report.
5. This report and consultation document were used to inform a public consultation that started at 00:01 on Tuesday 6 August 2013 and which concluded at midnight on Tuesday 1 October 2013. The details, responses and outcomes of this consultation process are summarised in Section 10, presented in detail in Volume 2 of this report, and have informed the TSAs.

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<sup>1</sup> The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust - Trust Special Administrators' Draft Report, July 2013. <http://tsa-msft.org.uk/wp-content/uploads/2013/07/TSA-Draft-Report-Volume-1-Main-report.pdf>

## 1.1 Purpose of this report

6. The TSAs have a statutory objective to ‘secure the continued provision of such of the NHS services provided by the NHS foundation trust at such levels as the commissioners of those services determine, so that it becomes unnecessary for the appointment of the Trust Special Administrator to remain in force.’<sup>2</sup>.
7. To meet this obligation, the TSAs must make a recommendation to Monitor as to whether MSFT is retained or whether it is dissolved and its assets and liabilities merged with another foundation trust or transferred to the Secretary of State. In doing so, the TSAs were required to put forward recommendations with regards to the future of provision of those services currently provided by MSFT and how they could be delivered in a sustainable and affordable manner for a period of up to ten years.
8. This report is the **final report** of the TSAs that is presented to Monitor. Since the publication of the TSAs’ draft report, the TSAs have undertaken a range of activities and analysis that are presented in this final report. These activities are as follows:
  - Managing the statutory public and stakeholder consultation;
  - Providing support to the independent Health and Equality Impact Assessment steering group;
  - Conducting a more detailed assessment of the capital investment requirements necessary to support the implementation of the TSAs’ recommendations;
  - Working with a range of stakeholders, including local providers, commissioners and national bodies to refine the TSAs’ financial evaluation of their draft recommendations and to determine the appropriate methods of funding required to deliver the TSAs’ recommendations; and
  - Reviewing and responding to the outputs from the statutory consultation. This has included additional analysis and work with a range of stakeholders to refine and develop the TSAs’ proposed clinical model as a consequence of the responses raised during the consultation.
9. This report contains:
  - a summary of the work undertaken by the TSAs, including the wide ranging consultation process, and how it meets the obligations placed upon the TSAs;
  - the conclusions the TSAs have reached, taking into account the consultation responses, with regards to proposals for the future of services currently provided by MSFT;

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<sup>2</sup> Statutory guidance for Trust Special Administrators appointed to NHS Foundation Trusts’ - 5 April 2013



- the TSAs' analysis that supports these proposals;
- the TSAs' recommendations to Monitor with regards to MSFT as an organisation providing secondary care services within the locality of Stafford and Cannock;
- the TSAs' recommendations as to how to achieve the statutory objective of the TSA, as stated above; and
- a range of broader observations that would support the delivery of the TSAs' recommendations, based upon the TSAs' engagement with a range of stakeholders, that could further enhance the future delivery of healthcare services across the wider Local Health Economy.

## 1.2 Structure of the report

10. This report presents a range of relevant background information with regards to MSFT and the reasons why change is necessary. It then goes on to summarise the outcomes of the work that the TSAs have undertaken to:
  - develop their draft recommendations;
  - conduct a wide ranging consultation on these draft recommendations;
  - engage with local commissioners, local healthcare providers, national healthcare bodies and national clinical leaders to satisfy the TSAs that the recommendations can be safely and successfully implemented; and
  - prepare and evaluate their recommendations.
11. The structure of this report is set out below. In order to compare this report to the draft report, each section, appendix and annex has been categorised as either:
  - **Not modified:** This element has not been changed since the draft report.
  - **Updated:** This element has seen minor updates since the draft report.
  - **Revised:** This element has been substantially revised since the draft report in order to reflect additional information or analysis.
  - **New:** This element is new to the final report.

### Volume One ('Main report')

- Section 2: Summary of TSAs' final report (new) – summarises a) the TSAs' recommendations and conclusions to Monitor with regards to the future of MSFT; b) a series of service recommendations the TSAs have proposed to secure the safe and sustainable delivery of the services currently provided by MSFT; c) the key findings from the independent Health and Equality Impact Assessment (HEIA); d) the TSAs affordability assessment of their recommendations; and e)



the TSAs conclusions with regards to the implementation of their recommendations - which will be set out in detail in this report.

- Section 3: Meeting the TSAs' obligations (revised) – sets out the statutory obligations that the TSAs are working within and what the TSAs have done to meet those obligations.
- Section 4: Trust background (updated) – presents an overview of the Trust, including the population that it serves and the services that it provides.
- Section 5: MSFT performance (updated) – summarises key performance information about the Trust, including some benchmarks against national average performance and Local Health Economy performance.
- Section 6: The case for change (updated) – sets out the rationale for why change is essential at MSFT in order to deliver clinically sustainable services.
- Section 7: Commissioning in the Local Health Economy (updated) – outlines the role of local commissioners, both in working with the TSAs and in their broader work in commissioning health services for Mid Staffordshire.
- Section 8: Providers in the Local Health Economy (updated) – summarises the other healthcare providers in the Local Health Economy and some of the challenges they are facing.
- Section 9: The TSAs' draft recommendations (new) – summarises the process undertaken to develop the TSAs' draft recommendations and the draft recommendations that were put forward for consultation. This is essentially a summary of Sections 9 and 10 from the draft report.
- Section 10: Summary of the consultation (new) – describes how the consultation was undertaken and summarises the responses to the consultation.
- Section 11: The Independent Health and Equality Impact Assessment (HEIA) (new) - describes the conclusions presented to the TSAs by the HEIA steering group.
- Section 12: The TSAs' recommendation to Monitor with regards to MSFT as an organisation (new) – presents the TSAs' recommendations to Monitor, taking into account the consultation responses and the HEIA report.
- Section 13: The TSAs' recommendations with regards to clinical services (new) – presents the recommendations of the TSAs with regards to the clinical service model, taking into account the consultation responses and the HEIA report.
- Section 14: The affordability assessment of the TSAs' recommendations (new) – sets out the TSAs assessment of the financial implications of their final recommendations.



- Section 15: Stafford and Cannock Chase Hospitals (new) – a brief outline of how the infrastructure of Stafford and Cannock Chase Hospitals could be used to deliver the clinical services proposed by the TSAs.
- Section 16: Implementing the TSAs’ recommendations (new) – a high level summary of the key elements associated with implementing the TSAs’ recommendations.
- Appendices:
  - A: Glossary of terms
  - B: Letters to the TSAs from NHS England
  - C: Letters to the TSAs from clinical advisory groups
  - D: Letters to the TSAs from local CCGs
  - E: The assessment of catchment population – Public Health Staffordshire
  - F: A copy of the letter from A&E leads in the West Midlands to the Trust Chief Executives and lead commissioners across the region

## Volume Two (‘Consulting on the draft recommendations’)

12. A collation of documents, reports and analysis associated with the consultation. These are as follows:

### Volume 2a

- Annex 2.1: A summary of the consultation process.
- Annex 2.2: The consultation document.
- Annex 2.3: Consultation FAQs.

### Volumes 2b/2c/2d

- Annex 2.4: Formal responses to the TSAs’ draft recommendations.

### Volume 2e

- Annex 2.5: The Ipsos Mori report on the consultation.
- Annex 2.6: The TSAs’ response to the consultation feedback.

## Volume Three (‘Supporting information and analysis’)

13. The TSAs have prepared and collated a series of annexes in support of this report.
- Annex 3.1: The local Clinical Commissioning Group (CCG) strategies
  - Annex 3.2: Clinical advisors to the TSAs – terms of reference and meeting notes
  - Annex 3.3: TSA governance
  - Annex 3.4: TSAs’ stakeholder engagement summary
  - Annex 3.5: TSAs’ financial evaluation

- Annex 3.6: TSAs' estates assessment
- Annex 3.7: TSAs' proposed approach to implementation

## Volume Four ('The HEIA report')

14. The report from the independent HEIA steering group, including the travel times methodology and copies of the memos sent from the HEIA steering group to the TSAs.

### 1.3 Location Specific Services (LSS)

15. LSS have been developed by local CCGs and are those services whose withdrawal, in the absence of alternative local provision, would be likely to have a significant adverse impact on health or significantly increase health inequalities, or fail to prevent such an adverse impact or fail to improve health inequalities.
16. The TSAs are obliged to propose a future service model that ensures – as a minimum – the retention of the LSS within the same locality as currently provided by MSFT.

### 1.4 Preparing the final report

17. This report, the final report of the TSAs, was initially due to be submitted 15 working days after the conclusion of the consultation process on 22 October 2013. On 21 October 2013, Monitor decided to extend the deadline by 40 working days to allow commissioners and providers to reach an agreement on the future funding of essential services. This report was therefore submitted to Monitor on 17 December 2013.
18. Monitor will review this report and determine whether it considers that the TSAs have completed their duties satisfactorily and that the action recommended in the final report would achieve the objective of the TSA. If satisfied, Monitor will submit the report to the Secretary of State. Monitor may seek further information from the TSAs to support their review.
19. If Monitor approves the report, it will be submitted to the Secretary of State **within 20 working days**, and the Secretary of State will have up to a further 30 working days to consider the report.
20. Under section 65KB of the National Health Service Act 2006, once the Secretary of State has received this report, the Secretary of State must decide if he is satisfied with a number of specific criteria:



- that commissioners have discharged their functions in connection with the TSA process;
  - that the TSAs have carried out the administration duties;
  - that Monitor has discharged its functions;
  - that the recommendations in the final report would secure the continued provision of the LSS;
  - that those recommendations would secure the provision of services of sufficient safety and quality; and
  - that the recommended actions would provide good value for money.
21. Of these criteria, the first three relate to processes or functions during the TSA process, and the last three relate specifically to the recommendations made by the TSAs to Monitor in this report. If the Secretary of State considers that any one of the six criteria has not been met, it must give reasons to the TSAs. The Secretary of State would then require the TSAs to re-work and resubmit the report to address the criteria on which the Secretary of State was not satisfied.
22. The Secretary of State will make a final decision on the TSAs' final report. If Monitor and the Secretary of State take the full complement of days to complete their reviews without requiring the TSAs to undertake further work, then the Secretary of State's final decision will be set out by 26 February 2014 at the latest.



## 2 Summary of TSAs' final report

23. The TSAs' final report sets out a series of recommendations for the future of MSFT and the services it currently provides. The TSAs' recommendations will mean that at least 91% of current patient visits will continue to take place locally at Stafford or Cannock Chase Hospitals and that the services provided at these hospitals will be clinically safe and sustainable.
24. The TSAs acknowledge that they have faced many challenges throughout the process of developing their recommendations. The TSAs also recognise that this is the first step in achieving a solution for the wider health economy, that will ensure that both the commissioning and the provision of health services across Staffordshire is placed on a clinically and financially sustainable footing for the long term. This is echoed in the letter sent by NHS England to the TSAs on 11 December 2013: *'We recognise the challenges the TSAs have faced in producing their final report. While all parties want to achieve a long term solution to the well documented issues that the Trust has faced, NHS England supports the important first steps that the TSAs have proposed in their report'*.
25. The TSAs' greatest challenge has been to secure the provision of clinically sustainable services that are also financially sustainable. The TSAs' recommendations will see a significant reduction (£34.4m per annum) in the cost of delivering healthcare services in Stafford and Cannock and will fully address the current financial deficit of MSFT (ca. £20m). However, the savings identified will not fully address the anticipated inflation in the cost of healthcare services over the next three years. This would mean that by 2017 the funding received for providing the services in the manner set out by the TSAs' recommendations would still be less than the cost of providing those services. The TSAs have assessed that the funding gap associated with our recommendations would be ca. £14.9m, compared to a potential gap of £42.5m if our recommendations were not implemented.
26. Local CCGs and NHS England have acknowledged the importance of the work that the TSAs have undertaken and support in large part the TSAs' proposed clinical model. However, the local CCGs are very clear that they will not and cannot be expected to be left with a financial deficit after a period of transition. To that end, NHS England have committed to provide time limited financial support to the local CCGs of £14.87m per annum, from 01 April 2017, following the conclusion of a three year transition period. NHS England also stated that they will work with the local



CCGs, who have commissioning responsibility, to reduce the financial deficit further and in a manner beyond the scope of the TSAs' work.

27. The TSAs are very pleased that there is a wide-ranging commitment from many local and national stakeholders to build upon the work and the recommendations of the TSAs, in order to ensure that the local populations of Stafford, Cannock and their surrounding areas have access to the safe, sustainable and high quality health services they rightly expect.
28. One of the key elements in MSFT not being clinically or financially sustainable, is its inability to attract and retain sufficient qualified, experienced permanent staff. This has been driven by a number of factors including its relative small size and serious operational issues exacerbated by the ongoing uncertainty over its future.
29. This issue is not unique to MSFT, but it is far more pronounced given its particular circumstances and has become more acute with increasing reliance on agency nurses and locum consultants. This will be exacerbated as the Trust enters the winter period with the typical increasing demand on services. The Trust has had to approach University Hospital of North Staffordshire NHS Trust (UHNS) to provide temporary additional consultant cover in its A&E in order to operate a safe, albeit 14 hours a day, service. It is likely that additional measures will need to be put in place in the near future to address other staff shortages within the Trust.
30. It is therefore essential that action is taken quickly to ensure the ongoing stability of service delivery in Stafford and Cannock. Failure to do so will jeopardise service quality. This is why the TSAs have recommended to Monitor that MSFT be dissolved as quickly as practically possible, and are proposing that Stafford Hospital should be operated by the UHNS and Cannock Chase Hospital should be operated by the Royal Wolverhampton NHS Trust (RWT) (see below for further detail on the TSAs' recommendations) as part of a clinical network with the larger hospital operated by those providers. This will bring much needed stability to local service delivery and provide the appropriate platform from which to deliver the necessary changes that will secure clinical sustainability over the longer term.



## **2.1 Developing the TSAs' recommendations**

31. The TSAs' recommendations, contained within this report, have been developed in three phases:

### **1: Pre-consultation:**

32. The TSAs carried out significant engagement with many stakeholders including clinical experts, local commissioners, local hospital trusts and the leadership team of MSFT to help develop draft recommendations for the future of MSFT.
33. The TSAs developed a draft clinical model with the objective of retaining as many services within Stafford and Cannock Chase Hospitals as possible.
34. The development of this model was informed by a market engagement exercise where multiple healthcare providers (NHS and independent sector) put forward proposals as to how services could be delivered in Stafford and Cannock.
35. The TSAs evaluated this model alongside two alternative models: a) the model developed by the Monitor appointed Contingency Planning Team (CPT); b) a model based upon retaining just the LSS.
36. This evaluation included working with panels of clinical experts, known as the National Clinical Advisory Group (CAG) and the National Nursing and Midwifery Advisory Group (NMAG), to ensure the TSAs' work was informed by the guidelines from their respective Royal Colleges and professions and their professional judgement and experience on what constitutes safe care.

### **2: Public consultation:**

37. The TSAs published their draft recommendations on 31 July 2013 and a formal public consultation on the draft recommendations was held between 06 August and 01 October 2013.
38. During the eight-week consultation, the TSAs:
- Sent out in excess of 50,000 copies of the consultation document and response forms.
  - Spoke to more than 2,600 people at eight public consultation meetings across the county, listened to their concerns and answered their questions.
  - Attended 3 non-consultation public meetings hosted by Jeremy Lefroy MP, Healthwatch Stoke-on-Trent and the Health Oversight Scrutiny Committee in Stoke.



- Held over 20 staff meetings, which were open to all staff and several meetings with staff from specific clinical areas of expertise, including Paediatrics, Maternity, Critical Care and the Surgical Assessment Unit as well as holding meetings with those staff working in support functions.
  - Held over 80 meetings with key stakeholder groups, including MPs, the Ministry of Defence, local authorities, local CCGs and the patient advocacy groups.
39. The TSAs' website received more than 5,800 hits during the consultation period and the TSAs also issued a significant number of press releases and placed adverts in the local papers to keep the general public informed of the consultation process.
40. The TSAs received in total over 2,800 responses to the public consultation.
41. During this period, the TSAs continued to work with local and national stakeholders to refine their financial evaluation and to assess the implications for the estate at Stafford and Cannock Chase Hospitals.
42. The TSAs have received consultation responses in a number of forms. The responses to the consultation are summarised in Section 10 and in detail in Volume 2 of this report.

### 3: Post-consultation:

43. After the consultation closed on 1 October 2013 the TSAs reviewed all the responses they had received and considered these along with the issues raised at the numerous meetings held during the consultation period and revised their recommendations.
44. The TSAs also reviewed and considered the independent report from the HEIA steering group, which was commissioned by the TSAs to impartially assess the impact of the TSAs' draft recommendations on the health of the local people, focussing on factors identified by the Equalities Act 2010, but also taking into account socioeconomic deprivation and rural isolation issues. The HEIA steering group was chaired by Sophia Christie, an experienced leader of NHS organisations, independent from the TSAs and the Trust.
45. On 21 October 2013 Monitor extended the time allowed for the TSAs to finalise their report by 40 working days, to enable an agreement to be reached on the future funding of services associated with the TSAs' recommendations.
46. As a result of the feedback received during the consultation the TSAs' have changed four of their draft recommendations (including the recommendation about MSFT as

an organisation and three of the service recommendations). Where a recommendation has changed, a brief explanation has been provided in this summary, with the full details in Sections 12 and 13.

47. The TSAs have also provided additional information and clarifications to support several of their recommendations in the detailed sections of this report. In many instances this was in response to requests for clarification or challenges presented during the consultation.
48. The remainder of this summary sets out the TSAs' recommendations, the affordability evaluation of their recommendations, the key findings from the HEIA report and proposed next steps, including a series of areas that NHS England have proposed could deliver savings over and above those identified by the TSAs.

## **2.2 The TSAs' recommendation to Monitor with regards to MSFT as an organisation**

49. The TSA's recommendations to Monitor with regards to MSFT as a provider of healthcare services in the locality of Stafford and Cannock are set out in Section 12. These recommendations are that Monitor should dissolve MSFT and transfer its assets to the Secretary of State. If the Secretary of State accepts this recommendation, he would then be free to exercise powers available to him to transfer the assets (Stafford Hospital and Cannock Chase Hospital) and services operated at those hospitals, to alternative providers to ensure the safe and sustainable delivery of services within the localities of Stafford and Cannock.
50. The TSAs consulted on the recommendation to dissolve MSFT (TSAs' draft recommendation 14) and have concluded that this is an appropriate course of action to secure the safe and sustainable delivery of the services identified in this report including LSS and a range of certain additional services not defined as LSS.
51. The wording of the TSAs' draft recommendation has been slightly modified to emphasise that the recommendation to dissolve MSFT is essential to enable the establishment of clinical networks with larger hospitals to ensure services in Stafford and Cannock are clinically sustainable. The TSAs' statutory recommendation to Monitor with regards to MSFT is therefore as follows:

**The TSAs' recommendation to Monitor with regards to MSFT as an organisation**

In order to ensure clinical sustainability and enable new clinical models based upon effective clinical networks with larger hospitals, Mid Staffordshire NHS Foundation Trust should be dissolved.

The services in Stafford and Cannock should be seen as individual models of care which should be delivered by organisations that can effectively operate a clinical network with each hospital.

52. The response to the TSAs' draft recommendation was divided, with 46% of respondents supporting the recommendation, 37% opposing the recommendation, and 16% unsure<sup>2</sup>. Responses from organisations or groups were more supportive than those from individuals with 66% of these responses supporting the recommendation.
53. There were a range of concerns raised by those respondents who opposed the recommendation, notably:
  - A desire that the MSFT be merged with another provider rather than taken over;
  - Concern that the current financial position at other local trusts would mean that they would 'asset strip' Stafford and Cannock Chase Hospitals.
54. The TSAs' proposed clinical model, as set out in the next sub-section, concludes that a range of services should be retained for provision in Stafford Hospital and Cannock Chase Hospital and operated as part of separate clinical networks with larger hospitals. The TSAs have assessed which providers would be best placed and capable to deliver the TSAs' proposed clinical model. The TSAs have concluded that:
  - Stafford Hospital should be operated by the University Hospital of North Staffordshire NHS Trust (UHNS); and
  - Cannock Chase Hospital should be operated the Royal Wolverhampton NHS Trust (RWT).
55. A range of providers operate services at Cannock Chase Hospital. The TSAs want to be clear that this conclusion relates to the management of the facility and the provision of the services currently provided by MSFT. Those services operated by providers other than MSFT will not be affected by the TSAs' conclusion that RWT operate Cannock Chase Hospital.
56. The TSAs have arrived at their conclusions for the following reasons:

<sup>2</sup> The % reported are those contained within the Ipsos Mori report (which is included in Volume 2e), where they have rounded the values to the nearest whole number.



- The geographic proximity of the trusts' primary sites to Stafford and Cannock Chase Hospitals means they can effectively operate the clinical networks that the TSAs' proposed clinical model is dependent upon and the TSAs' clinical evidence suggests is required for future sustainability of services;
  - Some patients will need to be transferred from Stafford or Cannock to another site for a small range of services. The other site should be close enough to minimise the distance and time of transfer;
  - Transferring patients to another site that is part of the same organisation will facilitate a smoother transfer, not least because there will be a single set of care management protocols and patient records; and
  - These two trusts were the only providers to confirm they would be able to provide the full range of services the TSAs' clinical model propose be retained in Stafford and Cannock Chase Hospitals.
57. Walsall Healthcare NHS Trust (WHT) put forward a proposal to operate Cannock Chase Hospital and their ability to operate an effective clinical network is equivalent to that of RWT, but they indicated they could not offer the full range of services that the TSAs' service model proposed for Cannock Chase Hospital.
58. The TSAs recognise that the consultation feedback indicated that local residents would prefer Stafford and Cannock Chase Hospitals to be merged with other hospitals. However, the statutory guidance for TSAs states that it is only possible for the TSAs to consider a merger with another hospital if that hospital is operated by another foundation trust. As both UHNS and RWT are non-foundation trusts the only option available to the TSAs is to conclude that the assets of MSFT should be transferred to the Secretary of State at the point that MSFT is dissolved.
59. The Secretary of State will decide, in due course, whether to accept the TSAs' conclusions that UHNS and RWT are best placed to take on the assets of Stafford and Cannock Chase Hospitals, respectively, and to provide those services that commissioners determine should be provided.
60. The TSAs understand why some respondents to the consultation raised concerns about whether other providers in the local health economy might seek to 'asset strip' Stafford and Cannock Chase Hospitals to address financial challenges they may face (i.e. move services from Stafford/Cannock to their primary site over time). The TSAs addressed this point on multiple occasions during the consultation and would wish to reiterate that it is up to commissioners, not providers, to determine what healthcare services are provided at specific locations. Should commissioners

determine in the future that it is appropriate to reconfigure services, they are bound by statutory requirements to undertake an appropriate consultation at such time.

### **2.3 The TSAs' service recommendations for Stafford and Cannock Chase Hospitals**

61. The TSAs are making a series of 'service recommendations' for the future of secondary care services in the locality of Stafford and Cannock Chase.
62. Ensuring that the LSS are retained for delivery in their current locality is a statutory obligation placed upon the TSAs. Monitor's statutory guidance for a TSA also requires the TSAs to set out, in this final report, what actions should be taken in relation to all of the services that MSFT currently provides so that high quality, sustainable services may continue to be delivered to local patients.
63. The TSAs' service recommendations set out a clinical model that ensures the continued provision of the LSS identified by commissioners, as well as retaining the greatest range of additional services within the locality - a stated desire of the local commissioners. The consultation response letter received NHS England (11 December 2013) confirm that the TSAs proposals, including the amendments made following the consultation will '*secure the provision of the LSS*'.
64. These service recommendations are based upon the TSAs' draft recommendations that were put forward for consultation. Three of the TSAs' thirteen draft recommendations, which relate to services in Stafford, have been modified based upon the feedback received during the consultation.
65. The TSAs' proposed clinical model depends, for its successful implementation, on the participation and support of other stakeholders. It cannot be implemented by the TSAs and Monitor alone, nor can the TSAs bind those other stakeholders to this model through this report. These other stakeholders will naturally consider any other requirements or processes that might apply to any aspects of implementation and in the context of their own statutory obligations.
66. In particular, the local CCGs and NHS England have clearly stated in their latest letters to the TSAs (see Appendices B and D) that the responsibility for procuring the services provided at each location lies with commissioners. The NHS England letter of 11 December 2013 states that: '*The [TSAs] report will recommend to commissioners and other stakeholders in the local health system a service model reflecting the consultation...the local CCGs will be responsible for working with providers to take forward this work and we will ensure appropriate arrangements are put in place*'.

## Proposed changes to the TSAs' draft recommendations for Stafford

67. As stated above, the TSAs have made changes to three of their recommendations about clinical services in Stafford. Table 1 summarises the changed service recommendations and the rationale for the changes made.

Table 1: The TSAs' recommendations with regards to clinical services in Stafford

Draft recommendation and consultation response	TSAs' service recommendation (changes in bold)	Rationale
<p><b>TSAs' Draft Recommendation 5</b></p> <p><b>Area:</b> Maternity</p> <p>Consultation responses</p> <p>(TO THE DRAFT RECOMMENDATION):</p> <ul style="list-style-type: none"> <li>20% Support</li> <li>72% Oppose</li> <li>8% Unsure</li> </ul>	<p><b><u>TSAs' service recommendation for Stafford 5</u></b></p> <p>Pre and postnatal outpatient services in Stafford will remain, unless there are post-23 week complications that require attendance at a more specialised obstetric unit. The outpatient service needs to be operated as part of a clinical network, most likely with UHNS, so that obstetricians can deliver outpatient clinics in Stafford.</p> <p>The obstetric service in Stafford should be decommissioned as soon as there is sufficient capacity established across the Local Health Economy. The TSAs are proposing that a plan should be established, and overseen by local commissioners, to ensure this capacity is created as quickly as possible.</p> <p><b>A Midwife Led Unit (MLU) should be established in Stafford to provide an opportunity for low risk births to be delivered locally. The MLU should be managed in a maternity network with other units/providers. However, this would need to be kept under review to ensure that the number of births is adequate to support the MLU's financial sustainability.</b></p> <p>The current maternity service has been identified only as a short term LSS by the local CCGs. The CCGs will need to be satisfied that there is sufficient capacity in the Local Health Economy before the obstetric service is decommissioned.</p> <p>This plan should create the additional capacity in the Local Health Economy to ensure there is continuing patient choice across multiple providers.</p>	<p>The TSAs have gathered further information with regards to the forecast number of births in Stafford over the following ten years. This includes an independent assessment from Public Health Staffordshire (PHS). This information has reinforced the TSAs view that there are and will continue to be an insufficient numbers of births to justify the retention of an obstetric led delivery unit. This recommendation was supported in the formal responses submitted to the TSAs by the Royal College of Obstetricians and Gynaecologists (who noted the model is in line with their guidelines) and the Royal College of Midwives (who requested that the TSAs validate their baseline data on the number of births, but support the TSAs' conclusion that an obstetric led unit would not be clinically sustainable if only managing so few births).</p> <p>However, many respondents to the consultation challenged the TSAs conclusion around the viability of an MLU, including the Royal College of Midwives and the independent Health and Equality Impact Assessment steering group. The TSAs have reviewed their initial rationale for excluding an MLU and gathered additional evidence in this area.</p> <p>The TSAs have concluded that an MLU in Stafford would need to manage a minimum of ca. 350 births per annum in order to cover the cost of the service. Whilst the evidence the TSAs used in their draft report shows that this number of births may not be achieved (this being based upon the average reduction in the number of births when an MLU replaces an obstetric led unit), there is evidence that shows that in some cases the impact on numbers is much lower and there are MLUs in England operating with a similar number of births.</p> <p>When the TSAs take into account the high level of public support for the retention of a maternity delivery service in Stafford and the fact that the location of delivery is highly influenced by patient choice, the TSAs have decided to put forward, in this final report, a recommendation to establish an MLU at Stafford.</p>





Draft recommendation and consultation response	TSAs' service recommendation (changes in bold)	Rationale
<p><b><u>TSAs' Draft recommendation 7</u></b></p> <p><b>Area:</b> Paediatric Assessment Unit</p> <p>Consultation responses</p> <p>(TO THE DRAFT RECOMMENDATION):</p> <ul style="list-style-type: none"> <li>• 48% Support</li> <li>• 44% Oppose</li> <li>• 8% Unsure</li> </ul>	<p><b><u>TSAs' service recommendation for Stafford 7</u></b></p> <p>A Paediatric Assessment Unit (PAU) will remain in Stafford to provide children with local access to an urgent assessment. <b>The service will be provided 14/7 and will be a function of the proposed A&amp;E service and led by paediatric trained A&amp;E doctors.</b></p> <p><b>Where paediatrician advice is needed it will be obtained either from the on-call team at a larger hospital or from the on-site paediatrician.</b></p> <p>Children will be admitted to the PAU via attendance at the A&amp;E department. The PAU will also accept direct referrals from community/primary care and specific care pathways, such as the management of long term conditions.</p>	<p>The recommendation with regards to the PAU received 4% more support than opposition in the responses to the consultation questions. However, the TSAs received a number of questions – especially from staff at MSFT – about the medical staffing model that would be used and the access to paediatric consultant input if the paediatric inpatient service was no longer retained.</p> <p>The Royal College of Paediatrics and Child Health recognise that operating a PAU without the support of a paediatric inpatient service is clinically viable if it is situated 'adjacent to the Emergency Department' where 'paediatric emergency medicine specialists' are deployed, so the TSAs are satisfied that the proposed model is clinically sound if the A&amp;E department deploys appropriately trained resources.</p> <p>This is the reason why the operational hours of the PAU have been reduced to mirror those proposed for A&amp;E.</p> <p>Furthermore, the TSAs are additionally proposing that for a minimum of five days a week, the PAU run paediatric consultant led 'hot clinics' which would provide on-site support to the PAU and assess urgent referrals from GPs. There will also be paediatric outpatient clinics five days a week which will be run by paediatric consultants.</p> <p>The TSAs have therefore revised the wording with regards to Recommendation 7 to be explicit about how the PAU would be operated and to provide further clarity with regards to the medical staffing model.</p>



Draft recommendation and consultation response	TSAs' service recommendation (changes in bold)	Rationale
<p><b><u>TSAs' Draft recommendation 9</u></b></p> <p><b>Area:</b> Critical care</p> <p>Consultation responses</p> <p>(TO THE DRAFT RECOMMENDATION):</p> <ul style="list-style-type: none"> <li>• 48% Support</li> <li>• 48% Oppose</li> <li>• 4% Unsure</li> </ul>	<p><b><u>TSAs' service recommendation for Stafford 9</u></b></p> <p>A small critical care unit should be retained in Stafford Hospital in order to support the acute medicine and elective surgery services. <b>This unit will provide 'level 2' (high dependency) care and a 24/7 rota of anaesthetists at Stafford Hospital who can deliver 'level 3' advanced respiratory support.</b></p> <p><b>Patients with critical care needs will be managed locally in Stafford if their condition can be appropriately managed with the skills available on site. Those patients that cannot be managed locally, will be stabilised prior to their transfer to an appropriate critical care facility. This will be supported by protocols developed by the appropriate provider and network.</b></p> <p>The 24/7 rota of anaesthetists should be managed as part of a clinical network with a larger more specialised hospital.</p>	<p>The recommendation with regards to critical care received equal levels of support and\ opposition in the responses to the consultation questions. However, there were several questions and challenges raised with regards to the safety of transferring critically ill patients and the impact this would have on skills and training for the staff at Stafford Hospital if no 'level 3' patients were managed at Stafford. There were also challenges around the TSAs' definition of levels of critical care.</p> <p>The TSAs have reconsidered their recommendation on the need to stabilise and transfer patients in all cases where they are identified as having 'level 3' critical care needs. A number of people, including MSFT staff, questioned the decision to transfer level 3 patients if it were possible to manage the patient locally in Stafford. The TSAs accept that it would be inappropriate to recommend such a rigid principle and that there should be more scope for clinical judgement about the decision to manage locally or whether to transfer the patient.</p> <p>The key factors in any decision should be the care needs of the patient and the availability of the relevant professionals to manage the patient locally. The TSAs and their National Clinical Advisory Group do not believe there will be a sufficient volume of level 3 patients in the future to operate a viable 24/7 rota for 'intensivists' in Stafford (doctors that are specifically trained in the management of level 3 patients), but accept there are some patients that would be categorised as 'level 3' patients that could be managed in Stafford, due to the TSAs' recommendation to have the 24/7 presence of anaesthetists.</p> <p>The wording of the recommendation has been updated to reflect the fact that the stabilisation and transfer of patients would be based upon clinical judgement.</p> <p>The TSAs are, however, satisfied that transferring patients with critical care needs is safe. This is something already undertaken by the local ambulance service, and the TSAs have been provided with specific examples by the Royal College of Surgeons Edinburgh where equivalent arrangements are safely operated today.</p>

### The TSAs' service recommendations for Stafford that have not changed

68. Table 2 summarises those draft recommendations for clinical services in Stafford that have not been changed and indicates the levels of support/opposition to each recommendation based upon the responses to the consultation. These seven unchanged recommendations, along with the three modified recommendations outlined above form the TSAs' ten (out of thirteen in total) service recommendations for Stafford.

Table 2: The TSAs' recommendations with regards to clinical services in Stafford

Draft No.	Area	TSAs' service recommendations for Stafford	Consultation responses		
			Support	Oppose	Unsure
1	Emergency and urgent care	<b><u>TSAs' service recommendation for Stafford 1</u></b> A consultant led A&E department should be retained in Stafford, open seven days a week from 08:00 – 22:00.	56%	43%	1%
2	Inpatient medical care for adults	<b><u>TSAs' service recommendation for Stafford 2</u></b> A physician led inpatient service for adults with medical care needs will remain in Stafford which will manage acutely unwell patients locally (both admissions from A&E and patient referrals from primary/community care).	85%	11%	4%
3	Inpatient medical care for adults	<b><u>TSAs' service recommendation for Stafford 3</u></b> The Medical Assessment Unit (MAU) at Stafford Hospital will be enhanced to include specialist support to the frail and elderly. The MAU will be a single point of contact for potential admissions from the 14/7 A&E, and step up admissions from primary care and community care providers. The MAU will need to have established admission and referral protocols and systems in place with all care providers. It will also need to establish systems to monitor capacity at these other providers.	87%	8%	5%
4	Inpatient medical care for adults	<b><u>TSAs' service recommendation for Stafford 4</u></b> MSFT currently operates a small number of 'step down' beds within Stafford Hospital. The number of these beds should be increased to enable a greater volume of repatriations back to Stafford Hospital from larger more specialised hospitals. The focus of the teams managing these step down beds should be to ensure the patients are discharged when appropriate and to ensure continuity of care management once they are discharged from Stafford.	83%	9%	8%
6	Paediatric services	<b><u>TSAs' service recommendation for Stafford 6</u></b> The paediatric inpatient service in Stafford should be decommissioned at such time that local commissioners are satisfied there is sufficient capacity to safely admit the volume of patients that would otherwise have been admitted to Stafford Hospital.	27%	67%	6%



Draft No.	Area	TSAs' service recommendations for Stafford	Consultation responses		
			Support	Oppose	Unsure
8	Non-elective /Emergency surgery	<p><b><u>TSAs' service recommendation for Stafford 8</u></b></p> <p>Non-elective/emergency general surgery and trauma surgery will no longer be undertaken at Stafford. The exception will be minor surgical procedures which can be performed at Stafford A&amp;E or where the patient can be stabilised at A&amp;E and scheduled to return to Stafford Hospital for minor surgery alongside elective surgical patients.</p> <p>This should happen as soon as possible and would mean that a Surgical Assessment Unit (SAU) would no longer be needed in Stafford.<sup>3</sup></p> <p>Clinical protocols will be established so that where obvious surgical cases are attended by the ambulance service, these patients will be taken directly to a larger more specialised hospital such as University Hospital of North Staffordshire NHS Trust (UHNS) and The Royal Wolverhampton NHS Trust (RWT).</p> <p>Less obvious cases will be taken to Stafford A&amp;E for an initial assessment. Walk-in cases to Stafford A&amp;E will also be assessed at Stafford A&amp;E.</p> <p>Processes and protocols will be established so that A&amp;E consultants in Stafford have remote access to a surgical opinion from the surgical teams at the larger more specialised hospital.</p> <p>Where a patient in Stafford A&amp;E is identified as needing emergency general surgery or trauma surgery, transportation to a larger more specialised hospital will be immediately arranged and the patient operated on as soon as possible upon arrival.</p> <p>The delivery of minor surgical procedures will remain in Stafford. Clinical protocols will be established to define which procedures can be categorised as minor.</p>	38%	57%	5%
		<p><b><u>TSAs' service recommendation for Stafford 10</u></b></p> <p>Elective surgery and day cases should remain in Stafford, but with a reduced number of specialties.</p> <p>The range of specialties will be determined through ongoing discussions with the CCGs and by the healthcare provider who ultimately operates services out of Stafford.</p> <p>Any procedures that do not continue to be delivered in Stafford will be consolidated with services at other sites in the Local Health Economy.</p> <p>NB (1): The TSAs cannot recommend that other Trusts consolidate some of their elective surgery into Stafford as this is beyond the remit of the TSAs. However, and dependent upon the provider operating services in Stafford, there may be an opportunity to repatriate Mid Staffordshire patients that currently have to travel to other hospitals for elective surgery.</p> <p>NB (2): Surgical diagnostic procedures (such as endoscopy) and day case chemotherapy were part of the list of LSS and as such will remain in Stafford.</p>	87%	8%	5%

<sup>3</sup> See Section 13 for the TSAs response to specific question raised about the functions of the SAU.

### The TSAs' service recommendations for Cannock

69. Table 3 summarises the draft recommendations for clinical services in Cannock. These recommendations have not been changed following the responses to the consultation and form the three (out of thirteen in total) service recommendations for Cannock.

Table 3: The TSAs' recommendations with regards to clinical services in Cannock

Draft No.	Area	TSAs' service recommendations for Cannock	Consultation responses		
			Support	Oppose	Unsure
11	Intermediate care	<b><u>TSAs' service recommendation for Cannock 1</u></b> A consultant led 'step down' facility should be introduced in Cannock to work alongside the existing GP-led intermediate care service. Clear clinical protocols will need to be established to ensure appropriate use of the facility and to ensure equitable access to primary care and secondary care providers.	81%	7%	12%
		<b><u>TSAs' service recommendation for Cannock 2</u></b> Elective surgery could be retained in Cannock. There will be a reduction in inpatient elective orthopaedic surgical activity as patients from Stafford and Surrounds will now be treated in Stafford, but this could be counteracted by the introduction of new surgical specialties into Cannock. Whether it is possible to retain a viable elective inpatient surgery service will be dependent upon the other services being delivered in Cannock and the capability and willingness of an alternative provider to deliver this service safely and within the local commissioning budget. The CAG have emphasised that this draft recommendation is dependent on the level of overnight medical cover on site.			
12	Elective inpatient surgery		79%	6%	15%
13	Day cases (surgical and medical)	<b><u>TSAs' service recommendation for Cannock 3</u></b> The current range of day case procedures (surgical and medical), including the Rheumatology service, should be maintained and, where possible, enhanced to provide a broader range of services.	83%	5%	12%

## 2.4 Key findings from the independent HEIA report

70. Monitor's guidance for TSAs states: *"Throughout their work, the Trust Special Administrator will be required to observe equality legislation and principles and demonstrate that due regard has been paid to the equality duty of the Equality Act 2010. The equality assessment should apply to patients, public and staff."*
71. To ensure that the TSAs' work met this requirement, the TSAs established an independent Health and Equality Impact Assessment steering group (HEIA) to provide independent advice to the TSAs. The HEIA is being chaired by an independent chair, Sophia Christie. Sophia has previous experience in managing impact assessments, through her role as chair of the HEIA sub-group of the Joint Committee of Primary Care Trusts for the Safe and Sustainable review.
72. The membership of the HEIA comprised five public and patient representatives and relevant expertise from local authorities, public health and the local CCGs.
73. The final report of the HEIA is included in Volume 4 of this report. The TSAs have reviewed the report, taken account of the points raised and the mitigations recommended in relation to the TSAs' draft recommendations. In particular:
  - **Additional travel times** - the TSAs' conclusions with regards to travel times were tested and the HEIA assessed that the additional travel times: would not have a detrimental impact on health outcomes; and would be the same or less than those faced by many others across the West Midlands and England.
  - **Affected groups** - the number of people directly impacted by the TSAs' recommendations is relatively small at 7,000 out of 184,885 current users of MSFT. The TSAs were reassured that there are many things which could mitigate the impact on these users.
  - **The expected benefits from centralising some services** - the HEIA recognised the benefits which the TSAs have stated from the centralisation of some services over retaining smaller sub-scale services, notably paediatric inpatient services.
  - **The impact of population growth on services** - the HEIA steering group drew the same conclusions as the TSAs regarding the impact of the 10,000 new houses in the future and the repatriation of the military troops, namely that there would be an increase in the demand for acute services in Stafford, but not sufficient levels of additional demand to counter the TSAs' conclusions.
74. The HEIA steering group proposed eleven broad mitigations to the impacts they identified when assessing the TSAs draft recommendations, these are:



- 1. Ensuring service provision in the future meets national clinical standards and guidelines;
- 2. Enhancing the interface with community services;
- 3. Ensuring there is capacity and capability in alternative provision;
- 4. Aligning 'front door' activity at Stafford and Cannock Chase hospitals to minimise confusion and disruption for the public and patients;
- 5. Maintaining continuity of care when it is spread across multiple locations and organisations;
- 6. Ensuring there is the capacity and capability to safely manage patient transport over longer distances (in the ambulance service);
- 7. Ensuring there is appropriate support for carer, staff and visitor journeys;
- 8. Putting in place the infrastructure to support carers and families in more distant hospitals;
- 9. Consideration of the range of services proposed, notably the introduction of a midwife led unit at Stafford Hospital;
- 10. Continued engagement with public and staff; and
- 11. Putting in place measures to monitor the impact of the TSAs' recommendations.

75. The TSAs have welcomed the detailed assessment of their draft recommendations and have addressed a number of the points raised by the HEIA in the revisions or additional information supporting their final recommendations. A number of the proposals made by the HEIA steering group relate to measures that should be established during implementation by commissioners and/or other local providers and fall outside the scope of work of the TSAs. The TSAs expect that the implementation of their recommendations should take these proposals into account and make sure these mitigations are in put in place as part of the implementation programme.

## **2.5 Conclusions and observations with regards to the affordability of the TSAs' recommendations**

76. The TSAs have assessed the size of the financial challenge that MSFT faces over the next three years of transition and the level of productivity and synergy savings that would be delivered if the TSAs' recommendations were implemented. This evaluation is set out in Section 14 and the detailed analysis and assumptions behind this evaluation is in Annex 3.4.
77. The TSAs' financial evaluation focused on four aspects:

- The financial benefit/consequence for the delivery of the services proposed;
- The capital expenditure required;
- The transitional costs; and
- The cost/funding required through a net present value calculation.

78. The evaluation concluded that:

- The deficit of MSFT at the end of the current financial year is forecast to be £20.2m;
- As a consequence of the cost pressures that all NHS providers will face over the next three years, the deficit of MSFT in April 2017 - if no changes or cost improvements are made during the period - will be **£42.5m**;
- The capital investment required to deliver the TSAs' recommendations is assessed to be **£130.2m**, this includes investment to increase capacity at other providers, reconfigure elements of Stafford and Cannock Chase Hospitals and address elements of the maintenance backlog at Stafford and Cannock Chase Hospitals<sup>4</sup>;
- This capital investment will need to be made at Stafford and Cannock Chase Hospitals and other hospitals in the Local Health Economy;
- The TSAs have identified potential savings associated with their recommendations of **£34.4m**;
- This level of savings is significantly higher than MSFT's forecast deficit for the end of the current financial year, but is not sufficient to address the forecast deficit for April 2017; and
- The TSAs have concluded that if their recommendations are implemented then because of the anticipated cost pressures and the additional depreciation and Public Dividend Capital (PDC) associated with the capital investment required, the deficit associated with MSFT and the services it provides will **reduce from £42.5m to £14.87m** for the first full year post transition in the year ending April 2018.

79. The majority of cost savings will come from productivity improvements including length of stay reductions, removal or reduction of estates costs, workforce redesign, changes to management structures and central functions and the reduction of the Board and executive team costs resulting from the dissolution of MSFT as a stand-alone organisation.

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<sup>4</sup> A separate evaluation of MSFT's current estate has shown that Stafford and Cannock Chase Hospitals will need capital investment of £69m in order to address the maintenance backlog at the two hospitals (see Section 15 and Annex 3.6).



80. The TSAs' have had extensive discussions with local providers throughout the period since the draft report was published in relation to both the operational and capital costs associated with the TSAs' draft recommendations. The TSAs' have also consulted with NHS PropCo. The TSAs' conclusions with regards to capital investment are made in light of these discussions and external advice. However, it should be noted that the other providers have some reservations as to the TSAs' forecasts and capital investment conclusions.
81. There are a number of further opportunities available to bridge the remaining financial gap that are outside the scope of the TSAs' work. These are summarised in the next sub-section.
82. Some of these opportunities will improve the flow of patients at the other hospitals in the Local Health Economy and will reduce the level of capital investment required at those sites.
83. The level of transition costs associated with implementing the TSAs' recommendations, excluding capital investment, is estimated to be £90.0m (£63.6m plus £26.4m for ongoing maintenance or replacement of assets). This means that the total funding requirement, including capital investment would be £220.2m.
84. Total funding for transition costs, capital and any time-limited ongoing deficit from 2017/18 onwards will be provided by a combination of financing from the Department of Health and income from NHS England. This has been confirmed by NHS England in their letter dated 11 December 2013 that is included in Appendix B.

## 2.6 Further reductions in the cost of service provision in the Local Health Economy

85. The TSAs' recommendations are limited to assuring the safe and sustainable delivery of the services currently provided by MSFT. Local CCGs, providers and central bodies all recognise that there are further opportunities to reduce costs that fall outside of the scope of work undertaken by the TSAs. The responses from both local CCGs and NHS England state that they believe there are additional cost saving measures:

***Extract from CCG response to the consultation (30 September 2013) – see Appendix D***

*"The fact is that services could be commissioned, provided and costed differently, underpinned by the drive to integrate services. The CCGs believe this different approach could deliver a more financially sustainable solution."*

*"Commissioners would wish to validate and test these assumptions using different costing models which promote service integration"*

*"In conjunction with other CCGs in Staffordshire they [member practices] will continue to*



*lobby central government about funding for South Staffordshire”*

*“What the CCG wishes to do is to ensure that acute services should be seen in the round alongside community provision.”*

*“The CCG as the responsible commissioner would wish to commission and procure services which are financially affordable through working differently with providers on costing and risk sharing which is reflected in contracts with these providers.”*

**Extract from NHS England letter to TSAs (11 December 2013) – see Appendix B**

*“We believe that there are a number of measures that could be applied to the recommended service model that would mitigate the current estimates of excess cost. We recognise that some of these may need further engagement or consultation with local stakeholders. These measures include;*

- 1. The integrated use of North Staffordshire community beds to increase overall system productivity and reduce reliance on new capital spend at UHNS.*
- 2. The refurbishment of spare capacity at Bradwell Community Hospital, to avoid capital expenditure on the acute site.*
- 3. The requirement for all new capital expenditure to have a signed off business case that takes full account of commissioning capacity plans - thus ensuring all new capital spend is genuinely unavoidable.*
- 4. Without changing the TSA recommended clinical model, commissioners will review case mix and patient flow to determine whether the proposed provider specification is necessary at all sites (for example with regard to the number of single rooms and requirement for operating theatre upgrades)*
- 5. The TSA model is currently based on current income levels - this will need to be updated to reflect future commissioning intentions and QIPP plans.*
- 6. The CCGs taking responsibility for the negotiation of revision to the ambulance contract and patient transport with a view to minimising the impact on patients and reducing the ambulance services proposed cost increase.*
- 7. Cannock Chase Hospital being subject to a placed based scheme developed with the local authority to fully explore the possibility of a landmark regeneration scheme that fully exploits the current site.*
- 8. The implementation of the TSA recommendations will need to reflect CCG responsibilities and enable them to exercise their commissioning intentions through service procurement where appropriate.*
- 9. We view the TSA clinical model as a start point for a wider-ranging Strategic Review that will ensure that both commissioning and provision across Staffordshire is placed on a clinically and financially sustainable footing for the long term.*
- 10. NHS England, Monitor and the NHS TDA will need to review proposed capital spend to ensure the most appropriate accounting treatment is consistently applied.*
- 11. All parties will need to be incentivised through the implementation arrangements to secure best value for money for the taxpayer.*

*We recognise that all of these actions will need extensive further engagement and we will work with local commissioners to support and help them develop these plans.”*



86. The TSAs are not in a position to comment as to the likely impact of either the CCG or NHS England proposals, but do welcome the commitment of local and national commissioners and other stakeholders to build upon the work and recommendations of the TSAs.

### 3 Meeting the TSAs' obligations

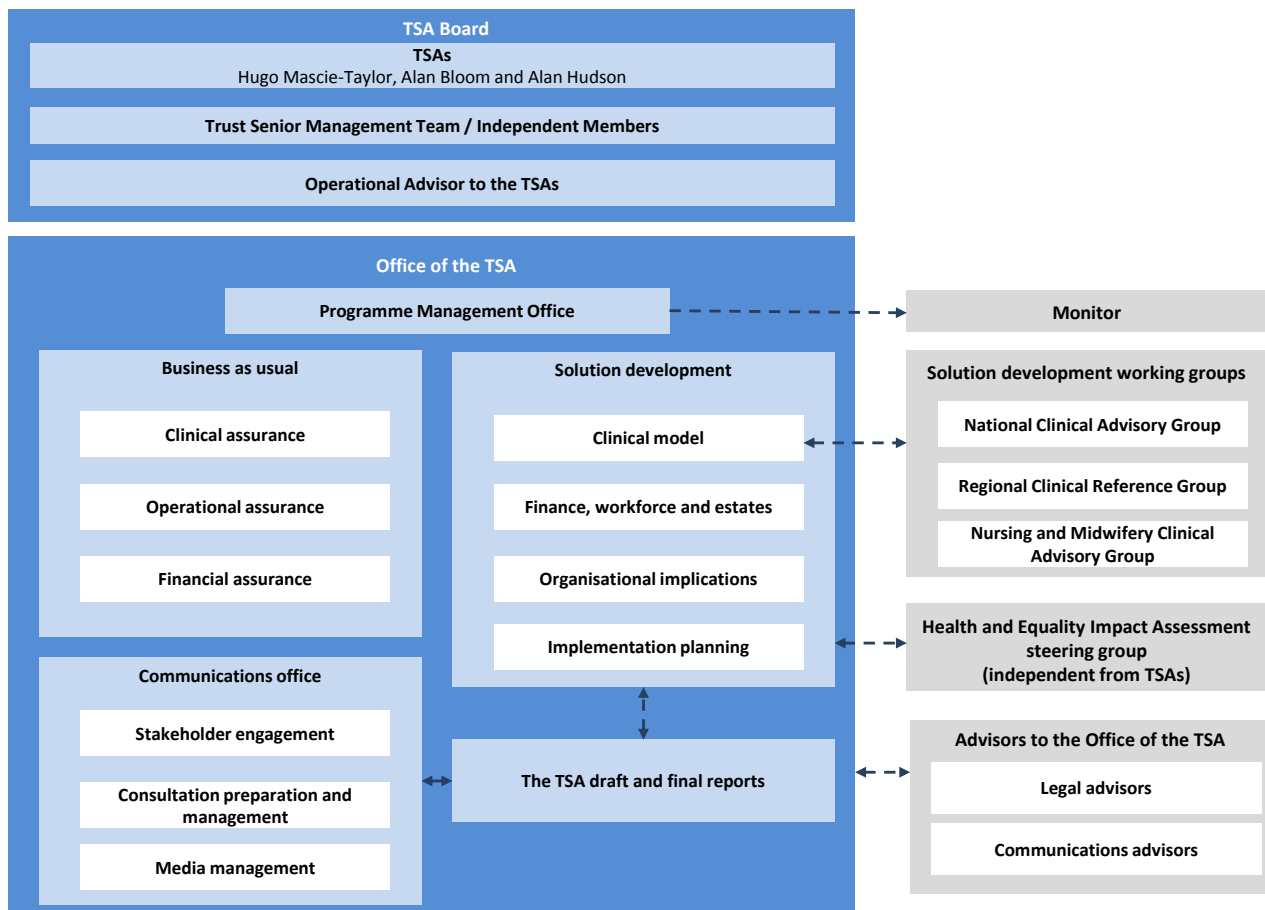
87. This section presents an overview of the responsibilities of the TSAs and the actions and activities undertaken by the TSAs in discharging their responsibilities. It summarises:

- the governance structure of MSFT and the TSA process;
- the statutory obligations of the TSAs, including the timetable that the TSAs have been obliged to work within;
- the engagement the TSAs have had with a broad range of stakeholders;
- the clinical guidance to the TSAs; and
- how stakeholder input was factored into the TSAs' recommendations.

#### 3.1 Governance of the MSFT and the TSA process

88. Following the appointment of the TSAs, the Trust Board (Executive and Non-Executive Directors, including the Chairman) and Council of Governors were suspended from office. Alan Bloom immediately took on the role of Accountable Officer for the Trust and the TSAs took on the functions of the Governors, Chairman and Directors of the Trust.
89. As the Accountable Officer for MSFT, Alan Bloom is accountable to Monitor in their role as regulator. Monitor must be satisfied that the TSAs have carried out certain duties under Chapter 5A of the National Health Service Act 2006.
90. Although the TSAs are accountable to Monitor, the TSAs are operating independently of Monitor, the Department of Health, the Secretary of State for Health and any other government entity.
91. Figure 1 shows a summary of the governance structure of the TSAs.

Figure 1: The governance structure of the TSAs



92. Key elements of the governance structure are:

- the TSAs have been working closely with the Trust’s senior management. Although their Executive powers have ceased, Trust senior management still have day to day responsibility for running the Trust;
- the TSAs have been supported by an operational advisor, a former Chief Executive of an NHS Foundation Trust, with regards to assuring ‘business as usual’ from an operational, clinical and financial perspective;
- this is the first Trust Special Administration of a Foundation Trust, therefore the TSAs have been taking regular legal advice;
- the TSAs have been regularly updating Monitor on the progress of the work being undertaken, and Monitor have been reviewing compliance with the guidelines for TSAs;
- three clinical advisory groups have been established, see Annex 3.2;
- an Independent Health and Equality Impact Assessment steering group (HEIA) has been established (see Section 11); and
- there have been five primary workstreams within the ‘Office of the TSA’:

- the 'Programme Management Office (PMO)' has managed the day to day progress and administration of the TSAs, including reporting to Monitor, regular risk assessments and programme coordination;
  - the 'business as usual' leads have been working with the senior management of the Trust to oversee the day to day operations of the Trust;
  - the 'solution development' team was a workstream focussed on developing the recommendations of the TSAs;
  - the 'communications office' has coordinated all stakeholder engagement activities and managed activities associated with external enquiries, correspondence, media briefings and social media. The communications office also oversaw the public consultation; and
  - 'The TSA reports' workstream has overseen the writing of the draft report, the consultation documentation (with the communications office) and this final report to Monitor.
93. In order to ensure continuing robust internal governance and to further build partnership working across the Local Health Economy, the TSAs established the Sustaining Services Board (the 'SSB'). This board includes Chief Executive and senior Director membership from the Trust and all adjacent provider organisations including UHNS, RWT, WHT and SSoTP.
94. The primary aim of the SSB is to promote system accountability and oversee the identification and management of system-wide risks associated with the delivery of patient care during the transitional phase. The SSB receives regular reports on progress, risks and mitigating actions from clinical and managerial groups established under the direction of the SSB, meeting on a monthly basis.
95. The initial work of the SSB has been to ensure that any risks associated with the continued safe and sustained delivery of high quality healthcare services by member organisations are identified and managed through transparent and open dialogue between relevant clinical and managerial staff of member organisations.



### 3.2 The statutory obligation of the TSAs

96. On 16 April 2013, Monitor appointed the TSAs under the National Health Service Act 2006, as amended by the Health and Social Care Act 2012. This is the first time that Monitor has appointed a Trust Special Administrator to take over the running of a Foundation Trust (FT).
97. The TSAs have been appointed to meet a series of obligations and processes established in the National Health Service Act 2006 and they are required to have regard to the guidance issued by Monitor<sup>5</sup>. In setting out the role of the TSA, the guidance states:

*“The failure regime, to be used in exceptional circumstances, is a transparent and robust process to provide a rapid resolution to problems within a significantly challenged foundation trust. In addition to maintaining the provision of high quality and sustainable services during the time the failure regime is in place, the key objective of the Trust Special Administrator is to develop and consult locally on a draft report, before making final recommendations to Monitor and ultimately the Secretary of State for Health in a final report. This final report should state what should happen to the organisation and the services it provides so that high quality, sustainable services continue to be delivered to the Local Health Economy. The public and NHS staff must be fully involved if the failure regime is used.”*

98. The process being followed by the TSAs involves a time limited statutory timetable , during which:
- Monitor must determine whether it is satisfied that the recommended action fulfils the objectives of special administration and that the TSAs have carried out their duties; and
  - If Monitor is satisfied, the Secretary of State for Health must determine whether he intends to exercise his limited grounds for veto.

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<sup>5</sup> Statutory guidance for Trust Special Administrators appointed to NHS Foundation Trusts’ - 5 April 2013

99. This timetable is illustrated in Figure 2.
100. The legal framework allows for Monitor to extend the 145 working day timetable ‘in exceptional circumstances’, through the extension of the periods for the draft report, consultation or report finalisation.
101. In this instance, and at the request of the TSAs, the period for the production of the TSAs’ draft recommendations was extended from 45 working days to 75 working days. The period for the public consultation was also extended from 30 working days to 40 working days (Annex 3.5 includes the TSAs’ published ‘FAQs’ which outline the reasons for this extension).
102. Subsequently, the period allowed to finalise the TSAs’ final report was extended from 15 to 55 working days.
103. The TSAs were obliged to undertake a series of actions within each of the phases of work. These obligations and the actions of the TSAs in meeting these obligations are summarised in the remainder of this sub-section.

Figure 2: The TSA timeline



\*On 19 June 2013 Monitor granted an extension of 30 working days for the publication of the TSAs’ draft recommendations and an extension of 10 working days to the public consultation period

\*\*On 21 October 2013 Monitor granted an extension of 40 working days for the submission of the TSAs’ final recommendations to Monitor



## Preparing the draft report

104. The TSAs were obliged to produce a draft report that set out a series of draft recommendations 'on how to provide high quality services in a sustainable way'<sup>6</sup>. This draft report would be the basis of the public consultation and would be published and available to the public at the start of consultation.
105. The draft recommendations within the draft report could propose to reconfigure services within the current Foundation Trust or to propose moving towards the dissolution of the Foundation Trust. In the latter case, the TSAs may propose that the assets and liabilities of the Foundation Trust are merged with another Foundation Trust or transferred to the Secretary of State for Health.
106. The TSAs published the draft report on the 31 July 2013, six days before the start of the consultation.
107. In drafting this report – and prior to the formal public consultation – the TSAs were obliged to engage with a range of stakeholders as set out below:
  - the Care Quality Commission (CQC) to ensure the proposed changes meet with the CQC's registration requirements;
  - NHS England with regards to the commissioning of services;
  - local commissioners to confirm LSS and to support the development of any proposed reconfiguration of services; and
  - any other person that Monitor instructed the TSAs to engage with. In the instance of the TSAs for MSFT, Monitor expected the TSAs to engage with:
    - Local providers in order to assess the impact of any proposed changes to services on these providers;
    - Clinical experts to ensure that patient safety and clinical sustainability is the priority in determining any proposed changes to services (see Section 3.4 for further details on the level of clinical input into the TSAs' work);
    - Monitor and the NHS Trust Development Agency (NHS TDA) to ensure they understand and endorse any proposed changes that may impact other Foundations Trusts and NHS Trusts (respectively); and
    - The Department of Health if the proposed changes are likely to require additional funding for implementation or long term financial support.
108. The TSAs engaged with all of these stakeholders. Appendices B-D include copies of correspondence received by the TSAs from NHS England, the local CCGs and the two

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<sup>6</sup> 'Statutory guidance for Trust Special Administrators appointed to NHS Foundation Trusts', 5 April 2013.

national clinical advisory groups formed by the TSAs prior to the publication of the draft report and the commencement of the consultation. This correspondence indicates the level of engagement that the TSAs have had with each group and their observations on the TSAs' draft recommendations. Annex 3.5 summarises the meetings the TSAs have had with a range of stakeholders since their appointment.

109. The TSAs were also expected to observe equality legislation and principles as set out in the Equality Act 2010. The TSAs were obliged to start work on an equality assessment so that the TSAs could identify and mitigate the impact of their recommendations on affected groups. The guidance recommended that this work commence as soon as possible.
110. Within four weeks of their appointment, the TSAs announced that they had established an independent HEIA steering group. This steering group, which is described in detail in Section 11, comprised an independent chair and membership from appropriate local subject matter experts from across the local health and social care economy and members of the public. The group's scoping paper was published alongside the TSAs' draft report and is an annex to their final report (which is presented in Volume 4 of this report). Their final report is published alongside this report. In establishing this group, the TSAs have exceeded their obligations, as the remit of this group significantly exceeds the TSA guidance in both its independence and the scope of their impact assessment.

### Consultation phase

111. The TSAs were expected to oversee a 30 working-day consultation. This was extended to 40 days to allow for the fact that it was scheduled to start during August 2013, a time when many members of staff and the general public are on holiday.
112. The objectives of the consultation period, as set out in the guidance, were to:
  - Give the TSAs an important opportunity to validate and adjust, where appropriate, their recommendations in the draft report;
  - To ensure the consultation is credible and genuinely engages all relevant stakeholders, including commissioners, staff, patients and the public; and
  - Engage with other providers so that they may contribute to potential solutions.
113. The TSAs were obliged, within the first five days of the consultation, to publish notices that provided details on how people could give their responses to the consultation and the date, time and venue of the public meeting the TSAs had to hold.

114. The TSAs met and exceeded these obligations having published these notices prior to the start of the consultation.
115. Monitor requested the TSAs sought written responses from the local CCGs and NHS England. The TSAs have done this and have included these as Appendices B and D alongside all of the formal responses, unedited and in full, in Volume 2, unless the response was marked as confidential.
116. The legal framework for the TSAs set out that the TSAs must hold specific meetings, as follows:
  - At least one meeting with staff and union representatives;
  - At least one public meeting;
  - At least one meeting with NHS England;
  - At least one meeting with commissioners; and
  - At least one meeting with any other persons if so directed by Monitor.
117. The TSAs have met and exceeded these obligations, as in most instances they have conducted multiple meetings with these stakeholder groups (e.g. eight formal public meetings, 21 staff meetings, weekly CCG meetings).

### Preparing the final report

118. The TSAs have used the responses to the consultation to inform their final report to Monitor and to ensure transparency must produce a summary of all responses to the consultation in their final report.
119. Volume Two of this report presents: the full details of the consultation; the outputs from the Ipsos Mori collation of consultation responses; copies of all formal responses from stakeholder groups; and the TSAs' response to the feedback from the consultation. Within the main report, Section 10 summarises the responses to the consultation, Section 11 summarises the outputs from the Independent Health and Equality Impact Assessment, and Sections 11 and 12 present the TSAs' final recommendations and observations, having taken the consultation feedback into account.
120. Where the TSAs make any amendments to their draft recommendations, then they are obliged to get written confirmation from the commissioners that the updated recommendations would still achieve the objective of securing the provision of the LSS. The TSAs have amended some of their draft recommendations and NHS England, as the body responsible for commissioning in England have confirmed in their letter on 11 December 2013 to the TSAs that the TSAs proposals '*as varied*,

*would achieve the objective of the TSA to secure the provision of the Location Specific Services identified by the local CCGs’.* A copy of the NHS England letter is included in Appendix B.

121. The TSAs are required to brief staff, the suspended chair, governors, directors and members of the Trust, with regards to their final recommendations. The TSAs issued a communication to all staff shortly before presenting their final recommendations at a pre-organised press conference. This email will set out the outcome of the consultation, the final recommendations and next steps. Immediately following the press conference, the TSAs will hold staff briefing sessions at both Stafford and Cannock Chase Hospitals.
122. The TSAs will also brief the Chairs and Accountable Officer of both local CCGs, local MPs and the local authorities on the day that this report is published.
123. The TSAs have held regular meetings with Monitor to ensure these obligations are being met.

### **3.3 Stakeholder engagement**

124. In addition to the formal obligations of the TSAs, Monitor expected that the TSAs would engage with a wide range of stakeholders, both during the development of draft recommendations and throughout the public consultation. This engagement is integral to the programme of work being undertaken by the TSAs and has taken different forms, including many formal consultation meetings.
125. Shortly after being appointed, the TSAs held a series of public meetings in Stafford and Cannock. These meetings were not part of the formal consultation and were used primarily as an opportunity to provide information to the public on the process the TSAs were following. Unedited recordings of these meetings are available to view on the TSAs’ website (<http://tsa-msft.org.uk/video-gallery/>).
126. The public consultation was an opportunity for staff and the public to ask questions about the draft recommendations. The TSAs held a series of staff and public meetings during the period.
127. Annex 3.5 presents detailed information on all of the stakeholder engagement activities undertaken by the TSAs until the end of the consultation phase.
128. Prior to the launch of the consultation:
  - The TSAs received in excess of 1,650 letters, 250 emails and 100 telephone calls from members of the public. The Office of the TSA have responded to every letter, email and telephone call received;



- The TSAs held 10 meetings with the national clinical advisory groups established to support the TSAs;
- The Office of the TSA had 84 meetings and 72 telephone calls with a range of stakeholders;
- The TSAs conducted 11 ward and departmental visits, held ten staff briefing sessions and seven staff drop-in sessions;
- The TSAs issued six stakeholder bulletins, all of which are available on the TSAs' website (<http://tsa-msft.org.uk/latest-news/>);
- The TSAs produced and regularly updated a series of Frequently Asked Questions (FAQs). Many of these questions are based upon themes of questions posed at the public meetings and through the various correspondence received by the TSAs. These FAQs are available on the TSAs' website (<http://tsa-msft.org.uk/faqs/>) and are captured in the stakeholder engagement summary (Annex 3.5); and
- The TSAs also met with the local authorities, local Members of Parliament, CCGs from across the Local Health Economy and healthcare providers from across the Local Health Economy.

129. During the consultation the TSAs:

- received in excess of 200 letters, 300 emails and 100 telephone calls from stakeholders, including members of the public. The Office of the TSA have responded to every letter, email and telephone call received;
- held 34 consultation meetings with the staff, staff unions, managers, executives, and/or members of MSFT;
- held eight public consultation meetings and attended three further public meetings;
- held two meetings with the national clinical advisory groups established to support the TSAs;
- and the Office of the TSAs held over 80 meetings with representatives from stakeholder organisations;
- and the Office of the TSAs held 9 meetings with local authorities and local Members of Parliament;
- issued eight stakeholder bulletins, all of which are available on the TSAs' website (<http://tsa-msft.org.uk/latest-news/>); and
- produced and regularly updated a series of Frequently Asked Questions (FAQs). Many of these questions are based upon themes of questions posed at the public meetings and through the various correspondence received by the TSAs.

These FAQs are available on the TSAs' website (<http://tsa-msft.org.uk/faqs/>) and are captured in the stakeholder engagement summary (Annex 3.5).

### 3.4 Clinical guidance to the TSAs

130. On the appointment of the TSAs for MSFT, Monitor made it clear that it was their expectation that the development of proposals for changes to services should routinely draw upon relevant clinical expertise. The TSAs have been working closely with clinical experts to:
- Identify where suitable alternative provision exists, and where it does not, to identify options for developing suitable provision;
  - Develop a solution to improve clinical standards and outcomes;
  - Assess the clinical sustainability of proposed solutions; and
  - Determine the conditions required to make the implementation of the TSAs' recommendations successful.
131. The TSAs fully recognise the importance of day to day clinical guidance in the work required in developing their recommendations. This is why one of the TSAs is a credible and highly experienced clinical leader. Professor Hugo Mascie-Taylor is a Fellow of the Royal College of Physicians. He has held key roles in the NHS including Medical Director, Director of Commissioning and Director of Strategic Development in NHS Trusts. He has also recently served as the Medical Director for the NHS Confederation.
132. In addition to Hugo Mascie-Taylor's day to day leadership of the work to develop a proposed solution, the TSAs have drawn upon a wide range of clinical advice, as follows:
- Regular meetings with the Chairs of Stafford and Surrounds CCG and Cannock Chase CCG – both of whom are long established GPs within the local area – to develop the TSAs' proposed clinical model;
  - Attended CCG membership meetings (CCG members being local GPs) to review the TSAs' recommendations and rationale;
  - The formation of a National Clinical Advisory Group (CAG) to provide the TSAs with their clinical advice. The CAG was jointly chaired by Professor Hugo Mascie-Taylor (joint TSA) and Professor Terence Stephenson (Chairman of the Academy of Medical Royal Colleges) and comprised representatives from each of the relevant Medical Royal Colleges. The remit of the CAG was to:



- Provide clinical advice to the Trust Special Administrator who retains responsibility for all decisions and recommendations to the Secretary of State for Health;
  - Provide its advice on the basis of available evidence, standards and current practice in the UK for ensuring the safety and quality of clinical services for the benefit of patients;
  - Comment, on the basis of the information available, on the clinical safety of proposals presented to the Group by the TSA rather than recommend ideal services which no organisation has offered to provide;
  - Comment on any aspect of the clinical safety of proposals for example
    - whether a proposal appears clinically safe or unsafe exactly as it is;
    - what adjustments or amendments would be required to make a proposal clinically safe;
    - the circumstances in which a proposal would or would not be clinically safe;
    - the evaluation required on an ongoing basis to judge whether the proposals remain clinical safe; and
    - whether they move services closer to designated College clinical standards.
  - Comment on the extent it believes specific proposals would or would not support the recruitment, retention, training and continuing professional development of appropriate medical staff; and
  - Acknowledge that the TSA will make public, if required, any advice given and the rationale for the advice.
- The formation of a National Nursing and Midwifery Clinical Advisory Group (NMAG) to provide the TSAs with their professional advice. The NMAG comprised senior nurse and midwifery representatives from professional bodies and Trusts nationally. The NMAG had a similar remit to the CAG.
  - The formation of a local Clinical Reference Group (CRG). This group was formed from the Medical Directors of local provider Trusts and the Chairs/Clinical leads from the local Clinical Commissioning Groups (CCGs) and provided the TSAs with a local clinical viewpoint on the draft clinical model; and
  - Held regular meetings with the executive teams of local providers, including the Medical Directors, to understand the potential for establishing clinical networks.



### 3.5 Stakeholder input into the recommendations

- 133. The TSAs have received 89 formal responses from stakeholder organisations as part of the consultation. These responses are included in Volume Two of this report and have been considered by the TSAs in their response to the consultation.
- 134. There are some stakeholders who the TSAs have worked closely with during the development of their recommendations. These activities are outlined in the remainder of this subsection.

#### An ongoing dialogue with commissioners

- 135. The leads of the TSAs' solution development team met with the leads of Stafford and Surrounds CCG and Cannock Chase CCG - as the lead commissioners for the services currently provided by MSFT – immediately upon appointment of the TSAs. This was firstly to confirm and finalise the LSS, and secondly to understand the CCGs' latest commissioning intentions. Annex 3.1 presents the commissioning strategies (2013/14) for both CCGs.
- 136. The TSAs have, throughout the TSA process to date, met with the CCGs on a weekly basis and worked with them on a number of areas to ensure that the clinical models that underpin any proposed service delivery models are aligned with the LSS and their broader commissioning intentions.
- 137. The CCGs confirmed, in their letters dated 22 and 24 July 2013, that they were satisfied that the TSAs proposals were appropriate for consultation (a copy of this letter is in Appendix D).
- 138. The CCGs clearly stated that they expected the TSAs' recommendations to achieve financial balance and confirmed this in their formal response to the consultation (see Appendix D).
- 139. In their formal response to the TSAs, the two local CCGs stated that they believed the TSAs had '*delivered the functions set out under the act*' and that they '*note the clinical model for future reference*', but that, '*further work through local commissioners now needs to take place*'. The context for these statements is that the local CCGs wish to undertake a review to look at health and social care provision across all providers in the Local Health Economy and have raised concerns about the TSAs forecast deficit at the end of a three transition period – a deficit that the CCGs do not wish to take responsibility for.





140. The TSAs understand the CCGs position and have worked with central government bodies during and subsequent to the consultation period in order to address the projected financial challenges that the TSAs have assessed would remain within the Local Health Economy (see below).

### **Engaging with potential providers of services in Stafford and Cannock**

141. The TSAs have conducted a market engagement exercise. The purpose of this exercise was to give any provider of healthcare services – NHS, independent sector and voluntary sector – the opportunity to put forward a proposal on their capability and willingness to provide services to the population of Stafford, Cannock and the surrounding areas.
142. It must be emphasised that this was not a procurement exercise and the results of the assessment of expressions of interest will not lead to any award of a contract, nor will any provider be prejudiced who wishes to apply for any future procurement opportunity. The purpose of the exercise was solely to help the TSAs to identify potential options for consideration and to develop a deliverable solution for consultation. The final decision about the need for any future procurement of services in Stafford and Cannock would be for local commissioners to decide, in accordance with their statutory responsibilities.
143. The TSAs' draft recommendations were based upon the dissolution of MSFT and establishing clinical networks, for both Stafford and Cannock Chase Hospitals, with larger hospitals. Whilst the TSAs made no recommendations about which providers would take on the running of services in Stafford and Cannock, the very nature of the required clinical networks means that there are geographic limitations on which providers would be able to manage these networks successfully. As such, the TSAs have continued to work closely with a number of providers in the Local Health Economy and have now concluded that UHNS would be best placed to operate Stafford Hospital and RWT to operate Cannock Chase Hospital.
144. Furthermore, given the potential scale of any proposed change, the TSAs met with providers in the Local Health Economy to discuss the local provision of services that may no longer be provided by the Trust. It was essential that the TSAs understood and their work identifies options to mitigate the potential impact of these changes.

## National agencies

145. The TSAs have held a series of meetings with a range of national agencies, including:
- **NHS England (NHSE)**, who at a local area and national level, has strategic responsibilities alongside local commissioners. The TSAs were required to formally consult with NHSE in the TSA process and have subsequently worked with NHSE to refine their financial assessments. NHSE have provided a range of commitments and potential future mitigations with regards to the ongoing financial position of the Local Health Economy (see Section 14 for further detail).
  - The TSAs needed to have regard to the fact that most of the local NHS Trusts with which MSFT might create clinical networks are currently under the supervision and direction of the **NHS Trust Development Agency (NHS TDA)** as they progress through to FT status. Therefore the TSAs engaged with and have taken account of the views of the NHS TDA into account when looking at the wider impacts of proposals. The NHS TDA have also worked with the TSAs and local providers to assess the future financial position of the Local Health Economy and future capital investment requirements.
  - The TSAs have worked with the **Department of Health (DH)** during their ongoing assessment of the future financial position of the Local Health Economy.
  - The TSAs have worked with **NHS Property Services (NHS PropCo)** to validate the capital investment requirements at Stafford and Cannock Chase Hospitals and other providers within the Local Health Economy.

### 3.6 The 'four tests' of health system reconfigurations

146. In 2010, the then Secretary of State for Health introduced 'four tests' that should be satisfied in any reconfiguration of health services.
147. In supporting Monitor's appointment of the TSAs, the Secretary of State asked that *'The TSA could provide an analysis of the final recommendations against the Government's four tests for reconfiguration'*.
148. Subsequently, during a Parliamentary debate on the future of Stafford Hospital, following the appointment of the TSAs, it was stated by The Parliamentary Under-Secretary of State for Health (Dan Poulter, MP for Central Suffolk and North Ipswich) that: *'...I would expect that any proposals meet the four tests for any service change and reconfiguration, which were set by the former Secretary of State for Health...'*

149. The following paragraphs analyse how these four tests have been addressed and should be read alongside the significant body of evidence that is contained in this report and the appendices.

### **Test 1: The changes have support from GP commissioners (CCGs)**

150. At the time the four tests were introduced, the Health and Social Care Bill was before Parliament. The bill introduced the concept of commissioning being moved away from Primary Care Trusts to GP commissioners. Since the passing of the Health and Social Care Act 2012, this concept has evolved into the establishment and authorisation of Clinical Commissioning Groups (CCGs). CCGs commission the majority of healthcare services for the local population they serve and on behalf of the GP membership of the CCG. In the case of MSFT, Stafford and Surrounds CCG and Cannock Chase CCG (referred to in this section as ‘the local CCGs’) commission over 90% of services provided by MSFT.
151. The work of CCGs is overseen by NHS England in their role as the body responsible for healthcare commissioning across England.
152. The local CCGs have been actively involved in the TSA process from the outset. Indeed, Monitor’s ‘Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts’ states that CCGs must have a formal role in the TSA. This is critically, but not exclusively, through the need for the CCG to be the responsible body for developing and signing off the LSS.
153. The CCGs have met with the TSAs’ solution development team on a weekly basis since the appointment of the TSAs. They were represented on the Local Clinical Reference Group and were integral in developing the TSAs’ draft clinical model through their definition of the LSS and their ongoing meetings with the TSAs.
154. As required by s65(F) of the National Health Service Act 2006, the TSAs were only able to publish their draft report, and commence the period of consultation after they received letters of support from the local CCGs (see letters from the 22 and 24 July 2013 in Appendix D).
155. The local CCGs and NHS England have also responded to the TSAs as part of the consultation process (see Appendices B/D and Annex 3.4). The CCGs and NHS England have all provided the TSAs with support for the proposed clinical model. However, this support is qualified by all parties with regards to the affordability of the proposed clinical model.

156. Therefore, when considering their responses the TSAs believe it appropriate to differentiate between the commissioners' views on the clinical model and the question of affordability of the proposed clinical model.

### Commissioner support for the proposed clinical model

157. On the matter of support for the proposed clinical model, the TSAs have received a series of letters from the local CCGs and NHS England prior to, during and following the period of consultation. These letters are included as appendices to this report.
158. The letters received from the local CCGs prior to the public consultation that enabled the TSAs to move to consultation included explicit support for the proposed clinical model, subject to assurance with regards to affordability (see below), as follows:

*"We are aware that the TSA considered three models for the provision of future services. All satisfied the requirements of the LSS however, the consultation document which has now been prepared by the TSA Office outlines the TSA preferred option. This option addresses not only the provision of the LSS but a more comprehensive range of service provision which is clinically more attractive to the CCG than the LSS alone"*

**Dr Margaret Jones, Chair, Stafford and Surrounds CCG (24 July 2013)**

*"I write to advise you that Cannock Chase CCG support the recommendations made by the Trust Special Administrator concerning services to be provided in the Stafford and Cannock areas, in that it fulfils the requirements of the Locality Specific Services, namely those services that the CCG insist have to be provided in Cannock Chase.*

*I can also advise you that the TSA model is clinically more attractive to our population, offering more services than originally required by the CCG in such a way that is considered safe by the National Clinical Advisory Group.'*

**Dr Johnny McMahon, Chair, Cannock Chase CCG (22 July 2013)**

159. The position of the local CCGs was supported by NHS England in a letter sent to the TSAs prior to the consultation, which stated:

*"We would support the clinical model and the intent to maintain a wider range of services in the Stafford and Cannock sites, subject to further assurance that financial sustainability can be secured without a tariff premium for commissioners."*

**Dr Paul Watson, Regional Director (Midlands and East), NHS England (23 July 2013)**

160. In responding to the consultation and their ongoing engagement with the TSAs, the local CCGs have focussed on their concerns with regards to the affordability of the TSAs' draft recommendations (see below). They have noted that:
- many of the TSAs' recommendations are in line with commissioner aspirations;
  - they wish to further explore different costing models and incentives that 'promote service integration between and across providers, where appropriate';



- they wish to work with local clinicians and the public to outline the choices available for future service provision;
  - they acknowledge that integration of services is outside the remit of the TSAs;
  - the TSAs' proposals 'meet or exceed the requirements set out in the CCGs Location Specific Services.';
  - 'The CCG believes that the TSA has delivered its functions under the act and the Mid Staffordshire Hospitals NHS Foundation Trust should be dissolved at a point when it is clear who will provide the future services.'; and
  - further work by local commissioners 'now needs to take place'.
161. NHS England sent a letter to the TSAs on 11 December 2013 which confirms that the TSAs have met their statutory obligation to secure the provision of the LSS. This letter notes that *'we confirm that those proposals, as varied, would achieve the objective of the TSA to secure the provision of the Location Specific Services identified by Commissioners'*.
162. The TSAs proposed service recommendations, as amended following the consultation, do not:
- affect the local CCGs right to change how they commission services in the future;
  - preclude the local CCGs from conducting a wider review of health and social care provision across the local health economy; or
  - present a barrier to evolving services over time in line with the commissioners aspirations to promote greater integration of care – indeed the TSAs would encourage the CCGs to explore all opportunities to enhance the integration of care across the local health economy.
163. Furthermore, the TSAs have received responses during the consultation from CCGs across the wider Local Health Economy, including:
- North Staffordshire CCG;
  - East Staffordshire CCG;
  - Telford and Wrekin CCG;
  - Walsall CCG; and
  - Wolverhampton CCG.
164. All of these CCGs support the clinical model proposed by the TSAs, with the exception that North Staffordshire CCG does not support the TSAs' proposals with regards to elective surgery and elective day cases at Cannock Chase Hospital, on the grounds that this would reduce the level of elective care provided at Stafford

Hospital and could adversely affect the financial position of UHNS – on the assumption that UHNS were providing elective services out of Stafford Hospital.

165. On the basis of the consultation responses, the TSAs are satisfied that there is widespread commissioner support (local CCGs, CCGs across the wider Local Health Economy and NHS England) for the TSAs' proposed clinical model, subject to qualifications with regards to the affordability of the proposed model and which organisation will have financial responsibility under the proposed service models.

### Commissioner qualifications on the affordability of the TSAs' recommendations

166. The local CCGs stated in their response to the consultation that they had received no assurance from the TSAs that their recommendations will not leave a financial deficit at the end of year three of the transition period. They had expressed similar concerns in their initial letter of support for the clinical model (dated 22 and 24 July 2013 - see Appendix D). On this basis, the CCGs proposed that:
- The transition timetable is extended from three to five years;
  - Revenue is provided to support the transition period;
  - A wider review of services, covering all health and social care services across the local health economy is undertaken in order to identify additional financial benefits; and
  - They, as local commissioners, are not responsible for any outstanding debts at the end of the transitional period.
167. The local CCGs also noted that they wished to explore different costing and (risk sharing/incentive) funding models that would promote service integration.
168. The TSAs understand these qualifications, but would maintain that this model provides the most appropriate balance between clinical safety and sustainability, local access to services and affordability that is currently achievable. However, the TSAs acknowledge the proposals by the CCGs and have taken these into account in preparing their final report.
169. The TSAs have been working with Monitor, NHS England, NHS Trust Development Agency, the Department of Health and local stakeholders to determine the funding requirements, both during and beyond the transition period and how this funding will be provided to ensure that the local CCGs are not disproportionately burdened with any future financial obligations associated with implementing the TSAs' recommendations.



170. The 11 December 2013 letter from NHS England stated that ‘NHS England would be prepared to provide time-limited commissioner support of up to £14.87m per annum from 01/04/2017 whilst local commissioners work through putting in place a more financially sustainable set of service arrangements in the County’. The letter also states that NHS England will provide £8m of the transition/implementation costs and the balance will be provided by the Department of Health.
171. Given that the funding, which includes transition costs, capital and the time-limited ongoing deficit, will be provided by a combination of financing from the Department of Health and income from NHS England to be paid via the CCGs, the TSAs believe that this will have addressed the concern of the local CCGs, however, it is recognised that the CCGs have commissioning freedom and will build on the TSA model as a part of a wider local health economy review.

### **Test 2: There has been strengthened public and patient engagement**

172. The TSAs have genuinely appreciated the levels of passion, interest and commitment that the local population have demonstrated in their engagement with the TSAs. The local population of Stafford, Cannock Chase and the surrounding areas are acutely aware of the challenges that MSFT have faced over a number of years and have shown great support for the hospitals and the staff that work within them.
173. As stated in Section 3.3, the TSAs engagement with the public and patient groups significantly exceeded the statutory requirements stated in Monitor’s guidance for TSAs. This means that the TSAs and the work they have undertaken has greatly benefited from continual high levels of public engagement and the final recommendations being put forward by the TSAs have been influenced, to an extent, by the public response to the consultation responses.
174. The TSAs are very aware that there are a range of well-established local advocacy groups in Stafford and Cannock Chase. Indeed, following the publication of the CPT report, and prior to the appointment of the TSAs, a range of these groups merged together to form the apolitical ‘Support Stafford Hospital’ group. In response to the CPT report, this group commenced a public petition of support for the retention of acute services at Stafford Hospital and organised a public march of support that was held, coincidentally, within a week of the appointment of the TSAs. The TSAs spoke directly with representatives of these groups before and during the consultation period.
175. The TSAs also recognise that it was important to engage with and understand the perspective of the wider population and smaller patient/public advocacy groups (for

example the National Childbirth Trust and the Stafford Parent Network), as well as ensuring steps were taken to engage with 'hard to reach' groups. The TSAs' consultation activities reflect this and the full range of meetings with stakeholders are set out in Annex 3.5. The HEIA also worked with such groups to understand their concerns.

176. Local opinion is divided with regards to the TSAs' draft recommendations. Several of the TSAs' draft recommendations for Stafford Hospital have widespread support, but the local population of Stafford strongly oppose some of the TSAs' draft recommendations. The local population of Cannock strongly support the TSAs' draft recommendations for Cannock Chase Hospital. This has been evident in the responses to the consultation and during the TSAs' many public meetings held across both local areas.
177. The TSAs have undertaken a wide range of stakeholder engagement activities, which have been documented in detail in Section 10 and Volume 2. With regards to public and patient engagement specifically, the TSAs have:
  - **Prior to the start of the consultation:**
    - Received, and responded to, in excess of 1,650 letters, 250 emails and 100 telephone calls from members of the public<sup>7</sup>.
    - Held three, independently chaired, public meetings in Stafford and Cannock within the first three weeks since appointment. The venues used were the largest available to the TSAs at the time<sup>8</sup>. Video recordings of each public meeting were made and published on the TSAs' website.
    - Issued fortnightly stakeholder bulletins on the TSAs' website.
    - Produced and regularly published Frequently Asked Questions (FAQs) on the TSA process and how the consultation would be undertaken.
    - Published in local media and sent out over 100,000 postcards containing the dates and venues for the public meetings that were to be held during the consultation.
    - Agreed with Monitor to extend the period of the consultation from 30 to 40 working days.
    - Formed the independent Health and Equality Impact Assessment steering group which included five independent members of the public.

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<sup>7</sup> The majority of responses to public enquiries prior to consultation were in the form of standard responses that set out the TSA process and encouraged the correspondent to respond to the consultation.

<sup>8</sup> The TSAs switched venues following advice from Staffordshire Police in order to accommodate the anticipated number of attendees.





- **During the consultation:**

- Printed and distributed 50,000 copies of the consultation document and consultation response form.
- Made available the documents in braille and other languages.
- Received, and responded to, in excess of 200 letters, 300 emails and 100 telephone calls from members of the public<sup>9</sup>.
- Held eight, independently chaired, public meetings across the catchment area, including outlying towns and villages, with a combined capacity in excess of 5,500 seats. Audio recordings of each public meeting were made and published on the TSAs' website.
- Attended and actively participated in three further public meetings held by stakeholders during the consultation period.
- Met with a large range of patient advocacy groups to gather their feedback on the TSAs' draft recommendations (see Annex 3.5 for full details).
- Issued weekly stakeholder bulletins on the TSAs' website.
- Produced and regularly published Frequently Asked Questions (FAQs) on the TSA process and how the consultation would be undertaken.
- Attended a dedicated session with the Staffordshire Health Select Committee ('Health Staffordshire Select Committee') – the body which holds healthcare providers to scrutiny on behalf of the public. This session was streamed live on the internet. It should be noted that the formal response from the committee supports the TSAs' draft recommendations with some caveats with regards to the financial evaluation undertaken by the TSAs.
- Attended and spoken at CCG patient forums.

178. The TSAs have engaged with the public through the traditional methods such as local media and direct mailshots. The TSAs have also published all materials online via their website ([www.tsa-msft.org.uk](http://www.tsa-msft.org.uk)). This website has had ca. 9,000 hits prior to the consultation and ca. 5,800 hits during the consultation period.

179. The TSAs have run an open and transparent consultation process and reflected the responses in detail in this report, with the inclusion of unedited copies of: the formal responses to the consultation; the Ipsos Mori analysis on the consultation responses; and the independent Health and Equality Impact Assessment report.

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<sup>9</sup> Where the correspondence included a question to the TSAs, the Office of the TSAs prepared and responded with discrete and specific responses to those questions. Comments were passed on to Ipsos Mori for inclusion in their analysis on the consultation responses.

180. Further evidence of how the TSA process has heightened public awareness includes:
- the local CCGs have held public meetings since the conclusion of the TSA consultation which have had to be held in venues sufficiently large to accommodate 200+ attendees;
  - the local media (Staffordshire Newsletter) have launched a dedicated section on their website to collate all of their coverage associated with the TSA process; and
  - ‘Support Stafford Hospital’ have had over 3,000 individuals sign up to their dedicated Facebook group and have held multiple public awareness events during and since the consultation process.
181. The TSAs have reviewed the full range of responses to the consultation and as a consequence have changed three of their draft recommendations. The details of the consultation responses and the TSAs subsequent changes to their recommendations is summarised in Section 13 and explained in detail in Annex 3.6.
182. Whilst the TSAs understand that their draft recommendations have not been fully supported by the public, and the revisions contained within their final recommendations will not fully address this public opposition, they firmly believe that public and patient engagement and interest in their local hospitals has been strengthened during the TSA process and that this test has been demonstrably achieved.

### Test 3: The recommendations are underpinned by clear clinical evidence

183. In supporting Monitor’s appointment of a TSA for MSFT, the Secretary of State reiterated the central theme of this test, stating: *‘I want to take this opportunity to emphasise the need to embed clinical advice at every stage of the process. The TSAs will want to ensure that there is appropriate local and national input from the doctors and other health professionals in shaping and defining the recommendations’.*
184. Both Monitor and the TSAs took unprecedented action in order to meet this expectation:
- Monitor appointed a joint ‘Clinical TSA’ in the form of Professor Hugo Mascie-Taylor.
  - The TSAs formed two national clinical advisory groups:
    - **The national Clinical Advisory Group (CAG)** with representation from the Royal Colleges and chaired by the Chairman of the Academy of Royal Colleges;

- **The national Nurse and Midwifery Clinical Advisory Group (NMAG)**  
which comprised senior nurses and midwives nominated by NHS England's Chief Nursing officer.
185. The TSAs formed the CAG and NMAG on the basis that they (the TSAs) believed these groups were best placed to objectively validate the clinical models developed by the TSAs - clinical models that would need to be clinically sustainable for up to ten years following the conclusion of the TSAs work (i.e. up to the year 2024).
  186. Developing safe and sustainable clinical models of care has been central to the work of the TSAs. Whilst the TSAs' objective is to secure clinical and financial sustainability, the TSAs have only conducted financial evaluations on service models that they believe to be clinically sustainable.
  187. At the heart of the clinical models evaluated by the TSAs has been the list of LSS developed by the local CCGs. It is implicit, in the CCGs definition of LSS, that they have judged it clinically acceptable for those services not on the list of LSS to be provided outside of the current localities.
  188. As they developed their clinical model, the TSAs held multiple meetings with the two clinical advisory groups. The terms of the reference for the CAGs and notes from each meeting are included in Annex 3.2. The TSAs and the CAGs would want to be clear that the CAGs were not asked to design the clinical models developed and evaluated by the TSAs, rather they were asked to assess the clinical safety of the models and whether they would, if implemented, have an impact on the recruitment and retention of qualified staff working within those services.
  189. During the consultation members of the CAG visited Stafford and Cannock Chase Hospitals in order to discuss the current service provision with the clinical staff at the hospitals, thereby enabling them to better support the TSAs' as they developed their final conclusions.
  190. Following the consultation, the TSAs met with the CAG to get their opinion on the proposed changes to the draft recommendations.
  191. The TSAs also invited the MSFT clinical leads from the three services most affected by their draft recommendations (maternity, paediatrics and critical care) to present their proposals for the future of their service at MSFT to the CAG.
  192. The CAG have provided the TSAs with letters that state they believe the TSAs draft and final recommendations to be clinically safe.
    - Their first letter - dated 22 July 2013, published in the TSAs' draft report and in Appendix C of this report - stated: *'The CAG is, however, satisfied that the*



*proposals the TSAs have recommended are founded upon principles that should deliver a clinically safe and sustainable solution for services at Stafford and Cannock Chase Hospitals for patients and staff’; and*

- Their latest letter – dated 21 October 2013 and published in Appendix C – addresses the three proposed changes to the TSAs’ draft recommendations and states:
  - **Maternity:** *‘The TSA is now proposing the inclusion of a Midwife Led Unit at Stafford...the CAG had been clear, on the advice of the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, that MLUs for low risk births provide a safe model of care. That continues to be our view.’*
  - **Paediatrics:** *‘The TSA recommendation on the Paediatric Assessment Unit has been revised to describe fully the level of Paediatrician cover on site to support the PAU. The 14/7 unit will be staffed by paediatric trained nurses with 14/7 support from paediatric trained A&E consultants. There will be Paediatric Consultant hot clinics and outpatient clinics a minimum of 5 days per week and these clinicians would be available on site to support the PAU if requested. Local clinicians proposed models dependent on whether maternity services would or would not be retained. The CAG felt that both models would be clinically safe.’*
  - **Critical care:** *‘The TSA originally stated that any patients requiring Level 3 critical care would be transferred out after 4-6 hours. This recommendation has been revised to say Level 3 patients will be transferred based on clinical need and not based solely on a time limit. If there is the capacity and capability to manage a Level 3 patient in Stafford then they will be kept in Stafford and not unnecessarily transferred... The CAG welcomed the more flexible approach of the TSA and stressed that the principle should be that Level 3 patients are treated at the original location for as long as there is sufficient capacity and capability to treat them effectively and safely. If it is anticipated that staffing of the correct capacity and capability will not be available patients must then be transferred.’*

193. With regards to the CAG comment on transferring patients with critical care needs, the independent Health and Equality Impact Assessment notes that they have taken evidence from the West Midlands Ambulance service. The HEIA report notes: *‘Although there are public concerns about the risks of transferring critically ill patients, the evidence on transfer was reassuring. The most important time factor in*



*critical care is to stabilise rapidly, and the patient can then be moved to the best site for on-going specialist care. The West Midlands Ambulance Service (WMAS) has confirmed that inter-hospital transfers for level 3 critical care are already common across the region and paramedics are trained for stabilisation and transfers’.*

194. The TSAs have received formal responses from a number of Royal Colleges and other professional bodies. Although the Royal Colleges and professional bodies were represented on the CAG, the TSAs welcomed individual and separate responses from each. These responses have been included in Annex 2.4. In general the responses supported the TSAs’ draft recommendations, although there were some qualifications to their support which the TSAs have considered in preparing their final recommendations, primarily:

- **Maternity:** Whilst the Royal College of Obstetricians and Gynaecologists supported the TSAs’ draft recommendations, the Royal College of Midwives were concerned that: a) the TSAs had underestimated projected increases in local births; b) the impact on capacity at UHNS; and c) the dismissal of a Midwife Led Unit (MLU) as being viable.
  - **TSA response:** The TSAs are now recommending an MLU and believe this would address points (b) and (c). The TSAs are also reassured that the analysis undertaken by Public Health Staffordshire - as part of the independent Health and Equality Impact Assessment - that assessed that *‘the analysis indicates that, even with the additional population growth over the next 20 years, the additional up to ca. 140 births’ would still mean that an obstetrics unit at Stafford Hospital would be a relatively small unit nationally...and the Steering Group is satisfied that its [the TSAs’] estimates are robust’.*
- **Critical care:** The Faculty of Intensive Care, the Royal College of Anaesthetists and the Royal College of Surgeons of Edinburgh all raised concerns that the reduced capability in critical care could undermine safety in A&E and – to some extent – acute medicine. There is also concern about the impact this would have on trainee anaesthetists if they spent prolonged periods working in a level 2 facility with no exposure to level 3 patients.
  - **TSA response:** The TSAs believe that their revisions to the critical care recommendations alongside the inherent commitment to rotate staff across sites will mitigate the concerns raised. This has been agreed with the CAG.



- **Paediatrics:** The Royal College of Paediatrics and Child Health strongly support the proposals put forward stating *'only by reducing the number of inpatient units will health outcomes for children and young people improve'*. They also support the proposed model for the Paediatric Assessment Unit (PAU). The Royal College of Surgeons of Edinburgh and the Royal College of Anaesthetists questioned the proposed staffing model for the PAU as the draft recommendations did not provide sufficient clarity with regards to input from paediatricians.
  - **TSA response:** Following further discussion with the CAG about staffing to support the PAU, the TSAs believe their revised recommendation on the PAU will address the concerns raised.
- **Patient transport:** The Faculty of Intensive Care and the Royal College of Surgeons of Edinburgh both stated that the patient transfer service would need dedicated investment and sufficient capacity to successfully support the TSAs' draft recommendations.
  - **TSA response:** The TSAs' proposals include investment in the local ambulance service, and the HEIA report states that *'inter-hospital transfers for level 3 critical care are already common across the region and paramedics are trained for stabilisation and transfers'*.
- **Implementation:** A number of the responses included broader statements that are directly relevant to the implementation of the TSAs' draft recommendations:
  - a) The Royal College of Radiologists stated that *'suitable levels of resourcing and, where relevant, education and training systems must be properly established'*;
  - b) The Royal College of Nursing proposed that there should be: a *'whole system healthcare commissioning approach'*; that there should be appropriate capacity for surgical, critical care, imaging and emergency services in place before any changes are made; there should be sufficient capacity in community services before any acute beds are reduced; and
  - c) The faculty of Public Health warned against unintended consequences of not completing a full risk assessment of proposals prior to implementation. They also urged greater involvement of public health professionals going forward.
  - **TSA response:** The TSAs acknowledge all comments received from the Royal Colleges and professional bodies and would expect those responsible for implementation to take on board all of these comments. In particular, the TSAs would expect full operational risk assessments to be conducted as detailed implementation plans are drawn up. This is normal practice within the NHS when translating strategic proposals into

the safe and sustainable transition and delivery of any services that the TSAs recommend should be moved to new service models.

#### **Test 4: The changes will ensure consistency with current and prospective patient choice**

195. MSFT was identified as clinically and financially unsustainable by Monitor. The TSAs' service recommendations allow for high quality services to continue to be provided from Stafford and Cannock Chase Hospitals. The change of management of Stafford and Cannock Chase Hospitals to other existing providers will result in one fewer provider from which patients can choose and the service changes recommended by the TSAs will result in changes in access to some services, primarily maternity, paediatric inpatients, emergency surgery and critical care.
196. However, in their previous configurations these services were being provided in a clinically and financially unsustainable manner. The service changes recommended preserve access to high quality services to the maximum extent practicable and therefore do not adversely impact patient choice.
197. This is because 'consistency with current and prospective patient choice' does not mean that the number of points of access to any single service should necessarily be the same or more than the current provision where one or more of those services are not of the appropriate clinical quality. The TSAs recommendations ensure patients can access services that are able to operate in line with national clinical guidelines, including those retained at Stafford and Cannock Chase Hospitals which otherwise would have fallen significantly below those guidelines. On this basis, whilst access to some services may be reduced, the TSAs proposals will increase patient access to services of the appropriate clinical quality.
198. Where services are to be removed from Stafford Hospital (the range of services provided by Cannock Chase Hospital will not be reduced), the key factor in the TSAs conclusions is that clinical quality will be improved if those services are provided with levels of consultant cover in line with clinical guidelines.
199. The TSAs believe that the weight of evidence, and the view of the CAG, supports the reduction of provision in those services the TSAs are proposing are reduced at Stafford Hospital. The independent HEIA also supports this view, on the proviso that the future service has the necessary capacity and is operated in line with national guidelines.





200. The TSAs recognise that it is desirable for patients to be treated in a hospital as close to their home as possible. This is precisely the reason why the TSAs have recommended that an increased range of 'step down' beds are established at Stafford and Cannock Chase Hospitals so that patients can be repatriated into a hospital bed closer to home when it is clinically appropriate to do so.
201. The TSAs have responded to the consultation feedback and the proposals from the independent HEIA steering group and have modified three of their draft recommendations, in the areas of maternity, paediatrics and critical care. Two of these modifications will have a positive impact on access to services in Stafford:
- **Maternity:** The TSAs have revised their maternity recommendation so that they are now recommending the introduction of a midwife led birthing unit (MLU) at Stafford Hospital. Whilst the TSAs recognise that the removal of the obstetrician led service will reduce the number of options available to patients that require obstetric led births, the TSAs have made this recommendation on the basis of clinical evidence and with the support of the Royal College of Obstetricians and Gynaecologists. On the premise that the current maternity unit in Stafford falls significantly below clinical guidelines for the minimum number of births, the introduction of the MLU will increase choice of clinically appropriate units for mothers-to-be that are appropriate to use such a facility; and
  - **Critical care:** The TSAs have revised their critical care recommendations so that the critical care facility at Stafford Hospital will have the ability to manage Level 3 patients as and when clinically appropriate. The consequences of this revision will be that: a) fewer patients requiring critical care will be transferred from Stafford Hospital to another facility; and b) fewer patients attended to by the ambulance service will be taken directly to a hospital other than Stafford Hospital. The TSAs have modified their recommendations to ensure that where patients will no longer be treated at Stafford Hospital it is on the basis of what is clinically appropriate.
202. It should also be noted that for some of those services retained within Stafford and Cannock, there will be an increase in patient choice due to the introduction of a full orthopaedic surgery service into Stafford Hospital and an increased range of elective surgical services at Cannock Chase Hospital. The basis for these recommendations is to improve local access to routine planned procedures, which is in line with commissioning intentions.
203. The TSAs final observation with regards to this test is that the Monitor appointed TSA process is dependent upon local CCGs defining LSS. The definition of LSS, by its



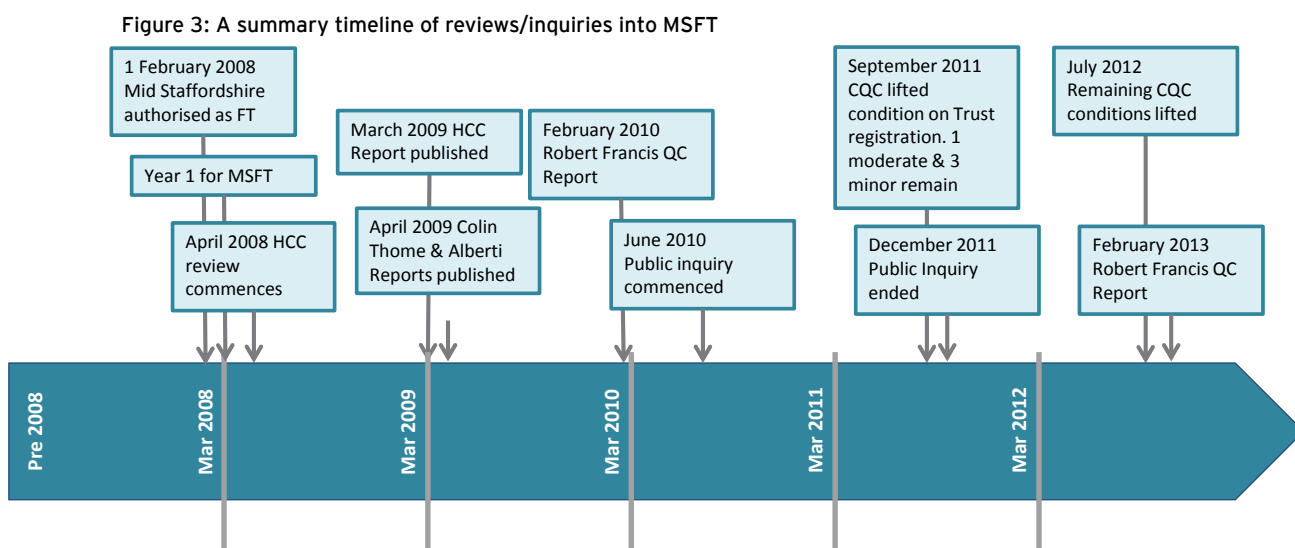


very construct, is a process whereby local CCGs evaluate and determine those services which they, as commissioners, expect to see retained for delivery within the current locality if a healthcare provider fails. By implication, this means that the CCGs are content that those services not designated as LSS could be provided by providers outside of the existing locations – thereby reducing local access to services currently available to the population that the CCGs commission services for. The CCGs support the dissolution of MSFT as it is clinically and financially unsustainable. The TSAs recommendations secure the delivery of the LSS plus a broader range of services within the current locality.

## 4 Trust background

### 4.1 Mid Staffordshire NHS Foundation Trust

204. MSFT is a 301-bed acute Foundation Trust located on two sites: Stafford Hospital (opened in 1983) and Cannock Chase Hospital (opened in 1991), and provides services to the populations of Stafford, Rugeley, Stone, Cannock and the surrounding areas<sup>10</sup>.
205. In 1993, shortly after the opening of Cannock Chase Hospital, the two hospitals were brought together into a single NHS Trust – the Mid Staffordshire General Hospitals NHS Trust. The Trust was awarded FT status on 1 February 2008. The Trust currently employs ca. 3,000 staff and has an annual income of ca. £155m.
206. Shortly after achieving FT status in 2008, the Trust was subjected to a review by the Healthcare Commission (HCC) into reported high levels of patient mortality and poor standards of care. Following this review there have been three further reviews, an independent inquiry and a public inquiry – the two inquiries being headed by Robert Francis QC. A timeline of these reviews/inquiries is shown in Figure 3.



207. The most significant of these reviews are the two inquiries led by Robert Francis QC<sup>11</sup>. The report of the second inquiry sets out the series of events behind the documented issues<sup>12</sup>. The TSAs have worked on the basis that these public inquiries

<sup>10</sup> [www.midstaffs.nhs.uk](http://www.midstaffs.nhs.uk)

<sup>11</sup> The results of these inquiries can be found at <http://www.midstaffspublicinquiry.com/>

<sup>12</sup> Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry, February 2013, Executive summary, London: The Stationery Office, p. 11.

were open, forensic and comprehensively documented. Reviewing and commenting in detail on the evidence is outside of the remit of the TSAs.

## 4.2 The catchment population of MSFT

208. There are various views about the catchment population for MSFT. The MSFT website states that they serve a population of 276,500, which is a reasonable position to take as the registered population of Stafford and Surrounds and Cannock Chase CCGs – their primary commissioners – is 276,500.
209. The Francis Report quoted the HCC report (2009) which also stated that the population served was 320,000<sup>13</sup> – it is likely that this information was taken from the MSFT published figures as there is no evidence of a separate assessment into the population being undertaken.
210. In 2012, Public Health Staffordshire (PHS) – part of Staffordshire County Council – conducted an evaluation of MSFT’s catchment population and this analysis was presented by the Contingency Planning Team (CPT) in their report into sustainability<sup>14</sup>. The key factor in this analysis was the distinction between the **catchment population** and the **population of the catchment area**.
211. PHS have subsequently updated their analysis to reflect the volume of first attendances to MSFT in 2012/13. Their updated paper is included as an appendix to this document (Appendix E). The key messages from their analysis are as follows:

*“Catchment areas are usually different to catchment populations. Catchment areas relate to the geographical area as a whole, whereas the catchment population refers to the people who would use the hospital if they needed treatment. The catchment area for Mid Staffordshire NHS Foundation Trust (MSFT) is higher than the catchment population.”*

*“Many factors, such as the type and size of a hospital, its proximity to other hospitals, characteristics of the population, reputation and patient choice affect a hospital’s catchment population.”*

*“The catchment population for MSFT for all admissions was estimated to be 226,300 in 2009. Locally derived information indicates a decline in the catchment population from 2009/10 onwards. Public Health Staffordshire’s (PHS) estimate, based on all hospital admissions between 2010/11 and 2012/13, suggest that the catchment population has fallen by around 11% to 204,400 with a likely range between 192,000 and 217,000.”*

<sup>13</sup> [http://www.midstaffsinquiry.com/assets/docs/Inquiry\\_Report-Vol1.pdf](http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf) (Page 141)

<sup>14</sup> Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust – Assessment of Sustainability, January 2013.

212. Information held by the Trust indicates that total patient first attendances<sup>15</sup> have dropped in the last five years (see Table 4). The two significant reductions in patient attendances were in 2009/10 and 2012/13. Both of these years saw extended media coverage of Stafford Hospital (2009 – HCC review; 2012 – overnight closure of A&E, Francis Report and the interventions by Monitor). Patient attendances did stabilise and marginally rise from 2010 – 2012, but these levels have dropped in the period April 2012 – March 2013.

Table 4: First attendance levels into MSFT for the period 2008/09 – 2012/13

	2008-09	2009-10	2010-11	2011-12	2012-13
<b>Total first attendances</b>	<b>146803</b>	<b>138706</b>	<b>140540</b>	<b>141381</b>	<b>133514</b>
+/- change (year on year)	-	-5.8%	1.3%	0.6%	-5.9%
+/- change (from 08/09)	-	-5.8%	-4.5%	-3.8%	-10.0%

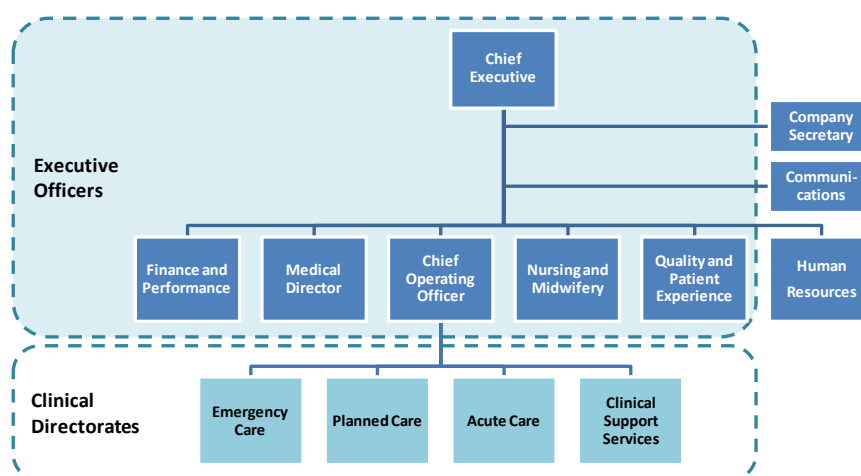
Source: Trust data

213. The TSAs consider that the numbers presented by PHS are a reasonable estimate of the population of people who would consider MSFT to be their acute hospital of choice.
214. If the number of patient first attendances were to increase back to 2008/09 levels then, by this form of assessment, the ‘catchment population’ of MSFT would increase to nearer the estimate from 2009 (226,300).

### 4.3 MSFT organisational structure and services

215. Figure 4 presents a high level view of the organisational structure.

Figure 4: An overview of the MSFT organisational structure



<sup>15</sup> First attendances represent the number of discrete patient spells that are being managed by the Trust. A spell can include multiple patient episodes. For example, a patient attending a first outpatient appointment, an associated day case procedure and two follow up appointments would have four episodes within this single spell.

216. MSFT provides a broad range of acute services, with some of the more complex and hyper-acute services being provided by the larger, more specialised hospitals in the region. The range of services currently provided by the Trust is spread across four clinical directorates:
- The **Planned Care** directorate contains a range of wards, departments and staff primarily focussed on managing the admission and in situ care needs of patients referred into MSFT.
  - The **Acute Care** directorate contains a range of wards and departments, primarily concerned with the ongoing care and treatment of unplanned patient activity.
  - The **Emergency Care** directorate primarily focuses on the immediate treatment and management of patients attending MSFT in an emergency. The directorate also manages paediatric care.
  - The **Clinical Support Services** directorate provide a range of integral and essential clinical support services to the other directorates.
217. The majority of non-elective/unplanned care is delivered at Stafford Hospital. Ambulances do not take emergency patients to Cannock Chase Hospital; all non-elective surgery takes place on the Stafford site; and the critical care service is provided in Stafford Hospital.
218. Table 5 outlines the range of services that are delivered at the two sites.

Table 5: A summary of the services provided at each of MSFT's hospitals

Service area	Stafford Hospital	Cannock Chase Hospital
A&E	✓	
Non-elective admissions	✓	
Elective surgery	✓	✓
Day case procedures	✓	✓
Paediatrics	✓	
Maternity births	✓	
Critical care	✓	
Outpatients	✓	✓
Diagnostics	✓	✓

219. To address some of the clinical challenges associated with being a small hospital, and in line with a national move to larger more specialist centres of excellence for some services, the Trust has reconfigured some clinical services resulting in MSFT not providing some services on a standalone basis. Table 6 sets out the services that are

not wholly provided by MSFT, or services that are run by other providers at Stafford or Cannock Chase Hospitals.

Table 6: A summary of services provided at Stafford and/or Cannock by providers other than MSFT

Service	Provided by	Site(s)	Description
Ophthalmology	Jointly with The Royal Wolverhampton NHS Trust (RWT)	Stafford and Cannock	RWH provides consultants, staff grade and nursing staff for ophthalmology outpatient services for new and follow-up patients in MSFT
Vascular surgery	University Hospital of North Staffordshire (UHNS)	UHNS (Stoke)	All patients from Mid Staffs region are referred directly to UHNS
Ear, Nose and Throat	Jointly with UHNS	Stafford and UHNS (Stoke)	Two visiting consultants from UHNS provide assessment and treatment for a range of conditions. The Consultants are accompanied by specialist Registrars for each outpatient and theatre session from UHNS  On-call rota shared between UHNS and MSFT. Suspected Head and Neck cancer referrals are treated at UHNS
Cancer	UHNS and RWT	Stafford and Cannock	Provide a range of cancer services in Stafford and Cannock
Renal	UHNS and RWT	Stafford and Cannock	Service operated out of Stafford by UHNS and Cannock by RWT
Maxillofacial	Jointly with UHNS	UHNS (Stoke) and Stafford	UHNS provides dental lab services at UHNS. UHNS provide visiting consultants for outpatient and theatre services in Stafford
Plastics	UHNS	Stafford and Cannock	UHNS provide visiting consultants for outpatient and theatre services in Stafford
Cardiology	UHNS and RWT	Stafford and Cannock	UHNS and RWT provide care for patients with acute coronary syndrome, or ST-elevated myocardial infarction
Minor Injuries Unit (MIU)	Staffordshire and Stoke-on-Trent Partnership Trust (SSoTP)	Cannock	SSoTP run the MIU in Cannock
MRI	Alliance Medical	Cannock	Alliance Medical run the MRI unit in Cannock

Service	Provided by	Site(s)	Description
General Surgery	Jointly with UHNS	Stafford and UHNS (Stoke)	<p>The surgical alliance between UHNS and MSFT enables a partnership between UHNS and MSFT to deliver a range of services between MSFT and UHNS</p> <p>Consultant appointments enable the delivery of this service primarily at MSFT with support being provided by UHNS</p> <p>The visiting consultants from MSFT will provide services for the treatment of a range of conditions</p>
Littleton Ward	SSoTP	Cannock	SSoTP run Littleton ward at Cannock which are GP and Nurse led beds for patients who are stepped down from Acute Care
Community paediatrics	South Staffordshire and Shropshire Healthcare NHS Foundation Trust	Stafford	The community paediatric team work with the paediatric inpatient team at MSFT (Shugborough Ward)

220. In addition to these services, UHNS also provides consultant input into the general surgery, gynaecology, neurosurgery and orthodontics services delivered by MSFT.
221. Since the publication of the TSAs' draft report, MSFT and UHNS have announced plans to merge their urology services<sup>16</sup>.
222. In December 2011, a decision was taken, on clinical grounds, to close the A&E department between the hours of 22:00 (10pm) and 08:00 (8am). This closure was initially intended to be temporary to enable a series of remedial actions to be put in place to enable the service to re-open. Although the Trust implemented a series of changes, the leadership of the Trust and local commissioners were not satisfied that the service could be safely operated on a 24 hours a day / 7 days a week basis and have not restarted the overnight service.
223. The TSAs believe the decision of the Trust and commissioners was correct. There are only six A&E consultants (of which two are substantive and accredited A&E consultants) available to the Trust to operate the 14/7 A&E service. This is significantly below national guidance of 10 consultants being required to operate a safe 24/7 A&E rota<sup>17</sup>. Indeed, since the publication of the TSAs' draft report, MSFT and UHNS have announced that UHNS will provide senior clinicians to support the A&E service at Stafford Hospital due to a shortage of permanent consultants<sup>18</sup>.

<sup>16</sup> [http://www.midstaffs.nhs.uk/About-Us/News-\(1\)/2013/September-2013/Joint-Statement-about-partnership-working.aspx](http://www.midstaffs.nhs.uk/About-Us/News-(1)/2013/September-2013/Joint-Statement-about-partnership-working.aspx)

<sup>17</sup> Emergency Medicine Taskforce - Interim Report (Dec 2012) – The College of Emergency Medicine.

<sup>18</sup> [http://www.midstaffs.nhs.uk/About-Us/News-\(1\)/2013/September-2013/Joint-Statement-about-partnership-working.aspx](http://www.midstaffs.nhs.uk/About-Us/News-(1)/2013/September-2013/Joint-Statement-about-partnership-working.aspx)

224. Following the overnight closure of the A&E in Stafford there has been a reduction in the numbers of A&E attendances at MSFT, although it has not had a consequent reduction on the number of non-elective spells. Table 7 summarises the full year activity levels for all services, including A&E and non-elective spells, provided by MSFT over the last three years.

Table 7: Number of patients treated at MSFT over the period 2010/11 - 2012/13

Patients Treated	2010/11	2011/12	2012/13
A&E attendances	52,185	50,451	46,168
Non-elective spells	27,701	27,516	27,587
Elective inpatient spells	4,439	3,981	4,055
Day case procedures	31,067	30,729	31,818
New outpatient attendances	77,002	79,900	82,990
Follow-up outpatient attendances	181,921	206,899	208,142

Source: Trust data

#### 4.4 Overview of the Trust's staff

225. Table 8 gives a breakdown of the Trust's average staffing for 2010/11 to 2012/13. The staff numbers are expressed as whole time equivalents (WTEs). Staffing levels (including temporary staffing) have reduced by ca. 3.5% during the period.

Table 8: A summary of MSFT's staffing for the last three financial years

WTEs	2010/11 <sup>19</sup>	2011/12	2012/13
Clinical staff, including scientific and therapeutic staff	1,806	1,702	1,736
Non-clinical staff	807	807	753
Total non-agency staff	2,613	2,509	2,489
Agency staff	159	176	177

Source: Trust data

226. A significant proportion of the staff deployed by MSFT are temporary staff, costing over £5m per annum in 2012/13. The levels of spend on temporary staffing did reduce in 2012/13 over the previous year when the Trust spent over £9m. When compared with the nine trusts most similar in size (based upon income), MSFT was

<sup>19</sup> The financial year in the NHS runs from 1 April to 31 March. FY11 is the period 1 April 2010 – 31 March 2011.



one of only three Trusts to reduce their spending on temporary staff in 2012/13 from the previous year (see Table 9).

Table 9: The proportion of expenditure spent on temporary staff as a percentage of Trust turnover (in 2012/13), at MSFT and the nine most similar trusts in England, based upon annual income

Trust	Income (2011/12, £m)	Bank, agency and non- permanent staff spend (£m)		Bank, agency and non- permanent staff spend as proportion of income (%)
		(2011/12)	(2012/13)	
Dartford & Gravesham NHS Trust	177.19	11.15	12.72	7.18%
Tameside Hospital NHS Foundation Trust	159.23	9.06	10.86	6.82%
James Paget University Hospitals NHS FT	173.16	8.74	10.24	5.91%
Southport and Ormskirk Hospital Trust	181.09	7.1	8.46	4.67%
Barnsley Hospital NHS Foundation Trust	167.59	6.23	6.02	3.59%
<b>Mid Staffordshire NHS Foundation Trust</b>	<b>159.08</b>	<b>9.44</b>	<b>5.29</b>	<b>3.33%</b>
Harrogate and District NHS Foundation Trust	173.07	3.1	4.7	2.72%
Burton Hospitals NHS Foundation Trust	174.72	1.7	3.5	2.00%
Dorset County NHS Foundation Trust	152.85	2.44	2.55	1.67%
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	167.38	5.89	2.2	1.31%

Source: Trust Annual Reports 2012/13

227. However, in the current year, the spending on temporary staffing after six months has been £3.15m. If the Trust continues at the same rate of spending for the next six months then spend will increase by ca. £1.0m in the current financial year. Furthermore, there is a seasonal impact with trusts typically spending more on temporary staffing during the winter than during the summer.

## 4.5 Overview of the Trust's estate

228. The Trust provides services from two sites, Stafford and Cannock, with the majority of acute services being provided at Stafford. Neither site has any Private Finance Initiative (PFI) commitments. Table 10 presents an overview on the Trust's estate. More detail on the estate is provided in Section 15 and Annex 3.6.

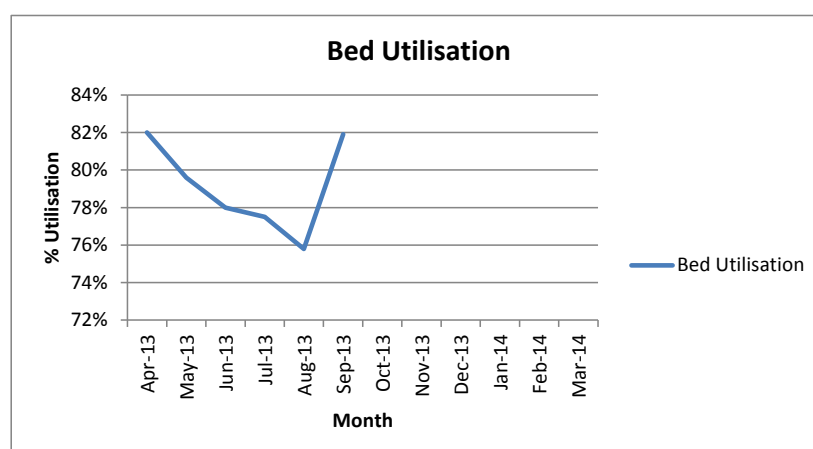
Table 10: A summary of the estate at MSFT's hospitals

Estate	Stafford Hospital	Cannock Chase Hospital
Site Area (ha)	14.64	3.35
Net Internal Area (m2)	31,788	18,190
Car Par Spaces	907	337
Net Book Value (£m) / Value of the asset	61.656	31.506

Source: Six facet survey, 2012

229. At Stafford there are fifteen ward-based areas, including paediatrics and maternity. One of these wards remains empty and is currently being used as spare clinical space to facilitate general improvements to the others. Cannock has nine available wards, of which only three are used: two wards run by the Trust and a ward run in collaboration with the local Community Trust (Staffordshire and Stoke-on-Trent Partnership NHS Trust).
230. Figure 5 shows that average bed utilisation for the first six months of the current year has been below 80% for four of the six months - which is lower than utilisation levels in the previous year (as presented in the TSAs' draft report).

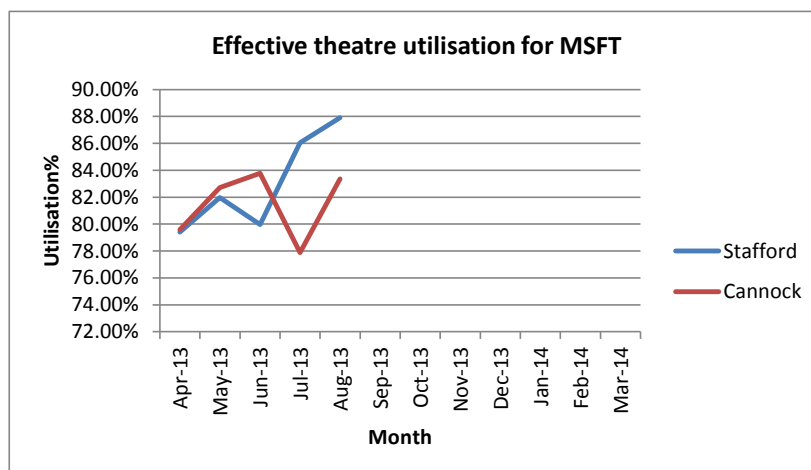
Figure 5: Average bed utilisation at MSFT year to date



Source: MSFT Trust data

231. There are seven theatres in use at Stafford and five at Cannock. Theatre utilisation for the first six months of the year, shown in Figure 6, is lower than should be expected, indicating over capacity of theatre space.

Figure 6: Average theatre utilisation at MSFT for FY13



Source: MSFT Trust data

232. There has been a relatively low level of investment in the estate over the last five years (see Annex 3.6). This has led to a significant backlog of maintenance and, given the general age of the Estate, there is additional investment required to bring the functional suitability of each hospital into line with NHS standards<sup>20</sup>.
233. A full condition appraisal was undertaken in February 2012 which estimated the costs of addressing the maintenance backlog and the additional cost required to bring the estate up to 'condition B standard' (meaning the estate is sound, operationally safe and exhibits only minor deterioration and complies with the relevant guidance and statutory requirements). These estimates were:
- £36.0m for Stafford; and
  - £8.3m for Cannock.
234. In November 2012, the Trust commissioned Strategic Healthcare Planning (SHP) to conduct a full review of the estate, including the levels of investment needed at both sites to enable the improvement of patient pathways, clinical efficiencies and estate utilisation. The review identified that 43% of the space at Cannock Chase Hospital was occupied by MSFT, 37% by third party providers and 20% was not utilised. Most of the third party utilisation is taken up with short term leases.

<sup>20</sup> NHS EstateCODE – Department of Health



235. This review identified the need to invest potentially:
- £18 – £34 million at Stafford; and
  - £9 – £19 million at Cannock.
236. These figures included some areas covered by the previous condition appraisal but not all. The conclusion of the analysis is that the following investment is required:
- £56.3m for Stafford; and
  - £13.5m for Cannock.
237. Further detail on this and the current use of the estate at Stafford and Cannock Chase Hospitals is provided in Section 15 and Annex 3.6.
238. The costs associated with managing the Trust's estates are more than £10m (6%) of its annual income, which compares with a national average of less than 1% for all Trusts and just over 1% for all Foundation Trusts<sup>21</sup>. The primary reason for this is the Trust having to manage the estate costs associated with two district general hospitals – something that is very unusual for trusts the size of MSFT. Some costs associated with running a hospital estate are linked to patient volumes (e.g. linen, catering) whilst others are related to the size of the estate. The three largest cost categories are all related to the size of the estate:
- Energy management = £2.75m
  - General estates expenses = £1.43m
  - Medical electronic devices = £1.00m

## 4.6 Overview of the Local Health Economy

239. Stafford and Surrounds and Cannock Chase CCGs commission services for a combined population of 276,500. Their main acute provider is MSFT and ca. 95% of hospital activity at the Trust comes from these CCGs. The CCGs were formed in 2012 and have been authorised as statutory bodies from 1 April 2013. Within the area covered by the CCGs:
- There are 41 GP practices, employing approximately 160 GPs and approximately 125 practice nurses;
  - There are approximately 45 dental practices and approximately 50 community pharmacies; and
  - Out of hours care is provided by Badger Healthcare.

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<sup>21</sup> Department of Health: QIPP national workstream: Back office efficiency and management optimisation



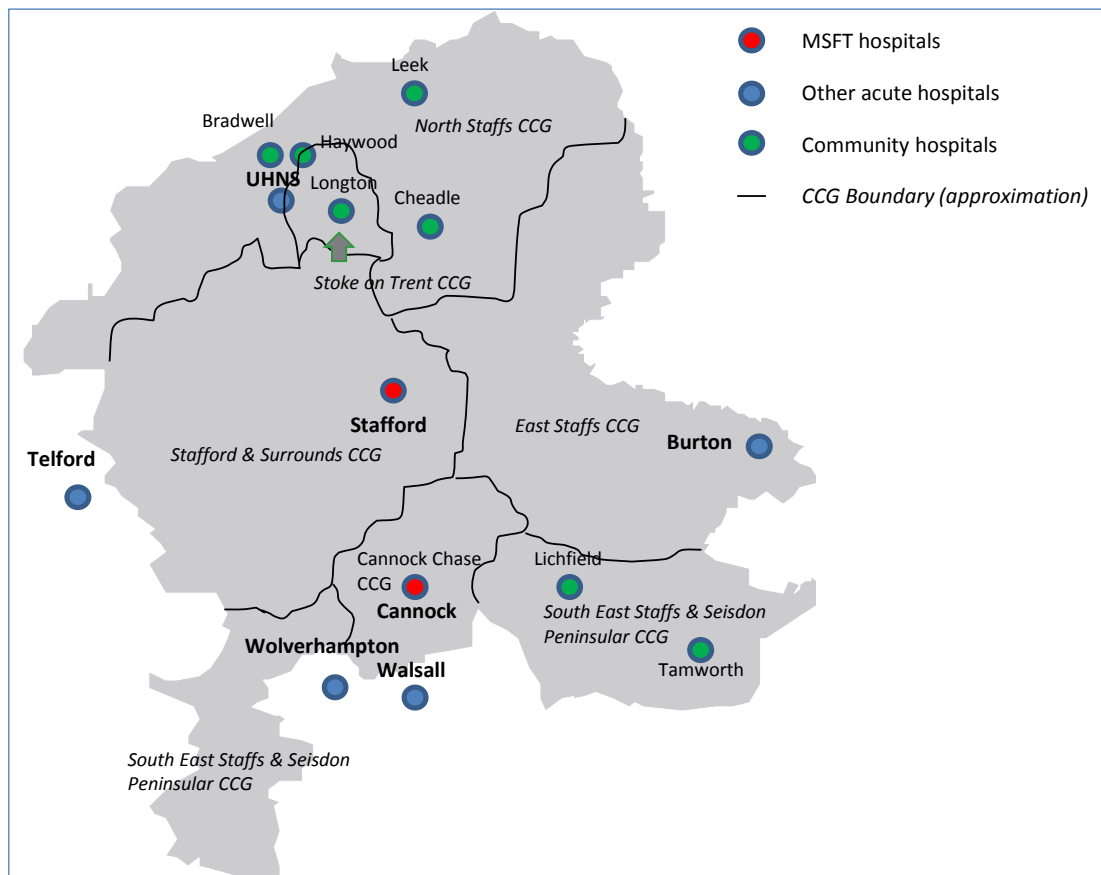
240. Across Staffordshire:

- The remaining 5% of activity at the Trust is commissioned by other CCGs, including the other CCGs in Staffordshire - North Staffordshire CCG, Stoke-on-Trent CCG, East Staffordshire CCG, and South East Staffordshire and Seisdon Peninsular CCG.
- There are two other acute trusts, University Hospital of North Staffordshire NHS Trust (UHNS) and Burton Hospitals NHS Foundation Trust (BHFT) – see below for more details.
- Community services are provided by the Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSoTP). SSoTP was formed in 2011 and brought together community health provision with social care into a single organisation serving all of Staffordshire.
- There are seven community hospitals, five in the North of the county (run by SSoTP) and two in the South East (run by BHFT).
- Mental health services are provided by South Staffordshire and Shropshire Healthcare NHS Foundation Trust.
- The CCGs also fund several hospices in the region.
- There are a small number of private providers locally, one of which, Rowley Hall Hospital with 14 beds, is located within the catchment area of the two CCGs. Rowley Hall performs a small amount of activity for the two CCGs which is mainly elective procedures for the following specialties: General Surgery, Urology, Trauma and Orthopaedics, Ophthalmology, Gastroenterology, and Gynaecology.

241. West Midlands Ambulance Service NHS Foundation Trust (WMAS) provides emergency ambulance services in Staffordshire and NSL Care Services operate patient transport services.

242. The Local Health Economy is not limited to Staffordshire, with three acute providers – in addition to the three providers in Staffordshire – within 20 miles of MSFT hospitals. Figure 7 shows the location of the providers and the CCGs within the Local Health Economy.

Figure 7: The geography of the Local Health Economy



243. Staffordshire is bisected by the M6 and there are five other acute providers within 20 miles of MSFT hospitals, as follows:
- To the North - University Hospital of North Staffordshire NHS Trust (UHNS), Stoke-on-Trent;
  - To the South – The Royal Wolverhampton NHS Trust (RWT), which runs New Cross Hospital, and Walsall Healthcare NHS Trust (WHT), which runs Manor Hospital;
  - To the East - Burton Hospitals NHS Foundation Trust (BHFT), which runs Queen’s Hospital and the community hospitals in Lichfield and Tamworth; and
  - To the West - Shrewsbury and Telford Hospitals NHS Trust (SaTH), which runs the Princess Royal Hospital, Telford.

244. A summary of the size and scale of each Trust is provided in Table 11.

Table 11: A summary of providers in the Local Health Economy

Trust	2012/13 Turnover	Number of staff	Number of beds
BHFT	£173m	ca. 2,500	482
RWT	£376m	ca. 6,500	812
SaTH	£309m	ca. 5,000	752
SSoTP	£373m	ca. 6,000	303 (community)
UHNS	£459m	ca. 6,700	1,045
WHT	£225m	ca. 5,000	489

Sources: Trust annual reports; NHS England: Bed Availability and Occupancy Data (January to March 2013)

245. Each of these trusts in the Local Health Economy has undergone, and in most cases is still undergoing, challenges of their own. These challenges include some trusts operating financial deficits, some with issues in their clinical services, and others in the process of reconfiguring their services/sites/organisational form. In Section 8, a more detailed overview is presented on each of these trusts and the issues they are facing.

## 4.7 Historic attempts to transform services

246. As previously noted, there have been multiple reviews undertaken at MSFT. Each of these reviews has led to some form of change, but the majority of changes have been relatively small scale and have not led to significant changes in the service model. One example of this would be the move of vascular surgery from MSFT to UHNS as a consequence of recommendations that some services should be consolidated into specialist centres.
247. The one exception to this is the Clinical Service Implementation Programme (CSIP) that was established in 2011. CSIP was a joint initiative between MSFT, local commissioning groups (South Staffordshire Primary Care Trust and the two embryonic CCGs) and Staffordshire County Council. The objective of the programme was to redesign major care pathways in line with evolving commissioning intentions and resulted in a series of recommendations aimed at delivering improved clinical and financial sustainability. Whilst some of the recommendations were implemented – notably within MSFT itself – the programme did not deliver the full range of anticipated improvements. There are several factors behind the limited success of the programme, the most notable being the challenges posed by the planned integration of community and social care into a single organisation (SSoTP) during the implementation period for the CSIP recommendations.



#### **4.8 Monitor's intervention to deliver sustainable services**

248. The Trust has been working closely with Monitor to improve its performance in recent years, and has made significant improvements in the clinical care provided for patients. However, the Trust is still losing money, and had to be given significant financial support (ca. £21m) from the Department of Health (DH) in 2011/12 in order to maintain provision of services for patients.
249. In October 2012, Monitor appointed the CPT to assess the sustainability of MSFT (clinically, financially and operationally) and, if it was deemed to be unsustainable, to develop a high-level plan which would enable services to be provided for local patients on a sustainable basis. The terms of reference for the CPT are available on Monitor's website<sup>22</sup>.
250. The CPT's work was carried out in two phases: 1) Assessing MSFT's sustainability and 2) Developing a contingency plan to deliver sustainability. The outcomes of the first of these phases are outlined below and are directly relevant to the work of the TSAs. The scope of the CPT, in developing its recommendations, was different to the scope of the work undertaken by the TSAs in developing their recommendations. The TSAs have been required to take into account the influence of and the impact upon the Local Health Economy when formulating their recommendations.
251. The TSAs' work has been informed by some of the analysis presented by the CPT and supported by stakeholder relationships established during the CPT. However, the TSAs are satisfied that the work undertaken during the CSIP, and subsequently by the CPT, has demonstrated that the problems faced by MSFT cannot be solved by changes made by MSFT alone. This observation is one of the central tenets of the case for change set out in Section 6.

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<sup>22</sup> <http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/latest-press-releases/terms-reference---contingency-planning-team->





## 5 MSFT performance

252. MSFT has delivered improvements over the last 1-2 years in clinical outcomes. It has also been subjected to numerous CQC inspections that have reported no areas for concern. This section provides a summary of recent performance.

### 5.1 Recent clinical performance

253. As previously noted, the TSAs have been determined to not expend time or effort reviewing, restating or commenting upon the well documented issues associated with the Trust during the middle to latter part of the last decade. The TSAs are of the view that it would be disingenuous to directly link the case for change to the reported problems of this period of history and that the local population would not welcome any attempts to do so. The only observation that the TSAs would make is that there have been reputational consequences of these events that have, in part, caused both clinical and financial challenges for the Trust.
254. The assessment undertaken by the CPT concluded that *'it has not identified any evidence that the Trust is currently delivering unacceptable standards of care'*<sup>23</sup>. The TSAs want to reiterate that statement and acknowledge the continuing hard work and commitment of the Trust's leaders and staff to deliver the best possible care for all patients that attend the two hospitals.
255. CQC unannounced inspections in the last 12 months at both Stafford and Cannock Chase Hospitals have confirmed that both hospitals are meeting expected standards<sup>24</sup>.
256. The following tables summarise some of these KPIs and how the Trust is performing against other trusts nationally and within the Local Health Economy over the period 2009/10 – 2012/13.

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<sup>23</sup> Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust – Assessment of Sustainability, January 2013, P14.

<sup>24</sup> CQC – Inspection Report (Stafford Hospital), 6 March 2013; CQC – Inspection Report (Cannock Chase Hospital), 23 April 2013.

Table 12: Summary of performance against the Four hour A&E target

<b>Four Hour A&amp;E</b> (This shows the percentage of patients who were seen and either admitted, transferred or discharged within four hours)				
	2009/10	2010/11	2011/12	2012/13
Mid Staffordshire NHS Foundation Trust	96.0%	87.6%	88.3%	93.8%
Peer group average	96.6%	94.1%	93.8%	95.5%
National average	95.8%	94.6%	94.5%	95.9%
Burton Hospitals NHS Foundation Trust	96.3%	97.6%	96.8%	94.0%
Shrewsbury and Telford Hospitals NHS Trust	87.8%	89.2%	91.5%	90.6%
The Royal Wolverhampton NHS Trust	98.8%	98.2%	97.1%	95.8%
University Hospital of North Staffordshire NHS Trust	96.7%	93.8%	88.1%	89.9%
Walsall Healthcare NHS Trust	97.2%	94.9%	96.0%	95.0%

Table 13: Summary of performance against the 18 week referral to treatment target

<b>Percentage of patients treated within 18 weeks of referral</b> (This shows the percentage of patients who received the relevant treatment required within 18 weeks of the original referral)				
	2009/10	2010/11	2011/12	2012/13
Mid Staffordshire NHS Foundation Trust	95.6%	96.5%	85.0%	86.2%
Peer group average	91.1%	90.8%	88.9%	92.3%
National average	91.4%	91.8%	90.5%	89.0%
Burton Hospitals NHS Foundation Trust	94.9%	94.2%	90.1%	89.1%
Shrewsbury and Telford Hospitals NHS Trust	90.6%	86.9%	69.1%	81.2%
The Royal Wolverhampton NHS Trust	92.1%	95.8%	94.4%	92.9%
University Hospital of North Staffordshire NHS Trust	88.3%	88.3%	89.3%	92.9%
Walsall Healthcare NHS Trust	92.6%	93.2%	93.5%	92.2%

Table 14: Summary of performance for the MRSA rates

MRSA bacteraemia rate (This indicator summarises how many MRSA infections were acquired by patients whilst an inpatient in an acute trust – expressed as the number of patients affected per 100,000 bed days)				
	2009/10	2010/11	2011/12	2012/13
Mid Staffordshire NHS Foundation Trust	1.5	1.5	1.5	0
Peer group average	3.1	2.2	1.0	1.1
National average	2.7	1.9	1.3	1.2
Burton Hospitals NHS Foundation Trust	5.9	0	0.8	0.7
Shrewsbury and Telford Hospital NHS Trust	2.2	0.7	0.4	0.4
The Royal Wolverhampton Hospitals NHS Trust	0.9	0	0	0.4
University Hospital of North Staffordshire NHS Trust	2.9	6.1	1.7	0.0
Walsall Hospitals NHS Trust	1.7	4.2	0	2.0

Table 15: Summary of performance for C.diff rates

C.diff rate (This indicator summarises how many Clostridium difficile (C.diff) infections were acquired by patients over the age of 65 whilst an inpatient in an acute trust – expressed as the number of patients affected per 100,000 bed days) NB: C.diff rates for 2012/13 published at time these statistic swere collated				
	2009/10	2010/11	2011/12	2012/13
Mid Staffordshire NHS Foundation Trust	105.4	80.5	80.5	-
Peer group average	93.2	72.0	70.2	-
National average	90.8	77.5	64.2	-
Burton Hospitals NHS Foundation Trust	89.9	59.3	69.7	-
Shrewsbury and Telford Hospital NHS Trust	80.7	71.4	52.2	-
The Royal Wolverhampton Hospitals NHS Trust	96.5	84.8	104.2	-
University Hospital of North Staffordshire NHS Trust	154.3	118.9	59	-
Walsall Hospitals NHS Trust	73.5	116	97.4	-

257. Since the publication of the TSAs' draft report, there has been extensive national coverage with regards to the use of various indicators of hospital mortality rates. The TSAs included the mortality rates for MSFT and other hospitals in its draft report; this was for information only. Given the continuing debate around mortality rates, the TSAs have conducted no further analysis on these indicators and they have not been included in this report.
258. Whilst acknowledging the improved performance of the Trust and commending the staff, it should be noted that a range of acutely sick patients are not treated at MSFT (notably a large cohort of patients with the signs and symptoms of cardiac and stroke conditions). As such, some of the performance measures for the Trust can be misleading when used in comparison with other trusts.

## 5.2 Recent financial performance

259. The Trust has had an underlying financial deficit since 2008 and at the end of the last financial year (April 2012 – March 2013), the deficit reported was £14.7m.
260. During this period the Trust delivered Cost Improvement Plans (CIPs) equating to £10.4m, which is equivalent to 6% of expenditure (£172m). The end of year position is set out in Table 16.
261. MSFT received £21m of subsidy funding, over and above activity related income, from the Department of Health in FY12 and a further £21.3m in FY13. Without these funds the Trust would have been unable to pay its staff and suppliers.

Table 16: A summary of financial performance for the period FY08 – FY13

Currency: £'000	FY08	FY09	FY10	FY11*	FY12	FY13
Recurrent Income	136,314	144,929	147,402	151,756	152,239	153,948
Recurrent Expenditure	(135,430)	(142,914)	(156,650)	(167,468)	(171,659)	(172,229)
<b>Underlying Surplus / (Deficit)</b>	<b>884</b>	<b>2,015</b>	<b>(9,248)</b>	<b>(15,712)</b>	<b>(19,420)</b>	<b>(18,281)</b>
<i>Non Recurrent Income:</i>						
Strategic Change Reserve	-	-	4,500	6,075	2,433	4,500
Other	-	-	-	-	783	465
Non Recurrent Expenditure	-	-	-	(4,330)	(3,707)	(1,424)
<b>Reported Surplus / (Deficit)</b>	<b>884</b>	<b>2,015</b>	<b>(4,748)</b>	<b>(13,967)</b>	<b>(19,911)</b>	<b>(14,740)</b>
Cash Balance	3,725	7,575	10,012	1,361	455	501
Cash Support Received	-	-	-	-	21,000	21,385
Trade Payables	12,765	9,102	16,140	18,545	14,711	15,289
Trade Receivables	5,568	5,721	7,792	5,680	5,804	7,171

\* FY11 Reported in year deficit differs by ca. £106,000 to MSFT's I&E accounts

Sources: Annual report and accounts 09-10, Final Accounts 2007/08, Annual report accounts 10-11, MSFT annual report & accounts 2011-12; Internal ledger and accounts 2012/13.



- 262. When the CPT conducted their review, the Trust was forecasting a year end deficit (in March 2013) of £15.0m. The Trust's final deficit reported at year end was £14.7m.
- 263. This final position included £4.5m of income from the Primary Care Trust from their Strategic Change Reserve (SCR). Following the transition of commissioning to the local CCGs in April 2013, SCR funding will no longer be available. Taking this, and other minor factors into account, the TSAs are forecasting that the deficit at the end of the current financial year (March 2014) will be ca. £20.2m. This is summarised in Section 14 and Annex 3.4.
- 264. The Trust is ahead of budget in the current year. It has reported an accrued deficit of £9.97m at the end of Month 7 (October 2013) compared to an expected deficit of £12.5m. The primary reasons for this are: a) the level of income the Trust has received is higher than budgeted for as a result of increased levels of clinical activity; and b) the delivery of their Cost Improvement Plan (CIP) programme is £791k ahead of plan at Month 7. The Trust and the TSAs are not revising their forecast deficit position at this point in time as more evidence is needed to demonstrate that this improvement will be sustained over the remainder of the year, particularly during the challenging winter period and in light of recent staff retention issues.



## 6 The case for change

265. This section outlines the reason why changes to the current model for delivering healthcare services are absolutely necessary. It summarises the key conclusions from the CPT's assessment of MSFT sustainability<sup>25</sup> and builds upon these conclusions to set out why change is needed at MSFT and across the Local Health Economy. It also highlights the consequences of not delivering change in the way services are currently delivered.

### 6.1 The CPT's assessment of MSFT sustainability

266. The CPT concluded that MSFT, in its current form, was neither clinically nor financially sustainable. This conclusion was widely accepted and the TSAs were appointed on the basis of the CPT's analysis and conclusions with regards to sustainability.

267. The CPT's specific conclusions with regards to the sustainability of the Trust were:

- The Trust's clinical performance is currently sound, and against some measures it is performing very well;
- It is achieving this performance at an average cost that is significantly higher than most other trusts in the country – this has caused the Trust to operate with a significant financial deficit since 2009;
- The major factors behind this financial deficit are:
  - the investment in additional staff to address the clinical issues of the past, whilst at the same time income has significantly reduced due to a reduction in patient spells;
  - incurring the costs of running two 'district general hospitals' whilst receiving a level of income typically associated with a small hospital trust operating a single site; and
  - using a high volume of temporary staff, which incurs a higher cost than permanently contracted staff.
- The Trust has experienced recruitment and retention issues, due to a combination of factors: national shortages in some clinical specialties; the preference of clinical staff to work in large hospitals; and reputational issues;

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<sup>25</sup> Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust – Assessment of Sustainability, January 2013.



- Despite investing in additional clinical staff, the Trust is currently operating some clinical services (notably A&E, emergency surgery and paediatric services) with consultant numbers that are significantly below Royal College guidelines;
- This is largely due to the fact that MSFT is one of the smallest trusts in the country and activity levels do not justify an increase in consultant levels – even if funding were available – because there would be insufficient patients treated to maintain the essential clinical skills of the workforce; and
- If the Trust were to deliver cost savings to bring it in line with the average cost of delivery of NHS services, it would undoubtedly adversely affect clinical outcomes.

268. For these reasons the Trust has been deemed neither clinically nor financially sustainable. Further detail on clinical and financial sustainability is provided below.
269. It is important to understand that the conclusion around sustainability is an assessment of MSFT, as the current provider of services in Stafford and Cannock. It does not mean that services cannot be delivered in a sustainable manner in Stafford and/or Cannock and it has therefore been the TSAs' responsibility to:
- determine how the LSS - see Section 7) can be delivered in Stafford/Cannock on a sustainable basis;
  - assess whether any additional services can be delivered alongside the LSS in Stafford/Cannock on a sustainable basis; and
  - determine how those services that cannot be delivered on a sustainable basis in Stafford/Cannock can be delivered on a sustainable basis in other locations, without creating health inequalities for the populations of Stafford or Cannock.

## **6.2 Why MSFT is not clinically sustainable**

270. As previously noted, the Trust's recent performance has improved in the last 12-24 months. However, there is a clear distinction between current performance levels (the 'here and now') and the question of clinical sustainability (the medium to long term delivery of clinical services). In determining that the Trust is not sustainable, it is not a judgement on the current staff and how they are delivering services, it is an assessment on whether the Trust is likely to be able to deliver acceptable levels of care into the future.
271. The core factors in assessing the Trust's clinical sustainability are: the scale of services and the consultant levels in key specialties in comparison to Royal College guidelines, now and into the future; and, the ability for the Trust to recruit and retain sufficient levels of appropriately skilled staff.

272. The TSAs have chosen to use the guidelines from the Royal Colleges because they are the most appropriate and most widely recognised standards to use when benchmarking current clinical standards in the NHS. The Royal Colleges also take on responsibility for looking at the direction of travel for healthcare provision in the UK – a key factor in the TSAs’ decision making. In doing so, there is an emphasis on how medical staff can manage the appropriate number of patients in order to maintain and develop their skills.
273. The TSAs acknowledge that their conclusions could be taken and applied to other healthcare providers in the UK. It is not within the remit of the TSAs to comment on, or to draw general conclusions that can be applied to, other healthcare providers.

### Trust scale and patient volumes

274. MSFT is a small trust. With regards to patient activity, the analysis undertaken by the CPT in December 2012 noted that:

*“In all services, the volume of activity at MSFT is below the national average and it is evident that, in some services MSFT is one of the smallest trusts in the country:*

- *For maternity births, MSFT ranks 135th out of 148 services in England.*
- *For A&E attendances, MSFT ranks 132nd out of 150 services in England.*
- *For non-elective (emergency) surgical spells, MSFT ranks 133rd out of 166 services in England.*
- *For paediatric spells over 1 day, MSFT ranks 116th out of 167 services in England.”*

275. Furthermore, the levels of patient activity have been dropping since 2008/09 as patients choose to be treated at other hospitals – as previously shown in Section 2.2 and repeated in Table 17.

Table 17: First attendances at MSFT hospitals for the period 2008/09 – 2012/13

	2008-09	2009-10	2010-11	2011-12	2012-13
<b>Total first attendances</b>	<b>146,803</b>	<b>138,706</b>	<b>140,540</b>	<b>141,381</b>	<b>133,514</b>
+/- change (year on year)	-	-5.5%	1.3%	0.6%	-5.6%
+/- change (from 08/09)	-	-5.8%	-4.3%	-3.7%	-9.1%

Source: Trust data

276. This reduction in patient first attendances has had a consequent impact on the assessed catchment population for MSFT – that being the population of people who choose to use MSFT (as distinctly different to the population of the catchment area). As noted in Section 4 and Appendix E, PHS has estimated that the **catchment**



**population** for MSFT is ca. 204,400 and this has reduced since 2009 due to the reducing volume of patient referrals.

277. The Royal College of Surgeons have previously produced guidelines that a population of 450,000 – 500,000 would be an appropriate catchment population for “an acute general hospital that provides the full range of facilities for both elective and emergency medical and surgical care” and that the minimum catchment population should be 300,000<sup>26</sup>. Neither the PHS estimation nor the Trust’s stated population (276,500) fall within these guidelines.
278. The TSAs are aware that the local population is forecast to increase:
  - New housing developments are being planned for Stafford. Stafford Borough Council has given permission for 2,911 new dwellings to be built within Stafford over the next six years. This is consistent with the stated planning provision of up to 500 new dwellings per year<sup>27</sup>; and
  - There is a planned relocation of some of the UK armed forces based in Germany by the end of 2015. From the TSAs’ discussions with the MoD, the current estimates are that an additional 1,040 troops and ca. 420 families will be relocated to MoD Stafford. Whilst this is not likely to include many older people – the largest users of acute hospital services – it may increase the number of births in the area.
279. The independent HEIA report has assessed the impact that these two factors will have on the number of additional births in the catchment area. Their assessment is that the estimated number of births in 2018 will be between 82 to 136 per year (the full HEIA report is included as Volume 4 of this report).
280. If the trend for reducing new attendances into MSFT were to be halted and reversed, and taking into account the predicted growth in local population, then it is possible that the catchment population may increase to nearer 300,000 over the next ten years, but, working on the basis of the PHS assessment of catchment population, it would still be significantly below the preferred population size recommended for a full scale acute general hospital by Royal College of Surgeons’ guidelines.

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<sup>26</sup> This was originally stated in ‘Provision of Acute General Hospital Services, Royal College of Surgeons of England, 1998’; but has subsequently been restated in other reports including ‘Delivering High Quality Surgical Services for the Future, the Royal College of Surgeons, 2006’.

<sup>27</sup> <http://www.staffordbc.gov.uk/the-plan-for-stafford-borough>

## Consultant levels

281. What this means in practice is that small hospitals, such as MSFT, face challenges in deploying the appropriate number of consultants in key specialties to ensure there is the appropriate consultant presence. This is particularly true for acute specialties such as A&E, emergency surgery, paediatrics and obstetrics where consultant presence is required at short notice any time of the day or week.
282. MSFT does not meet the relevant Royal College standards for the number of consultants required to deliver twenty four hour, seven days a week cover across a number of services, as shown in Table 18.

Table 18: Consultant levels at MSFT in selected specialties

Speciality	Recommended min consultant levels for 24/7 rota	Current level of consultant resources at MSFT	Source for guidelines
Paediatrics	10 WTE	5 WTE	Facing the Future: Standards of paediatric services (2011) – Royal College of Paediatrics and Child Health
A&E	10 WTE	6 WTE (14/7 service): 2 are substantive to MSFT with the remaining WTE a combination of UHNS consultants and locums	Emergency Medicine Taskforce - Interim Report (Dec 2012) – The College of Emergency Medicine
Emergency Surgery	10 WTE – for a 16/7 rota	8.4 (includes 2 x consultants who are on the UHNS vascular rota)	Emergency standards for Unscheduled Surgical Care (2011) – The Royal College of Surgeons of England

Source: MSFT establishment data as at October 2013

283. Consultants need to manage a regular and reasonable volume of casework in order to develop/maintain core skills, specialist skills, and in some cases professional accreditation. If the number of consultants were increased in these specialties, assuming funding were available, then given the volume of patients being treated, it is likely that these consultants would not be treating enough patients to maintain their skills.



### Recruitment and retention

284. MSFT faces a challenge in recruitment and retention. This is primarily due to national shortages of consultants in certain specialties meaning there are more positions available in some specialties than there are available consultants.
285. In addition, the CPT noted that MSFT is often seen as a less attractive employer, due to it being a small trust with low patient volumes and with historic and well publicised reputational issues. It is evident that the ongoing uncertainty with regards to the Trust over the last 18-24 months has also impacted retention levels within the Trust. This is evident from the high levels of spend on temporary staff.
286. The leadership of MSFT recognised some of these challenges over the last two to three years and took steps to mitigate the impact, notably for non-elective and specialist care, through:
- The overnight closure of A&E due to insufficient consultant cover to enable a safe 24/7 service and the recently announced agreement to deploy UHNS consultants in Stafford's A&E;
  - The cessation of treatment for patients: with cardiac or stroke signs or symptoms; or, who have suffered a major trauma. These patients are now treated at UHNS or RWT. It is current practice, where the West Midlands Ambulance Service are called to attend patients with such symptoms they take these patients directly to either UHNS or RWT; and
  - The establishment of a clinical network with UHNS to deliver some services, e.g. vascular surgery.

### 6.3 Why MSFT is not financially sustainable

287. MSFT has been operating at a financial deficit since 2009. The level of the deficit reported in April 2013 is £14.7m. The deficit is expected to deteriorate in the current financial year due to the withdrawal of the local commissioners 'Strategic Change Reserve' which provided MSFT with £4.5m of non-activity related income in 2012/13.
288. In order to continue operating (i.e. paying staff and suppliers), the DH has had to provide £21m of additional funding to MSFT in FY13. A similar subsidy was provided by DH in FY12. Without this ongoing funding from DH, MSFT would be insolvent.
289. Put into simple terms it costs approximately £15-21m more per year to operate MSFT than it receives in income. Either costs are too high, or income is insufficient – or both.

## Tariff payments

290. The primary source of income is associated with payments for treating patients. Providers of NHS services are paid a tariff for the patients they treat. These tariffs are set nationally and are based upon an assessment of the average cost to deliver each specific treatment. Inevitably, providers that consistently deliver the majority of their services at above the average national cost are likely to be in a position where the tariff does not cover the cost of delivery. Local commissioners have the discretion to modify some tariffs, but they are obliged to do this in the context of a fixed budget. Therefore, if they agree to pay above tariff for one or more specific services, there is a reduced budget available to pay for other services. In the context of MSFT, the two local CCGs are in deficit and have stated and reiterated that they are not in a position to pay above tariff for the delivery of acute based services (see CCG letters, dated 30 September 2013, in response to the consultation – Appendix D).
291. The DH has used the tariff system to try and influence changes to working practices in order to reduce the number of emergency admissions:
- In the ‘Payment by Results’ guidance for 2010/11<sup>28</sup> - the payment for emergency admissions which exceeded 2008/09 levels was reduced to *“provide an added incentive for closer working between providers and commissioners, to support the shift of care out of hospital settings and keep the number of emergency admissions to a minimum.”*
  - In the ‘Payment by Results’ guidance for 2011/12 - the payment for emergency readmissions within 30 days of discharge was removed to *“ensure that hospitals are responsible for patients for the 30 days after discharge.”*
292. However, MSFT does not have comparatively high level of emergency admissions and they have not exceeded 2008/09 levels, so these ‘incentives’ will not be the cause of the financial issues at the Trust.
293. It should be noted that in NHS England’s response to the consultation (Appendix B) they stated that they would not support tariff adjustments as *‘there is no apparent justification for what would effectively be a permanent subsidy’*.

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<sup>28</sup> The Department of Health’s tariff framework.

## Trust expenditure

294. Setting aside the question of tariff payments, it is evident that the primary cause of the financial challenges at the Trust is that their costs are too high.

295. The CPT noted:

*“Following the initial investment in nursing the Trust further increased the number of substantive and temporary nursing posts in both FY11 and FY12 in response to the Healthcare Commission report and the absence of a fully recruited nursing workforce to staff the rotas. Additional investment in Medical and Administrative staff was also funded...After the substantial increases in costs the Trust recorded a Reference Cost Index (RCI) for FY11 and FY12 of 1.15 and 1.18 respectively, indicating that the costs of delivering services are significantly higher for the Trust than other NHS organisations.”*

296. The RCI is a comparative measure of the cost of delivering healthcare services in acute hospitals. An RCI of 1.18 in FY12<sup>29</sup> indicates that on average it costs MSFT 18% more per patient treated than the average cost in the NHS in England. Clearly if costs could be safely reduced by 18%, then MSFT’s costs would be less than £150m and significantly below the income it receives.

297. The CPT’s aim was to try to identify a course of action that could enable MSFT to break even after five years. In their assessment, there were no major transformation options within the gift of the Trust that would solve a substantial element of the financial deficit. The most obvious option was to consider closing one of the two hospital sites, but the CPT concluded:

*“...that closure of the Cannock site is not within the immediate gift of the MSFT Board, therefore alternative use of the site and the receipt of additional rental income is the main opportunity available.”*

298. Therefore, the CPT determined that the only way that MSFT could deliver a break even position in five years – as a standalone organisation and delivering the current range of services – would be to embark on a large scale cost reduction programme. This programme would need to deliver in excess of 7% savings each year for the next five years. At the same time the Trust would need subsidising by DH at a cost of at least £70m to cover the deficit during this period.

299. However, there is no evidence that demonstrates any NHS provider in the UK has delivered such a level of cost reductions over a five year period. The CPT concluded, and the TSAs agree, that if any attempt was made to do so, **it would have a**

<sup>29</sup> The RCI for FY13 will be published later in the current financial year.

**significant and detrimental impact on front line services and clinical outcomes.** As such, the TSAs do not currently believe it is an appropriate course of action.

### Financial issues in comparison with other NHS acute providers

300. Other Foundation Trusts and NHS Trusts are also experiencing financial difficulties, but the issue at MSFT is more significant than at almost all other trusts.
- **NHS Trusts:** In October 2013, the NHS Trust Development Agency (TDA) published a report<sup>30</sup> that stated that 30 acute NHS trusts were forecasting a financial deficit at the end of the current financial year.
  - **Foundation Trusts:** In June 2013, Monitor reported that 16 acute Foundation Trusts were forecasting a financial deficit for the current financial year<sup>31</sup>.
301. Although the absolute level of the deficit for MSFT is lower than many of these other trusts, when it is taken as a proportion of total income it is higher than virtually all other trusts. This is shown in Table 19 and demonstrates that fully addressing the deficit will be harder at MSFT than at most other trusts.

Table 19: Comparing MSFT with other trusts with a forecast deficit for the end of the current financial year

Trust	Forecast deficit by March 2014	Forecast deficit as % of turnover
Peterborough and Stamford NHS Foundation Trust	See note	ca. 17%
University Hospitals of Morecambe Bay NHS Foundation Trust	See note	ca. 13%
<b>Mid Staffordshire NHS Foundation Trust</b>	<b>£20.2m</b>	<b>12.9%</b>
Milton Keynes Hospital NHS Foundation Trust	See note	ca. 11.8%
Princess Alexandra Hospital NHS Trust, Harlow	£16.6m	9%
Sherwood Forest Hospitals NHS Foundation Trust	See note	ca. 9%
Mid Essex Hospital Services NHS Trust	£19.5m	7.1%
University Hospital of North Staffordshire NHS Trust	£31.4m	6.7%
George Eliot Hospital NHS Trust, Nuneaton	£7.9m	6.5%
Wye Valley NHS Trust, Hereford	£9.1m	5.5%
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	See note	ca. 5.4%
North West London Hospitals NHS Trust	£20.3m	5.3%
South London Healthcare NHS Trust	£24.1m	5.1%
Weston Area Health NHS Trust, Weston-super-Mare	£5.0m	5.1%
East Sussex Healthcare NHS Trust	£19.3m	5%
<i>21 further NHS Trusts and 10 further Foundations Trusts have a forecast deficit of 5% or less</i>		

Sources: TDA and Monitor reports (see footnotes)

Note: The absolute forecast deficit of these foundations trusts has not been published. The figure presented as the 'Forecast deficit as a % turnover' is based upon reading from charts published by Monitor.

<sup>30</sup> [http://www.ntda.nhs.uk/wp-content/uploads/2013/09/NTDA\\_summer\\_report\\_FINAL.pdf](http://www.ntda.nhs.uk/wp-content/uploads/2013/09/NTDA_summer_report_FINAL.pdf)

<sup>31</sup> <http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/reports-nhs-foundation-trusts/nhs-fou-20>



#### **6.4 Change is required across the Local Health Economy**

302. The remit for the TSAs is to propose a plan that ensures the services currently delivered by MSFT can be delivered into the future in a sustainable manner. The TSAs have not put forward any recommendations with regards to other providers in the Local Health Economy or indeed recommendations that would change how existing services are delivered within or across other organisations. Although the local CCGs wish to explore changes across secondary, community and social care (see the CCG response to the consultation – Appendix D) changes of this nature are beyond the scope of the TSA process for MSFT.
303. However, it is evident that delivering sustainable services will require cooperation with local providers. This presents a challenge to the TSAs because there is not one single provider in the Local Health Economy that is not experiencing challenges of its own. Section 8 presents an overview of the local providers and outlines these issues. These issues have been widely reported and the local population of Stafford and Cannock are very aware of them.
304. One immediate challenge is that there is currently little available capacity at any of these providers to be able to deliver some of the services that may no longer be delivered in Stafford or Cannock. This lack of capacity differs between providers and by services, but regardless, it is inconceivable that changes could be made to MSFT services without:
- increasing the capacity for certain services at one or more of the other local providers; and/or
  - reducing the demand being placed upon acute services across the Local Health Economy; and/or
  - reconfiguring the way in which services are delivered across the Local Health Economy.
305. The TSAs have been in regular contact with the leaders of the local providers and commissioners. The TSAs are confident that all parties recognise the challenges in their own organisation and the Local Health Economy overall and are determined to address these issues in order to strengthen the Local Health Economy.



## **6.5 What are the consequences of doing nothing?**

306. MSFT as an NHS provider is not sustainable. If nothing is done to address the clinical and financial issues in a planned programme of transformation, it is inevitable that the Trust will need to make piecemeal changes in order to address clinical safety issues and reduce costs. The potential consequences of 'doing nothing' are likely to include some or all of the following. It should be noted that this is not an exhaustive list and is based upon a reasonable assessment of the challenges that MSFT faces.
- Despite commissioner expectations that services are retained in Stafford and Cannock, MSFT may need to close one of the two hospitals. This alone would not address the financial challenges the Trust faces, but would deliver a reduction in operating costs.
  - Some acute services are likely to continue to operate at significantly below the recommended levels of consultant cover. It is therefore likely that these services would need to reduce the level of service offered, or implement changes to how the service is staffed. The recent announcement of the deployment of UHNS consultants in the A&E at Stafford is an example of where change has already become necessary.
  - Low volume services may need to be decommissioned as the patient volumes will make the service unviable. This would mean that patients would need to travel to receive all elements of this service – including outpatient appointments.
  - Cost improvements would still need to be delivered. Savings of the levels required by MSFT to break even (ca. 7%) would certainly impact front line services, although the changes outlined above would deliver some cost improvements.
  - Any unplanned or piecemeal changes to the services in Stafford would mean a drift of patient activity to other providers in the Local Health Economy – some of whom are having capacity issues.
  - Funding from local commissioners and the Department of Health would need to be provided to ensure the Trust remains solvent. These funds come from a finite CCG/NHS budget, which means that other services would need to be rationalised in order to generate these funds.
  - The Trust would not have funds available to invest in much needed capital/estate improvements, the latest medical technologies or medicines.
307. Some of these potential outcomes would be triggered due to the need to make savings. If the current level of subsidy (ca. £20m per annum) were made available to





the Trust indefinitely then some of these outcomes are less likely. However, the Trust would still:

- operate a number of critical services with staffing levels significantly below Royal College guidelines;
- have the same challenges around recruitment and retention of staff; and
- be understaffed in certain specialties.

308. The TSAs do not propose that any of these outcomes are desirable, rather that the programme of transformation set out in this report is the safest and most assured way in which the population of Stafford and Cannock can access high quality, safe and sustainable services for the foreseeable future.

## **6.6 Change must be delivered as quickly as possible**

309. The recommendations made by the TSAs are complex and will require the cooperation of many organisations. Consequently these recommendations will take a reasonable period of time to implement.

310. The uncertainty about the future of services in Stafford and Cannock has been challenging for the staff and has exacerbated the recruitment and retention issues previously highlighted. In 2013, a number of staff have left, or have indicated they are planning to leave, the Trust and the vacancy levels at the Trust are higher than at any time in the last two years. This includes vacancies for senior clinical staff within critical areas of the Trusts (such as A&E) and the impending departure of three of the Executive Directors.

311. Whilst this issue of staff shortages in key specialities is not unique to MSFT - as noted there is a national shortage of qualified staff in certain clinical areas – but it is far more pronounced at MSFT given its particular circumstances and has become more acute in the last six months with increasing reliance on agency nurses and locum consultants. The Trust has had to approach UHNS to provide additional temporary consultant cover in its A&E in order to operate a safe, albeit 14 hours a day, service. It is likely that additional measures will need to be put in place in the near future to address other staff shortages within the Trust.

312. It is therefore essential that action is taken quickly to ensure the ongoing stability of service delivery in Stafford and Cannock. Failure to do so presents a genuine risk that services will be adversely affected. This will, in turn, impact other providers in the Local Health Economy.



313. The TSAs recognise the desire of the local commissioners to develop more far reaching proposals for the Local Health Economy over time. However, the TSAs feel compelled to highlight the urgency of the need for a clear way forward for the staff of MSFT, and the patients who use the services at Stafford and Cannock Chase Hospitals. The staff and particularly the executive and senior team at the Trust, have repeatedly expressed to the TSAs their real concerns that if any change is deferred for a significant period, the potential consequences outlined in the previous section ('do nothing') could rapidly become a reality.
314. It is therefore essential that changes are clearly communicated, thoroughly planned and are executed as quickly as possible.

## 7 Commissioning in the Local Health Economy

315. Commissioning across the NHS has undergone a significant change in the last 1-2 years. The traditional commissioning bodies (Primary Care Trusts and Specialised Commissioning Groups) have been replaced by local CCGs and the regional 'Local Area Teams' who work under the strategic direction of NHS England. These new commissioning bodies took over responsibility for commissioning healthcare services in April 2013.
316. The TSAs and the CPT before them have been working closely with local CCGs (primarily Stafford and Surrounds and Cannock Chase CCGs) and this section presents a high level outline of:
- an overview of the local commissioners;
  - their current commissioning intentions;
  - the need to commission affordable healthcare;
  - and the steps the CCGs are taking to reduce the demands being placed in secondary care providers; and
  - the finalisation of LSS.

### 7.1 Commissioners in the Local Health Economy

317. Stafford and Surrounds and Cannock Chase CCGs commission services for a registered population of 276,500<sup>32</sup> and for a large proportion of this population (estimated by PHS to be ca. 204,400) their main acute provider is MSFT. Indeed ca. 95% of GP referrals to MSFT are from referrals within the Stafford and Cannock CCG catchment areas.
318. GPs within these two CCGs made over 40,000 new referrals to MSFT in 2012/13 and whilst the volume of referrals reduced during the period 2009/10-2011/12 from the 2008/09 levels, the referral numbers (from local GPs) in 2012/13 are almost back to 2008/09 levels (see Table 20). However – as noted in Section 4 – total first attendances at MSFT are 10% lower than 2008/09 levels (first attendances also comprise A&E attendances and hospital consultant referrals).

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<sup>32</sup> NB: As per Section 2.2, this is distinctly different to the catchment population for MSFT.

Table 20: MSFT referrals from local CCGs

Year	2008/09	2009/10	2010/11	2011/12	2012/13
Stafford and Surrounds CCG new referrals	20,476	19,273	18,939	18,033	20,889
Cannock Chase CCG new referrals	20,497	19,099	18,624	19,061	19,812

Source: CCGs. South Staffordshire PCT referrals data has been used to estimate referrals numbers prior to the formation of the CCGs

319. Stafford and Surrounds CCG and Cannock Chase CCG are committed to ensuring that services are delivered as locally as possible and centralised where necessary in order to ensure that the local population receives the highest possible standards of care. This is reiterated in their letters to the TSAs that give their support to the draft recommendations that were put forward for consultation (dated 22 and 24 July 2013 - see Appendix D).
320. The CCGs accept that the scope, style and scale of these services may be significantly different in the future and they also understand and support the need for local health services to be both clinically and financially sustainable. On this basis, the CCGs have acknowledged that the services currently delivered by MSFT will need to change and this means that some services may need to shift away from Stafford and/or Cannock.
321. In their response to the consultation, both local CCGs stated that they would wish to see further work undertaken before they can make long term commissioning decisions (their full response is included in their letters dated 30 September which are included in Appendix D).
322. This additional work is in the context that the CCGs are not prepared to take responsibility for any ongoing deficit and believe these actions will support a move to improved financial stability.

## 7.2 Commissioning intentions (provided by CCGs)

323. Both CCGs have developed clear commissioning intentions with regards to service provision for their resident population in the future; each CCG has developed a number of goals to underpin its commissioning intentions. These goals set the direction of travel for future service provision which signals a significant shift in activities from acute to self-care, primary care and community services.

324. Each CCG was sent a data benchmarking pack by the DH when they were authorised in April 2013. The information in these packs indicates that the two CCGs have higher levels of acute activity than the national average, as summarised in Table 21.

Table 21: Admission rates for MSFT vs. national average

CCG	Non-elective admission rates (per 1,000 population)		Elective admission rates (per 1,000 populations)	
	CCG rate	National average rate	CCG rate	National average rate
Stafford and Surrounds	117	111	138	123
Cannock Chase	122	111	133	123

Source: CCG benchmarking data, Department of Health

325. The CCGs are clear that it is critical for the CCGs that they identify mechanisms for reducing the admission rates at MSFT.
326. The CCGs have a particular focus on patients who have ambulatory care sensitive conditions, where evidence<sup>33</sup> indicates that patients with these conditions can and should be managed outside of acute hospitals.
327. Future services need to be clinically safe and affordable and be tailored to meet specific population needs. Therefore, the CCGs expect beds at Stafford and Cannock to be particularly focused on provision for the frail elderly and that in the future many more people with chronic conditions should be managed in Primary Care and Community Services, with admissions to hospital for this group being the exception rather than the rule.
328. The commissioner aspirations are for a more integrated provider landscape which reduces service fragmentation and care pathways spread across multiple organisations, ultimately reducing acute interventions as a consequence of a failing system of care. More specifically, commissioners wish to ensure that:
- Emergency and Urgent Care is adequate to meet most population needs whilst being safe and affordable (this includes enhancing the provision of minor injuries at Cannock, which would have been designated as a location specific service had the service been provided by MSFT);
  - Planned care pathways are robust enough to safely manage patients effectively in Primary Care for longer through the use of new interventions; and
  - The provision of new services using technological advances in healthcare is maximised.

<sup>33</sup> Source: NHS Institute: The Directory of Ambulatory and Emergency Care for Adults.



329. The commissioning prospectus for each CCG is included in Annex 3.1 and the detailed CCGs commissioning intentions can be found at:  
[www.cannockchaseccg.nhs.uk](http://www.cannockchaseccg.nhs.uk) and [www.staffordsurroundsccg.nhs.uk](http://www.staffordsurroundsccg.nhs.uk).

### **7.3 Affordability of commissioned services**

330. The primary responsibility for CCGs is to commission a broad range of high quality, safe services to meet the healthcare needs of their local population.
331. In achieving this objective, CCGs are going to be measured against a broad set of outcomes, which are aggregated under five headings<sup>34</sup>:
- Preventing people from dying prematurely;
  - Enhancing quality of life for people with long term conditions;
  - Helping people to recover from episodes of ill health or following injury;
  - Ensuring that people have a positive experience of care; and
  - Treating and caring for people in a safe environment and protecting them from avoidable harm.
332. These measures are all – quite rightly – quality indicators, rather than financial indicators. However, CCGs operate with finite financial resources and commission healthcare services from multiple healthcare providers, including those delivering secondary (acute) care, mental healthcare and community care.
333. It is the responsibility of CCGs to ensure that these financial resources are used to deliver the highest positive impact for the local population. Spending money on financially inefficient services deprives other parts of the Local Health Economy from funding, funding which – in the CCGs’ assessment – may be more effective at meeting their commissioning outcomes.

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<sup>34</sup> Source: The CCGs outcomes indicator set 2013/14 – NHS England.

334. Table 22 outlines the broad split of how the two CCGs spend their budgets.

Table 22: Allocation of CCG funds

CCG	Primary areas of spend					
	Acute / hospital care	Community services	Mental health	Prescribing / drugs	Out of hospital care / CHC	Ambulance services
Stafford & Surrounds	59%	7%	9%	15%	7%	3%
Cannock Chase	54%	10%	9%	15%	8%	3%

Source: CCG prospectus

335. The CCGs are currently exploring different procurement mechanisms to improve the affordability of services. In their response to the consultation they stated: *'The CCG as the responsible commissioner would wish to commission and procure services which are financially affordable through working differently with providers on costing and risk sharing which is reflected in contracts with those providers. The option appraisal work which defines the procurement strategy is underway'.*

## 7.4 Managing the demand for acute services

336. Demand for healthcare services is rising and putting many parts of the healthcare system under increasing pressure. Initiatives that seek to reduce demand for acute hospital services are typically known as 'demand management' initiatives. The CCGs expect to work with their local providers on demand management initiatives in order to:
- Reduce the volume of patients that need healthcare interventions;
  - Reduce the volume of patients that are referred to or self-present at acute hospitals; and
  - Reduce the volume of patients that re-attend acute hospitals for further treatment (whether through readmissions or through excess follow-up appointments).
337. In 2013/14, the CCGs have established plans to deliver a range of demand management targets:
- Outpatients – both CCGs are aiming to reduce first outpatient appointments by 5%, through improvements in care pathways and better GP to consultant communications;



- Elective admissions – both CCGs are aiming to reduce elective admissions (Stafford and Surrounds CCG: 2%; Cannock Chase CCG: 5%), through improvements in care pathways leading to more treatment out of hospital;
- A&E attendances – both CCGs are aiming to reduce A&E attendances by 6%, through changes in health/social care interface, roll out of case management for patients with long term conditions and targeted support to nursing homes; and
- Non-elective admissions – both CCGs are aiming to reduce emergency admissions by 6%, as a consequence of reducing A&E attendances (as above).

## 7.5 Location Specific Services (LSS)

338. The Failure Regime for Unsustainable NHS Providers, as set out in Chapter 5A of the National Health Service Act 2006 ('the failure regime'), is intended to ensure the continued provision of health services in the event that a healthcare provider fails.
339. As part of this regime, one of the obligations of the CPT was to support local CCGs as they draft a list of 'protected services'. The process undertaken aligned with Monitor's draft guidance on "Ensuring continuity of health services and designating Commissioner Requested Services and Protected Services".
340. This guidance was finalised in 2013, with some minor modifications to the process and the language – notably the change in terminology to LSS<sup>35</sup>.
341. LSS are those services which, if withdrawn, and in the absence of alternative local provision, the CCGs determine would be likely to lead to:
- a significant adverse impact on the health of persons in need of the service or significantly increase health inequalities; or
  - a failure to prevent or ameliorate either a significant adverse impact on the health of such persons or a significant increase in health inequalities.
342. The guidance sets out that, during the first phase of the TSA process<sup>36</sup>, CCGs are required to reconsider their draft LSS and formally sign off the list of LSS that they wish the TSAs to take into account during their work.
343. The TSAs were expected to only consider options for changes in services that, at a minimum, provide for the continued provision of LSS for up to ten years following the cessation of their appointment<sup>37</sup>. All options should ensure that the provision of such services satisfies the principles of effectiveness, efficiency and economy.

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<sup>35</sup> <http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-19>

<sup>36</sup> Where an extension is granted, as it was in this instance, this would be within 75 working days.

<sup>37</sup> Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts, Monitor, April 2013



344. The TSAs' obligations are to explore how the services included, by the CCGs, in the list of LSS could be retained for delivery locally. The CCGs in their response to the TSAs' draft report have questioned the affordability of the services they have identified as LSS. The wider financial implications of providing those services is something that the CCGs are concerned about, but the TSAs are not empowered to address wider affordability issues.
345. In addition, the TSAs may make recommendations relating to LSS that impact upon organisations other than the provider in trust special administration (i.e. other than MSFT). Such recommendations should be, over the medium-term, financially sustainable and improve or maintain clinical standards, and these must be in line with clinical commissioning intentions<sup>38</sup>.
346. It is important to note that only services provided by the 'failing' provider can be protected and that only services that currently exist can be protected. In addition, if a particular local service is not designated for protection, this does not mean it is not required or that it will not be commissioned. When a service is not protected, this is either due to availability of feasible alternatives or because commissioners believe they can commission it without extra regulatory protection<sup>39</sup>.
347. In preparing the list of LSS, four criteria were considered by the CCGs:

Table 23: The criteria used when nominating LSS

Criterion	Question being addressed
<b>Access to alternative providers</b>	<ul style="list-style-type: none"> <li>Do alternative providers of a similar service exist?</li> <li>Is the distance (travel time) to alternative providers acceptable?</li> <li>Are these services of 'equivalent' quality?</li> </ul>
<b>Available capacity at alternative providers</b>	<ul style="list-style-type: none"> <li>Would alternative providers have the capacity and capabilities to deliver the services?</li> <li>Could new capacity be created – either by existing providers or by new entrants - over a reasonable time period?</li> </ul>
<b>Impact on health inequalities</b>	<ul style="list-style-type: none"> <li>Would withdrawing a service have a disproportionate impact on disadvantaged groups, who have lower health outcomes?</li> <li>Are there any unique and hard to replicate relationships with patient groups or other public services?</li> </ul>
<b>Inter-dependencies between services</b>	<ul style="list-style-type: none"> <li>Are there any services which need to be protected because they are interdependent with services already selected for protection?</li> </ul>

<sup>38</sup> Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts, Monitor, April 2013

<sup>39</sup> Mid Staffordshire NHS Foundation Trust: Recommendations of the CPT, Monitor, March 2013.

The CCGs have confirmed their list of the LSS as set out in Table 24.

Table 24: The confirmed list of Location Specific Services

Stafford and Surrounds CCG	Cannock Chase CCG
<p><b>At Stafford:</b> Services identified as an LSS on the basis that not doing so would impact health inequalities:</p> <ul style="list-style-type: none"> <li>• Outpatients</li> <li>• Patient-facing diagnostics</li> <li>• Day case chemotherapy</li> <li>• Pre-natal and post-natal care</li> <li>• Step down beds</li> </ul> <p><b><i>These are the 'Core LSS' for Stafford.</i></b></p>	<p><b>At Cannock:</b> Services identified as an LSS on the basis that not doing so would impact health inequalities:</p> <ul style="list-style-type: none"> <li>• Outpatients (including pre-natal and post-natal care)</li> <li>• Patient-facing diagnostics</li> </ul> <p><b><i>These are the 'Core LSS for Cannock'.</i></b></p>
<p><b>At Stafford:</b> Services identified as an LSS on the basis that there is currently insufficient capacity at alternate providers:</p> <ul style="list-style-type: none"> <li>• Current 14/7 A&amp;E <sup>40</sup></li> <li>• Routine obstetrics</li> <li>• Selected emergency (non-elective) admissions / inpatients <sup>41</sup></li> <li>• Select elective admissions for a range of medical specialties</li> </ul> <p><b><i>Each service will cease to be identified as an LSS when CCGs are content that suitable alternate capacity is available.</i></b></p>	
<p><b>At Stafford:</b> Services identified as an LSS on the basis that they are interdependent with another service that is identified as an LSS:</p> <ul style="list-style-type: none"> <li>• High dependency services commensurate with services on site</li> <li>• Sufficient neonatal resuscitation to support services on site</li> <li>• Adult Anaesthetics</li> </ul> <p><b><i>Each service will cease to be identified as an LSS if/when the interdependent service is no longer an LSS.</i></b></p>	
<p><b>At Cannock:</b> No services are identified as LSS in Cannock by Stafford and Surrounds CCG</p>	<p><b>At Stafford:</b> No services are identified as LSS in Stafford by Cannock Chase CCG</p>

<sup>40</sup> Commissioning intentions are to redesign the services and commission 24/7 Emergency and Urgent Care service

<sup>41</sup> There are certain categories of patients who are admitted to hospital on an emergency basis and do not require specialist care or interventions. These patients would be suitable for receipt of services in Stafford until capacity was provided elsewhere

## 8 Providers in the Local Health Economy

348. Every hospital operates within a Local Health Economy comprising a range of health commissioners, healthcare providers, social care providers and public health programmes that seek to positively influence, manage and treat the healthcare needs of a local population.
349. In developing the draft recommendations presented within this report, the TSAs have had to be aware of:
- the influences that the Local Health Economy have upon MSFT;
  - the impact that any changes proposed for MSFT will have on other organisations within the Local Health Economy; and
  - how possible changes in these other organisations will impact the delivery of healthcare services to the local population of Stafford and Cannock.
350. This section provides an overview of the other main healthcare providers within MSFT's Local Health Economy. It summarises: the key characteristics of each provider; some of the key parameters associated with each provider (e.g. income, number of staff); and, most pertinently, the key challenges each provider is currently facing.

### 8.1 Overview of providers in the Local Health Economy

351. The following tables present an overview of the acute and community trusts in the Local Health Economy providers in terms of the size and type of services they provide (the source for this information is the published annual reports).

Table 25: A summary of UHNS

University Hospital of North Staffordshire NHS Trust (UHNS)					
2011/12 turnover	2011/12 surplus/ (deficit)	2012/13 turnover	2012/13 surplus/ (deficit)	Number of staff	Number of beds
£426m	£3m	£470m	£0.2m <sup>42</sup>	ca. 6,700	1045

University Hospital of North Staffordshire is a major acute trust providing services predominantly from the City General Hospital in Stoke-on-Trent. The City General Hospital was redeveloped under a PFI scheme in 2012. It provides specialist treatment such as major trauma and neurosurgery to not only the local populations of Newcastle-under-Lyme and Stoke on Trent but to the wider population of Staffordshire and South Cheshire and Derbyshire.

<sup>42</sup> This small surplus was delivered by "receipt of significant sums of non recurrent funding and the additional payments negotiated for the activity delivered above the originally contracted levels." – June 2013 Board papers

Table 26: A summary of BHFT

Burton Hospitals NHS Foundation Trust (BHFT)					
2011/12 turnover	2011/12 surplus/ (deficit)	2012/13 turnover	2012/13 surplus/ (deficit)	Number of staff	Number of beds
£171m	(£5.3m)	£173m	(£3m)	ca. 2,500	482

Burton Hospitals NHS Foundation Trust provides general acute hospital services to the population of Burton and its surrounding areas. As well as providing general hospital services, it operates two community Hospitals: The Samuel Johnson Community Hospital in Lichfield and the Robert Peel Hospital in Tamworth. They host community services at these hospitals and provide a range of outpatient and inpatient services there.

Table 27: A summary of WHT

Walsall Healthcare NHS Trust (WHT)					
2011/12 turnover	2011/12 surplus/ (deficit)	2012/13 turnover	2012/13 surplus/ (deficit)	Number of staff	Number of beds
£227m	£3.6m	£225m	£4.2m	ca. 5,000	489

Walsall Healthcare NHS Trust is a provider of general acute hospital and community services to Walsall and its surrounding areas. The main acute based services are provided from the Manor Hospital in Walsall which was redeveloped under a PFI scheme in 2010. In addition to its general acute services it provides specialist bariatric surgery to areas of the West Midlands. As well as providing acute services it also provides community based services within Walsall which includes the provision of some intermediate care beds.

Table 28: A summary of RWT

The Royal Wolverhampton NHS Trust (RWT)					
2011/12 turnover	2011/12 surplus/ (deficit)	2012/13 turnover	2012/13 surplus/ (deficit)	Number of staff	Number of beds
£374m	£8.7m	£376m	£7.4m	ca. 6,500	812

The Royal Wolverhampton NHS Trust is a major acute trust providing services largely from New Cross Hospital in Wolverhampton. It provides a comprehensive range of services, including specialist services such as major trauma and cancer, for the people of Wolverhampton, the wider Black Country, South Staffordshire, North Worcestershire and Shropshire. As well as providing major acute services, in April 2011 it took on the provision of Community services for the population of Wolverhampton.

Table 29: A summary of SaTH

Shrewsbury and Telford Hospitals NHS Trust (SaTH)					
2011/12 turnover	2011/12 surplus/ (deficit)	2012/13 turnover	2012/13 surplus/ (deficit)	Number of staff	Number of beds
£300m	(£1m)	£309m	£3.2m	ca. 5,000	752

Shrewsbury and Telford Hospitals NHS Trust is an general acute trust providing services from two main sites: The Royal Shrewsbury Hospital and the Princess Royal Hospital, Telford. Services are predominantly provided to the population of Shropshire, Telford & Wrekin and Mid Wales. The trust is currently reviewing the services provided at both sites and developing plans to reconfigure services across these sites ensuring clinically sustainable services in the future.

Table 30: A summary of SSoTP

Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSoTP)					
2011/12 turnover	2011/12 surplus/ (deficit)	2012/13 turnover	2012/13 surplus/ (deficit)	Number of staff	Number of beds
£204m	£1.5m	£373m	£2m	ca. 6,000	303 (community)

The Staffordshire and Stoke-on-Trent Partnership NHS Trust provides community health care and adult social care services in Staffordshire and community health services in Stoke-on-Trent. The trust was formed in September 2011. In April 2012 the Trust took on responsibility for Adult Social care in South and North Staffordshire. As well as providing community care across the whole borough, it also operates five community hospitals in the north of the county with approximately 300 community beds.

352. Alongside the acute and community trusts, the South Staffordshire and Shropshire Healthcare NHS Foundation Trust and the North Staffordshire Combined Healthcare NHS Trust provide mental health services in the Local Health Economy.

## 8.2 Immediate challenges faced by the local providers

353. There are a range of challenges for the providers across the Local Health Economy. In some cases these challenges are significant and increasing.
354. From a financial perspective, both UHNS and BHFT (along with MSFT) are reporting financial deficits – although in both cases the level of deficit (in relation to turnover) is somewhat lower than the 10% deficit at MSFT.
- BHFT reported a deficit of £3m (2% of turnover) at the end of the last financial year, an improvement of over £2m from the previous year.
  - In May 2013, the auditors at UHNS wrote to the Secretary of State for Health reporting a forecasted deficit for the end of the current financial year of greater

than £30m (which would be ca. 7% of turnover). The latest board report at UHNS (June 2013) reported:

*"The letter outlines the financial position for 2012/13, whereby financial balance was only achieved through the receipt of significant sums of non-recurrent funding and the additional payments negotiated for the activity delivered above the originally contracted levels.*

*The current position for 2013/14 is summarised in the letter, whereby the provisional plan forecasts a shortfall of income over expenditure of £31.4m, subject to the outcome of the ongoing discussions with the NTDA."*

355. In addition to the financial challenges faced by some providers, many trusts in the LHE face significant challenges at being able to sustain the current quality of care and access levels particularly within A&E and emergency admissions.
356. In May 2013, the clinical leads for the 18 A&E departments in the West Midlands wrote a joint letter to the CCG leads and Trust Chief Executives. The letter sought to highlight the recent challenges that have been prevalent and widely reported across all parts of the NHS (the full letter is presented in Appendix F):

*"Following a winter and spring of sustained, extraordinary pressures throughout the Emergency Departments (EDs) in the region, we now believe we are in a state of crisis which needs to be more widely acknowledged and moreover urgently addressed. This issue has in recent days and weeks been highlighted by NHS England, the Care Quality Commission, the Royal College of Nursing and the College of Emergency Medicine; we echo the sentiments of these organisations and highlight the fact that this crisis has been particularly and intensely felt throughout the West Midlands and surrounding region. It has come to a point where we must voice our most pressing concerns regarding the safety and quality of care currently being delivered in EDs across the region."*

357. In the last 12 months, A&E performance has, in general, deteriorated across England. In response NHS England have asked all hospital trusts and CCGs to develop specific plans for reducing demand on each A&E within the country.
358. In July 2013, BHFT were one of eleven trusts across England that were placed into 'special measures' following the Keogh Review.
359. All NHS Trusts should be working towards achieving FT status. To become FTs, each provider will have to demonstrate sustained good performance in clinical operations, governance and financial management. MSFT and BHFT are the only current FTs in the Local Health Economy.
360. As noted in Section 4, MSFT has undergone recent inspections by the CQC who have not reported any concerns with the quality of care at MSFT. All of the other providers

in the LHE have also undergone recent inspections and no major concerns have been reported at any of these providers (see Table 31).

Table 31: A summary of CQC inspections across the Local Health Economy

Provider	Date of last full inspection	Number of standards the Trust was measured against	Compliant	Improvement required
BHFT	Jul 12 <sup>43</sup>	6	5	1
SaTH	Shrewsbury Nov 12	6	6	0
	Telford Apr 13	5	3	2
RWT	Mar 13	5	5	0
UHNS	Sep 12	9	9	0
WHT	Aug 12	7	6	1

Source: [www.cqc.org.uk](http://www.cqc.org.uk)

361. The areas for improvement noted in this table are:

- At its last full inspection in July 2012 BHFT had a concern related to medicine management. At a follow up visit in December 2012 BHFT were found to be compliant in this area;
- WHT received a concern for its record keeping at its routine visit in August 2012. The Trust was reassessed against this in December 2012 and still received a concern in this area; and
- The last inspection at The Princess Royal Hospital in Telford showed that there were two areas for improvement: 1) People should be treated with respect, involved in discussions about their care and treatment and able to influence how the service is run; and 2) People should get safe and appropriate care that meets their needs and supports their rights.

362. In October 2013, the CQC announced the first assessments from their new 'Intelligent Monitoring' programme<sup>44</sup>. This programme uses more than 150 different indicators to help the CQC assess where to direct their inspection teams. The outcome from these assessments was that every NHS provider operating an acute hospital was placed into one of six bands. The bands are based upon the number of indicators that are identified as 'risk' or 'elevated risk', or where there are known and current serious concerns with the trust (for example, all of the Trusts recently placed into special measures are in 'Band 1 – Highest risk').

<sup>43</sup> This was the last multi-standard inspection. There have been two subsequent single standard inspections in May 2013 and December 2012, both of which assessed BHFT as having met the standard.

<sup>44</sup> <http://www.cqc.org.uk/public/hospital-intelligent-monitoring>

363. The CQC have been clear that this banding does not prove there are issues with the quality of care provided by a trust, but is being used to prioritise their inspection teams going forwards.
364. Table 32 shows the how the bands have been established, notes the total number of trusts in each band and highlights which band each of the trusts within the Local Health Economy have been placed into. Band 1 contains the trusts showing the 'highest risk' and Band 6 the 'lowest risk'.

Table 32: CQC risk assessment bandings

Band	% of indicators showing 'risk' or 'elevated risk' to fall within the band	Number of trusts within the band	Local Health Economy hospitals
1	>= 7.0%	24	BHFT
2	5.5% - 6.99%	20	SaTH
3	4.5% - 5.49%	30	-
4	3.5% - 4.49%	25	MSFT
5	2.5% - 3.49%	24	UHNS, RWT
6	< 2.5%	38	WHT



## 9 The TSAs' draft recommendations

365. The TSAs' draft report set out in detail the process, conclusions and rationale that informed their draft recommendations<sup>45</sup>. Rather than repeat those details in this report, this section summarises the process undertaken by the TSAs to develop their draft recommendations which were used as the basis for the consultation.
366. All of the information presented in this section is as it was presented in the draft report and has not been changed to reflect the ongoing work of the TSAs or feedback received during the consultation period.

### 9.1 The guiding principles for the TSAs

367. In developing their draft recommendations, the TSAs established a series of guiding principles, as follows:
- **Principle 1:** First and foremost, each service must be assessed on its own merit and the TSAs must be assured that each service (retained in the current locality or otherwise) will be clinically safe and affordable.
  - **Principle 2:** Where possible, services should be retained locally. Moving any single service away from the current locality must be discretely justified.
  - **Principle 3:** If the TSAs identify an opportunity to enhance a service or introduce a new service (whether that service is retained locally or moved to another provider) they will work with commissioners to identify the feasibility of doing so.
  - **Principle 4:** The TSAs must be conscious that there are pressures on the NHS and the Local Health Economy which cannot be fully addressed locally. However, the TSAs must identify and assess the impact on the whole Local Health Economy of their recommendations, and where that impact is detrimental, must identify how this impact can be mitigated.
  - **Principle 5:** The TSAs should not discount short term investment if they believe it will deliver longer term benefits for the local population.

### 9.2 Developing the TSAs' draft recommendations

368. The remit of the TSAs is to develop recommendations that will ensure the services currently provided by MSFT can be provided over the long term in a clinically and financially sustainable manner. Although potential alternate models of services were

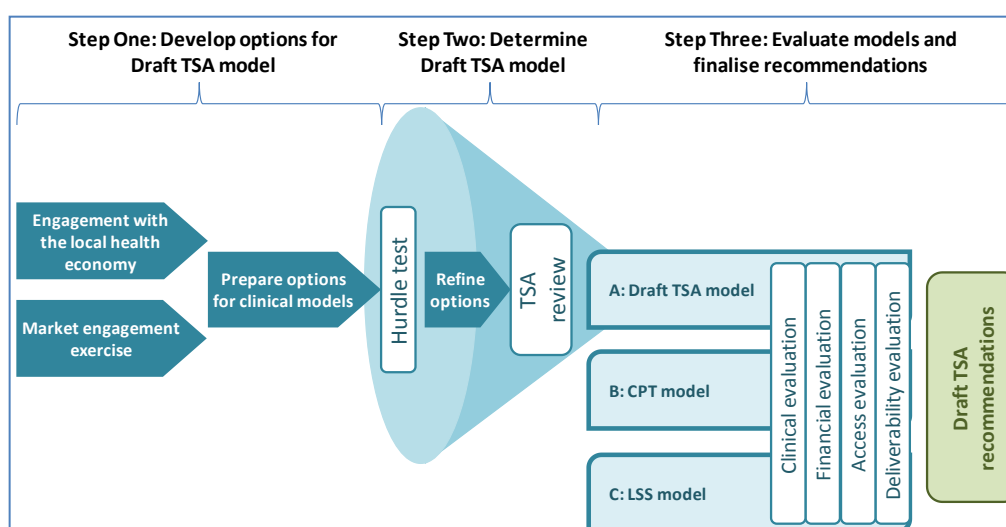
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<sup>45</sup> The Office of the Trust Special Administrator of Mid Staffordshire NHS Foundation Trust - Trust Special Administrators' Draft Report, July 2013. <http://tsa-msft.org.uk/wp-content/uploads/2013/07/TSA-Draft-Report-Volume-1-Main-report.pdf>

already established prior to the appointment of the TSAs (see below), the TSAs undertook a separate process to develop a draft clinical model with no pre-determined solution in mind and taking into account their guiding principles.

369. Prior to the appointment of the TSAs, the CPT had produced a series of recommendations for the future of clinical services in Stafford and Cannock<sup>46</sup>. The remit of the CPT was to consider what MSFT, as a stand-alone organisation, could do to achieve clinical and financial sustainability. This model of services (the ‘CPT model’) was an option which the TSAs could use as a comparator to alternative service models.
370. During their work with the CPT, the CCGs identified a range of LSS – see Section 7 – that the TSAs were obliged to ensure would be delivered in the future in Stafford and Cannock. The TSAs therefore used services identified as LSS as another service model (the ‘LSS model’) for purposes of comparison.
371. To prepare their draft recommendations, the TSAs followed a three step process:
- **Step One:** Develop options for a clinical model in line with the TSAs remit and guiding principles.
  - **Step Two:** Assess these options to determine a ‘Draft TSA model’.
  - **Step Three:** Evaluate the ‘Draft TSA model’ alongside the ‘CPT model’ and the ‘LSS model’ to determine which model would be the basis for the TSAs’ draft recommendations.
372. This process is illustrated in Figure 8 and summarised below.

Figure 8: The approach taken by the TSAs to develop its draft recommendations



<sup>46</sup> Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust – Recommendations of the CPT, March 2013.

### Step One: Develop options for the Draft TSA model

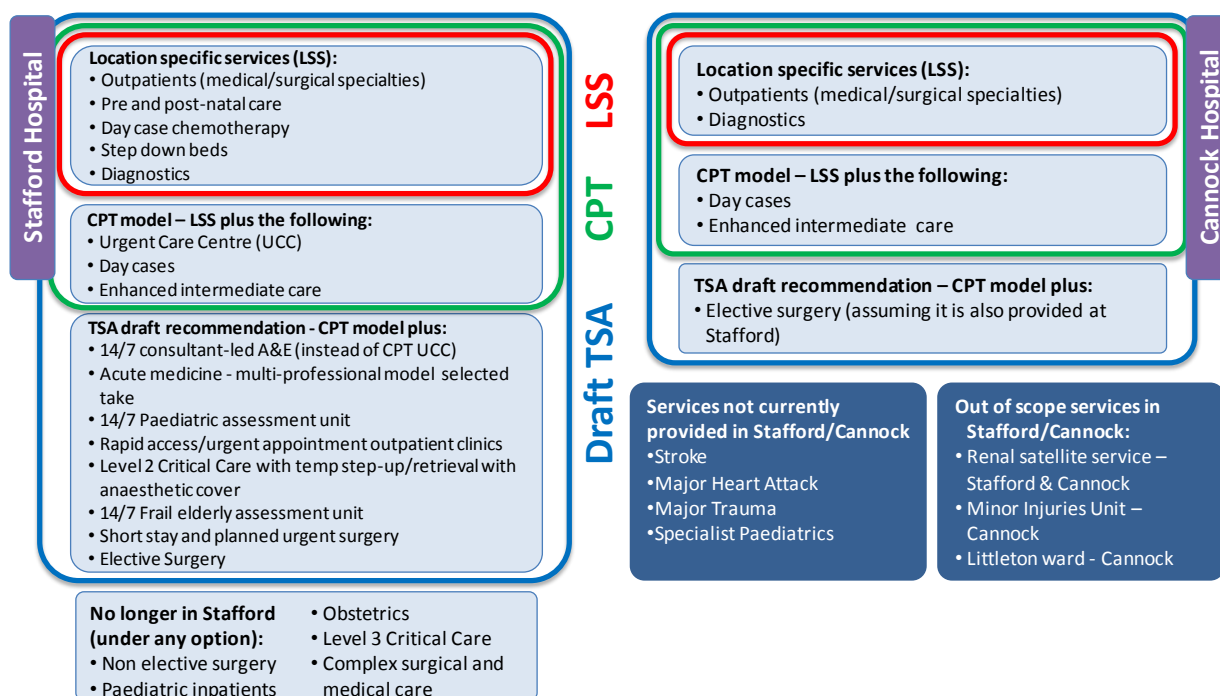
373. The TSAs sought to generate options for clinical models that other healthcare providers would be willing to deliver. They did this through a market engagement exercise and discussions with providers in the Local Health Economy.
374. This approach did not mean that the TSAs had concluded which organisations should be the providers of the proposed service model, but it assured the TSAs that there are providers willing to deliver the Draft TSA model.
375. The providers in the Local Health Economy that expressed an interest in delivering some of the services currently provided by MSFT were asked to put forward formal responses to the market engagement exercise.
376. In total, the TSAs received responses from 12 different organisations who between them submitted 14 different proposals (organisations could submit more than one proposal).
377. The TSAs tested these proposals with the local commissioners to ensure that the evaluation process would effectively align with the commissioners' broader intentions and sought clarifications from the providers as and when necessary.

### Step Two: Determine the Draft TSA model

378. The TSAs applied the following two hurdle tests against each proposal:
  - the TSAs would only consider clinical models which would satisfy the requirements of both regulators, Monitor and CQC. Therefore the TSAs would only consider proposals from organisations which could: a) confirm their CQC registration, and b) demonstrate appropriate governance arrangements for managing the delivery of services in Stafford and Cannock.; and
  - that the proposed model meets the minimum commissioner requirements for services to be provided locally – in this instance, the delivery of LSS in either Stafford or Cannock.
379. All proposals passed the first hurdle test and six proposals passed the second hurdle test. These six proposals were submitted by five different providers – including NHS and independent sector providers.
380. The TSAs held further discussions which each of the providers who submitted a proposal that passed both hurdle tests in order to clarify elements of their proposals and to satisfy the TSAs that the proposals were credible.

381. Following these discussions, it was determined that the Draft TSA model would be based upon the proposal for Stafford from UHNS, and the proposal for Cannock from RWT.
382. The basis for selecting these models was that they retained the largest amount of services locally within Stafford and Cannock and were most in line with the TSAs' guiding principles.
383. The Draft TSA model includes LSS, those additional services proposed by the CPT and a range of additional acute services. Figure 9 summarises each of the services within the three models that the TSAs evaluated.

Figure 9: An outline of the range of service included in each model evaluated



### Step Three: Evaluate the three models and determine which would be the basis for the TSAs' draft recommendations

384. The TSAs evaluated each of the three models against a series of criteria and used a balance of quantitative evidence and the assessments of external advisory groups to arrive at their conclusions. Table 33 summarises the conclusions for each of the four criteria. The draft report contains the full detail of these evaluations.

Table 33: A summary of the evaluation exercise

Criteria	Conclusions
<p><b>Is the model clinically sustainable?</b></p> <ul style="list-style-type: none"> <li>• In the opinion of the CAG and NMAG, is the model clinically safe?</li> <li>• Are the services sufficiently close to Royal College guidelines to satisfy the CAG that they would be sustainable?</li> <li>• Is it likely, in the opinion of the CAG and NMAG, to improve recruitment and retention of staff?</li> </ul>	<ul style="list-style-type: none"> <li>• <b>LSS:</b> No immediate clinical safety concerns but have concerns as to the impact on other providers in the Local Health Economy ; potential challenges for overnight cover in Stafford; likely to have significant impact on emergency care in the Local Health Economy; would need a fully networked clinical workforce to improve recruitment and retention.</li> <li>• <b>CPT:</b> Only low risk surgery could be undertaken due to no critical care; Concerns about step up care; potential challenges for overnight cover in Stafford; likely have significant impact on emergency care in Local Health Economy; would need a fully networked clinical workforce to improve recruitment and retention; may be difficult to recruit middle grade doctors for fear of impact on career progression.</li> <li>• <b>Draft TSA:</b> No clinical safety concerns; prefer not to have a separate critical care unit; less impact on Local Health Economy; two site networked acute provider would be attractive to potential recruits; nursing recruitment for PAU may be impacted if standalone.</li> </ul>
<p><b>Is the model reasonable with regards to access to services?</b></p> <ul style="list-style-type: none"> <li>• Is access for patients and visitors of patients reasonable (i.e. retaining as many services locally as possible)?</li> <li>• Do patients have reasonable access to short duration visits (e.g. outpatients)?</li> </ul>	<p>The TSAs assessed the proportion of activity that would continue to be provided locally under each of the models. Taking the current activity levels of MSFT as a baseline, the proposed clinical models were compared against this baseline to show the impact this would have on patients having to access services outside of the current locality.</p> <ul style="list-style-type: none"> <li>• <b>LSS:</b> 75% of patients attendances in Stafford or Cannock would still be in Stafford or Cannock.</li> <li>• <b>CPT:</b> 84% of patients attendances in Stafford or Cannock would still be in Stafford or Cannock.</li> <li>• <b>Draft TSA:</b> 91% of patients attendances in Stafford or Cannock would still be in Stafford or Cannock.</li> </ul>



Criteria	Conclusions
<p><b>Is the model financially sustainable?</b></p> <ul style="list-style-type: none"><li>• Within three years of implementation starting, does the income associated with delivering the activity currently associated with patients from MSFT exceed the cost of delivery?</li><li>• Do the proposed changes ensure there is not a detrimental impact on the finances of another NHS organisation?</li></ul>	<p>The TSAs the three models from a financial perspective. The conclusions of this analysis was:</p> <p>The TSAs forecast for the end of the current financial year (March 2014), is that MSFT deficit will be £20.2m and the impact of cost inflation and tariff deflation would mean that the deficit would increase to £42.5m by March 2017 if no changes were made.</p> <ul style="list-style-type: none"><li>• There would need to be investment in capital at Stafford and Cannock Chase Hospitals to make them fit for purpose, plus investment in additional capacity at other hospitals in the Local Health Economy. This investment ranged from £132m-£197m for the Draft TSA model to £192m-£260m for the LSS model.</li><li>• Any capital investment would attract additional annual depreciation and capital charges of £10m - £10.5m and require investment in the local ambulance service of £1.2m to £2.7m.</li></ul> <p>Therefore, in order to break even the models would need to deliver savings in excess of £49m<sup>47</sup> over the same period.</p> <ul style="list-style-type: none"><li>• Each model presented opportunities for delivering savings. These savings ranged from £39.7m for the LSS model to £40.8m for the Draft TSA model.</li><li>• This meant every model would deliver savings greater than the current deficit, but would still have a deficit at the end of a three year transition period of between £8.5m and £10.8m due to the impact of cost inflation.</li></ul> <p>Transition costs would range from £108m for the Draft TSA model to £114m for the LSS model (the majority of this is deficit funding during the transition period)</p> <p>Total funding required ranged from £305m for the Draft TSA model to £356m for the CPT model</p>
<p><b>Is the model deliverable?</b></p> <ul style="list-style-type: none"><li>• Is there likely to be stakeholder acceptance of the model?</li><li>• Is the degree of change likely to be implemented successfully?</li></ul>	<p>The TSAs assessed five factors in this evaluation: 1) Scale of change; 2) Stakeholder acceptability; 3) Ease of implementation; 4) Timescale for change; and 5) Impact on other providers.</p> <p>The TSAs made the following conclusions:</p> <ul style="list-style-type: none"><li>• <b>LSS:</b> Would require the largest programme of change; this programme of change would take the longest period; the proposed clinical model would meet the greatest level of stakeholder concern; would require the largest capital programme; would have the greatest impact on other providers.</li><li>• <b>CPT:</b> Would enable the redesign of some services; some services would need to be moved en masse to other providers; would need strict protocols for emergency care due to introduction of Urgent Care Centre; reaction from stakeholders to the CPT model was mixed; primarily moves non-elective activity which is costly and higher risk – this could have a detrimental impact on other providers.</li><li>• <b>Draft TSA:</b> Smallest change programme; quickest to implement; likely to be welcomed by Cannock residents, but anticipated challenges from Stafford population due to removal of some services; least impact on other providers.</li></ul>

<sup>47</sup> The impact of cost inflation would reduce if savings were achieved.

## Conclusion

385. On the basis of the analysis undertaken, the TSAs ranked the three models against each of the criteria. Table 34 summarises these rankings.

Table 34: A summary of the evaluations and final ranking of the models

Criteria	LSS	CPT	Draft TSA
Clinical	2 <sup>nd</sup> =	2 <sup>nd</sup> =	1 <sup>st</sup>
Access	3 <sup>rd</sup>	2 <sup>nd</sup>	1 <sup>st</sup>
Financial	3 <sup>rd</sup>	2 <sup>nd</sup>	1 <sup>st</sup>
Deliverability	3 <sup>rd</sup>	2 <sup>nd</sup>	1 <sup>st</sup>
Conclusion	3 <sup>rd</sup>	2 <sup>nd</sup>	1 <sup>st</sup>

386. Therefore, the draft recommendations of the TSAs that were put forward for the consultation, and which are summarised over the coming pages were based upon the Draft TSA model.

## 9.3 The TSAs' draft recommendations

387. The TSAs made 14 draft recommendations and a number of associated observations. These were set out in six areas, as follows:

- Observations about the use of clinical networks;
- Draft recommendations and observations about the clinical model for Stafford;
- Draft recommendations and observations about the clinical model for Cannock;
- Draft recommendations and observations about implications for MSFT as an organisation;
- Observations with regards to the funding associated with the TSAs' draft recommendations; and
- Observations about actions that would support the implementation of the TSAs' draft recommendations.

388. These observations and draft recommendations are summarised below.

## Clinical networks

389. Clinical networks bring together groups of health professionals and stakeholder organisations with a common purpose to work on a collaborative basis in the delivery of clinical services.



390. Although there is no single definition, there are three clear characteristics of a clinical network that are essential when considering the benefits for Stafford and Cannock, namely:
- The network enables resilience in the delivery of services;
  - The network places the burden of travel on those delivering the service, rather than those receiving the service; and
  - The network enables closer coordination of service delivery across the organisations in the network.
391. One of the central arguments around whether MSFT is clinically sustainable is that many of its services are sub-scale. This means that deploying sufficient numbers of appropriately skilled resources is a challenge and those resources may not be exercising those skills on enough occasions to maintain them to an appropriate standard.
392. The TSAs believe that the establishment of a clinical network for Stafford will address this issue for some of the services that are currently unsustainable. This will enable a greater number of services to be retained locally – one of the guiding principles for the TSAs when developing their draft recommendations.
393. Although the clinical sustainability challenges are more associated with services currently based in Stafford (A&E, emergency surgery and paediatric care), it is likely that a clinical network will be necessary for the services in Cannock and the Draft TSA model has been developed on this basis.
394. Clinical networks will not address all of the problems of clinical sustainability. There are some services where the patient volumes are not sufficient to ensure a viable service can be maintained due to the impact on staff retention and recruitment and maintenance of essential skills in staff that would not rotate between sites in the clinical network.
395. When considering which organisations may currently be in a position to manage a clinical network in Stafford and in Cannock, there are limitations on the range of providers that could do this in an effective manner. The most notable limitation is the distance between the provider's site(s) and the sites in Stafford and Cannock. This is a factor, because:
- Some of the clinical staff will need to work across multiple sites. A clinical network can introduce potential inefficiencies in the staff deployment model associated with the cost and time incurred due to the staff member travelling between sites; and

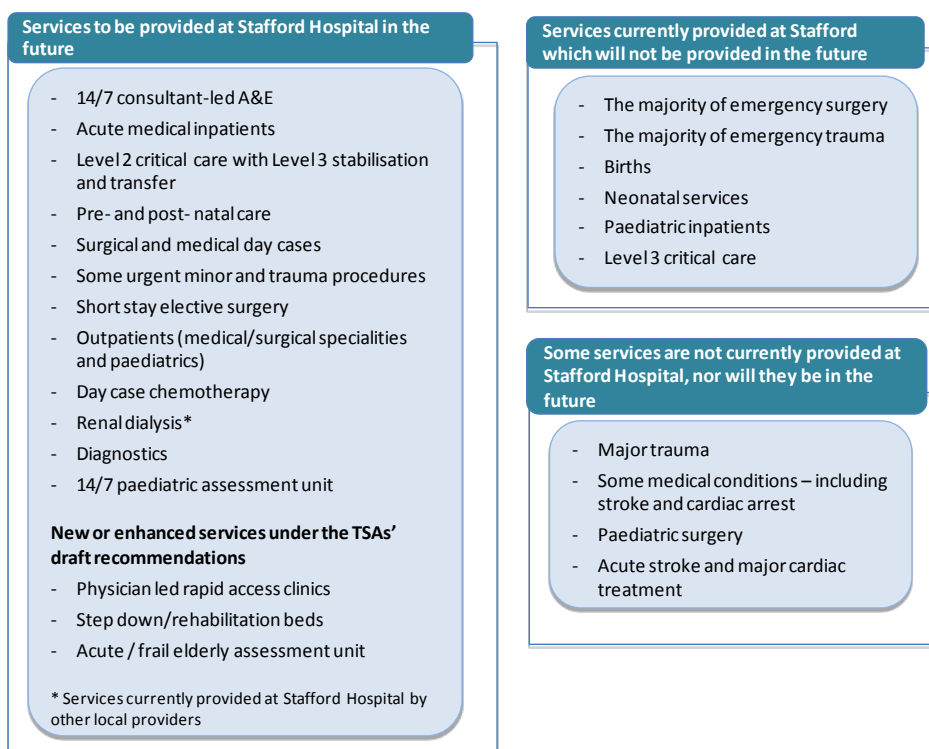


- The network will enable all outpatient services to be delivered locally (which is necessary as outpatient appointments are part of the list of LSS for Stafford and Cannock), but there will be some associated inpatient procedures that are not conducted in Stafford and Cannock. The further away the provider's inpatient service is from Stafford and Cannock, the greater burden (time and cost) that will be placed upon the patient to travel for their inpatient treatment.

### The clinical model for Stafford

396. The TSAs' draft recommendations for services to be delivered in Stafford were based upon the establishment of a clinical network and were over and above those identified as LSS for Stafford, which were:
- Outpatients
  - Patient-facing diagnostics
  - Day case chemotherapy
  - Pre-natal and postnatal care
  - Step down beds
397. Figure 10 summarises the service model proposed by the TSAs in their draft recommendations for Stafford.

Figure 10: A summary of the proposed clinical model for Stafford



398. Table 35 summarises the draft recommendations for the clinical model in Stafford.

Table 35: Summary of the TSAs' draft recommendations for Stafford

Draft recommendation	Rationale	Additional comments
1: A consultant led A&E department should be retained in Stafford, open seven days a week from 08:00 – 22:00.	<ul style="list-style-type: none"> <li>The TSAs believe that reducing the current 14/7 A&amp;E service provision in Stafford would present a significant risk to the other providers in the LHE.</li> <li>The number of consultants currently operating in the department is significantly lower than the Royal College guidance on staffing levels to operate a safe 24/7 A&amp;E service and the TSAs believe that MSFT are operating a 14/7 rota within a fine margin of what would be clinically safe.</li> <li>Establishing a clinical network to deliver a 14/7 A&amp;E would significantly improve resilience in the consultant rota and will address the current clinical sustainability issues.</li> <li>Increasing the current 14/7 service to a 24/7 would require additional consultants to ensure there is sufficient resilience in the clinical network. Given the low volumes of patients that would be treated overnight at an A&amp;E in Stafford, this would be uneconomic to operate and unattractive for consultants to work within.</li> </ul>	<ul style="list-style-type: none"> <li>The current pathways for taking acutely ill emergency patients to larger more specialised hospitals, such as UHNS and RWT, should remain in place (e.g. those with the signs/symptoms of major cardiac problems and stroke).</li> <li>There are some additional patient cohorts who should be taken directly to larger more specialised hospitals as certain acute services would no longer be provided in Stafford. These include: <ul style="list-style-type: none"> <li>cases where it is evident that emergency surgery is required;</li> <li>very sick children who may have a life threatening illness; and/or</li> <li>very sick adults/older people.</li> </ul> </li> </ul>
2: A physician led inpatient service for adults with medical care needs will remain in Stafford which will manage acutely unwell patients locally (both admissions from A&E and patient referrals from primary/community care).	<ul style="list-style-type: none"> <li>The demand for acute medicine and care of the elderly services in Stafford is expected to increase in the future due to the forecast demographic changes in the local population.</li> <li>With the proposed retention of a 14/7 A&amp;E in Stafford, it is sensible and appropriate to ensure there is the ability for non-elective patients to be admitted into an inpatient bed at the same location for ongoing treatment.</li> <li>This service needs to change in order to better meet the changing needs of the local population and the intentions of local commissioners (see draft recommendations 3 &amp; 4).</li> </ul>	<ul style="list-style-type: none"> <li>There should be closer working between the providers of acute, primary, community and social care. This will ensure patients are treated in the right place and that an admission to hospital is only made when it is the best place for the patient to be treated. This is particularly crucial as the current emergency admission rates of MSFT are higher than average.</li> <li>There should a managed reduction in the number of acute medical beds over time as changes to patient pathways reduce the number of patients that could need acute medical care (in line with stated commissioner intentions and commissioner led demand management plans).</li> </ul>



Draft recommendation	Rationale	Additional comments
<p><b>3:</b> The Medical Assessment Unit (MAU) at Stafford Hospital will be enhanced to include specialist support to the frail and elderly. The MAU will be a single point of contact for potential admissions from the 14/7 A&amp;E, and step up admissions from primary care and community care providers.</p>	<ul style="list-style-type: none"> <li>The needs of older people are often complex and the acute hospital is not always the best care setting. There are circumstances when rapid referral to a community care, social care or mental healthcare provider would avoid the need to inappropriately admit the older person into an acute inpatient bed.</li> <li>The current MAU at Stafford Hospital should be enhanced to include a specialist focus on assessing the frail and elderly. The MAU should ensure that only acutely unwell patients end up in an acute bed, and less acutely ill patients are referred for treatment in a more appropriate setting.</li> </ul>	<ul style="list-style-type: none"> <li>Admissions into the MAU will be between 08:00 and 22:00, seven days a week (in line with the recommended A&amp;E opening times), but the beds in the unit will be operated 24 hours a day. Patients can be admitted into the MAU by the A&amp;E at Stafford and directly referred to the MAU by community care and primary care providers.</li> <li>The precise staffing model for the MAU is still being developed, but should include a combination of consultant geriatricians during the day and Advanced Nurse Practitioners at night.</li> </ul>
<p><b>4:</b> MSFT currently operates a small number of 'step down' beds within Stafford Hospital. The number of these beds should be increased to enable a greater volume of repatriations back to Stafford Hospital from larger more specialised hospitals.</p>	<ul style="list-style-type: none"> <li>The range and volume of patients who will be treated at a larger/more specialised hospital will increase under the TSAs' draft recommendations. It is important that these patients can be 'repatriated' back to Stafford Hospital as quickly as possible so that their rehabilitation and ongoing treatment can take place as close to home as possible.</li> <li>MSFT already operate a small number of 'step down' beds which are used to repatriate some of these patients back into Stafford Hospital (e.g. those patients that have suffered a stroke and are being treated at a larger more specialised hospital). These beds were identified by the local CCGs as being part of the core set of LSS. The TSAs' proposed clinical model includes an increase in the number of 'step down' beds.</li> <li>This is aligned with the stated commissioning intention to provide 'care closer to home'.</li> </ul>	<ul style="list-style-type: none"> <li>The focus of the teams managing these step down beds should be to ensure the patients are discharged when appropriate and to ensure continuity of care management once they are discharged from Stafford Hospital.</li> <li>As a large number of patients who would be suitable for repatriation back to Stafford will be older patients, it is recommended that the staffing model for the step down beds includes geriatricians whose primary focus will be on the safe, effective and timely discharge of older patients from the step down facility.</li> <li>The TSA believes that the effectiveness of the service would be enhanced if there is some form of collaboration/integration with local community/social care services.</li> </ul>



Draft recommendation	Rationale	Additional comments
<p><b>5:</b> The obstetric service in Stafford should be decommissioned as soon as there is sufficient capacity established across the Local Health Economy.</p> <p>Pre and postnatal outpatient services in Stafford will remain, unless there are post-23 week complications that require attendance at a more specialised obstetric unit.</p>	<ul style="list-style-type: none"> <li>Stafford currently has an obstetric led delivery suite in Stafford which sees ca. 1800 births a year . The maternity service also provides ante and post natal care for women at Stafford. This service is one of the smallest in the country.</li> <li>National standards require at least 40 hours of consultant presence per week on the delivery suite. A unit managing less than 2,500 births per annum is unlikely to be able to support training as a stand-alone unit.</li> <li>This could be addressed by a clinically networked solution. However, an obstetric unit requires the presence of paediatrics, critical care, general surgery and other support services. It is likely that managing less than 2,500 births per annum will be uneconomic. During the market engagement exercise there was no organisation willing to provide an obstetric service - on financial grounds.</li> <li>A midwife led unit (MLU) could be clinically viable, but the TSAs do not believe it will be financially viable as the staffing cost would be significantly more than the income received.</li> </ul>	<ul style="list-style-type: none"> <li>The service cannot be decommissioned until capacity is established in the Local Health Economy. This will require some investment at other providers.</li> <li>The TSAs do not believe that this capacity should be concentrated on a single site.</li> <li>Ante and post natal care are on the core list of LSS and will continue to be provided in Stafford once the obstetric service is decommissioned. These services will need to be provided as part of a clinical network with an obstetric led service based at another site.</li> <li>Where there are complications post-23 weeks, patients will need to be seen at the most appropriate obstetric unit and not in Stafford.</li> </ul>
<p><b>6:</b> The paediatric inpatient service in Stafford should be decommissioned at such time that local commissioners are satisfied there is sufficient capacity to safely admit the volume of patients that would otherwise have been admitted to Stafford Hospital.</p>	<ul style="list-style-type: none"> <li>The guidelines from the Royal College of Paediatrics are that the minimum number of paediatricians required to support a clinically safe inpatient paediatric unit is ten consultants. Currently Stafford has five which is significantly below the recommended levels. The TSAs believe that continuing to deliver a paediatric inpatient unit would not be clinically sustainable with the current staffing.</li> <li>The TSAs considered the use of a clinical network to address the levels of staffing, but have concluded that there are insufficient volumes of paediatric inpatient cases treated at Stafford to support a dedicated unit on economic grounds.</li> <li>The level of paediatric admissions into Stafford Hospital is higher than the national average. If the admission rate were to reduce in line with the national average, then the number of patients would reduce further, making it even less economic to operate.</li> <li>The Royal College of Paediatrics and Child Health have stated they want to see the number of paediatric inpatient units reduce so that scarce paediatric resources are not spread too thinly.</li> </ul>	<ul style="list-style-type: none"> <li>Children should continue to be taken to the Stafford A&amp;E for initial assessment. However, very sick children should be taken directly by the ambulance service to a larger more specialised hospital and very sick children who arrive at Stafford A&amp;E by other means should be immediately transferred to a larger more specialised hospital.</li> <li>Where a child seen at Stafford A&amp;E cannot be discharged immediately, they will be further assessed in the Paediatric Assessment Unit (PAU) in Stafford.</li> </ul>



Draft recommendation	Rationale	Additional comments
<p><b>7:</b> A Paediatric Assessment Unit (PAU) will remain in Stafford to provide children with local access to an urgent assessment. The service will be provided 14/7 and will work alongside the proposed A&amp;E service.</p> <p>The PAU will have the input and support from Paediatricians where needed and will to be operated as part of a clinical network.</p>	<ul style="list-style-type: none"> <li>The primary objective of the PAU will be to assess the ongoing treatment needs of the patient and to coordinate the delivery of this treatment, including admission to a paediatric inpatient bed at a larger more specialised hospital, or referral to community/primary care for ongoing treatment.</li> </ul>	<ul style="list-style-type: none"> <li>Children will be admitted to the PAU via attendance at the A&amp;E department. The PAU will also accept direct referrals from community/primary care and specific care pathways, such as the management of long term conditions.</li> <li>UHNS currently operate a 'Paediatric Hospital @ Home' service which is primarily used to care for children at home after discharge from hospital. The TSAs are working with the CCGs to determine the potential for a similar service in Mid/South Staffordshire which should complement any existing community paediatric services.</li> </ul>
<p><b>8:</b> Non-elective/emergency general surgery and trauma surgery will no longer be undertaken at Stafford.</p> <p>The exception will be minor surgical procedures which can be performed at Stafford A&amp;E or where the patient can be stabilised at A&amp;E and scheduled to return to Stafford Hospital for minor surgery alongside elective surgical patients.</p>	<ul style="list-style-type: none"> <li>No major trauma patients are treated in Stafford. These patients are taken to larger more specialised hospitals.</li> <li>The provision of non-elective general surgery has been one area where MSFT has already transferred some of the more specialist procedures to larger more specialised hospitals, e.g. vascular surgery was moved to UHNS.</li> <li>In 2009, the Royal College of Surgeons conducted a review into surgical practices at MSFT. This review highlighted serious concerns about the sustainability of the emergency surgery service.</li> <li>An emergency surgery service should provide 24 hour access per day which is staffed at all times and a dedicated emergency theatre. The rota for this service should be staffed by a minimum of eight general surgeons. MSFT employs five general surgeons on the emergency surgery rota, and whilst the rota is staffed 24/7 there is not a dedicated emergency theatre.</li> <li>The view from the CAG was an emergency surgery service with these low volumes is not sustainable. The low volume of cases does not provide an environment for training both medical and nursing staff and has the potential to de-skill the theatre team in the long term.</li> </ul>	<ul style="list-style-type: none"> <li>Clinical protocols will be established so that where obvious surgical cases are attended by the ambulance service these patients will be taken directly to a larger more specialised hospital.</li> <li>Less obvious cases will be taken to Stafford A&amp;E for an initial assessment. Walk-in cases to Stafford A&amp;E will also be assessed at Stafford A&amp;E.</li> <li>Processes and protocols will be established so that A&amp;E consultants in Stafford have remote access to a surgical opinion from the surgical teams at the larger more specialised hospital.</li> <li>The only exceptions to this are: <ul style="list-style-type: none"> <li>any minor surgical cases which can be managed by emergency physicians at Stafford A&amp;E (during the hours of 08:00 to 22:00); and</li> <li>any surgical case that is not urgent and where the patient can be brought back the next day for an elective/planned procedure.</li> </ul> </li> </ul>

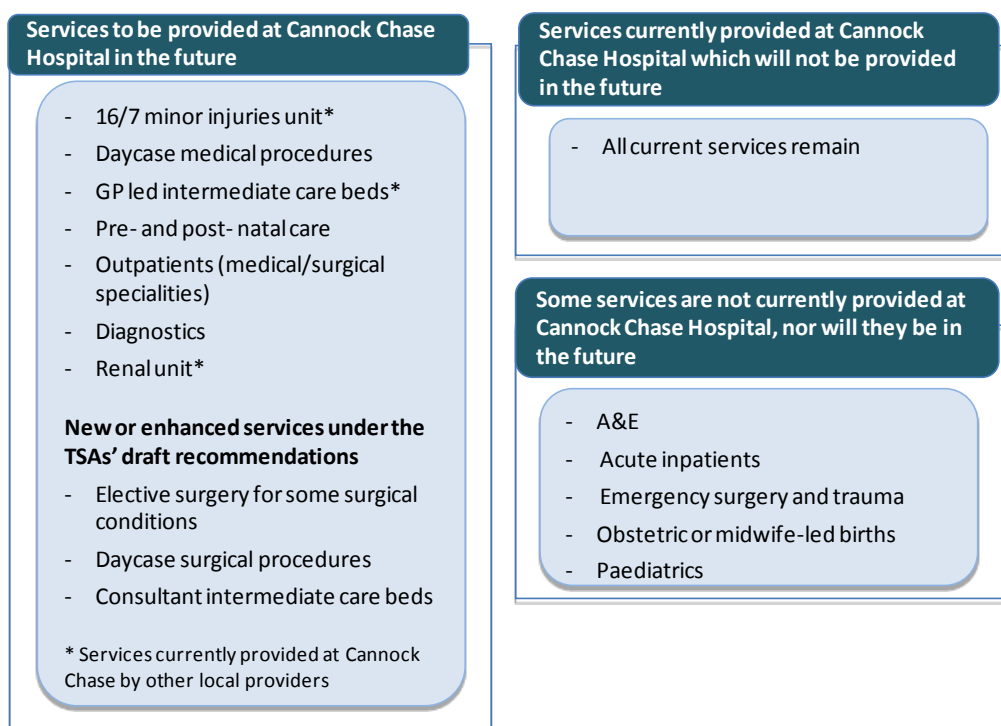


Draft recommendation	Rationale	Additional comments
<p><b>9:</b> A small critical care unit should be retained in Stafford in order to support the acute medicine and elective surgery services. This unit will provide 'level 2' (high dependency) care and a 24/7 rota of anaesthetists at Stafford who can deliver short term 'level 3' stabilisation of patients prior to their transfer to an appropriate critical care facility.</p>	<ul style="list-style-type: none"> <li>A range of services within Stafford Hospital need to be co-located with a critical care unit in order to operate a safe service. 39% of patients that are admitted to the critical care unit are surgical patients, specifically non-elective/emergency surgical patients.</li> <li>The reduction in the volume of surgical activity proposed will reduce the demand at Stafford for a critical care unit, especially 'level 3'/intensive care.</li> <li>The staffing levels required for a 'level 3' unit means that the current small unit is already financially challenging for MSFT, and this reduction in demand for 'level 3' care will make this even more challenging.</li> </ul>	<ul style="list-style-type: none"> <li>Although there will be less demand for critical care from post-surgery patients, the TSAs are recommending the retention of an acute medicine/care of the elderly inpatient service.</li> <li>The 24/7 rota of anaesthetists should be managed as part of a clinical network with a larger more specialised hospital.</li> <li>This service should comprise of a small number of 'level 2'/high dependency beds and the 24/7 presence of anaesthetists at Stafford.</li> </ul>
<p><b>10:</b> Elective surgery and day cases should remain in Stafford, but with a reduced number of specialties. The range of specialties will be determined through ongoing discussions with the CCGs and by the healthcare provider who ultimately operates services out of Stafford.</p>	<ul style="list-style-type: none"> <li>Elective work is typically high in volume and tariffs typically ensure there is a financial margin. This means that such work is attractive for healthcare providers as they typically deliver a positive financial contribution.</li> <li>Regardless of this, any provider of elective surgery needs to manage a critical mass of patient volumes through their elective service. This is essential due to the broad range of specialties covered by elective surgery and the need to maintain the skills of the professionals delivering the service.</li> <li>The need for a critical mass of procedure volumes is rising due to the increasing specialisation of surgeons and advances in medical technology.</li> <li>A range of elective procedures should be delivered at Stafford Hospital providing local access for elective care to Stafford-based residents.</li> </ul>	<ul style="list-style-type: none"> <li>This need for a critical mass at specialism and sub-specialism level is leading to a need to consolidate some specialties into a smaller number of sites. However, this doesn't mean consolidation of all specialties into a single site, rather that some hospitals within a Local Health Economy should deliver some specialties whilst other hospitals in the same Local Health Economy should deliver other specialties.</li> <li>The exact range of elective procedures that would be delivered in Stafford would be dependent on discussions with CCGs and the provider that operates the elective service.</li> </ul>

### The clinical model for Cannock

399. The TSAs' draft recommendations for services to be delivered in Cannock were based upon the establishment of a clinical network and were over and above those identified as LSS for Cannock, which were:
- Outpatients
  - Patient-facing diagnostics
  - Pre and postnatal care
400. Currently, Cannock Chase Hospital is poorly utilised in comparison to Stafford Hospital. Continuing in this manner is not feasible. Therefore, the TSAs' draft recommendations proposed that a broader range of services is offered in Cannock than at present and that these services should primarily be provided for the residents of Cannock Chase.
401. It is the TSAs' view that this can only happen if Cannock Chase Hospital is operated as a satellite hospital to a larger hospital than Stafford. The draft recommendations with regards to the services in Cannock were made on this basis.
402. Figure 11 summarises the service model proposed by the TSAs in their draft recommendations for Cannock.

Figure 11: The proposed service model for Cannock





403. A nurse led Minor Injuries Unit (MIU) is currently provided in Cannock by SSoTP. The service operates 16 hours a day, seven days a week (08:00 - 24:00). As the MIU is not provided by MSFT, it cannot be included in the development of LSS for Cannock. However, it is a stated commissioning intention of Cannock Chase CCG that there remains an MIU in Cannock. It may be appropriate for the provider who is delivering the majority of services in Cannock to take on the running of the MIU, but this would be subject to decisions made by the CCGs.
404. At present there is one ward, run by SSoTP, in Cannock Chase Hospital which provides 27 GP-run intermediate care beds (Littleton ward) which predominantly provides rehabilitation services. As with the MIU, this service was not considered for inclusion in the list of LSS as they are not provided by MSFT. Cannock Chase CCG wish to retain this service in Cannock as it is aligned with their commissioning intentions to reduce patient admissions to acute hospital beds.
405. Table 36 summarises the draft recommendations for the clinical model in Cannock.

Table 36: Summary of the TSAs' draft recommendations for Cannock

Draft recommendation	Rationale	Additional comments
<b>11:</b> A consultant led 'step down' facility should be introduced in Cannock to work alongside the existing GP-led intermediate care service.	<ul style="list-style-type: none"> <li>Currently, there are not substantial acute medical or surgical services in Cannock. Therefore, in order to support the commissioning intentions of delivering care closer to home, it is recommended that consultant led 'step down' beds are introduced into Cannock.</li> <li>This will enable the repatriation of Cannock patients from other hospitals (notably New Cross in Wolverhampton and the Manor in Walsall) to complete the rehabilitation and continuing care associated with their inpatient procedures. This in turn will release some capacity at those other providers.</li> </ul>	<ul style="list-style-type: none"> <li>The TSAs want to see closer working between health and social care providers to make sure patients are being treated in the most appropriate care setting and to avoid unnecessary and inappropriate hospital admissions. Therefore the TSAs proposed that the new 'step down' facility should be staffed by a multi-disciplinary team.</li> </ul>





Draft recommendation	Rationale	Additional comments
<p><b>12:</b> Elective surgery could be retained in Cannock. There will be a reduction in inpatient elective orthopaedic surgical activity as patients from Stafford and Surrounds will now be treated in Stafford, but this could be counteracted by the introduction of new surgical specialties into Cannock.</p>	<ul style="list-style-type: none"> <li>• The TSAs have recommended that elective orthopaedic surgery for Stafford patients should form part of the clinical model for Stafford. This means that there will be some elective surgical capacity in Cannock which could be used for other services.</li> <li>• A reduction in the elective surgical capacity in Cannock would cause a detrimental impact on the financial sustainability of Cannock services. This is not a desirable outcome.</li> <li>• The willingness of alternate providers to deliver elective inpatient surgery in Cannock could be influenced by their ability to use the capacity in Cannock to relocate activity that is currently being delivered at another site.</li> <li>• Therefore, the TSAs are recommending that an increased range of elective inpatient surgical procedures are established at Cannock.</li> </ul>	<ul style="list-style-type: none"> <li>• The current provision of elective inpatient surgery is predominantly limited to orthopaedics. Cannock has a suite of laminar flow theatres - which are necessary to minimise deep wound infections. MSFT currently provide orthopaedic surgery in Cannock for both Cannock and Stafford patients.</li> <li>• A key consideration, and one that the CAG has emphasised, is that the range of surgical procedures that can be provided in Cannock will be dependent on the level of overnight medical cover on site.</li> </ul>
<p><b>13:</b> The current range of day case procedures (surgical and medical), including the Rheumatology service, should be maintained and, where possible enhanced to provide a broader range of services.</p>	<ul style="list-style-type: none"> <li>• A range of day case procedures (surgical and medical) is currently provided in Cannock, including Rheumatology which is used by local patients and patients from outside of the catchment area. These services are clinically sustainable and are not detrimental to the financial sustainability of services in Cannock. Therefore, there is no rationale as to why they should no longer be provided in Cannock.</li> </ul>	<ul style="list-style-type: none"> <li>• A number of providers indicated that it may be possible to introduce a more comprehensive range of day case procedures into Cannock for the local population.</li> <li>• This would be possible by using a clinical network to rotate consultants and nurse specialists into Cannock from the provider's primary site.</li> </ul>

## Implications for MSFT as an organisation

406. To successfully deliver the proposed clinical model will require changes with the organisations delivering services in Stafford and Cannock. On this basis the TSAs' draft recommendations included one recommendation with regards to dissolving MSFT. This is set out in Table 37.

Table 37: The TSAs' draft recommendation for MSFT as an organisation

Draft recommendation	Rationale	Additional comments
<p><b>14:</b> In order to deliver the recommended clinical models for Stafford and Cannock, Mid Staffordshire NHS Foundation Trust should be dissolved.</p> <p>The services in Stafford and Cannock should be seen as individual models of care which should be delivered by organisations that can operate those services as part of effective clinical networks.</p>	<ul style="list-style-type: none"> <li>The draft recommendations for the clinical models in Stafford and Cannock are dependent on the use of clinical networks. Networking with a larger more specialised secondary care provider will enable a shared pool of resources to be deployed over multiple sites for some services (for example, A&amp;E, outpatient obstetrics, and critical care), addressing several of the clinical sustainability issues.</li> <li>If MSFT continues to operate as a standalone organisation, then a number of the necessary draft recommendations will not be possible. The financial margins associated with elective and emergency/non-elective activity differ and if the proposed reorganisation of activity were between hospitals operated by two separate trusts, then it would negatively impact the trust receiving more non-elective activity. Therefore, TSAs believe the clinical networks would need to be operated from within a single organisation (through a merger, acquisition or transfer).</li> </ul>	<ul style="list-style-type: none"> <li>The TSA believes that it is unlikely a single provider will be able to provide the proposed service models for both Stafford and Cannock. Therefore, the proposed service models have been developed on the assumption that Stafford and Cannock are networked with different hospitals.</li> <li>On this basis, the TSAs believe that in the future Stafford and Cannock Chase Hospitals should no longer be part of the same organisation. The TSAs have concluded that Mid Staffordshire NHS Foundation Trust should be dissolved at an appropriate point in time to enable the recommended clinical models to be established.</li> </ul>

## Funding required to deliver the TSAs' draft recommendations

407. The TSAs estimated the level of funding that will be required to:
- manage the transition of services to proposed service model;
  - subsidise the deficit associated with MSFT during that transition period;
  - invest in the redevelopment and refurbishment of the hospitals in Stafford and Cannock to enable the safe and sustainable delivery of services proposed for retention at those sites; and
  - invest in the development/reconfiguration of facilities at some providers in the local healthy economy in order to enable the safe and sustainable delivery of those services that will no longer be delivered in Stafford and/or Cannock.

408. Table 38 sets out the range of funding estimated by the TSAs to deliver the draft recommendations.

Table 38: A summary of the estimated funding requirements to deliver the TSAs' draft recommendations

Cost element		Amount (£)
Transition costs	Deficit funding	£77.1m
	Implementation costs	£18m
	Redundancy costs	£5.3m
	Double running costs	£8m
	Sub-total	£108.4m
Capital expenditure		£112m - £197.4m <sup>48</sup>
Total		£220.4m - £302.8m

### Actions that would support the TSAs' draft recommendations

409. The TSAs have identified a range of actions that, if implemented alongside the draft recommendations, could support the delivery of the TSAs draft recommendations:
- Commissioner led demand management initiatives through improvements in care pathways and hospital admission prevention schemes. The TSAs believe that delivering demand management benefits will deliver benefits for the local population by ensuring some patients are treated in a care setting more appropriate than an acute hospital;
  - Investment in the ambulance service is essential. This investment will ensure that the ambulance service is able to transport patients safely and appropriately to other hospitals when it is not appropriate for them to be taken to Stafford, and also to transfer patients to Stafford or Cannock from another hospital when they are repatriated into the step down beds at each hospital (as per the TSAs' draft recommendations). The TSAs have been engaged with the West Midlands Ambulance Service throughout the TSA process;
  - Care pathways are often delivered by multiple care providers. Stafford and Surrounds and Cannock Chase CCGs are working to develop a prime provider model for Cancer, End of Life Care and Dementia services. The principle of a prime provider model is that one provider looks after the whole care pathway and sub-contracts elements of the pathway to organisations which have the capability and capacity to deliver those elements. The objective and benefits of

<sup>48</sup> The range in capital expenditure is due to the differing assessments of the capital requirement made by the TSAs and local providers



the model would be to increase integration of services, reduce fragmentation of the clinical pathway and create a more seamless delivery of care for patients. It is possible that this model could be implemented for other services, should the pilots be successful; and

- A gain share arrangement for reducing inappropriate admissions into hospital is currently being piloted between commissioners in the North of Staffordshire with SSoTP with the objective of reducing admissions to UHNS. A similar scheme for MSFT could be adopted as MSFTs' admission rates are higher than the national average.



## 10 Summary of the consultation

410. The TSAs have overseen a wide consultation that has gone beyond the statutory obligations placed upon the TSAs (as summarised in Section 3).
411. Volume Two of this report is a detailed summary of the consultation process, the responses received by the TSAs – including the independent report on the consultation responses prepared for the TSAs by Ipsos Mori – and the TSAs' assessment of and reaction to these responses.
412. This section summarises the information presented in Volume Two and also summarises the process the TSAs have undertaken to assess and react to the consultation responses.

### 10.1 Overview of the consultation

413. The TSAs have overseen a public consultation whose process and timeframe is set out in statute in Chapter 5A of the National Health Service Act 2006.
414. The consultation ran from 00:01 on Tuesday 6 August 2013 and finished at midnight on Tuesday 1 October 2013. This period was the statutory period of 30 working days plus the extension of ten working days granted to the TSAs.
415. The TSAs prepared and published four documents to support the consultation process:
- The full draft report - over three volumes - that was submitted to Monitor and which was laid before parliament;
  - The consultation document that summarised the draft report and whose intended audience was the general public;
  - An easy read version of the consultation document; and
  - A consultation response form, which included: a) a series of 'closed' questions with regards to support or opposition to each of the TSAs' 14 draft recommendations; and b) multiple opportunities to provide additional comments on the work of the TSAs and their draft recommendations.
416. During the consultation period the TSAs have made every effort to engage with the public and other stakeholders, including but not limited to the following actions:
- At the start of the consultation period ca. 115,000 postcards advertising the public meeting dates were delivered to all households in the Trust's catchment area;



- The dates for the public meetings were widely advertised in local media;
- ca. 50,000 consultation documents and response forms were distributed to over 700 organisations within Staffordshire including GP practices, libraries, charities and schools;
- The consultation documents were made available to download from the TSA website;
- Copies of the consultation document were handed out to all attendees at each of the public meetings;
- The TSAs attended ca. 110 meetings with the public, staff and stakeholder groups during the consultation period, including:
  - Eight public meetings, at which over 2,600 people attended;
  - Three additional public meetings, hosted by and at the invitation from various stakeholders;
  - Over 20 staff meetings (in total) at both Stafford and Cannock Chase Hospitals, including open meetings where any member of staff could attend, and specific meetings for staff working in services that would be directly impacted by the TSAs' draft recommendations;
  - Weekly meetings with local CCGs – 25 meetings have been held with CCGs since the TSAs' appointment; and
  - Over 80 meetings with key stakeholder groups.
- Audio recordings of each of the public meetings were made and uploaded onto the TSAs' website<sup>49</sup>;
- The TSAs engaged with the public online through the TSA website and via their Twitter account. Since the TSA website was launched it has received more than 14,900 hits of which more than a third (5,800) were received during the consultation period;
- The TSAs received over 2,800 consultation response forms, emails and letters during the consultation period, which were all considered in drafting the final recommendations; and
- The TSAs responded to every email and letter received during the consultation – the majority of responses being provided within two working days – answering direct questions and forwarding on all questions and comments to Ipsos Mori.

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<sup>49</sup> <http://tsa-msft.org.uk/media/audio/>

## 10.2 Responses to the consultation questions

417. In total, the TSAs have received over 2,800 responses to the consultation. All responses to the consultation were collated by Ipsos Mori. This included all questions and issues raised directly with the TSAs via letters and emails as they were subsequently forwarded onto Ipsos Mori for inclusion.
418. Ipsos Mori conducted an independent analysis of the responses and submitted a report to the TSAs following the consultation. The full report is included in Annex 3.5, and what follows are some relevant extracts from the report with regards to the responses to the consultation.

*The consultation ran for 40 working days and received a total of 2,874 responses. Respondents used a number of channels to feed back their views:*

- A response form with questions about each of the recommendations, available online and in hard copy
- Written comments submitted in letters and e-mails
- Petitions
- Attending one of the formal public meetings (eight were held in total), with opportunities to ask questions directly to the TSAs or submit a question form
- The Health and Equality Impact Assessment steering group, established by the TSAs to provide independent advice and to commission a Health Equality Assessment of their proposals, also held consultation events and conducted supplementary qualitative research.

*The numbers of each received are detailed below.*

Method	Total
Hard copy response forms	2,042
Online response forms <sup>50</sup>	457
Written comments from individuals (letters & emails)	284 <sup>51</sup>
Written comments from stakeholders (letters & emails)	90
Petitions	1 <sup>52</sup>
<b>TOTAL</b>	<b>2,874</b>

419. The TSAs are aware that a petition was prepared and presented to Parliament by Jeremy Lefroy in July 2013. This petition was established in response to the recommendations of the CPT and was presented to Parliament before the TSAs had

<sup>50</sup> Multiple responses were accepted from individual IP addresses to ensure, for example, that staff from the same department were all able to submit individual responses. The 457 completed online responses came from 209 unique IP addresses. One IP address accounted for 68 of received responses via the online response form; this IP address was registered to the NHS.

<sup>51</sup> This includes 133 responses from individuals received using one of the Support Stafford Hospitals campaign templates.

<sup>52</sup> One petition was received in response to the consultation. This was on behalf of Drakeford Court Residents Social Club, and it contained 30 signatures.

published their draft recommendations and started their formal consultation. Therefore, the position that the TSAs are required to take is that this petition was not in response to their draft recommendations. However, the TSAs acknowledge the strength of public support for the retention of acute services in Stafford (it is the first common response theme that we address below) and know that the issues raised in the petition around A&E, critical care and maternity have also been raised in the public meetings and through the consultation responses.

420. The TSAs have reviewed the Ipsos Mori report and used it to inform their response to the consultation. It has informed the TSAs' thematic review of the consultation feedback and has informed the revisions made to the TSAs' recommendations.

### **10.3 Formal stakeholder responses**

421. In total 122<sup>53</sup> formal responses were received from organisational stakeholders. Most of the stakeholders agreed that there was a need for change, with some commenting on the difficulties involved in finding a clinically and financially viable solution.
422. The TSAs have included unedited copies of each of these responses in Volume Two of this report.

### **10.4 Common themes from the consultation responses**

423. There are a number of common themes that have been repeatedly stated in the consultation meetings with the public and staff, the correspondence received by the TSAs and the submitted responses to the consultation. These themes covered a range of issues, questions, challenges and support (or otherwise) that the TSAs would need to address when preparing their final recommendations. These common themes have been used to inform the ongoing work of the TSAs.
424. In order to provide respondents with more information and to clarify areas of misinterpretation, the TSAs published a range of FAQs on their website, during the consultation, to address emerging themes and questions.
425. Table 39 sets out the common themes from the consultation and the TSAs' response to each. This includes common themes that relate to multiple recommendations.

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<sup>53</sup> This includes 89 letters and 33 responses on response forms.



Table 39: Common consultation themes and the TSAs response

Common response theme	TSA response
A wish to retain all current acute services in Stafford and Cannock	<p>The TSAs recognise the desire from the local communities to retain all acute services in Stafford and Cannock.</p> <p>The process undertaken by the TSAs to develop their draft recommendations explicitly states in their guiding principles (see Section 9) that <i>“Where possible, services should be retained locally. Moving any single service away from the current locality must be discretely justified”</i>.</p> <p>The decision to recommend the removal of any services from Stafford or Cannock has been made for either clinical and/or financial sustainability reasons. The TSAs have also had to consider the impact on the local health economy.</p> <p>The TSAs have also taken into account the impact of their proposals through the establishment of the independent HEIA steering group.</p> <p>Finally, the TSAs have, through their discussions with multiple providers, not identified one provider, or indeed a combination of providers, who would be willing to provide the full range of services currently provided by MSFT (for example, no provider has proposed to deliver obstetrician led births, emergency surgery or inpatient paediatrics in Stafford<sup>54</sup>).</p>
The standards, reputations and financial issues of other hospitals in the Local Health Economy relative to Stafford and Cannock Chase Hospitals	<p>The TSAs accept that the quality of many of the services at Stafford and Cannock Chase Hospitals are good and that they are currently safe. However, MSFT is not clinically or financially sustainable in its present form. This means that the hospitals will not be able to provide safe, high quality services within budget in the future unless things change.</p> <p>However, the CCGs will only commission services from other organisations when they are able to demonstrate their own quality standards meet the expectations set by the NHS.</p> <p>The TSAs note that in the recently published CQC risk assessment categories (see Section 8) MSFT was placed into Category 4 (where category 1 is high risk and category 6 is low risk). The three local trusts who submitted formal proposals to deliver a range of services in either Stafford or Cannock (UHNS, RWT and WHT) were all placed in lower risk categories than MSFT (UHNS &amp; RWT = 5, WHT = 6).</p> <p>The financial position at UHNS was cited as being of particular concern. Currently the forecast deficit of UHNS is £31m for 2013/14. It was suggested by some that UHNS would use Stafford Hospital to solve its own problems and not focus on delivering sustainability for Stafford based services.</p> <p>The TSAs have worked very closely with other providers to ensure that the recommendations are affordable for all parties. However, the TSA process is not about dealing with any financial difficulties of any other trust, those issues are for their own organisations to deal with.</p>

<sup>54</sup> Section 9.6, paragraphs 274 – 277, Draft Report of the TSAs.



Common response theme	TSA response
Concerns regarding travel times and the impact on patients, especially: <ul style="list-style-type: none"><li>• <b>Transporting patients will be unsafe and have a detrimental impact on their health;</b></li><li>• <b>Local infrastructure is insufficient to support the additional movements; and</b></li><li>• <b>The proposed changes will detrimentally impact the ability of friends and families to visit patients.</b></li></ul>	<p>The TSAs' draft recommendations will mean that 91% of patient attendances will remain locally in Stafford or Cannock. Indeed, for some of the patients in the 91%, journey times will be reduced as more services will be provided at Cannock Chase Hospital for Cannock residents and orthopaedic surgery will now be provided at Stafford Hospital as well as Cannock Chase Hospital. For a more detailed breakdown of what happens to the 9% of patient attendances, see Section 13.</p> <p>The transportation of sick patients to larger centres which are further away than smaller hospitals is a concept which, in recent years, has been implemented in a number of areas both in Staffordshire and nationally. For example, in Staffordshire major trauma patients and acute stroke patients are taken to specialist hospitals such as UHNS instead of Stafford Hospital.</p> <p>The TSAs have considered the distances that patients would be expected to travel to receive some services in the future if they were to be provided at other providers within the local health economy. The TSAs' view is that these journeys would not be excessive when compared to journeys already being made in Staffordshire by some people. The TSAs do accept that there will be changes for patients in how they access their hospitals but this, in the TSAs' view, should not have a detrimental impact on their health.</p> <p>Furthermore, the independent HEIA steering group also looked at the increases in travel times as one of their key impact areas. The detail of their independent assessment can be read in Volume Four of this report, but their conclusion was that the increases in travel times associated with the TSAs' recommendations are within the norms for travel for NHS services nationally and will not have a detriment to health outcomes. Their assessment concluded that the evidence demonstrated that in some specialist areas (especially paediatrics), the centralisation of services will lead to better health outcomes.</p> <p>The HEIA report (see Section 11) stated '<i>.. from the evidence it appears that these journeys will be safe and unlikely to lead to poorer outcomes.</i>'</p> <p>A number of respondents raised concerns about the ability to travel on the M6 due to it frequently being blocked either from heavy traffic or regular accidents. The HEIA looked at this specifically and their report noted: '<i>the Steering Group recognises that the M6, if congested, will significantly increase journey times within Stafford and to Walsall. Traffic data show that M6 users would have benefited from diverting off the motorway and using Stafford's local road network on 11 occasions in 2010/11 (for both directions of travel). This indicates that periods of an extraordinary increase in congestion within Stafford are relatively few.</i>' The impact of using the local road network in such circumstances was included in the overall travel time data set which was assessed by the HEIA and to which they reached the conclusion above.</p> <p>The HEIA also identified a number of mitigations that could be put into place to minimise the impact on the affected groups, including: more ambulances, greater parking and more relative's accommodation at other hospital sites. These specific areas are discussed in more detail in the TSAs' detailed response to the consultation.</p>

Common response theme	TSA response
The data used by the TSAs when drafting their recommendations was incorrect	<p>There were several challenges to the TSAs with regards to the data that had been used as the basis for their draft recommendations, particularly in paediatrics and obstetrics. Several of these challenges were raised at the start of the consultation process, so the TSAs reviewed their numbers with the departments at the Trust who had raised the challenges – especially as the TSAs had used Trust owned data as the basis for their work – to understand why there was a difference of opinion. In doing this the TSAs have identified three main drivers for the different views:</p> <ul style="list-style-type: none"> <li>• The TSAs used spell level data to develop the baseline in activity for the volume of inpatients. Spell level data is made up of one or more clinical episodes. For example, a sick child who is assessed in the Paediatric Assessment Unit (PAU) before being admitted to the paediatric ward would have two clinical episodes (PAU and paediatric inpatient ward) but only one spell of care is used to determine the level of activity which is paid for by commissioners. However, some departments at the Trust collate episode level data locally – which would by definition be a higher number than spell level data. The TSAs have continued to use the spell level data as their baseline because this is consistent with how commissioners and providers agree their activity volumes during contract planning processes;</li> <li>• In some circumstances the descriptions used by the TSAs to present the numbers caused confusion and different interpretations of the TSAs draft report. The TSAs have noted these areas and have updated the descriptions around some of the numbers to avoid confusion; and</li> <li>• There were two instances where the data presented by the TSAs was incorrect. The first was the current opening hours of the PAU which was stated to be 14 hours a day, when in fact it operates 24 hours a day. This was identified in the first week of the consultation and an addendum was immediately released. The second data error was the number of paediatric admissions direct from GP referral which was a sub-set of overall admissions. The change to the number does not have an impact on any recommendation and has been updated in the TSAs' final report.</li> </ul>
The proposed changes will have a negative impact on other hospitals in the Local Health Economy; There is insufficient capacity at other hospitals to manage the activity no longer provided in Stafford or Cannock	<p>The levels of available capacity in the Local Health Economy was one area which was assessed by commissioners when deciding on their LSS. Indeed some services were designated as LSS in the short term and until such a point that capacity in the system has been established.</p> <p>The lack of immediate capacity in some services has been noted and acknowledged by the TSAs at every step of the process. The TSAs' position – and indeed that set out in the guidance the TSAs are following - is that no services should be moved until local commissioners are satisfied that there is sufficient and appropriate capacity available across the Local Health Economy.</p> <p>The TSAs' assessment of the cost of their recommendations includes funding for capital investment at other hospitals in order to ensure there is sufficient capacity.</p>



Common response theme	TSA response
The proposed changes will have a negative impact on junior doctors and other training at Stafford and Cannock Chase Hospitals	<p>The provision of training posts for trainee doctors and other students is mostly dependant on the availability of senior clinicians to supervise work and access and exposure to an appropriate volume and mix of patients. It is also important that trainees have the ability to train in different settings.</p> <p>In some areas MSFT have struggled to offer appropriate training posts due to the current clinical sustainability issues (due to the low volume of patients and the ability to attract and retain staff to key clinical posts).</p> <p>This situation is likely to worsen in the future and if no changes are made the ability to be able to offer sufficient training opportunities is likely to diminish.</p> <p>The TSAs' model will improve the recruitment and retention issues that are currently being faced, a point supported by the CAG. In doing so there will be more senior clinicians recruited to posts which are currently difficult to fill. This will provide more opportunities for supervision for the services being retained in Stafford.</p> <p>The TSAs recommendations will see 91% of current activity remaining in Stafford or Cannock. This represents a significant volume of patients still being treated at the hospitals for the services which are being retained. Most services in the TSAs recommendations will also be networked with another provider meaning that members of staff will have the opportunity to work across multiple sites, and sites which have much higher acuity and more sub-specialties. This will increase the exposure to patients, conditions and services.</p> <p>If the TSAs' recommendations are implemented and during the implementation phase, the relevant providers and education providers will need to review the education and training opportunities at Stafford and Cannock Chase Hospitals to ensure they are fully taken advantage of.</p>

Common response theme	TSA response
The TSAs evidence base is flawed and the use of Royal College guidelines and the Royal Colleges involvement in the CAG is inappropriate	<p>The TSAs have a duty to deliver a clinically sustainable and safe model of care for the services currently provided by MSFT. In performing this function the TSAs have not undertaken a detailed review of the published evidence for every service or specialty published nationally or internationally. Instead the TSAs have used the guidance published by the recognised professional bodies for the NHS in England and Wales. The Royal Colleges guidelines are based on best practice evidence and the TSAs believe that these guidelines are the appropriate benchmarks to use.</p> <p>The TSAs only drew conclusions where, in assessing clinical sustainability, MSFT fell significantly below Royal College guidelines (for example, number of births in a viable obstetric unit, the catchment population for a hospital operating all acute services, staffing levels in specific services).</p> <p>The TSAs have also sought advice and direction from the Clinical Advisory Groups to understand the safety and recruitment and retention issues associated with the clinical models under consideration. Two CAGs were established: the National Clinical Advisory Group (CAG) and the National Nursing and Midwifery Advisory Group (NMAG).</p> <p>The CAG is chaired by the Academy of Medical Royal Colleges, and the TSAs asked the Academy to nominate independent clinical experts from the Medical Royal Colleges in the clinical areas relevant to MSFT, including physicians, obstetricians, gynaecologists, surgeons, paediatricians, pathologists, radiologists, anaesthetists, public health physicians, GPs and emergency doctors.</p> <p>The NMAG members were nominated, primarily, by the NHS Chief Nurse. The group consisted of senior nursing and midwifery leaders currently practising in the NHS and members of the RCN and RCM.</p> <p>The TSAs also engaged with clinicians from local provider and commissioning organisations to develop plans which are viewed locally as safe and sustainable models of care. This local Clinical Reference Group was consulted initially to provide a view of the clinical sustainability of the draft recommendations.</p> <p>The advice received from the clinical advisory groups was viewed by the TSAs in the context of and alongside assessments of the impact on financial sustainability. The CAG have stated that their conclusion that the TSAs' clinical model is safe and sustainable, does not mean there are no other models of care that could be clinically sustainable. Alternate proposals from some of MSFT's clinical leaders were presented to the clinical advisory groups and they were deemed clinically sustainable. However, these have not formed part of the TSAs' final recommendations as the TSAs have assessed that they would impact other areas of sustainability. These have been discussed in more detail in the response to the relevant recommendations.</p>

Common response theme	TSA response
The TSAs didn't sufficiently involve local staff in developing their draft recommendations	<p>The TSA process at MSFT is the first of its kind and the TSAs had to design a process that would enable them to put forward a realistic set of recommendations, for consultation, within a very short period of time. To ensure they could develop their draft recommendations within the required timeframe, the TSAs decided to engage with five key groups during the period allocated to drafting their recommendations:</p> <p><b>1: Senior management of MSFT:</b> The TSAs started discussions with the Trust's senior management team from the outset, to understand what changes to the clinical model they thought would be achievable and realistic. The senior management team were clear that the solution would need to make extensive use of clinical networks in order to address the clinical sustainability issues. This was taken on board by the TSAs and is evident in the TSAs' draft recommendations.</p> <p><b>2: The Programme Management Office (PMO) of MSFT:</b> The TSAs worked with the PMO from the outset to coordinate the gathering of appropriate and consistent data needed to inform the TSAs' draft recommendations.</p> <p><b>3: National clinical advisors:</b> The TSAs formed the national clinical advisory groups to ensure that any proposals would be clinically safe and aligned with the views of the Royal Colleges as to the direction of travel for the delivery of healthcare services.</p> <p><b>4: Local commissioners:</b> The TSAs met routinely with commissioners to ensure that any proposals were in line with LSS and their commissioning intentions.</p> <p><b>5: Healthcare providers, especially those in the Local Health Economy:</b> The TSAs conducted a market engagement exercise, to ensure there would be providers willing to deliver the proposed clinical model. Without this any model would merely be a theoretical one.</p> <p>The TSA process is, by necessity, an assessment of the delivery of healthcare services over a 10-15 year period. The TSAs therefore decided that early engagement with the senior management team at MSFT would give them the local strategic context needed to inform their draft recommendations (in alignment with Monitor's guidance), but that it would be most appropriate to consult with staff working in specific services during the consultation process.</p> <p>During the consultation, the TSAs held 34 meetings with a range of staff groups and MSFT members, at both Stafford and Cannock Chase Hospitals. These meetings included open meetings where any member of staff could attend, and specific meetings for staff working in service that would be directly impacted by the TSAs draft recommendations.</p> <p>The comments and views made by the staff at these meetings have been reviewed and considered, alongside all of the consultation feedback.</p>

Common response theme	TSA response
MSFT and the local population are being punished for past failings. and	The findings in the Francis Report are well documented. Many patients received poor care during a period of time, some years ago. Since then the Trust has been subject to multiple reviews and changes which have placed additional scrutiny and pressures on it. The Trust has responded since then to make significant improvements and the current standard of care has not been questioned.
The TSAs' conclusions could equally apply to many other hospitals in the UK. In arriving at their conclusions, the TSAs are making an unfair and inappropriate comparison.	<p>However, the Trust has been in breach of its terms of authorisation as a Foundation Trust since 2009 on the basis of its financial position. No other Foundation Trust has been in breach for such a prolonged period of time. This is the reason that Monitor appointed the TSAs.</p> <p>Whilst the Trust's current deficit position of ca. £20m is less than a number of other trusts facing financial challenges, when you consider the deficit as a proportion of income MSFT position stands at ca. 13%. This is considerably higher than most organisations that are similarly challenged.</p> <p>The TSAs have been aware throughout this process that as a small district general hospital, MSFT is not unique in facing some of the challenges described earlier in this report. However, the TSAs' scope of work has been to only look at MSFT and the services it provides.</p> <p>As has been described earlier, MSFT remains one of the smallest DGHs in England and is delivering a range of services that are clinically and financially unsustainable.</p> <p>The TSAs sole objective was to make a series of recommendations that would secure the sustainable delivery of the services currently provided by MSFT.</p>

426. As previously stated, all of these themes were repeated by multiple parties. In preparing their final recommendations, the TSAs have considered those common themes that relate to their draft recommendations alongside some very specific comments for each recommendation. The TSAs have sought to balance the consultation feedback alongside the rationale for making each of the recommendations and the three changes proposed have been made as a direct consequence of the feedback received.

## 10.5 Process undertaken to review and account for consultation responses

427. Following the end of the consultation period, the TSAs have undertaken a process to review the feedback received and to develop this final report containing their final recommendations.
428. As stated, the TSAs have received over 2,800 responses to the consultation. Given the timescales involved it has been essential that the TSAs establish and follow a clear process for reviewing the responses. This process is summarised below in Table 40.



429. The process the TSAs have followed has not been sequential and some of the elements have run concurrently.

Table 40: The process followed by the TSAs to review the consultation responses

Process step	Action
Regular internal reviews of the consultation responses	The TSAs reviewed the formal stakeholder responses as they were received during the consultation. The majority of the responses were received in the last week of the consultation period, so the TSAs and the team working with the TSAs held multiple internal review meetings during the period allotted to prepare their final report. The purpose of these meetings was to identify additional themes being put forward beyond those already recorded.
Detailed review of formal responses	<p>The TSAs conducted a detailed review of the formal stakeholder responses. This review identified all challenges, questions and alternative solutions proposed in the stakeholder responses. The majority of these aligned with the themes already identified by the TSAs in their initial assessment of stakeholder responses.</p> <p>For those that could not be aligned with a key theme, the TSAs considered whether: a) it was appropriate to respond (for example, a number of the issues raised fell outside of the remit of the TSAs); b) it would change any of the draft recommendations; and c) whether it required the TSAs to undertake any further analysis.</p>
Review of Ipsos Mori reports	The TSAs received an early draft of the Ipsos Mori report that presented the final analysis on the responses against each of the closed questions. The TSAs used this to begin to gauge the support or opposition levels to each of their recommendations and to further develop the emerging themes to consider whilst developing their final recommendations. When Ipsos Mori submitted their final report, the TSAs conducted a further review to finalise and test the key themes from the responses and assess whether any of the information would impact the TSAs' recommendations. Overall, the majority of the responses were consistent with the formal responses previously reviewed and the feedback given to the TSAs during the consultation process.
Review of HEIA memos and report	<p>The independent HEIA steering group issued a series of memos to the TSAs during the period of their assessment. These memos are included as appendices to the HEIA report (Volume Four) and gave the TSAs early indications as to the likely conclusions and proposals that would be made by the HEIA steering group.</p> <p>The TSAs reviewed these memos to understand whether any of these proposals would impact any of the 14 recommendations. The memos contained a number of proposals for mitigating actions and further information that the HEIA expected to see in the final report. Where appropriate, the TSAs have included these in their detailed descriptions of the recommendations.</p> <p>The HEIA steering group submitted their full report to the TSAs in the third week of this phase of work. Whilst none of the proposals have caused the TSAs to change their recommendations, some have helped the TSAs address areas where TSAs needed to provide further information and assurances with regards to their recommendations.</p> <p>More detail on the HEIA and the TSAs response to the HEIA is included in Section 11.</p>



Process step	Action
Identify if any recommendations should be modified	Based upon: a) the review of the formal responses; b) the draft Ipsos Mori report; and c) the further work of the TSAs during consultation, the TSAs began the process of determining whether it would be appropriate to modify any of their draft recommendations. The provisional view of the TSAs at this stage was that there were three recommendations (5, 7 and 9) that should be changed in the TSAs' final report.
Review with CAG	The TSAs redrafted the three recommendations that they determined should be modified. These recommendations were then taken to a combined meeting of the National Clinical Advisory Group and the Nursing and Midwifery Clinical Advisory Group in order for that group to provide their professional opinion as to whether the redrafted recommendations would be clinically appropriate.
Review with CCG	The TSAs presented the redrafted recommendations to the CCGs, in order to assure themselves that: a) the redrafted recommendations were in line with the CCGs' commissioning intentions; and b) satisfied the need to preserve the delivery of the LSS.

430. The outcome of the TSAs assessment of the consultation responses is provided in Annex 3.6 and is summarised in Sections 10, 12 and 13.
431. In addition to the common response themes and the repeated concerns, questions and challenges associated with individual recommendations (covered in Sections 12 and 13), there have been other comments/questions repeatedly raised in the consultation responses. Many of these relate to areas outside of the scope of the TSAs, areas that cannot be addressed until implementation, or areas that have been covered by previous FAQs. Annex 3.6 summarised the small number of questions/comments not covered by the FAQs or addressed in this main report.

## 11 The independent Health and Equality Impact Assessment

432. Monitor's guidance for TSAs states:

*"Throughout their work, the Trust Special Administrator will be required to observe equality legislation and principles and demonstrate that due regard has been paid to the equality duty of the Equality Act 2010. The equality assessment should apply to patients, public and staff. It is recommended that the assessment is undertaken early on in the failure regime to allow the Trust Special Administrator to identify, for example, groups with protected characteristics that may be affected and which their draft report can take into account."*

433. To ensure that the TSAs' work met this requirement, the TSAs established an independent HEIA.

434. The HEIA was established to provide independent advice to the TSAs. The HEIA has been convened with an **independent chair** and a membership that is **independent to the TSAs and the Office of the TSAs**. The Office of the TSAs provided information and analysis to support the work of the HEIA, which has been ongoing throughout the consultation period.

435. The HEIA is being chaired by an independent chair, Sophia Christie. Sophia has previous experience in managing impact assessments, through her role as chair of the HEIA sub-group of the Joint Committee of Primary Care Trusts for the Safe and Sustainable review.

436. The membership of the HEIA includes five public and patient representatives, including the Chief Executive of Engaging Communities Staffordshire.

437. The other members of the HEIA are:

- The Director of Public Health, Staffordshire County Council;
- The Commissioner for Care, Staffordshire County Council;
- The Commissioner for Transport and the Connected County, Staffordshire County Council;
- The Head of Policy and Improvement, Staffordshire County Council;
- The CCG Public Health Lead, Stafford and Surrounds CCG and Cannock Chase CCG;
- The Head of Specialised Commissioning (West Midlands), NHS England; and
- The Accountable Officer, Stafford and Surrounds / Cannock Chase CCGs.

438. The TSAs' draft report included the terms of reference for the HEIA and its scoping report was included as an Annex to the draft report (Volume Three). An unedited copy of the HEIA's final report is included as Volume Four of this report and an unedited version of the executive summary is included in this section.

## 11.1 HEIA report – Executive summary

439. What follows is an unedited extract of the executive summary to the HEIA report with the exception that the technical footnotes have not been included in this extract. In the next sub-section the TSAs have provided a brief response to the conclusions of the HEIA steering group.

### 1.1 Purpose, objectives and timing of the impact assessment

Monitor, the national regulator for foundation trusts, has appointed Trust Special Administrators to manage Mid Staffordshire NHS Foundation Trust (MSFT) and develop proposals for the future provision of services at its two hospital sites: Stafford Hospital and Cannock Chase Hospital. The proposals represent significant changes within the definition of the Equality Act 2010, which establishes a general equality duty on public authorities to have due regard to “understand the potential impact of their decisions on people with different protected characteristics” and “identify potential mitigating steps to reduce or remove adverse impacts”. A Steering Group has been engaged to carry out an assessment of the impact of the TSAs' draft recommendations. The assessment has been carried out in two parts:

- The Scoping Report: understanding the local population and its health status, including prioritising sub-groups within this local population; and
- The Impact Assessment Report (this document): describing (both qualitatively and quantitatively) the impacts of the TSAs' draft recommendations and providing proposals to potentially minimise negative and maximise positive impacts.

### 1.2 Governance and scope of the impact assessment

The TSAs wished to ensure an objective and independent assessment of Health and Equality Impact. They therefore appointed a chair who is independent both of themselves and of Monitor, and asked her to convene a Steering Group to oversee the impact assessment process. The chair selected members of the Steering Group to bring a balance of professional and technical expertise and stakeholder perspectives, including active participation by patient representatives and members of the public.

The Steering Group has the remit to assess the potential health and equality impact of the TSAs' draft recommendations for the local population of the hospitals, according to guidance set out by HM Government. After assessment (as set out in the Scoping Report), the Steering Group defined the population of impact as the 276,500 people who make up the registered population of the two local clinical commissioning groups of Stafford and Surrounds Clinical Commissioning Group (CCG) and Cannock Chase CCG.



### **1.3 The in-scope characteristics**

The protected characteristics set out in the Equality Act 2010 are: age; disability; gender reassignment; race (this includes ethnic or national origins, colour or nationality); religion or belief (this includes lack of belief); sex (gender): and sexual orientation. The Act also applies to marriage/civil partnership and pregnancy/maternity but largely for the purposes of preventing discrimination in employment. Based on the nature of the TSAs' recommendations and the local population profile, the Steering Group agreed in the Scoping Report that the focus of the impact assessment for MSFT should be on age, disability, sex (gender) and race. The Steering Group also agreed to add two further areas of concern to the list of in-scope characteristics: socioeconomic deprivation and rural isolation.

### **1.4 Assessment of impacts**

#### **1.4.1 Overview of the impact assessment process**

Monitor has established a strict timescale for the administration process. The health and equality impact assessment has therefore run parallel to the TSAs' development of their draft recommendations, as published in July 2013. Throughout this impact assessment, all mentions of the TSAs' plans for MSFT refer to these draft recommendations, which are subject to change following the public consultation. As not all of the TSAs' draft recommendations were specific, it has not been possible to carry out a detailed analysis of the recommendations relating to either elective and day case services, or to the impact on staff. Any further changes to services arising from the consultation or as otherwise set out in the TSAs' final recommendations to Monitor should also be considered according to the approach set out here.

The TSAs' draft recommendations have prompted concern both across the local community and amongst the MSFT workforce. The Steering Group understands the anxiety that such significant proposals for the local hospital are bound to cause. Based on the qualitative evidence gathered from focus groups, much of this concern has been driven by the perception that all access to hospital services will be affected, including outpatient and elective/day case surgery, which are the services most used by local people. In fact, the TSAs' draft recommendations are centred on the removal of obstetric delivery (birth), inpatient paediatrics, emergency surgery and level 3 critical care from Stafford Hospital, together with the establishment of a frail elderly assessment unit (FEAU) there. These are services which most people use only on an occasional basis. Services at Cannock Chase Hospital will broadly remain as they are now, with some potential to extend the range of activity, and there will therefore be a minimal or positive impact for users of that site.

The Steering Group's assessment has focused on the services that the TSAs have recommended removing from Stafford Hospital, and has considered both issues arising from analysis of the data and those voiced as concerns by local people. The Steering Group welcomes the public debate on the proposals, and recognises that the review of services at Stafford Hospital offers the opportunity to develop a blueprint for providing safe and sustainable services for a small district general hospital, which will be relevant to many communities across the country.

#### 1.4.2 Framework for assessment

To fully consider the range of ways in which changes may impact on a community's experience of health care, the Steering Group has looked at the TSAs' draft recommendations in relation to five of the six criteria for quality in healthcare put forward by Maxwell (see table below).

Questions that help to define and expand the label "quality"	
Effectiveness	Is the treatment given the best available in a technical sense, according to those best equipped to judge? What is their evidence? What is the overall result of the treatment?
Acceptability	How humanely and considerately is the treatment/ service delivered? What does the patient think of it? What would/ does an observant third party think of it ("How would I feel if it were my nearest and dearest?") What is the setting like? Are privacy and confidentiality safeguarded?
Access	Can people get this treatment/service when they need it? Are there any identifiable barriers to services – for example distance, waiting times, opening times or straightforward breakdowns in supply?
Relevance	Is the overall pattern and balance of services the best that could be achieved, taking account of the needs and wants of the population as a whole?
Equity	Is this patient or group of patients being fairly treated relative to others? Are there any identifiable failings in equity – for example, are some people under-represented in service usages?
Efficiency	Is the output maximised for a given input or (conversely) is the input minimised for a given level of output? How does the unit cost compare with the unit cost elsewhere for the same treatment/service?

Source: RJ Maxwell 'Dimensions of Quality Re-visited' in *Quality in Health Care* 1992 1:171-177

The first four criteria (effectiveness, acceptability, access and relevance) look at the impacts on the population as a whole. The fifth criterion (equity) is where the Steering Group has specifically considered the impact of the TSAs' draft recommendations in relation to the Equality Act 2010 and the impact on staff. The criterion of efficiency would require a detailed financial analysis, which is outside the scope for this impact assessment.



#### **1.4.3 Effectiveness**

The TSAs drew on the advice of a dedicated National Clinical Advisory Group (CAG) of experts to make a judgement on clinical safety and the recruitment/retention implications of any proposed clinical models. The Steering Group has thoroughly debated the question of effectiveness, and concluded that the National CAG is best placed to form this judgement; the Steering Group has therefore largely relied on their advice, focusing its comments on areas where information seemed to be missing or incomplete.

The Steering Group welcomes the proposals to build on MSFT's recent history of developing clinical networks and ensure that in future clinical teams are working as part of extended groups with ready access to wider expertise and infrastructure. The Steering Group would want to see any changes at MSFT supporting the readiness of proposed alternative providers to meet these standards in future, particularly across the range of emergency and urgent services: obstetric delivery, emergency surgery and critical care, and inpatient paediatrics.

Specific concerns have been raised by local people about the safety of patient transport in emergencies where there are longer journeys involved. There will be some longer emergency journeys, following the same pattern as happens now between 10pm and 8am each day when Stafford Hospital's accident and emergency (A&E) department is closed. However, from the evidence it appears that these journeys will be safe and unlikely to lead to poorer outcomes. The Steering Group's analysis indicates that all the journeys are estimated to take less than 40 minutes; this longer travel time is currently experienced in other rural areas within the West Midlands. The West Midlands Ambulance Service (WMAS) has advised the Steering Group that it has the capability to stabilise and safely maintain patients during these journeys. The additional work will require adequate resources to ensure available capacity.

#### **1.4.4 Acceptability**

The proposal to retain all current services at Cannock Chase Hospital has been well-received and should have no negative health or equality impacts. However the draft recommendations for Stafford Hospital raise significant concerns about local acceptability. Much of this challenge arises from concerns about future access to services in relation to length and cost of journeys, and the safety of patient transport in emergencies; these issues are discussed in detail in a dedicated section of the impact assessment (Section 10), as well as under 'Access' below.

Other concerns include the risk of disruption to continuity of care, impact on visitors and carers and the status of the local hospital and, by association, the county town. There are specific issues about communication and responsiveness, particularly for people with disabilities. Several similar issues were raised by members of the South Asian community; however in this case there may also be benefits arising from treatment in hospitals with a significant proportion of patients from minority ethnic groups, and associated cultural competence and services.

#### **1.4.5 Access**

Extended journey times and the associated costs are the areas that have caused the most concern locally. Some 184,885 of the 276,500 residents of Stafford and Surrounds CCG and Cannock Chase CCG currently have Stafford as their nearest hospital and around 90% of them have access to the site within 20 minutes by private car or ambulance. Inevitably, the



reduction in specific services will have a negative access impact particularly on those who live very close to Stafford Hospital, face socioeconomic deprivation, and/or have other barriers to travel.

Travel to access services that will no longer be provided in Stafford Hospital under the TSAs' draft recommendations (obstetric-led birth, inpatient paediatrics, emergency surgery and level 3 critical care) will mostly be by ambulance or car (private car or taxi). This is because mothers giving birth, children ill enough to require an inpatient stay, or patients requiring emergency surgery or level 3 critical care are not likely to try and travel by public transport.

The TSAs state that MSFT had 400,000 patient contacts ("spells") in 2012/13; this includes all outpatient, day case, Accident and Emergency (A&E), and inpatient spells. As the services affected are largely those for the very ill or for specific events (giving birth), the number of actual users impacted is relatively small. From the 184,885 residents who are impacted, it is estimated that approximately 7,000 will be users of services that will no longer be provided in Stafford Hospital under the TSAs' draft recommendations every year; this is about 20 people per day. These users will need to travel further to access alternative hospitals with journey times within 45 minutes by private car or 40 minutes by ambulance.

Approximately 1,830 of the 7,000 impacted users (about five people per day) will have journey times over 30 minutes (but still less than 40 minutes by ambulance and 45 minutes by car); the remaining ca. 5,170 will have journey times less than 30 minutes. Stafford Hospital users already experience these longer travel times when the A&E is closed at night (22:00 to 08:00). Furthermore, the impact on access is not disproportionate on individuals with the in-scope characteristics (i.e. average travel times for individuals with the in-scope characteristics are not longer than those for the general population).

However, the Steering Group recognises that, despite the relatively limited impact of the new travel times, there is public anxiety about travel to non-MSFT sites. This is especially the case where journeys are unfamiliar and/or irregular and involve women in labour, ill children, or older people who could find the journey more difficult. In addition to the anxiety surrounding an unfamiliar journey, there is substantial public concern around both the cost and capacity of car parking at local hospitals. The Steering Group noted that the national Healthcare Travel Costs Scheme (HTCS) and other local arrangements are in place to offset travel costs for those on low incomes, for example if a parent with no access to a car brings a sick child to A&E in a taxi after assessment by a GP. However, any alternative providers should seek to improve current arrangements to address these public concerns (see below).

The most significant impact is on visitors and carers without access to private transport, as this group of people would have to rely upon (often infrequent) bus services, expensive taxis or the help of family and neighbours. The Steering Group notes that, as the number of patients affected by the TSAs' draft recommendations is relatively low, the number of visitors and carers is commensurately small. However, this still means there could be ca. 24,000 visitor journeys associated with the estimated 7,000 patients admitted to more distant hospitals, or 66 journeys per day.

Although Staffordshire has high car ownership rates (82% in the county) and public transport usage rates are low (only 3.3% of the population of Staffordshire commutes to work by bus), there will be a segment of the population that is reliant on public transport. The 17% of people who do not own cars are likely to be part of the older population and/or on a low income. Furthermore, there are some areas where relying on friends and family for





access to a car is not an option as some communities do not have this level of car ownership. Even for those with access to a car, qualitative evidence highlighted that with older couples, often only one of them is able or confident to drive.

Nationally there is no NHS-funded support for visitors travelling to hospital to see patients. Locally there are limited schemes available for all travel (including to hospitals) for people meeting certain eligibility criteria (e.g. concessionary bus travel for older people).

Visitors and carers from some areas in Staffordshire currently have no access or limited access to public transport to visit loved ones in hospital; the TSAs' draft recommendations provide an opportunity to address this need. The impacts of increased travel will fall disproportionately on communities living in socioeconomic deprivation, communities living in rural isolation, and older people. Individuals with more than one of these characteristics will be at particular disadvantage. The Steering Group's proposals therefore seek to mitigate the impacts on the relatively small number of people affected, but for whom the impact is most significant (see Section 1.5 of this executive summary).

#### **1.4.6 Relevance**

Acute care in England is developing towards the provision of services that is balanced between a concentration of specialist and emergency care into larger hospitals with a full range of facilities which can safely sustain 24/7 delivery, and delivery of assessment, rehabilitation and other on-going treatment as close to home as possible. The TSAs' draft recommendation to move emergency surgery from MSFT largely reflects this trend. The Steering Group is disappointed that the limitation of the TSAs' focus to hospital services may represent a missed opportunity to do more to support care closer to home, particularly for older people and children, who may face particular anxiety and disruption from a hospital stay that takes them away from family and carers.

The public has expressed particular concern that the TSAs may have underestimated the need for local hospital services, by failing to take sufficient account of housing growth and an increase in military families stationed in the area. The Steering Group has considered all of the general population growth and demographic changes, and investigated the impacts of specific planned local housing growth and the increase in the local population as a result of Armed Forces personnel moving into the area. The Steering Group has concluded that although this growth may seem significant (some 3,000 additional new homes and 420 military families), the services proposed to move from Stafford Hospital are largely emergency and acute and most families will never or rarely use them. The exception to this is obstetrics delivery, where there will be growth in the population of women of child-bearing age, many of whom will have a baby in the next five years. Even in this case, the additional number of births due to these two factors is estimated to be on a range of ca. 80 to 140 per year, or less than an additional three per week. The population growth on all three factors is therefore well within the planning assumptions for the TSAs' draft recommendations and there should be adequate capacity to respond to all the service changes that have been proposed.

The Scoping Report's analysis of historic service use at MSFT compared to national benchmarks suggests that some patients have been escalated to a higher level of care, for a longer period of time, than may have been necessary. This is particularly true for decisions to admit relating to children. The TSAs' draft recommendations should mean that overall, local people receive a safer balance of assessment, intervention and advice on how to care





at home than has previously been the case. There may be a small number of families who have become very reliant on the hospital-based paediatric service, and who should receive particular support in the transition to the new model of care.

The Steering Group considers that the TSAs' draft recommendations have the potential for a positive impact on the relevance of services by both addressing the over-utilisation of acute services (especially paediatrics) and introducing new services to meet the needs of a growing part of the population (the Frail Elderly Assessment Unit). In order to successfully implement the TSAs' draft recommendations, community services will need to respond to provide interventions and advice to support care at home. The effect on patients if community services are not able to respond is a potential negative impact of the TSAs' draft recommendations. The Steering Group recognises that community services are outside the scope of the TSAs' work (except where they are delivered by MSFT, e.g. community midwifery). Nevertheless, the interface with community services is in scope and properly managing this interface could mitigate the potential negative impacts.

#### **1.4.7 Equity**

As noted above, due to the emergency and specialist focus of the services affected by the TSAs' draft recommendations, the overall number of patients impacted is relatively small. This is particularly true at the level of specific protected characteristics (age, sex, disability, and race). However, within the protected characteristics, there are different levels of impact, and older people will be particularly vulnerable to any potential negative impact of the proposals.

With respect to age, there is a broadly positive impact on older people as they are majority users of emergency and acute services, and the proposals should improve the overall safety, effectiveness and sustainability of emergency treatment. In addition, the proposals for the Frail Elderly Assessment Unit (FEAU) will create a dedicated facility supporting continued access to local diagnosis and stabilisation. Further clarity is required on both the interface with community care and the model for local step down care to ensure that the (frail) elderly only have to be admitted to a hospital setting when this is clinically appropriate, and are able to return home with support for rehabilitation and convalescence at the earliest safe opportunity.

Also with respect to age, the Steering Group accepts that there is an opportunity to redesign paediatric services to decrease the very high rates of attendances and admissions at MSFT, and that becoming part of a wider clinical network should support this. Parents also need help in understanding where to turn for help in the event of a child being ill (e.g. the '111' service, or local out of hours GP services for assessment and advice), rather than assuming that they have to travel to A&E.

Centralisation of paediatric inpatient services for acutely ill children follows the direction of travel set out in national guidelines for safety and effectiveness. However, there will always be a small group of chronically ill children who require contact with hospital services. As with the FEAU, the Steering Group welcomes the commitment to sustain a Paediatric Assessment Unit (PAU) parallel to A&E at Stafford Hospital, as a means of maintaining local access for a very vulnerable group. However, for those children requiring regular contact or admission at more remote units, providers will need to ensure they have the capacity and processes to respond more flexibly to families who live further away and may need additional help and support, including overnight accommodation.



In relation to sex (gender), the main impact is on maternity services. There is huge disappointment and concern amongst the local community at the proposed loss of obstetric delivery at Stafford Hospital. In future, women will continue to receive antenatal and postnatal care locally, but would have to travel to one of the other four delivery units in the wider area to give birth. Again, the Steering Group understands the logic of the argument about concentration and availability of limited medical expertise into a smaller number of units, with a full range of neonatal support. However, the TSAs' draft recommendations seem to neglect the potential of the Midwifery Led Unit (MLU) at Lichfield as a model or an option, and say little about the arrangements which will be necessary to ensure continuity of care and planning between community midwifery and a more remote delivery unit.

In relation to disability, the Steering Groups considers that the impacts will generally be the same as those experienced by the general population. However, there are specific concerns in relation to access. Qualitative evidence from focus group discussions drew attention to the importance of continuity of care and to the availability and resilience of specialist communication services (e.g. for the hard of hearing or those with learning disabilities). There are also issues about availability, siting and cost of disabled parking, and movement around large and confusing hospital sites, to which providers should respond.

The Steering Group considers that, in general, the TSAs' draft recommendations do not have a disproportionate impact on minority ethnic groups. There may be some additional positive impacts. For example, where services are delivered in hospitals that care for a larger number of patients from minority ethnic groups, there is likely to be a broader range of support, greater awareness, and more capacity to respond to specific cultural practices or needs (e.g. interpretation services).

The impacts on the other in-scope characteristics (socioeconomic deprivation and rural isolation) are mostly similar to the impacts on the general population, with the exception of access by public transport for visitors or carers (see the above discussion on access). Although the numbers affected are relatively small, the impact could be significant and will fall on people in these groups who are already facing stressful circumstances.

### **1.5 Service-specific impact: maternity services**

The TSAs' draft recommendations do not propose changes to antenatal and postnatal services at Cannock Chase or Stafford Hospitals. However, there is a recommendation to close the obstetric-led delivery unit at Stafford Hospital, which would mean all women seeking a medically supervised birth would have to go to one of five other units in the surrounding area (at Burton, Stoke, Telford, Walsall, or Wolverhampton) or could choose a midwife supported birth in the MLU at Lichfield. The TSAs' draft recommendations therefore have an impact on women of child-bearing age (15 to 44); this relates to two of the in-scope protected characteristics: age and sex.

The public has expressed particular concern at the loss of the choice of giving birth in their local hospital. Although about a quarter of women from Stafford Hospital's catchment area already choose to go elsewhere to give birth, there is significant concern about travelling to alternative hospitals during labour. WMAS is confident that safe transport arrangements will be put in place, although these may need to be reinforced to manage any additional volume arising if more women in labour have to rely on ambulance transport to a more distant hospital site. Midwives will need to ensure that women and their birthing partners consider travel to hospital as part of their birth plans, and women (or their partners) make



themselves familiar with the hospital site and route if using private transport. The proposals do little to take forward Changing Childbirth and other national policy, which emphasises choice in style and site of delivery. Commissioners should ensure that they explore wider opportunities arising from any changes to increase awareness of local alternatives, including the Midwifery Led Unit at Lichfield and home birth, for the majority of healthy women who can give birth with a minimum of medical procedures.

The Steering Group recognises the financial limitations facing the TSAs and the importance of finding a sustainable solution for MSFT. The obstetric proposals place strong emphasis on the importance of national standards and guidelines to drive improvements in the safety and sustainability of maternity care. The Steering Group is concerned that these changes will only be valuable where alternative local providers are able to meet those national standards as a result of reconfiguring the current maternity workforce at Stafford Hospital. It is also essential that changes to obstetric activity are matched by investment in other associated services, including neonatal care and the ambulance service.

The Steering Group further believes that it is essential that alternative providers of obstetric-led care ensure the provision of a robust community midwifery service available through local sites. This service should support continuity of care, clear birth planning, and exercise of choice in style and site of birth; it will also need to have the capacity and skills to undertake assessment in labour, and provide active support.

Although local people have been concerned about capacity to support hospital births if the unit at Stafford Hospital closes, the Steering Group is satisfied that the TSAs' draft recommendations do adequately reflect local population growth and expected birth rates. However, commissioners should assure themselves of the capacity available across the range of alternative sites, particularly in neonatal support, including the provision of routine post-birth paediatric assessment.

### **1.6 Service-specific impact: paediatric services**

There is a range of positive health impacts which should arise from the draft recommendation to concentrate paediatric inpatient services within a wider clinical network and on sites with more specialist support. This is consistent with national trends and should support effectiveness, safety and the right range of services being available to the small number of children requiring frequent or regular contact with paediatric services. The retention of a Paediatric Assessment Unit (PAU) on site at Stafford Hospital opening at the same hours as A&E, together with input from the paediatric team at the relevant Paediatric Inpatient Units (PIUs), will maintain local access to urgent specialist assessment between 08:00 and 22:00. The transition to a clinical network should encourage care as close to home as possible, and therefore minimise the number of children who experience the anxiety and disruption of 24 hour medical supervision due to requiring inpatient care.

There has been a history of very high levels of admission and recall at the MSFT paediatric unit; 12.9% of MSFT admissions were for the age group 0-14, compared with 11.4% nationally. There will be families, well known to the service, who may need extra support and advice during the transition to a new model. It is clear from the comments in focus groups and public meetings that current arrangements for urgent care and advice are confusing and that parents have been resorting to A&E as their default option when a child is sick, as they know when it is open and where it is. This has then increased concerns about access to paediatric care if inpatient services move out of Stafford Hospital. Commissioners



and GPs should be more proactive in advising the public about the use of 111 for immediate advice over the telephone or primary care (in and out of hours) for medical assessment close to home. Where a parent is concerned that their child is seriously ill, 999 will result in a paramedic attending, who will be able to provide immediate assessment and stabilisation, and ensure safe transportation by ambulance to a fully equipped specialist unit. No seriously ill child will have to rely on public transport to access hospital care.

Although a significant proportion of paediatric admissions in England consists of children with minor illness or injury, there is a small group of children who do need regular contact with inpatient services. The Steering Group is concerned about the lack of emphasis on the interface between hospital and community services for chronically and seriously ill children, and the possible disruption to the care pathway between local primary/community services and a remote acute paediatric team. There is also an increased risk of missing signs of children at risk of neglect or abuse where a variety of teams are involved in the care of the child; the development of an effective clinical network across community and hospital services will be vital to minimise this safeguarding risk.

The Steering Group is concerned that the small number of families with a child requiring frequent or an extended admission, which do not have access to private transport, will need active support to maintain contact during a stay and minimise costs to the family. Providers should ensure adequate capacity for parents to stay with their child, and arrangements that are flexible enough to respond to families who may need to travel some distance to visit.

### **1.7 Service-specific impact: emergency, urgent and critical care services**

The changes to emergency, urgent and critical care (EUCC) services will have an impact on the general population whose closest site is Stafford Hospital and could have an additional impact on individuals with protected characteristics (particularly the elderly and those with disabilities) or facing socioeconomic deprivation or rural isolation.

The TSAs' draft recommendations contain a commitment to retain Accident and Emergency (A&E) services at Stafford Hospital and the Minor Injuries Unit (MIU) at Cannock Chase Hospital. As with other proposals, the Steering Group welcomes the extension of a clinical network approach and the opportunity this offers of more sustainable and safer services. The service changes proposed all relate to emergency and other care of the critically ill, and patients will primarily be accessing these services by ambulance conveyance, either to or between hospitals. Whilst most patient transport will be arranged by the NHS, there could be a significant burden on visitors and carers of older people who are admitted to a more remote hospital and who may be dependent on friends, relatives or public transport to maintain contact with their loved ones.

The Steering Group welcomes the dedicated focus on care of the elderly offered by the proposal for a Frail Elderly Assessment Unit (FEAU) and the commitment to develop step down arrangements, which will support the transfer of older people back from more remote hospitals into Stafford as they become medically stable. The Steering Group is concerned that: (i) the model of care makes no comment on the interface with community services, which are vital to the experience and recovery of older people; and (ii) the focus on hospital care may encourage the tendency to rely on hospital beds when people (particularly if confused) may be better off at home with the appropriate support. In particular, the Steering Group would be concerned that multiple moves are associated with increased mortality in the elderly, and that commissioners should track the impact and outcomes of



the new model of care if it is introduced.

In relation to emergency surgery and the level 3 critical care service at Stafford Hospital, the Steering Group notes that the National Clinical Advisory Group (CAG) views this service as unsustainable due to low volumes, previous concerns raised by the Royal College of Surgeons, and evidence that supports the drive towards centralisation of these services. The potential safety benefits of concentrating critical care into a larger unit will rely on ensuring that there is the right capability at Stafford Hospital to intervene during a surgical or medical emergency (including intubation and respiratory support) and stabilise for transfer, and the right capacity at other sites to receive patients. Although there are public concerns about the risks of transferring critically ill patients, the evidence on transfer was reassuring. The most important time factor in critical care is to stabilise rapidly, and the patient can then be moved to the best site for on-going specialist care. The West Midlands Ambulance Service (WMAS) has confirmed that inter-hospital transfers for level 3 critical care are already common across the region and paramedics are trained for stabilisation and transfers.

#### **1.8 Service-specific impact: elective and day case services**

The TSAs have confirmed that the current range of elective and day case activity delivered at Cannock Chase Hospital will be maintained, and that there may be opportunities to extend the range and volume of local activity. Stafford Hospital will continue to offer a range of elective and day case work but the TSAs propose to reduce the range of specialties and activity. At the time of publication of their draft recommendations, the TSAs did not specify which specialties or procedures would be affected. It has therefore proved difficult for the Steering Group to assess the impact. The draft recommendation to maintain and, if possible, to enhance day cases (surgical and medical) is likely to have a positive impact on access. Again, to optimise the benefits, the Steering Group would have liked to see some reference to the interface with community services, particularly in relation to the potential for early supported discharge.

The Steering Group notes that the proposal to maintain activity at Cannock Chase Hospital has been positively received and will largely maintain the current situation. The Steering Group would like reassurance that there is a commitment to sustaining the historically more specialist outpatient and day case activity that has previously been available locally, possibly through other providers.

#### **1.9 Impact of the draft recommendations on staff**

It has not been possible to carry out a detailed analysis of the impact for staff. All the current staff at MSFT will be impacted by the TSAs' draft recommendations, through the dissolution of the Trust and/or by the changes in services provided at Stafford Hospital (the current services at Cannock Chase Hospital are not affected). It is likely that any negative impacts would affect those on low pay or with limited qualifications the most. Evidence from a focus group suggests that the three main concerns for staff are: pay and conditions; communications; and travel/access, including the impact of extended travel times on current child-care arrangements.

Pay and condition changes would primarily impact support services or administrative staff, were they to transfer under future arrangements to non-NHS employers. Any alternative provider would be bound by Transfer of Undertakings (Protection of Employment)



Regulations 1981 (TUPE) and other employment legislation. The workforce at MSFT has been facing significant uncertainty and this will remain until the Secretary of State for Health makes a decision on the future of the organisation and/or the proposals for specific services. Staff would welcome early and frank communication from the TSAs about their future and emerging arrangements. They are particularly concerned about the future impact of working across multiple sites over greater distances, and the Steering Group highlights an early review of staff travel plans by provider organisations as a priority once future arrangements are confirmed. In particular these should consider multiple-site parking permits, car-pooling or other arrangements for travel between sites.

### **1.10 Mitigating proposals**

The Steering Group has identified a range of proposals that could mitigate the risks associated with some elements of the TSAs' draft recommendations and/or reinforce the potential positive outcomes. More detailed proposals relevant to each service area (e.g. maternity and paediatrics) are given in the relevant sections.

#### ***1. Meeting national clinical standards and guidelines***

The TSAs' draft recommendations are based on discussions with the National CAG, which have placed a high value on rationalising services at MSFT in order to promote compliance with a variety of national standards and guidelines. In particular, this consideration has had a significant impact on the draft recommendations to concentrate obstetric expertise outside of MSFT, move paediatric inpatients off-site, and stop emergency surgery and level 3 critical care. It is therefore essential that, if positive health impacts are to be realised, these changes facilitate alternative local providers in meeting the relevant national standards.

#### ***2. Enhancing the interface with community services***

Further work needs to be done on the interface between hospital services and community services. The TSAs should be more explicit about how this interface will be developed to ensure that as much care as possible is delivered closer to (or at) home, especially for the elderly and children. The TSAs and local providers should consider how the development of clinical networks to support the future delivery of many of the services covered by the draft recommendations can include community clinicians. In particular, assertive management within the clinical network should seek to minimise disruption to the lives of children living with disabilities or chronic conditions, including optimising the development of community support as an alternative to hospital contact. Commissioners may wish to consider how they can adjust the balance of investment to support alternatives to hospital care where appropriate.

#### ***3. Capacity and capability in alternative provision***

Many of the TSAs' draft recommendations entail a transfer of activity to alternative providers in order to deliver improved health outcomes and a more sustainable local health economy. If these benefits are to be realised, it will be essential that these alternative providers have both the capability and the capacity to cope with this additional activity. Particular concern has been expressed throughout this process about whether UHNS will be able to meet the scale of this challenge in a range of the specialities affected, including paediatrics and critical care.

The TSAs' draft recommendations are predicated on a model in which patients will be either taken to more remote units (involving longer ambulance journeys than at present), or





stabilised and transferred between units (involving more ambulance journeys). WMAS has demonstrated elsewhere in the region that it has the skills to undertake this work safely. However, it will be essential that commissioners consider what level of investment is required to ensure that the service also has the capacity to maintain current standards of response.

#### **4. Aligning 'front door' activity**

The public response to the proposals has revealed genuine confusion about first response services, and how to access advice and assessment for acute illness. Commissioners will want to work with primary care to ensure that GPs proactively support their patients in making best use of 'front door' services, particularly in educating those with a history of using A&E for minor and self-limiting conditions; A&E colleagues should reinforce these messages.

The paediatrics team will need to work closely with those families with a history of regular contact and admission to support them through the transition to any new model of service.

It will be essential that the hospital emergency and urgent care services are aligned with A&E. The Early Pregnancy Assessment Unit (EPAU) proposed for Stafford Hospital should operate at the same hours as A&E and with shared protocols (in a similar way to the draft recommendation for the Paediatric Assessment Unit (PAU)). There must be clear arrangements in place, visible to primary care and the ambulance service, for alternative arrangements for both the PAU and EPAU services between 22.00 and 8.00 each day.

#### **5. Maintaining continuity of care**

There is public concern about potential compromise to continuity of care given that the TSAs' draft recommendations introduce a division between specific outpatient and hospital inpatient services. This should be addressed through the clinical network process but requires additional attention to communications across sites, between different clinical teams, and at the interface with community services. This is true particularly for:

- Arrangements for community midwifery, choice of site and style of delivery, planning travel to hospital, and advice and assessment during onset of labour;
- Paediatric services relating to chronic care and the exacerbation of chronic conditions, and/or where there are safeguarding concerns;
- People in need of specialist communications support; and
- Those with multiple conditions.

#### **6. Safety of patient transport over longer distances**

The evidence from research and the experience of WMAS elsewhere in the region suggests that whilst journey times will be extended, they should be safe. What will be critical is having the capability, both with paramedics and on site in the local hospitals, to intervene (including intubation and respiratory support) and stabilise for transfer.

There will need to be increased capacity to support the transfer of patients, and this will potentially include additional activity for neonatal transfer.

#### **7. Carer, staff and visitor journeys**

The Steering Group considers that the greatest potential negative impact arising from the



TSAs' draft recommendations is the effect on carers and visitors of extended journeys to more remote hospitals to visit inpatients. The Steering Group proposes that the TSAs work with alternative providers of services to actively review:

- Extended financial support to facilitate travel for the small number of visitors who are most in need. To ensure viability, this scheme should be by exception only and cover different modes of travel including taxi and private car; however, providers need to promote this scheme to ensure public awareness and design it for simplicity of use;
- The application and awareness of the national Healthcare Travel Costs Scheme;
- Capacity and availability of car parking and arrangements for charging, including multi-site permits and multi-day passes;
- The scale, siting (proximity to the hospital) and charging for disabled parking;
- Support for Voluntary Transport Schemes (VTS) to ensure their continued existence. Additionally, there may be new areas that could benefit from such schemes and communities in those areas should be offered assistance in setting them up if there is interest; and
- Signage and seating which would help with negotiating unfamiliar and larger sites.

The workforce has highlighted the arrangements for travel, both to and from work and across multiple sites, as a source of significant concern. All providers have staff transport policies, and as implementation proposals become clearer, the host employers should review and develop these. There are opportunities for initiatives which could limit the negative impact on staff including multi-site parking permits, car-pooling, designated 'in-transit' parking, or the extension of 'shuttle bus' schemes.

#### ***8. Infrastructure to support carers and families in more distant hospitals***

Hospitals already make arrangements to support parents visiting young children, but their capacity should be reviewed to ensure that they are able to cope with greater numbers of families living at longer distances from the site. They may need to extend onsite family accommodation, or consider how to support parents to stay locally.

The Steering Group recognises the challenge of limiting local hospitals' visiting hours to optimise treatment time, and minimise tiring of patients and the risk of infection. However, the TSAs and alternative providers may want to consider how to respond flexibly to carers and parents living at a distance to support contact and recovery (particularly where they are dependent on infrequent public transport services).

#### ***9. Range of services***

The Steering Group is concerned that limiting the scope of the TSAs' remit to the current hospital services has limited the extent to which they can explore appropriate alternatives to the current hospital provision. The discussion of obstetric care pays little attention to national policy on extending choice of site and style in childbirth. In particular, the TSAs should reconsider their analysis of a midwifery-led unit (MLU) at Stafford Hospital to take into account the experience of the MLU at Lichfield. For emergency surgery, the Steering Group proposes that the TSAs work with commissioners to develop the step down model and ensure that resources are targeted where they will deliver most benefit for older people.





The limits placed on the TSAs have driven relatively traditional proposals, during a period of significant change, where there is the opportunity to develop thinking of national significance on the future role of the district general hospital. This has no doubt supported constructive debate about service effectiveness, but potentially at the expense of access, relevance and responsiveness. Commissioners will have the opportunity to further consider how the spirit of these proposals could be reflected in implementation, with the aim of delivering more care closer to home.

#### ***10. Engagement with public and staff***

The TSA process, coming after several years of high profile investigations into the failings in local services, has generated enormous local interest and debate. The Steering Group has experienced exceptionally generous participation by local people, and this has been reflected in its focus group discussions and participation in public meetings. There is real local energy and interest in being involved in shaping the future of health services; the Steering Group would urge commissioners and future providers to encourage this and actively engage with members of the public and particular interest groups as they move towards implementation.

The workforce has indicated that, once the Secretary of State for Health has made a decision about the future arrangements, this is clearly communicated and the local health system moves quickly to end uncertainty and take action in response. Where the process of implementation is itself experienced as engaging and empowering of staff and patients (of all ages), this will itself provide a positive health impact.

#### ***11. Monitoring the impact of the TSAs' recommendations***

There is genuine public anxiety around safety and capacity issues arising from the TSAs' draft recommendations. The Steering Group suggests that commissioners should agree a set of metrics with all future providers, aligned with the TSAs' final recommendations to Monitor, which addresses the areas of public (and staff) concern. These metrics should be published and measured regularly to provide on-going reassurance that the proposals have realised their intended benefits and that potential risk has not translated into negative consequences.

## 11.2 TSAs response to HEIA

440. The TSAs have welcomed the report prepared by the HEIA steering group and have noted the points raised and the mitigations and suggestions related to the TSAs' draft recommendations. In particular:
- **Additional travel times** - the TSAs' conclusions with regards to travel times were tested and the HEIA assessed that the additional travel times: would not have a detrimental impact on health outcomes; and would be the same or less than those faced by many others across the West Midlands and England.
  - **Affected groups** - the number of people directly impacted by the TSAs' recommendations is relatively small at 7,000 out of 184,885 current users of MSFT. The TSAs were reassured that there are many things which could mitigate the impact on these users which are discussed in more detail in the detailed HEIA report (Volume 4).
  - **The expected benefits from centralising some services** - the HEIA recognised the benefits which the TSAs have stated from the centralisation of some services over retaining smaller sub-scale services, notably paediatric inpatient services.
  - **The impact of population growth on services** - the HEIA steering group drew the same conclusions as the TSAs regarding the impact of the 10,000 new houses in the future and the repatriation of the military troops, namely that there would be an increase in the demand for acute services in Stafford, but not sufficient levels of additional demand to counter the TSAs' conclusions.
441. The HEIA steering group proposed eleven broad mitigations to the impacts they identified when assessing the TSAs draft recommendation. Table 41 summarises the TSAs response to these mitigations.

Table 41: The eleven HEIA mitigations and the TSAs' response

HEIA mitigation	TSAs' response
1. Meeting national clinical standards and guidelines	<p>The TSAs have made their recommendations precisely for the reason that it will enable patients to access services that are in more line with national clinical standards and guidelines – which they would not have been were they retained for delivery in Stafford or Cannock by MSFT.</p> <p>Whilst it will be the responsibility of the future service providers services to ensure they meet the relevant standards and guidelines expected of them, the TSAs are confident that they and local commissioners will ensure that services are maintained in line with these standards and guidelines.</p>

HEIA mitigation	TSAs' response
2. Enhancing the interface with community services	<p>The TSAs scope of their work did not cover changes to community services, but they fully believe that an effective interface between the hospital and community services is essential for managing the groups of patients who typically rely on these services - such as the frail and elderly or the management of long term conditions in adults and children.</p> <p>The consultation response from the local CCGs demonstrates that they too are looking to introduce funding mechanisms that encourage and reward closer integration of services.</p> <p>The TSAs' recommendations, particularly for acute medical care and paediatrics, have been developed with this in mind.</p>
3. Capacity and capability in alternative provision	<p>The TSAs are clear that no services should be transferred until sufficient capacity is created elsewhere.</p> <p>Local commissioners will be responsible for decommissioning the services in Stafford when they are satisfied that the receiving Trusts have the capacity and capability to deliver those services.</p> <p>It should be also noted that the CCGs will only commission services from other organisations when they are able to demonstrate their own quality standards meet the expectations set by the NHS.</p>
4. Aligning 'front door' activity	<p>The TSAs have considered the points made by the HEIA regarding the alignment of the front door activity. To ensure there is consistency across emergency and urgent care services at MSFT, such as the MAU, PAU, and FEAU, the TSAs have recommended that these services have the same access hours, which is: 08:00 – 22.00.</p> <p>In relation to clarity for members of the public, the relationship between all 'front door' services was raised frequently throughout the consultation by a number of parties. The TSAs would urge commissioners to consider these issues in the future planning and commissioning of relevant services.</p>
5. Maintaining continuity of care	<p>The TSAs have acknowledged that communication within and between services is vital to ensure continuity of care for patients.</p> <p>The TSAs have described how services should be organised and see the networking of services as being crucial in supporting continuity of care.</p> <p>The TSAs believe this HEIA mitigation should be considered during implementation.</p>

HEIA mitigation	TSAs' response
6. Safety of patient transport over longer distances (mitigation relates to ambulance service capacity)	<p>The TSAs acknowledge that there will need to be an increased provision of ambulance transport to support the recommendations. The TSAs have engaged with WMAS to understand this investment and has included this in its financial modelling and investment proposals.</p> <p>Ensuring this additional investment and capacity is established will be the responsibility of local commissioners.</p> <p>The TSAs believe this HEIA mitigation should be considered during implementation.</p>
7. Carer, staff and visitor journeys	<p>The provision of transport for carers, staff and visitors is outside of the scope of the TSAs recommendations.</p> <p>The TSA would expect these services to be provided locally as appropriate and would urge local commissioners and providers to consider these.</p> <p>The TSAs believe this HEIA mitigation should be considered during implementation..</p>
8. Infrastructure to support carers and families in more distant hospitals	<p>The TSAs would expect local providers to ensure that there is sufficient infrastructure in place to support carers and families when visiting patients in the hospital.</p> <p>Commissioners and providers will need to determine the appropriate levels to provide and ensure they are in place before the new service models are implemented.</p> <p>The TSAs believe this HEIA mitigation should be considered during implementation.</p>
9. Range of services	<p>The TSAs have reconsidered the draft recommendations regarding the provision of an MLU and the establishment of an MLU now forms part of their final recommendations.</p> <p>The TSAs' recommendations are based upon establishing a clinical network with a larger hospital, thereby ensuring the significant majority of services can be retained locally within the smaller 'district general hospital'.</p> <p>Although the use of clinical networks is not new in the NHS, the TSAs would observe that in many instances these networks tend to be in place to deliver specialised services.</p> <p>The recommendation of a clinical network across a wide range of acute services which seeks to maintain local services in a small district general hospital would, in the TSAs' opinion, be a model that could be considered in the broader debate on the future role of the district general hospital.</p> <p>Any wider review of services across secondary, primary and community care would need to be commissioner led.</p>

HEIA mitigation	TSAs' response
10. Engagement with public and staff	<p>The TSAs would agree with the HEIA steering group's comments and urge local commissioners and providers to actively engage with members of the public and particular interest groups as they move into a period of transition.</p> <p>The CCGs, in their consultation response to the TSAs, have indicated this is very much in their plans.</p>
11. Monitoring the impact of the TSAs' recommendations	<p>The TSAs would agree with the HEIA steering group's suggestion that a set of metrics should be established with all future providers, aligned with the TSAs' final recommendations to Monitor, which addresses the areas of public and staff concern. Local commissioners would be best placed to establish and assess these metrics and the letter from NHS England (11 December 2013) has indicated that they and other central government bodies will monitor the CCGs ongoing action towards implementing a safe and sustainable future service model across Staffordshire.</p> <p>The TSAs believe this HEIA mitigation should be considered during implementation.</p>

## **12 The TSAs' recommendation to Monitor with regards to MSFT as an organisation**

- 442. The TSAs, and the CPT before them, have concluded that there is no course of action that MSFT, in its current form, can undertake to fully address the clinical and financial challenges that it faces.
- 443. The TSAs' remit includes the options to explore changes to the organisational form, such as dissolution of the trust, merger with other Foundation Trusts or the transfer of all assets and liabilities to the Secretary of State for Health.
- 444. This section summarises the TSAs recommendations and associated considerations with regards to organisational form.

### **12.1 Use of clinical networks**

- 445. The clinical model that the TSAs are recommending is predicated on Stafford and Cannock Chase Hospitals being part of clinical networks with larger more specialised hospitals. Clinical networks bring together groups of health professionals and stakeholder organisations with a common purpose to work on a collaborative basis in the delivery of clinical services.
- 446. One of the central arguments around whether MSFT is clinically sustainable is that many of its services are sub-scale. This means that deploying sufficient numbers of appropriately skilled resources is a challenge and those resources may not be exercising those skills on enough occasions to maintain them to an appropriate standard.
- 447. The TSAs believe that the establishment of clinical networks for Stafford and Cannock will address this issue for some of the services that are currently unsustainable. Within these networks, some services will operate clinical rotas across multiple sites. This substantially improves the resilience of clinical staffing models by increasing the pool of clinical resources that are available and as a consequence it enables a greater number of services to be retained locally – one of the guiding principles for the TSAs when developing their recommendations.

## 12.2 The TSAs' draft recommendation with regards to MSFT as an organisation

448. The TSAs made one draft recommendation with regards to MSFT as an organisation.

### TSA DRAFT RECOMMENDATION 14

In order to deliver the recommended clinical models for Stafford and Cannock, Mid Staffordshire NHS Foundation Trust should be dissolved.

The services in Stafford and Cannock should be seen as individual models of care which should be delivered by organisations that can operate those services as part of effective clinical networks.

449. Whilst clinical networks can cross organisational boundaries the TSAs concluded that if MSFT were to continue as a stand-alone organisation, then a number of the necessary draft recommendations would not be feasible.
450. This is because the clinical model is based upon the movement of some emergency activity from Stafford/Cannock to other hospitals with the potential for an amount of elective activity moving in the opposite direction. The financial margins associated with elective and emergency/non-elective activity differ and if the proposed reorganisation of activity were between hospitals operated by two separate trusts, then it is inevitable that the financial position of one trust (the one receiving more non-elective activity) would be negatively impacted.
451. The TSAs believe that it is unlikely a single provider will be able to effectively provide the proposed service models for both Stafford and Cannock. This is primarily due to the distances that staff would be required to travel (for example, Stoke to Cannock if UHNS were to operate both Stafford and Cannock Chase Hospitals). Furthermore, whilst some organisations did propose to deliver services in both Stafford and Cannock – during the market engagement exercise - none of these proposals offered the full range of services that the TSAs are recommending for each location.
452. On this basis, the TSAs believe that in the future Stafford and Cannock Chase Hospitals should no longer be part of the same organisation. The TSAs have concluded that Mid Staffordshire NHS Foundation Trust should be dissolved to enable the recommended clinical models to be established.

### 12.3 The response to the TSAs' draft recommendation

453. There was marginal support for the TSAs' draft recommendation to dissolve MSFT. Table 42 is a summary of the responses from the consultation.

Table 42: Summary of responses for Draft recommendation 14

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,425	27%	22%	50%	11%	35%	46%	4%

454. It should be noted that there was significantly more support (66%) for this recommendation from those responding on behalf of organisations and groups, rather than individual respondents.
455. In their response to the consultation both local CCGs confirmed that 'Mid Staffordshire NHS Foundation Trust should be dissolved at a point when it is clear who will provide the future services'.
456. A series of themes have been identified in the responses to the questions. The TSAs have grouped these themes as either observations on, or challenges to, the recommendations:
- **Observations:**
    - Much of the support is linked to criticisms of previous management and the view that this would present a 'fresh start';
    - Several responses noted that it did not matter which organisation ran the hospitals, but better management would be required into the future; and
    - There was some support for partnership working and the use of networks.
  - **Challenges:**
    - Some respondents stated that the best solution would be a true partnership rather than a take-over of services by another organisation;
    - Much of the opposition to the recommendation was linked to concerns about financial and capacity issues at trusts in the Local Health Economy;
    - Other opponents to the recommendations stated their belief that MSFT was being dissolved in order to help other hospitals (primarily UHNS) address their own publicised issues; and
    - This last point was linked to a broader concern that Stafford and Cannock would effectively be 'asset stripped' by the organisations that run services in the future and this would lead to the subsequent loss of local services in the future.



457. Each of the challenges have been addressed later in this sub-section.

#### 12.4 The TSAs' final recommendation to Monitor

458. The wording of the TSAs' draft recommendation has been slightly modified to emphasise that the recommendation to dissolve MSFT is essential to enable the establishment of clinical networks with larger hospitals that will be essential to ensure services in Stafford and Cannock are clinically sustainable. The TSAs' statutory recommendation to Monitor with regards to MSFT is therefore as follows:

**The TSAs' recommendation to Monitor with regards to MSFT as an organisation**

In order to ensure clinical sustainability and enable new clinical models based upon effective clinical networks with larger hospitals, Mid Staffordshire NHS Foundation Trust should be dissolved.

The services in Stafford and Cannock should be seen as individual models of care which should be delivered by organisations that can effectively operate a clinical network with each hospital.

462. The TSAs fully understand the concerns that were raised during the consultation and have provided further information (see below) that they hope will assuage some of those concerns raised during the consultation.
463. Contrary to much of the external reporting on the TSAs' draft recommendations, the TSAs did not recommend which organisations should run the services in Stafford and Cannock in the future. Indeed, the TSAs cannot make such a recommendation in this report. However, it is evident that there are a limited number of organisations that would be able to effectively manage clinical networks that include either Stafford or Cannock Chase Hospitals.
464. The TSAs' proposed clinical model, as set out in the next section, concludes that a range of services should be retained for provision in Stafford Hospital and Cannock Chase Hospital and operated as part of separate clinical networks with larger hospitals. The TSAs have assessed which providers would be best placed and most capable to deliver the TSAs' proposed clinical model. The TSAs have concluded that:
- Stafford Hospital should be operated by the University Hospital of North Staffordshire NHS Trust (UHNS); and
  - Cannock Chase hospital should be operated the Royal Wolverhampton NHS Trust (RWT).



465. The TSAs have concluded that the Stafford services should be transferred to UHNS on the following basis:
- The TSAs' proposed service model is based upon a range of services provided on the Stafford site that need to be networked in order to be clinically sustainable. UHNS are the only appropriate option to operate this clinical network because:
    - Some patients will need to be transferred from Stafford to another site for a small range of inpatient services. This site will need to be close enough to minimise the distance and time of transfer;
    - Transferring sick patients to another site that is part of the same organisation will facilitate a smoother transfer, not least because there will be a single set of care management protocols and patient records.
    - A larger acute provider will present a greater opportunity for referrals to sub-specialists within the same organisation; and
    - Staff will be rotated through a larger site to ensure they are seeing and treating enough patients to maintain their clinical skills and to enable them to conduct and participate in robust clinical audit/peer review.
  - Furthermore, UHNS were the only provider to confirm they would be able to provide the full range of services the proposed by the TSAs for retention at Stafford Hospital.
466. The TSAs recommend that the Cannock services should be transferred to RWT on the following basis:
- Elective inpatient surgery can only be provided sustainably on the Cannock site if networked through a larger site. This was the view from the CAG particularly regarding the ability to recruit the middle grade doctors needed to provide the out of hours cover;
  - This networked arrangement would mean that the other site would have to be geographically close enough to provide the on-call cover and allow staff to rotate between the two sites - RWT or WHT would be the providers capable of doing this; and
  - RWT is much the larger acute trust, enabling a greater degree of sub-specialisation and cover, and has volunteered to provide elective inpatient surgery at Cannock site whereas WHT has not.

## 12.5 Addressing the consultation responses

467. As stated above, four challenges were repeatedly raised with regards to 'Draft recommendation 14' during the consultation (as set above). The TSAs have provided further information and clarification on three of these below. The challenge around the capacity at other organisations in the Local Health Economy is related to the proposed clinical model and as such is addressed in common themes in Section 10.

### Challenge One: The formation of future organisation(s)

468. If the TSAs' recommendation is accepted and implemented MSFT will be the first NHS Foundation Trust to be dissolved. In such circumstances, there are a number of options with regards to the transaction process that can be followed to reassign the future management of services and ownership of the assets and liabilities of the Foundation Trust. These options are set out in legislation and are dependent on the nature of the trusts that are likely to run the hospitals and deliver services in the future.
469. The TSAs recognise that the consultation feedback indicated that local residents would prefer Stafford and Cannock Chase Hospitals to be merged with other hospitals. However, the statutory guidance for TSAs states that it is only possible for the TSAs to consider a merger with another hospital if that hospital is operated by another foundation trust. As both UHNS and RWT are non-foundation trusts the only option available to the TSAs is to conclude that the assets of MSFT should be transferred to the Secretary of State at the point that MSFT is dissolved.
470. The Secretary of State will decide, in due course, whether to accept the TSAs' conclusions that UHNS and RWT are best placed to take on the assets of Stafford and Cannock Chase Hospitals, respectively, and to provide those services that commissioners determine should be provided.

### Challenge Two: The TSAs' recommendations are designed to help other organisations

471. The TSA process is not about shifting the financial issues onto neighbouring trusts. The TSAs have worked very closely with other providers to ensure that the recommendations are financially sustainable for all parties. However, the TSA process is not about dealing with any financial difficulties of any other trust, those are for their own organisations to deal with.



**Challenge Three: The proposal to dissolve MSFT creates the opportunity for services to be stripped from Stafford and Cannock in the future**

472. Two things will make this impossible. Firstly, the commissioners decide where they want the services to be delivered from. They will not pay for or agree to the services being delivered anywhere else. Secondly, the arrangements proposed by the organisations are only affordable if based at the Stafford and Cannock sites and being delivered through clinical networks.
473. The delivery of healthcare services does evolve over time and local commissioners will play a leading role in any changes to future delivery of healthcare in the region. The TSAs cannot guarantee that services will not change, but any substantial future changes to services will be subject to established processes for public and patient involvement and engagement.

## 13 The TSAs' recommendations with regards to clinical services

474. The TSAs have undertaken a review of the consultation responses, formal stakeholder responses and the HEIA report. The TSAs have also gathered additional information and held regular meetings with many stakeholders during the consultation period.
475. The outcome is that the TSAs have changed or modified three of the ten draft recommendations that they proposed for the clinical service model in Stafford. These changes are in the areas of maternity services (Draft recommendation 5), paediatric services (Draft recommendation 7) and critical care (Draft recommendation 9). The TSAs have not changed the remaining seven draft recommendations for clinical services in Stafford or the three draft recommendations for Cannock.
476. Two of the recommendations that the TSAs have not changed were opposed by the majority of respondents to the consultation (Draft recommendations 6 and 8). The TSAs have not changed these recommendations because they are satisfied that based upon the best available evidence and advice from the CAG the recommendations are appropriate and necessary to delivery clinically and/or financially sustainable services.
477. Volume 2 of this report covers the consultation in detail and includes (in Annex 3.4) the details of the TSAs' review of the consultation responses. The TSAs have collated a range of common response themes, several of them which relate to the recommendations. These common response themes and the TSAs' response to these themes are summarised in Section 10.
478. This section summarises the TSAs' service recommendations following the review of the consultation responses. For each service recommendation, or group of service recommendations it sets out:
- The draft recommendation;
  - A summary of the support or opposition to the draft recommendation;
  - Comments and key concerns raised repeatedly during the consultation;
  - The TSAs' final service recommendation;
  - The rationale and additional information associated with the TSAs' final service recommendation; and

- The TSAs' response to repeated concerns/comments raised in the consultation if not covered in the rationale/additional information.

## 13.1 Emergency and Urgent Care in Stafford

### Draft recommendation and consultation response

479. The TSAs made one recommendation with regards to emergency and urgent care in Stafford. This recommendation and a summary of the consultation responses is presented in Table 43.

Table 43: Draft recommendation 1 and a summary of consultation responses.

#### Draft recommendation 1

A consultant led A&E department should be retained in Stafford, open seven days a week from 08:00 – 22:00.

#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,431	31%	26%	57%	10%	32%	42%	2%

#### Consultation comments

- Most respondents who opposed the recommendation did on the basis that the unit should open 24/7.
- The main concerns raised were:
  - Availability of overnight access to A&E for the local population, and the impact on patient conditions, associated with further travel distance to access A&E (see Common response themes, Section 10);
  - Would this impact training for junior doctors (see Common response themes, Section 10);
  - Insufficient capacity at other hospitals in the Local Health Economy (see Common response themes, Section 10);
  - Are patients who would have ordinarily had cause to attend Stafford A&E overnight now delaying their access to A&E until 8am in order to avoid having to attend an alternative A&E?;
  - Would the A&E be viable in the long term if no emergency surgery was performed at Stafford Hospital;
  - Could an urgent care service be provided between the hours of 10pm and 8am to allow for 24/7 access at Stafford Hospital?; and
  - The changes would create confusion regarding when and which emergency services to access



### The TSAs' conclusion

480. The TSAs have:
- reviewed the consultation responses; and
  - conducted further analysis on the economics of operating a 24/7 A&E unit.
481. The TSAs are satisfied that there is no basis on which to revise their draft recommendation.

#### **TSAs' service recommendation for Stafford 1**

A consultant led A&E department should be retained in Stafford, open seven days a week from 08:00 – 22:00.

### Rationale for this recommendation and supporting Information

482. The A&E department at MSFT reduced its opening hours to 08:00 – 22:00 in December 2011. The reason for this was, primarily, the inability to maintain the medical rotas needed to staff the department safely.
483. The workforce situation in the A&E department at Stafford remains challenged and in September 2013 MSFT approached UHNS to help sustain the current A&E opening hours. UHNS have agreed to some of their A&E consultants working in Stafford to support the A&E service. Without the support from UHNS the Trust would have to consider whether to make further reductions in the opening hours of the A&E service.
484. The TSAs and the CAG believe that reducing the current 14/7 A&E service provision in Stafford would present a significant risk to other providers in the Local Health Economy by increasing the pressure on already challenged A&E departments. This could jeopardise the ability of other providers to effectively manage their emergency care provision.
485. Providing an A&E in Stafford as part of a clinical network with an A&E unit at a larger hospital will help with the recruitment and retention of key clinical staff and will address issues of clinical sustainability due to the resilience associated with operating the A&E consultant rota from a larger pool of consultants. This is a view supported by the CAG and UHNS.
486. The HEIA report also welcomed the proposals for the A&E department at Stafford *'the Steering Group welcomes the extension of a clinical network approach and the opportunity this offers of more sustainable and safer services'*.



487. Increasing the current 14/7 service to a 24/7 service on a networked basis would require additional consultants to be employed to ensure there is sufficient resilience in the clinical network. Given the low volumes of patients that are likely to be treated overnight at an A&E in Stafford, the TSAs believe that this would be uneconomic to operate and less attractive for consultants to work within.
488. The TSAs have undertaken further analysis on the economics of operating the A&E service as a 24/7 service. This analysis is presented in Annex 2.6, and in summary:
- It is estimated that on average 26 patients would attend Stafford A&E between 22:00 and 08:00 if it were open;
  - This would be one of the smallest levels of overnight attendance at A&Es across the West Midlands, with only one provider treating less than this level;
  - The additional costs associated with opening the A&E overnight is estimated to be £2.5m per annum. This excludes premium costs associated with overnight working allowances and excluded overhead costs; and
  - The income associated with 26 A&E attendances and an average number of associated emergency admissions would be £2.4m per annum.

### **The TSAs response to consultation comments**

489. As noted above, there were a range of repeated comments raised during the consultation. Some of these aligned with the common response themes which are covered in Section 10, but there were three specific comments that were repeatedly stated specifically about the TSAs' draft recommendation on emergency and urgent care. The TSAs' responses to these comments are in Table 44.



Table 44: The TSAs response to consultation comments specific to emergency and urgent care recommendation.

Comment	TSA response
Would an overnight urgent care service be viable?	<p>If this was implemented it would mean there would be day time access to a full A&amp;E department 14/7 and night time access to an out of hours urgent care centre 10/7.</p> <p>An urgent care service is one which typically does not accept patients brought in by emergency ambulances but will accept walk in patients and will provide treatment for a number of minor conditions. The TSAs have assessed that approximately 10 out of the 26 patients per night would access the service (see Annex 2.6). The TSAs do not believe that staff working in this arrangement could maintain their core clinical skills with such a low number of patients treated. With a premium cost for staff working overnight it is also difficult to see how such a service would be financially sustainable.</p> <p>An alternative suggestions is that the GP out of hours service could be relocated to Stafford hospital to provide some access to urgent care overnight. As a primary care service, this is outside of the scope of the TSAs recommendations however this is a suggestion which commissioners have stated repeatedly to the TSAs that they would explore.</p>
Is A&E viable in the long term with the removal of emergency surgery?	<p>The advice from the CAG supports the provision of A&amp;E without emergency surgery on the basis that there is still access to a surgical opinion. The majority of patients would still be assessed in the A&amp;E in Stafford before being transferred to an appropriate hospital for the procedure to be undertaken or booked for planned surgery in the near future at Stafford Hospital if appropriate.</p>
Are patients delaying access to A&E until 8am?	<p>In the first full 12 months of operating a 14/7 A&amp;E (2012/13), the average number of daily attendees to the A&amp;E in Stafford increased from 120 to 126.</p> <p>The TSAs have reviewed the average number of patients per hour attending A&amp;E in each year from 2009 – 2013 (see Annex 2.6). This shows that in 2012/13 the increase in average attendances was spread across the day so some of the increase from 120 – 126 can be attributed to the increase in A&amp;E attendances seen across England.</p> <p>However, this analysis did show that the period when there was the largest increase was between the hours of 08:00 – 09:00 (an additional 2-2.5 patients during this hour, compared to an additional 0.5 patients seen during other opening hours). It is therefore possible that the hypothesis that 1-2 patients per day are preferring to wait until the A&amp;E in Stafford opens rather than attend an alternative service is true.</p> <p>However, the TSAs do not believe that this would justify extending the opening hours of the A&amp;E in Stafford (as per the rationale set out above), but do acknowledge and agree with the proposal from the HEIA steering group that there is enhanced communication on the best use of ‘front door’ services available.</p>
Confusion regarding when and which emergency services to access	<p>The communication with primary/community/social care will be critical in ensuring that patients are accessing the most appropriate service for their condition. In relation to clarity for members of the public, the relationship between all ‘front door’ services was raised frequently throughout the consultation by a number of parties and in the HEIA.</p> <p>The TSAs would urge commissioners to consider these issues in the future planning and commissioning of relevant services. The TSAs view is that the other supporting urgent services such as the MAU, FEAU &amp; PAU are aligned with the A&amp;E in terms of their access hours. The A&amp;E interface with the rest of the hospital is important and it is essential that these services are aligned.</p>

## 13.2 Inpatient medical care for adults in Stafford

### Draft recommendations and consultation response

490. The TSAs made three recommendations with regards to inpatient medical care for adults in Stafford. These recommendations and a summary of the consultation responses are presented in Table 45.

Table 45: Draft recommendations 2-4 and a summary of consultation responses.

#### Draft recommendation 2

A physician led inpatient service for adults with medical care needs will remain in Stafford which will manage acutely unwell patients locally (both admissions from A&E and patient referrals from primary/community care).

#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,427	59%	26%	85%	3%	7%	11%	4%

#### Draft recommendation 3

The Medical Assessment Unit (MAU) at Stafford Hospital will be enhanced to include specialist support to the frail and elderly. The MAU will be a single point of contact for potential admissions from the 14/7 A&E, and step up admissions from primary care and community care providers.

The MAU will need to have established admission and referral protocols and systems in place with all care providers. It will also need to establish systems to monitor capacity at these other providers.

#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,437	57%	30%	87%	3%	5%	8%	5%

#### Draft recommendation 4

MSFT currently operates a small number of 'step down' beds within Stafford Hospital. The number of these beds should be increased to enable a greater volume of repatriations back to Stafford Hospital from larger more specialised hospitals.

The focus of the teams managing these step down beds should be to ensure the patients are discharged when appropriate and to ensure continuity of care management once they are discharged from Stafford.

#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,443	56%	27%	83%	4%	5%	9%	8%

#### Consultation comments

- Many responses were supportive of providing services for patients closer to their homes and welcomed the inclusion of a specific service for the management of the frail and elderly.
- Questions were raised around the opening times and whether it was only for the frail and elderly (see below, where more specific detail is provided to address the areas of confusion).
- Some respondents also felt it was vital that the service is integrated with the community.
- The main concerns raised were:
  - The HEIA raised concerns around there being appropriate levels of parking at other hospitals in the Local Health Economy;
  - Decision making of the ambulance service, i.e. they would, over time, routinely take patients directly to other hospitals rather than Stafford Hospital (see Common response themes, Section 10);
  - HEIA raised some concern regarding potentially unnecessary transfers of elderly patients and the impact this may have on them;
  - Would the service be viable without level 3 critical care?

### The TSAs' conclusions

491. The TSAs have:
- reviewed the consultation responses; and
  - developed additional information around the proposed services.
492. The TSAs are satisfied that there is no basis on which to revise their draft recommendation.

#### **TSAs' service recommendation for Stafford 2**

A physician led inpatient service for adults with medical care needs will remain in Stafford which will manage acutely unwell patients locally (both admissions from A&E and patient referrals from primary/community care).

#### **TSAs' service recommendation for Stafford 3**

The Medical Assessment Unit (MAU) at Stafford Hospital will be enhanced to include specialist support to the frail and elderly. The MAU will be a single point of contact for potential admissions from the 14/7 A&E, and step up admissions from primary care and community care providers.

The MAU will need to have established admission and referral protocols and systems in place with all care providers. It will also need to establish systems to monitor capacity at these other providers.

#### **TSAs' service recommendation for Stafford 4**

MSFT currently operates a small number of 'step down' beds within Stafford Hospital. The number of these beds should be increased to enable a greater volume of repatriations back to Stafford Hospital from larger more specialised hospitals.

The focus of the teams managing these step down beds should be to ensure the patients are discharged when appropriate and to ensure continuity of care management once they are discharged from Stafford.

### Rationale for these recommendations and supporting information

493. Currently, at least 51% of all non-elective medical bed days at MSFT are for patients aged 65 years or older.
494. This means that the demand for acute medicine and care of the elderly services in Stafford is expected to increase in the future due to the forecast demographic changes in the local population. Whilst this increase is a national challenge, the projected rate of growth in the catchment area for the age group 65+ is higher than the national average (see Table 46).

Table 46: The projected rate of growth for the age group 65+

Area	2011 population for age group 65+	Predicted 2021 population for age group 65+	% change
Stafford and Surrounds CCG	23,700	28,900	+21.9%
Cannock Chase CCG	30,000	36,600	+22.2%
All Staffordshire CCGs	160,600	197,400	+22.9%
England	9,055,900	10,787,100	+19.1%

Source: GP registered populations 2012/13 Q2 and 2011-based interim population projections, Office for National Statistics, Crown copyright

495. Therefore, the TSAs believe that an acute medicine/care of the elderly inpatient service should remain in Stafford, however this service needs to change in order to better meet the changing needs of the local population and the intentions of local commissioners.
496. Patients will access this service via a referral or having attended the A&E at Stafford. Most patients will be initially assessed within the Medical Assessment Unit (MAU) prior to admission to an inpatient bed.
497. MAUs are very common in hospitals. The MAU at Stafford is currently a service for any adult over the age of 18 including the frail and elderly. The MAU provides access to initial diagnostics and treatment for the acutely unwell patient before the patient is either discharged home or admitted to one of the specialty inpatient beds in the Hospital.
498. The TSAs' recommendation is to retain the MAU for acutely unwell patients and enhance it by ensuring there is a focus on the frail and elderly through a Frail and Elderly Assessment Unit (FEAU) function. This function should include community geriatrician support because this will ensure that the large cohort of the frail and

elderly who are admitted to the MAU will get early access to a senior doctor who specialises in the care of the elderly.

499. This will ensure patients are treated in the right place and that an admission to hospital is only made when it is the best place for the patient to be treated. This is particularly crucial as the current emergency admission rates of MSFT are higher than average (see Table 47).

Table 47: Admission rates for the local CCGs

Area	Admissions per 1,000 population (2011/12)
Stafford and Surrounds CCG	122
Cannock Chase CCG	117
National average	111

Source: National General Practice profiles, Public Health England

500. The MAU would not just be a service for the frail and elderly. It is currently and would continue to be a service for any acutely unwell adult and will be staffed by a mix of acute physicians and community geriatricians.
501. With regards to opening hours, the MAU will be operated 24/7 and will manage patients once admitted until the decision is made to move them to a general ward at Stafford, transfer to another provider or to discharge them home. However, admissions into the MAU will be between 08:00 and 22:00, seven days a week (in line with the recommended A&E opening times). Patients can be admitted into the MAU by the A&E at Stafford and directly referred to the MAU by community care and primary care providers.
502. There are a range of Stafford residents who are already treated at larger more specialised hospitals and should then be 'repatriated' back to Stafford Hospital as quickly as possible so that their rehabilitation and ongoing treatment can take place as close to home as possible. This would include the Stafford residents who are currently treated at other hospitals having suffered a cardiac arrest, stroke or major trauma.
503. MSFT already operate a small number of 'step down' beds which are used to repatriate some of these patients back into Stafford Hospital (e.g. those patients that have suffered a stroke and are initially treated at a larger more specialised hospital). These beds were identified by the local CCGs as being part of the core set of LSS.
504. The TSAs' proposed clinical model includes an increase in the number of 'step down' beds in Stafford. This is because the recommendations of the TSAs will see a greater

number of patients being treated at larger, more specialised hospitals than at present (e.g. patients having had major surgery).

505. This proposal is aligned with the stated commissioning intention to provide 'care closer to home'. As a large number of patients who would be suitable for repatriation back to Stafford will be older patients, it is recommended that the staffing model for the step down beds includes geriatricians whose primary focus will be on the safe, effective and timely discharge of older patients from the step down facility.

### The TSAs response to consultation comments

506. As noted above, there were a range of repeated comments raised during the consultation. Some of these aligned with the common response themes which are covered in Section 10, but there were three specific comments that were repeatedly stated specifically about the TSAs draft recommendation on medical inpatient services for adults. The TSAs' responses to these comments are in Table 48.

Table 48: The TSAs response to consultation comments specific to medical inpatient services for adults recommendations

Comment	TSA response
Integration with community services	It is outside of the scope of the TSAs to make a recommendation on integrating the frail and elderly service with the community provision. The TSAs do however believe that the secondary care and community/social care services need to work closely together to ensure patients receive the appropriate care in the most appropriate setting. The community geriatrician will be a key link between the two services. The TSAs are pleased to note that there is a commitment, in the consultation responses, to improve working arrangements between secondary care and community/social care from both local providers and commissioners.
The unnecessary transfer of elderly patients	<p>The TSAs understand that any movement of any patient can be unsettling for patients, especially the frail and elderly (including movements between wards/departments within the same hospital) and would expect that movements are only made when it is absolutely necessary. Indeed, West Midlands Ambulance Service - who support these recommendations – are very clear that they would routinely take all acutely unwell adults to Stafford unless there is a clear protocol to take them directly to another provider.</p> <p>Where patients with more complex needs, such as dementia, learning disabilities etc. are to be transferred, it will be essential that there is clear communication with the patients and their friends/families/carers, as to what is happening.</p>

Comment	TSA response
Viability of the services without level 3 critical care	<p>The TSAs acknowledge that concerns have been raised about the longer term viability of the service without access to routine level 3 critical care. The view of the CAG is that the proposed Acute Medicine service at Stafford will be safe.</p> <p>As per the TSAs' revisions to the recommendations on critical care, the decision to admit would be taken in the MAU and based on medical judgement. The proposals with regards to critical care would mean that there is the ability to provide short-term level 3 critical care support to any admitted patient if their condition deteriorates. The most important factor would be that medical patients can be managed at Stafford as long as there is the capacity and capability to properly and safely manage them.</p> <p>The TSAs are satisfied that the proposed medical inpatient service will be viable in the long term.</p>
The supporting infrastructure for patients and families	<p>It will be the responsibility of the local commissioners and providers to ensure that the appropriate amount of parking is made available for visitors at other hospitals particularly to meet the needs of any specific groups such as those with learning disabilities. However, in the TSAs discussions with other providers the TSAs have noted that the local providers have included estimates of capital requirements to increase their car parking capacity as a result of the TSAs recommendations.</p>

### 13.3 Maternity services in Stafford

#### Draft recommendations and consultation response

507. The TSAs made one recommendation with regards to maternity services in Stafford. This recommendation and a summary of the consultation responses are presented in Table 49.

Table 49: Draft recommendation 5 and a summary of consultation responses.

#### Draft recommendation 5

The obstetric service in Stafford should be decommissioned as soon as there is sufficient capacity established across the Local Health Economy. The TSAs are proposing that a plan should be established, and overseen by local commissioners, to ensure this capacity is created as quickly as possible.

This plan should create the additional capacity across multiple providers in the Local Health Economy to ensure there is continuing patient choice across multiple providers.

The current maternity service has been identified only as a short term LSS by the local CCGs. The CCGs will need to be satisfied that there is sufficient capacity in the Local Health Economy before the obstetric service is decommissioned.

Pre and postnatal outpatient services in Stafford will remain, unless there are post-23 week complications that require attendance at a more specialised obstetric unit. The outpatient service needs to be operated as part of a clinical network, most likely with UHNS, so that obstetricians can deliver outpatient clinics in Stafford.



#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,405	12%	10%	22%	11%	59%	70%	8%

#### Consultation comments

- Assessment of annual birth projections is incorrect.
- There should be the ability to have deliveries in Stafford:
- Why wouldn't a clinical network make the obstetric service sustainable?
- Why haven't the TSAs considered a midwifery led unit in Stafford?
- The main concerns raised were:
  - Safety associated with having to travel further for deliveries (see Common response themes, Section 10);
  - The recommendation will cause more mothers –to-be to choose home births and the community midwifery service will not have capacity to support this increase;
  - Larger birthing centres will not be able to provide the level of support that women need.
  - Capacity to accommodate close family during long periods of labour and the period immediately after delivery.

### The TSAs' conclusion

508. The TSAs have:
- reviewed the consultation responses; and
  - conducted a series of further analyses to address the consultation responses.
509. The TSAs have concluded that the draft recommendation should be changed to include the recommendation that a midwifery led unit is provided at Stafford Hospital.

#### TSAs' service recommendation for Stafford 5

Pre and postnatal outpatient services in Stafford will remain, unless there are post-23 week complications that require patient attendance at a more specialised obstetric unit. The outpatient service needs to be operated as part of a clinical network so that obstetricians can deliver outpatient clinics in Stafford.

The obstetric delivery service in Stafford should be decommissioned as soon as there is sufficient capacity established across the Local Health Economy. The TSAs are proposing that a plan should be established, and overseen by local commissioners, to ensure this capacity is created as quickly as possible.



A Midwife Led Unit (MLU) should be established in Stafford to provide an opportunity for low risk births to be delivered locally. The MLU should be managed in a maternity network with other units/providers. However, this would need to be kept under review to ensure that the number of births is adequate to support the MLU's financial sustainability.

The current maternity service has been identified only as a short term LSS by the local CCGs. The means the CCGs will need to be satisfied that there is sufficient capacity in the Local Health Economy before the obstetric service is decommissioned.

The plan should create the additional capacity in the Local Health Economy to ensure there is still continuing patient choice across multiple providers.

### Rationale for this recommendation and supporting information

510. Stafford currently has an obstetric (consultant) led delivery suite in Stafford which is one of the smallest in the country. In 2012/13 it ranked 127th out of 139 maternity services in England, based upon number of births. The maternity service also provides ante and post natal care for women at Stafford and operates the local community midwifery service.
511. Ante and postnatal care are on the core list of LSS and will continue to be provided in Stafford. These services will need to be provided as part of a clinical network with an obstetric led service based at another site. This will ensure that mothers-to-be will be able to access routine ante and post natal appointments locally.
512. Where there are complications post-23 weeks, mothers-to-be will need to be seen at an alternative obstetric unit and not in Stafford.
513. Patients who have complications pre-23 weeks will be seen in an Early Pregnancy Assessment Unit (EPAU) in Stafford. The TSAs proposed in their draft recommendations that the EPAU will operate during the day Monday – Friday. The HEIA report stated that the TSAs should consider the provision of the EPAU seven days per week. The National Institute for Health and Care Excellence (NICE) guidelines for the EPAU state that: *'Regional services should be organised so that an early pregnancy assessment service is available seven days a week for women with early pregnancy complications, where scanning can be carried out and decisions about management made'*<sup>55</sup>. The TSAs have discussed this with local commissioners and providers and have agreed that during implementation commissioners and

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<sup>55</sup> NICE GC154 – Ectopic pregnancy and miscarriage: Diagnosis and initial management in early pregnancy of ectopic pregnancy and miscarriage.



providers will work together to ensure that there is 7 day EPAU services available for expectant mothers including clear guidance on the point of contacts for access out of hours.

514. National standards<sup>56</sup> require at least 40 hours consultant presence per week for a unit that is managing a minimum of 2,500 births per annum. The view from the CAG is that a unit managing less than 2,500 births per annum is unlikely to be able to support training and keep the skills of the staff up to date as a standalone unit.
515. The HEIA report understood the arguments for the centralisation of obstetric led births at larger units; *'Again, the Steering Group understands the logic of the argument about concentration and availability of limited medical expertise into a smaller number of units, with a full range of neonatal support'*.
516. The basis of the TSAs' draft recommendation to decommission obstetric deliveries in Stafford was that the number of births was significantly lower than 2,500 births (the TSAs' draft report states levels as being as low as ca. 1,800 birth per annum) and would be highly unlikely to exceed this level. This conclusion has been challenged by many of the consultation responses, with the expansion of MoD Stafford and new housing developments in the region being cited as reasons as to why the levels should be expected to significantly increase in the medium term.
517. In responding to the consultation the Royal College of Obstetricians and Gynaecologists (RCOG) and the Royal College of Midwives (RCM) both fully supported the TSAs recommendation to decommission the obstetrician led unit in Stafford. The RCOG stated that the TSA recommendations were in line with RCOG guidance. The RCM supported the recommendation with the caveat that the TSAs validate that they had used the appropriate birth numbers as a baseline – see below.
518. The TSAs assumed that the expansion of MoD Stafford would see up to 100 additional births in the catchment area. Having spoken to the Base Commander of MoD Stafford, her opinion is that this estimate is higher than her assumption and based upon recent numbers of births at MoD Stafford this number is more likely to be nearer 45 additional births per year. As part of their support to the HEIA, Public Health Staffordshire have produced a projection of the future level of births that could be expected at Stafford Hospital. This projection takes into account the growth of the population from proposed 10,000 new houses and the expansion of MoD

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<sup>56</sup> 'Towards Safer Childbirth' - Royal College of Obstetricians and Gynaecologists, Royal College of Midwives (1999), based upon guidance from the NHS Litigation Authority as part of their Clinical Negligence Scheme for Trusts maternity standards (CNST)

Stafford; and uses demographic projections of women of a child bearing age and the fertility rate of the population.

519. Their conclusion is that in the short term (by 2015) the annual numbers of births are likely to increase 2,050 births but in the medium-long term there is likely to be an overall decrease in birth levels from that level. The projections are shown in Table 50. On this basis, the TSAs believe that their original conclusion with regards to birth levels being unsustainable is appropriate.
520. The TSAs view is supported by the HEIA which said *'Although local people have been concerned about capacity to support hospital births if the unit at Stafford Hospital closes, the Steering Group is satisfied that the TSAs' draft recommendations do adequately reflect local population growth and expected birth rates'*.

Table 50: Births at MSFT projection (extract from HEIA report – see Volume 4)

	2012 (provisional)	2015	2020	2025	2030
Cannock and Stafford CCGs	2,968	3,040	2,980	2,850	2,630
Estimated number of births at MSFT	1,869	2,050	2,030	1,940	1,790
Proportion at MSFT	63%	67%	68%	68%	68%

Source: Birth extracts, Office for National Statistics, Public Health Birth Files, Office for National Statistics and 2010 and 2011-based subnational population projections natural change and migration summaries, Office for National Statistics

521. A number of stakeholder responses questioned why the TSAs could not make a case for networking obstetric births in Stafford with another provider to make it clinically sustainable with low volumes – similar to the conclusion around the A&E service.
522. The TSAs have concluded that you could make this clinically sustainable but it comes at a significant cost. This point was also raised by the CAG - although they did have reservations regarding the volumes seen at Stafford and the impact on maintaining the essential skills of the clinical workforce.
523. A safe obstetric led birthing unit requires a range of support services, including: caesarean section theatre, Special Care Baby Unit (SCBU), and a paediatric consultant rota. The assessment of the TSAs is that this would be significantly uneconomic. The cost of these additional functions would be ca. £10.1m, yet the income associated with the low number of births would be ca. £6.6m.
524. The TSAs have therefore concluded that their original recommendation with regards to obstetrician led births is appropriate.



525. However, the obstetric service is on the list of short-term LSS. This is because the local commissioners do not believe there is, at present, sufficient capacity at other local providers to manage the level of births that are forecast to be required for the population currently served by MSFT. Therefore, the obstetric service in Stafford cannot be decommissioned until such capacity is established in the Local Health Economy. This will require some investment in the facilities located at other providers. The TSAs do not believe that this capacity should be concentrated on a single site, as a wide range of alternative choices should be available for mothers-to-be.
526. The TSAs were asked by many respondents to reconsider their view that a midwife led delivery unit (MLU) should not be provided in Stafford. This included the response from the Royal College of Midwives and a proposal from the independent Health and Equality Impact Assessment steering group.
527. The TSAs previously concluded that an MLU would not be financially viable. This conclusion was based upon evidence that only 10-12% of mothers-to-be choose to give birth at a stand-alone MLU. If this level were seen in Stafford this would mean that only ca. 200 births would take place at an MLU.
528. The TSAs have conducted further analysis on the financial model for an MLU and concluded that for an MLU to be financially viable in Stafford then it would need to manage a minimum of ca. 350 births per year. This analysis is based upon:
- information provided by Burton Hospital NHS Foundation Trust who run the MLU at Lichfield community hospital;
  - a review of MLU staffing models nationally; and
  - information presented to the TSAs by the RCM on the staffing model needed to run a small MLU.
529. This means that ca. 20% of mothers-to-be who would ordinarily choose to give birth at Stafford if there were an obstetric unit, would need to choose to give birth at the MLU.
530. Whilst the TSAs' analysis does show that on average nationally only 10-12% of mothers-to-be choose to use an MLU, the TSAs are aware that there are examples of MLUs where the take up has been significantly higher. The RCM in their response to the consultation state that the Blackburn birthing centre (MLU) delivers ca. 1,000 births per year. The Office of National Statistics (ONS) publish the total number of births in local areas nationally. Their records show that in 2011 there were 2,344

births in total in the Blackburn and Darwen Unitary Authority<sup>57</sup>. Assuming that the catchment area for the Blackburn birthing centre is broadly equitable to the Blackburn and Darwen Unitary Authority, it would be reasonable to conclude that this MLU delivers 40% of the local births. This supports the assertion that some MLUs do attract more than 10-12% of local births (the national average) and more than the 18-20% of current MSFT births needed for an MLU in Stafford to break even.

531. Given the strength of feeling from the general public around retaining births in Stafford that was evident from the consultation, it is also not unrealistic to conclude that an MLU in Stafford would have more than 350 mothers-to-be choosing to use the unit per year.
532. Taking the above into account the TSAs are revising their recommendation to include the provision of an MLU in Stafford which is delivered as part of a managed maternity network, providing ante and post natal care locally as well as linking to a larger obstetric unit. The MLU should be strongly linked to the community midwifery service and the local delivery of ante and post natal care in a model akin to a Maternity Centre model implemented in other locations in England, for example in Portsmouth. The evidence from the consultation and that presented by the RCM would demonstrate to the TSAs that there would be sufficient demand for this service to make it financially sustainable.

### The TSAs response to consultation comments

533. As noted above, there were a range of repeated comments raised during the consultation. Some of these aligned with the common response themes which are covered in Section 10, but there were two specific comments that were repeatedly stated specifically about the TSAs' draft recommendation on maternity services. The TSAs' responses to these comments are in Table 51.

Table 51: The TSAs response to consultation comments specific to maternity recommendations

Comment	TSA response
Impact on home births	Homebirths are an important choice for women if they are having a low risk birth. To ensure that homebirths are undertaken safely a managed maternity network is essential to ensure that women are supported and they get the appropriate access to the relevant professionals. If a women, during a home birth, needs to be taken to an obstetric unit this would be undertaken by an ambulance as is the case now.

<sup>57</sup> Source: Live births by local authority of usual residence of mother, numbers, General Fertility Rates and Total Fertility Rates, Office of National Statistics, 2011

Comment	TSA response
Large birthing centres do not provide the level of service needed	<p>It was suggested that obstetrician run units which deliver more than 6000 per year struggle to deliver personalised care to women and therefore are equally as undesirable as smaller units.</p> <p>The RCOG and RCM do not identify any concerns regarding the potential to create birthing centres with the annual births exceeding 6,000, but the RCM stated that they would be concerned if UHNS was delivering more than 8,000 births. The RCOG also states that 8,000 births would be un-economical as they would have to operate a double rota.</p> <p>The number of births managed at the UHNS maternity unit last year was just less than 6,000. The TSAs have assessed that ca. 650 additional births will take place at UHNS following the closure of the obstetric led unit in Stafford. This would mean that the UHNS maternity unit is still managing significantly less than 8,000 births per year.</p>
Supporting infrastructure for families	To minimise the volume of journeys families will need to make to other locations, the providers will need to assess their provision of accommodation for families who will have their obstetrician led birth at their centres.

## 13.4 Paediatric services in Stafford

### Draft recommendations and consultation response

534. The TSAs made two recommendations with regards to paediatric services in Stafford. These recommendations and a summary of the consultation responses are presented in Table 52.

Table 52: Draft recommendations 6-7 and a summary of consultation responses.

#### Draft recommendation 6

The paediatric inpatient service in Stafford should be decommissioned at such time that local commissioners are satisfied there is sufficient capacity to safely admit the volume of patients that would otherwise have been admitted to Stafford Hospital.

#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,396	16%	14%	30%	12%	52%	64%	6%

### Draft recommendation 7

A Paediatric Assessment Unit (PAU) will remain in Stafford to provide children with local access to an urgent assessment. The service will be provided 14/7 and will work alongside the proposed A&E service.

The PAU will have the input and support from paediatricians where needed and will be operated as part of a clinical network.

Children will be admitted to the PAU via attendance at the A&E department. The PAU will also accept direct referrals from community/primary care and specific care pathways, such as the management of long term conditions.

### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,377	25%	25%	50%	10%	32%	42%	8%

### Consultation comments

- The data used by the TSAs for their work on paediatrics was incorrect.
- The TSAs had stated there is no paediatric surgery in Stafford, when evidence was presented that there is.
- Can the TSAs provide more information about consultant support to the PAU?
- The main concerns raised were:
  - Cost and time required to travel to alternative hospitals (see Common response themes, Section 10);
  - The ability for parents to routinely visit paediatric inpatients (which was also raised by the HEIA);
  - Safety of transporting sick children to another hospital if PAU is closed (see Common response themes, Section 10);
  - Why the PAU could not be open 24/7;
  - The TSAs had missed the fact that there is an existing community paediatric team.



### The TSAs' conclusion

535. The TSAs have:
- reviewed the consultation responses; and
  - conducted a series of further analyses to address the consultation responses.
536. The TSAs are satisfied that there is no basis on which to revise 'Draft recommendation 6', but have concluded that 'Draft recommendation 7' should be amended.

#### TSAs' service recommendation for Stafford 6

*The paediatric inpatient service in Stafford should be decommissioned at such time that local commissioners are satisfied there is sufficient capacity to safely admit the volume of patients that would otherwise have been admitted to Stafford Hospital.*

#### TSAs' service recommendation for Stafford 7

A Paediatric Assessment Unit (PAU) will remain in Stafford to provide children with local access to an urgent assessment. The service will be provided 14/7 and will be a function of the proposed A&E service and led by Paediatric Trained A&E Doctors.

Where Paediatrician advice is needed it will be obtained either from the on-call team at a larger hospital or from the on-site Paediatrician.

Children will be admitted to the PAU via attendance at the A&E department. The PAU will also accept direct referrals from community/primary care and specific care pathways, such as the management of long term conditions.

### Rationale for these recommendations and supporting information

537. Concern was expressed by the paediatric department at MSFT that the numbers used by the TSA were significantly lower than those held by the department. As noted in Section 10, the TSAs have revalidated the data used and are satisfied that the volume of emergency paediatric inpatients quoted in the TSAs' draft report is aligned to the records held by the department.
538. The guidelines from the Royal College of Paediatrics and Child health are that the minimum number of paediatricians required to support a clinically sustainable

inpatient paediatric unit is ten consultants<sup>58</sup>. Currently Stafford has five which is significantly below the recommended levels.

539. The view of the CAG is that a paediatric inpatient unit of this size is unsustainable and this was substantiated by a recent statement from the Royal College of Paediatrics and Child Health<sup>59</sup>.

*“There are too few paediatric consultants across the UK and too many general units to deliver the best possible healthcare for children, according to the latest workforce census conducted by the Royal College of Paediatrics and Child Health (RCPCH).”*

**Dr Hilary Cass, President of the Royal College of Paediatrics and Child Health, said:**

*“The problem is three-fold. Firstly there are not enough senior doctors available to maintain the safety of current paediatric care; we need a 50% increase in the consultant workforce if we’re to have a round-the clock consultant presence. Secondly, expertise is spread too thinly – we have too many small units and not enough specialist centres. If we had staff and resources concentrated in fewer specialist centres, treatment would be better coordinated and of a higher standard. And finally, there are too many trainees for long term sustainability of the paediatric workforce if the current rate of recruitment into training is maintained – when they qualify to be consultants there won’t be enough posts for them to fill. “*

540. Despite there being a net opposition to this recommendation there is a clear distinction between individual patient responses and responses from groups or stakeholders who were more inclined to favour the recommendation based on the likely improved clinical outcomes from centralising paediatric inpatient services.
541. The TSAs believe that continuing to deliver a paediatric inpatient unit in Stafford would not be clinically sustainable with the current staffing and that the paediatric inpatient service should be decommissioned as soon as is practically possible.
542. The decommissioning of paediatric inpatient services in Stafford was also supported by the HEIA which said *‘There are a range of positive health impacts which should arise from the draft recommendation to concentrate paediatric inpatient services within a wider clinical network and on sites with more specialist support. This is consistent with national trends and should support effectiveness, safety and the right range of services being available to the small number of children requiring frequent or regular contact with paediatric services’*.
543. The TSAs do note the recommendations from the HEIA regarding the need for additional support for the transportation and accommodation for families. The TSAs support these recommendations and would expect providers and commissioners to

<sup>58</sup> Facing the Future: Standards of paediatric services (2011) – Royal College of Paediatrics and Child Health

<sup>59</sup> <http://www.rcpch.ac.uk/news/shortage-consultants-and-too-many-units-reveals-latest-census-children%E2%80%99s-doctors>



work together to ensure that the relevant infrastructure is in place to support the families.

544. There was marginally more support than opposition with regards to the TSAs' recommendation for the PAU.
545. The majority of opposition stated concerns about the impact on patient safety associated with increased travel times (see TSAs' response to common themes, Section 10) and the lack of detail in the draft recommendations with regards to specialist medical cover supporting the PAU.
546. The TSAs are recommending that the PAU would be a function within the A&E department at Stafford Hospital. It would be staffed by paediatric nurses and paediatric trained Emergency Department doctors. Paediatric consultants will be on site in Stafford providing "Hot Clinics" which will take urgent next day referrals from GPs and also urgent referrals/advice from the PAU if appropriate. As well as the Hot Clinics there will be paediatric outpatient clinics on site in Stafford providing further paediatric consultant presence on site.
547. This proposed model for the PAU is recognised and encouraged by the Royal College of Paediatrics and Child Health in circumstances where there is no on-site paediatric inpatient service<sup>60</sup>. The TSAs have redrafted 'Recommendation 7' in order to better summarise the proposed PAU service.
548. Increasingly, more paediatric patients can be treated at home if there are suitable services available for children who have a known care plan. If this service were introduced for GP referrals, this would reduce the number of patients that are being admitted for inpatient treatment. In the draft report it was stated that 313 out of the 2,362 admissions into the paediatric inpatient service in Stafford were direct from a GP. The TSAs have reviewed this information with the paediatric team at MSFT and it is incorrect - the number is in fact 753, but this does not impact the conclusions or analysis of the TSAs.
549. Community paediatrics in South Staffordshire is predominantly provided by South Staffordshire and Shropshire Healthcare Foundation Trust which is the main provider of mental health, learning disabilities and specialist children's services in South Staffordshire.

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<sup>60</sup> Short Stay Paediatric Assessment Units – Advice for commissioners and providers. Royal College of Paediatrics and Child Health, 2009

550. A 'Paediatric Hospital @ Home' service is operated in North Staffordshire which is primarily used to care for children at home after discharge from hospital. In 2012/13 this service had 874 referrals from the hospital and 1,830 referrals direct from GPs.
551. The TSAs would encourage local commissioners to review the current community service in order to ensure there is a service to support keeping children out of hospital and which follows up children post-discharge on the basis of clinical need.

### The TSAs response to consultation comments

552. As noted above, there were a range of repeated comments raised during the consultation. Some of these aligned with the common response themes which are covered in Section 10, but there were three specific comments that were repeatedly stated specifically about the TSAs' draft recommendations on paediatric services. The TSAs' response to these comments is in Table 53.

Table 53: The TSAs response to consultation comments specific to Emergency and urgent care recommendations

Comment	TSA response
The TSAs stated that paediatric surgery is not undertaken at Stafford Hospital	<p>The TSAs draft report stated that MSFT does not undertake paediatric surgery. This statement was challenged because many children have surgical procedures, such as tonsillectomies, undertaken at the Trust.</p> <p>The statement is technically correct, but evidently open to misinterpretation. The TSAs used the terminology paediatric surgery as defined by the RCS, where it refers to specialist paediatric surgery undertaken by paediatric surgeons - which is normally undertaken at larger tertiary centres or specialist children's hospitals.</p> <p>Children's surgery is undertaken at MSFT, mainly on a daycase and non-elective/emergency basis. These are surgical procedures undertaken by a surgeon attached to a specific specialty rather than a specialist paediatric surgeon. For example the Ear, Nose and Throat (ENT) surgeons at MSFT will operate on children as well as adults.</p> <p>The analysis on and recommendations about children's surgery were included within the recommendations for emergency, elective and daycase surgery, but the draft report did not explicitly state this.</p>



Comment	TSA response
24/7 opening of the PAU	<p>The draft report stated that the current arrangements at MSFT were for a 14/7 PAU. This is incorrect and the TSAs issued an immediate addendum that it is in fact open 24/7.</p> <p>However, many respondents have questioned why the PAU could not be open 24/7 to provide greater local access and to avoid confusion. The TSAs have considered this, but do not believe it would be safe as there will not be any emergency department doctors in Stafford overnight. Therefore any patient who is admitted directly to the PAU could have a long wait before a paediatric trained doctor is available to assess the patient - which could potentially delay access to emergency treatment.</p> <p>There will need to be clear protocols with regards to children who are still in the PAU at 22:00. Whilst the A&amp;E and the PAU will no longer admit any further patients after this time, it will be staffed beyond this time to ensure that any child who attends before the doors close are not immediately transferred unnecessarily - if they can be assessed and sent home.</p>
The TSAs did not acknowledge the community paediatrics team	<p>In the TSAs' draft report, it was observed that a 'Paediatric Hospital@Home' service could be introduced in the areas served by MSFT. Many respondents were concerned that the TSAs had overlooked the existing community paediatric team that partly operate out of Stafford Hospital (managed by South Staffordshire and Shropshire Healthcare Foundation Trust) and that this could mean the TSAs' draft recommendations were based on a misunderstanding of the current service.</p> <p>The TSAs were aware of this service (indeed the draft report stated the 'Paediatric Hospital@Home' service <i>'should complement any existing community paediatric services'</i> - <i>paragraph 431</i>), but would suggest that local commissioners undertake a review of what is currently provided.</p>

## 13.5 Non-elective/emergency surgery in Stafford

### Draft recommendations and consultation response

553. The TSAs made one recommendation with regards to non-elective/emergency surgery in Stafford. This recommendation and a summary of the consultation responses are presented in Table 54.

Table 54: Draft recommendation 8 and a summary of consultation responses

#### Draft recommendation 8

Non-elective/emergency general surgery and trauma surgery will no longer be undertaken at Stafford. The exception will be minor surgical procedures which can be performed at Stafford A&E or where the patient can be stabilised at A&E and scheduled to return to Stafford Hospital for minor surgery alongside elective surgical patients.

This should happen as soon as possible and would mean that a Surgical Assessment Unit (SAU) would no longer be needed in Stafford.

Clinical protocols will be established so that where obvious surgical cases are attended by the ambulance service these patients will be taken directly to a larger more specialised hospital, such as UHNS and RWT.

Less obvious cases will be taken to Stafford A&E for an initial assessment. Walk-in cases to Stafford A&E will also be assessed at Stafford A&E.

Processes and protocols will be established so that A&E consultants in Stafford have remote access to a surgical opinion from the surgical teams at the larger more specialised hospital.

Where a patient in Stafford A&E is identified as needing emergency general surgery or trauma surgery, transportation to a larger more specialised hospital will be immediately arranged and the patient operated on as soon as possible upon arrival.

The delivery of minor surgical procedures will remain in Stafford. Clinical protocols will be established to define which procedures can be categorised as minor.

#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,428	19%	21%	40%	17%	38%	55%	5%



### Consultation comments

- How would medical patients get access to a surgical opinion if there isn't an on-call resident surgeon.
- The TSAs' draft report stated that the Surgical Assessment Unit (SAU) would no longer be required, but the SAU provides a wide range of essential services that would still be needed, even if emergency surgery were not performed in Stafford.
- The main concerns raised were:
  - Capacity at other providers (see Common response themes, Section 10);
  - Concerns around patient safety if travel time is increased (see Common response themes, Section 10);
  - More specifically, would this inappropriately delay treatment?

### The TSAs' conclusion

554. The TSAs have:
- reviewed the consultation responses; and
  - gathered further information to assess the consultation responses.
555. The TSAs are satisfied that there is no basis on which to revise their draft recommendation.

#### TSAs' service recommendation for Stafford 8

Non-elective/emergency general surgery and trauma surgery will no longer be undertaken at Stafford. The exception will be minor surgical procedures which can be performed at Stafford A&E or where the patient can be stabilised at A&E and scheduled to return to Stafford Hospital for minor surgery alongside elective surgical patients.

This should happen as soon as possible and would mean that a Surgical Assessment Unit would no longer be needed in Stafford.

Clinical protocols will be established so that where obvious surgical cases are attended by the ambulance service these patients will be taken directly to a larger more specialised hospital, such as UHNS and RWT.

Less obvious cases will be taken to Stafford A&E for an initial assessment. Walk-in cases to Stafford A&E will also be assessed at Stafford A&E.

Processes and protocols will be established so that A&E consultants in Stafford have remote access to a surgical opinion from the surgical teams at the larger more specialised hospital.

Where a patient in Stafford A&E is identified as needing emergency general surgery or trauma surgery, transportation to a larger more specialised hospital will be immediately arranged and the patient operated on as soon as possible upon arrival.

The delivery of minor surgical procedures will remain in Stafford. Clinical protocols will be established to define which procedures can be categorised as minor.



### Rationale for this recommendation

- 556. Emergency surgery is currently provided in Stafford by a range of clinical specialties which can be categorised as trauma and non-elective general surgery.
- 557. No major trauma patients are treated in Stafford. These patients are taken to larger more specialised hospitals, for example UHNS or RWT. There are protocols for the ambulance service to take these patients directly to a larger more specialised hospital.
- 558. In 2009, the Royal College of Surgeons conducted a review into surgical practices at MSFT<sup>61</sup>. This review highlighted serious concerns about the sustainability of the emergency surgery service.
- 559. Furthermore the review, conducted into MSFT by Professor Sir George Alberti, noted that with regards to emergency surgery:

*"The issue is that "general" surgery is now less acceptable as a discipline. Surgery has become much more specialised and constant practice at any operation is required to retain skills and deliver consistently good results. Many surgical specialties have already split away and now run their own rotas, often on the basis of regional or sub-regional networks. Examples include ENT, urology, thoracic surgery and vascular surgery. It is likely that this will happen for the rest of surgery. This creates major problems for small and medium-sized acute Trusts where it is not possible to employ sufficient numbers of each type of surgeon to provide a viable rota, particularly if, as is desirable, a consultant-delivered service is to be organised. Mid-Staffordshire Foundation Trust is one such example."*

- 560. This was a driver for the consolidation of major trauma surgery and vascular surgery into UHNS. It is expected that increasing sub-specialisation of surgery will push more activity to larger units in the future and in September 2013 (outside of the TSAs process) it was announced that the urology service would be moved to UHNS.
- 561. An emergency surgery service should provide 24 hour access per day which is staffed at all times and with a dedicated emergency theatre. Currently, there are insufficient volumes of emergency surgery patients to effectively operate a dedicated emergency theatre.
- 562. On average the emergency theatres at Stafford undertake four procedures per day across general surgery and orthopaedics. The theatre data provided to the TSAs by the Trust shows that on average each emergency general surgery case took 1 hour and 15 minutes and each emergency trauma/orthopaedic case took 1 hour and 30

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<sup>61</sup> This review was not published, but was reported to the public inquiry chaired by Robert Francis QC.  
[http://www.midstaffsinqury.com/assets/docs/Inquiry\\_Report-Vol1.pdf](http://www.midstaffsinqury.com/assets/docs/Inquiry_Report-Vol1.pdf)





minutes. When considering the volume of activity seen each day then on average there is approximately six hours of operating time on average per day spread across two emergency theatres which are both provided almost entirely 24/7.

563. The view from the CAG was that an emergency surgery service with these low volumes is not sustainable in the long term. The low volume of cases does not provide an environment for training both medical and nursing staff and has the potential to de-skill the theatre team in the long term.
564. There was some concern expressed regarding whether the proposals would result in patients experiencing a delay in getting immediate treatment that they may need. The Royal College of Surgeons standards for emergency surgery patients identified as being high risk states that a patient must be reviewed by the consultant surgeon within four hours. The TSAs, and the CAG, do not believe that the proposal to cease emergency surgery at Stafford would jeopardise patient safety and introduce an inappropriate and unsafe delay to patient access to emergency surgery.
565. The TSAs have considered whether ceasing to perform emergency surgery would undermine the ability to provide a surgical opinion to the medical wards. Although this would mean there would not be an emergency on-call consultant rota, there will routinely be surgeons on site in Stafford during the day time. These surgeons will be performing day case procedures, elective lists or undertaking outpatient clinics. More urgent surgical input will need to be provided from the on-call team at the larger hospital who manage the clinical network with Stafford Hospital.

### **The TSAs response to consultation comments**

566. As noted above, there were a range of repeated comments raised during the consultation. Some of these aligned with the common response themes which are covered in Section 10, but there were one specific comment that was repeatedly stated specifically about the TSAs draft recommendation on emergency surgery. The TSAs' response to this comment is in Table 55.

Table 55: The TSAs response to consultation comments specific to emergency surgery recommendation

Comment	TSA response
The need to retain the Surgical Assessment Unit (SAU)	<p>The TSAs acknowledge that the SAU currently performs a range of functions that will need to be provided on site in Stafford Hospital. There is also clearly a need to be able to assess surgical patients if they present at the A&amp;E department.</p> <p>However, the TSAs do not believe that a dedicated SAU will be required to perform these functions. Where a surgical opinion is needed this will be provided from either a surgeon who is on-site or from the on-call team at a larger networked hospital.</p> <p>Of the other functions currently provided by the SAU, several of these can be (and indeed often are) undertaken within A&amp;E departments and do not need to be provided in a dedicated SAU, such as the diagnosis and management of non specified abdominal pain.</p>

## 13.6 Critical care in Stafford

### Draft recommendations and consultation response

567. The TSAs made one recommendation with regards to critical care in Stafford. This recommendation and a summary of the consultation responses are presented in Table 56.

Table 56: Draft recommendation 9 and a summary of consultation responses

#### Draft recommendation 9

A small critical care unit should be retained in Stafford in order to support the acute medicine and elective surgery services. This unit will provide 'level 2' (high dependency) care and a 24/7 rota of anaesthetists at Stafford who can deliver short term 'level 3' stabilisation of patients prior to their transfer to an appropriate critical care facility.

This unit will not have a dedicated 'level 3' (intensive care) area.

The 24/7 rota of anaesthetists should be managed as part of a clinical network with a larger more specialised hospital.

#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,425	27%	22%	50%	11%	35%	46%	4%



### Consultation comments

- Is transferring critically ill patients to another hospital a risk to their safety?
- Removing the service would undermine other services at Stafford (A&E, medical inpatients, elective surgery);
- What is the difference between level 2 and level 3 care?
- Why would you automatically transfer someone after 4-6 hours if you could manage them in Stafford?
- The main concern raised was:
  - There is insufficient capacity at other providers in the Local Health Economy (see Common response themes, Section 10);

### The TSAs' conclusion

568. The TSAs have:
- reviewed the consultation responses; and
  - gathered further information to assess the consultation responses.
569. The TSAs have concluded that there is sufficient information available to change their recommendation.

### TSAs' service recommendation for Stafford 9

A small critical care unit should be retained in Stafford in order to support the acute medicine and elective surgery services. This unit will provide 'level 2' (high dependency) care and a 24/7 rota of anaesthetists at Stafford who can deliver 'level 3' advanced respiratory support.

Patients with critical care needs will be managed locally in Stafford if their condition can be appropriately managed with the skills available on site. Those patients that cannot be managed locally, will be stabilised prior to their transfer to an appropriate critical care facility. This will be supported by protocols developed by the appropriate provider and network.

The 24/7 rota of anaesthetists should be managed as part of a clinical network with a larger more specialised hospital.



### Rationale for this recommendation

570. Stafford hospital has a small critical care unit that has the capability to provide level 2 and level 3 critical care. The Intensive Care Society has a published document which describes these levels in more detail<sup>62</sup> but in general terms:
- Level 2 patients are typically those who require single organ support, require pre-operative optimisation, extended post-operative support or patients stepping down from level 3 care; and
  - Level 3 patients are typically those who require advanced respiratory support (ventilation) or require multi organ support.
571. In 2012/13 there were 425 critical care spells at Stafford Hospital<sup>63</sup>. Of these spells, 200 were medical patients and 225 were surgical patients. Of the surgical patients, 147 were admitted following emergency surgery and 78 were admitted following elective surgery. Of the 78 elective patients, only six had level 3 critical care needs.
572. As the TSAs have recommended that non-elective/emergency general surgery and trauma surgery will no longer be undertaken at Stafford hospital it is evident that there will be a significant reduction in the demand at Stafford for critical care, especially 'level 3'/intensive care.
573. The staffing levels required for a dedicated 'level 3' intensive care unit means that the current small unit is already financially challenging for MSFT, and this reduction in demand for 'level 3' care will make this even more challenging.
574. Therefore, the TSAs concluded – and recommended in their draft report – that there should no longer be a dedicated 'level 3' critical care service in Stafford and that all patients who require 'level 3' care should be stabilised and transferred to a dedicated unit at a larger more specialised hospital.
575. The draft recommendation for critical care is supported by the HEIA which states *'In relation to emergency surgery and the level 3 critical care service at Stafford Hospital, the Steering Group notes that the National Clinical Advisory Group (CAG) views this service as unsustainable due to low volumes, previous concerns raised by the Royal College of Surgeons, and evidence that supports the drive towards centralisation of these services. The potential safety benefits of concentrating critical care into a larger unit will rely on ensuring that there is the right capability at Stafford Hospital to intervene during a surgical or medical emergency (including*

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<sup>62</sup> Levels of critical care for adult patients: Intensive care society, 2009

<sup>63</sup> Source: Trust data

*intubation and respiratory support) and stabilise for transfer, and the right capacity at other sites to receive patients'.*

576. Much of the feedback from the consultation questioned whether it was appropriate to use the general definitions for levels of critical care as the determining factor as to whether a patient should be treated at Stafford or stabilised and transferred. With the TSAs recommending that there be a 24/7 rota of anaesthetists at Stafford hospital the TSAs were challenged whether there could be some patients defined as 'level 3' who could be suitably managed in Stafford. The TSAs have accepted this point and have revised their recommendation so that the decision whether to stabilise and transfer a patient should be based upon the individual needs of the patient and whether there was the capability to manage that patient without the need to transfer.
577. The key determinant for what patients could be managed locally will therefore be the availability of the relevant professionals to manage the patient. The TSAs are still recommending that there be a 24/7 presence of anaesthetists, who would have the skills to ventilate patients if needed. The TSAs have reviewed whether there would be the need for an intensivist rota (a doctor who is specifically trained in the management of critical care patients) but do not believe this would be justifiable, because no emergency surgery would be performed at Stafford and higher risk elective procedures would also be performed at other sites.
578. The TSAs understand the concern that was raised regarding whether it is safe to transfer patients with critical care needs. The TSAs are reassured that transfer of critical care patients currently happens and there are protocols in place that ensure this is performed safely by WMAS. Furthermore, the Royal College of Surgeons Edinburgh have provided specific examples of where this service operates elsewhere and examples of how this could work in Staffordshire. For example, a patient retrieval system for level 2 and level 3 critical care patients is being delivered between two hospitals in Derby. The TSAs would encourage commissioners to look at how an equivalent service could be commissioned on a networked basis.

### **The TSAs response to consultation comments**

579. As noted above, there were a range of repeated comments raised during the consultation. Some of these aligned with the common response themes which are covered in Section 10, but there was one specific comment that was repeatedly stated specifically about the TSAs draft recommendation on critical care. The TSAs' response to this comment is in Table 57.

Table 57: The TSAs response to consultation comments specific to critical care recommendations

Comment	TSA response
No level 3 critical care would undermine other services	<p>This concern has been repeated in response to multiple questions. The TSAs would note that:</p> <ul style="list-style-type: none"> <li>• Only six patients in 2012/13 who attended Stafford Hospital for elective surgery required level 3 critical care. The view of the CAG is that high risk elective surgery should only be performed at larger more specialised hospitals.</li> <li>• In 2012/13, 79 of the 200 medical patients who required critical care treatment needed level 3 care. To put this in context, there were ca. 8,500 medical inpatient spells at MSFT during 2012/13. This equates to 2.3% of medical inpatients requiring critical care and less than 1% needing level 3 care. The revisions to the TSAs proposals alongside the ability to safely transfer patients if needed means that this is not expected to undermine the medical inpatient service.</li> <li>• The unit will have the capability to identify and stabilise a deteriorating patient quickly. The patient will then either, depending on the needs of the patient, be managed in Stafford if clinically appropriate or transferred to UHNS to receive more specialist care.</li> </ul>

## 13.7 Elective surgery and day cases (surgical and medical) in Stafford

### Draft recommendations and consultation response

580. The TSAs made one recommendation with regards to elective surgery and day cases (surgical and medical) in Stafford. This recommendation and a summary of the consultation responses are presented in Table 58.

Table 58: Draft recommendation 10 and a summary of consultation responses

#### Draft recommendation 10

Elective surgery and day cases should remain in Stafford, but with a reduced number of specialties.

The range of specialties will be determined through ongoing discussions with the CCGs and by the healthcare provider who ultimately operates services out of Stafford.

Any procedures that do not continue to be delivered in Stafford will be consolidated with services at other sites in the Local Health Economy.

NB:

1) The TSAs cannot recommend that other Trusts consolidate some of their elective surgery into Stafford. However, and dependent upon the provider operating services in Stafford, there may be an opportunity to repatriate Stafford resident patients that currently have to travel to other hospitals for elective surgery.

2) Surgical diagnostic procedures (such as endoscopy) and day case chemotherapy were part of the list of LSS and as such will remain in Stafford.

### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,403	61%	27%	87%	2%	5%	7%	5%

### Consultation comments

- Want to see more details on which services would be delivered in Stafford in the future.

### The TSAs' conclusion

581. The TSAs have:
- reviewed the consultation responses.
582. The TSAs are satisfied that there is no basis on which to revise their draft recommendation.

### TSAs' service recommendation for Stafford 10

Elective surgery and day cases should remain in Stafford, but with a reduced number of specialties.

The range of specialties will be determined through ongoing discussions with the CCGs and by the healthcare provider who ultimately operates services out of Stafford.

Any procedures that do not continue to be delivered in Stafford will be consolidated with services at other sites in the Local Health Economy.

NB:

1) The TSAs cannot recommend that other Trusts consolidate some of their elective surgery into Stafford. However, and dependent upon the provider operating services in Stafford, there may be an opportunity to repatriate Mid Staffordshire patients that currently have to travel to other hospitals for elective surgery.

2) Surgical diagnostic procedures (such as endoscopy) and day case chemotherapy were part of the list of LSS and as such will remain in Stafford.



### Rationale for this recommendation

583. Elective inpatient surgery is currently conducted in Stafford across a range of surgical and medical specialties. The primary specialties are: gynaecology, colorectal, gastroenterology, general surgery, Ear, Nose and Throat (ENT), Gastro-intestinal surgery and breast surgery.
584. Elective day case procedures (surgical and medical) are also currently conducted in Stafford across a wider range of specialties than elective inpatient surgery. Specialties include those named for elective inpatient surgery, some specialist surgery areas such as oral surgery and day case medical procedures, such as day case chemotherapy.
585. MSFT splits elective surgery across the Stafford and Cannock sites, with a range of orthopaedic surgical procedures being carried out in Cannock.
586. Elective work is typically high in volume and low in cost. This means that such work is attractive for healthcare providers as they typically deliver a positive financial contribution. Regardless of this, any provider of elective surgery needs to manage a critical mass of patient volumes through their elective service. This is due to the broad range of specialties covered by elective surgery and the need to maintain the skills of the professionals delivering the service. The need for a critical mass of procedure volumes is rising due to the increasing specialisation of surgeons and advances in medical technology.
587. The TSAs cannot – at this stage - be specific about the exact range of elective procedures that would be delivered in Stafford. This would be dependent on discussions between CCGs and the provider that operates the elective service in the future. That said, the TSAs' recommendation is based on an expectation that:
- Short stay surgery remains in Stafford with procedures on patients who are assessed as having a low risk of complication from specialties such as ENT, oral and maxillofacial surgery;
  - Orthopaedic surgery will be provided in Stafford for Stafford residents, rather than being provided from Cannock;
  - A wider range of day case surgery for both medical and surgical patients would be provided in Stafford; and
  - The provision of day surgery on children will be provided as per the guidelines set out by the Royal College of Surgeons and endorsed by the Royal College of Paediatrics and Child Health . The guidelines are specific for day case children's surgery in units where there is no paediatric inpatient service.



## 13.8 Clinical services in Cannock

### Draft recommendations and consultation response

588. The TSAs made three recommendations with regards to clinical services in Cannock, in the areas of intermediate care, elective inpatient surgery and day cases.
589. The TSAs also noted in their draft report that the following services currently operated at Cannock Chase Hospital by other providers are beyond the remit of the TSAs, and are subject to standard commissioning and performance management processes:
- 16/7 Minor Injuries Unit;
  - GP-led intermediate care beds;
  - Renal unit; and
  - MRI scanner.
590. The TSAs' draft recommendations and a summary of the consultation responses are presented in Table 59.

Table 59: Draft recommendations 11-13 and a summary of consultation responses

#### Draft recommendation 11

A consultant led 'step down' facility should be introduced in Cannock to work alongside the existing GP-led intermediate care service.

Clear clinical protocols will need to be established to ensure appropriate use of the facility and to ensure equitable access to primary care and secondary care providers.

#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,353	50%	32%	81%	3%	4%	8%	11%

### Draft recommendation 12

Elective surgery could be retained in Cannock. There will be a reduction in inpatient elective orthopaedic surgical activity as patients from Stafford and Surrounds will now be treated in Stafford, but this could be counteracted by the introduction of new surgical specialties into Cannock.

Whether it is possible to retain a viable elective inpatient surgery service will be dependent upon the other services being delivered in Cannock and the capability and willingness of an alternative provider to deliver this service safely and within the local commissioning budget.

This CAG have emphasised that this draft recommendation is dependent on the level of overnight medical cover on site.

#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,319	47%	32%	79%	3%	3%	7%	14%

### Draft recommendation 13

The current range of day case procedures (surgical and medical), including the Rheumatology service, should be maintained and, where possible enhanced to provide a broader range of services.

#### Consultation responses

No. of Responses	Strongly Support	Tend to Support	Net Support	Tend to Oppose	Strongly Oppose	Net Oppose	Not Sure
2,300	57%	26%	83%	2%	3%	5%	12%

#### Consultation comments

- All of the draft recommendations were strongly supported;
- The services should be properly linked with community/social care services;
- More detail is needed about which elective and day case services would be provided in Cannock;
- The main concern raised was:
  - Could the TSAs clarify their comment that there may be issues with overnight cover at Cannock Chase Hospital that could impact what services could be provided in Cannock.

### The TSAs' conclusions

591. The TSAs have:
- reviewed the consultation responses; and
  - developed additional information around the proposed services.
592. The TSAs are satisfied that there is no basis on which to revise their draft recommendations with regards to services in Cannock.

#### **TSAs' service recommendation for Cannock 1**

A consultant led 'step down' facility should be introduced in Cannock to work alongside the existing GP-led intermediate care service.

Clear clinical protocols will need to be established to ensure appropriate use of the facility and to ensure equitable access to primary care and secondary care providers.

#### **TSAs' service recommendation for Cannock 2**

Elective surgery could be retained in Cannock. There will be a reduction in inpatient elective orthopaedic surgical activity as patients from Stafford and Surrounds will now be treated in Stafford, but this could be counteracted by the introduction of new surgical specialties into Cannock.

Whether it is possible to retain a viable elective inpatient surgery service will be dependent upon the other services being delivered in Cannock and the capability and willingness of an alternative provider to deliver this service safely and within the local commissioning budget.

This CAG have emphasised that this draft recommendation is dependent on the level of overnight medical cover on site.

#### **TSAs' service recommendation for Cannock 3**

The current range of day case procedures (surgical and medical), including the Rheumatology service, should be maintained and, where possible enhanced to provide a broader range of services.



### **Rationale for these recommendations and supporting information**

593. Cannock Chase Hospital costs more to operate than the income it receives for the treatment of patients. This is largely due to the inefficiency of operating a facility with unused space and low utilisation in those areas that are used. Continuing in this manner is not feasible. Therefore, the TSAs' recommendations are predicated on the basis that the existing services provided at Cannock Chase Hospital are retained and a broader range of services are offered in addition - primarily for the residents of Cannock Chase.
594. It is clear, through discussions with the CCGs, the CAG and other organisations, that if Cannock Chase Hospital is operated as part of a clinical network with a larger more specialised hospital than Stafford Hospital there are opportunities to provide a broader range of clinically sustainable services in Cannock than currently exist.
595. The TSAs have identified and recommended additional areas of acute medical and surgical services that should be offered in Cannock going forward. The specific specialties that will be provided in Cannock will be dependent upon the nature of the organisation that manages the hospital, and following agreement with local commissioners. It is possible that multiple providers may provide complementary services in Cannock.
596. The acute medical or surgical services that the TSAs have recommended for delivery in Cannock are:
- consultant led 'step down' beds which will enable the repatriation of Cannock patients from other hospitals (notably New Cross in Wolverhampton and The Manor in Walsall) to complete the rehabilitation and continuing care associated with their inpatient procedures;
  - an extended range of elective surgical procedures (currently only orthopaedic surgery is routinely provided in Cannock for residents of both Stafford and Cannock) which would significantly improve local access for Cannock residents to a range of elective surgical procedures; and
  - an extended range of day case procedures (surgical and medical) which would significantly improve local access for Cannock residents.
597. The question of integration with community/social care provision is outside the TSAs' remit, however the TSAs expect to see closer working between health and social care providers to make sure Cannock patients are being treated in the most appropriate care setting and to avoid unnecessary and inappropriate hospital admissions. Closer working with community/social care providers is most likely to



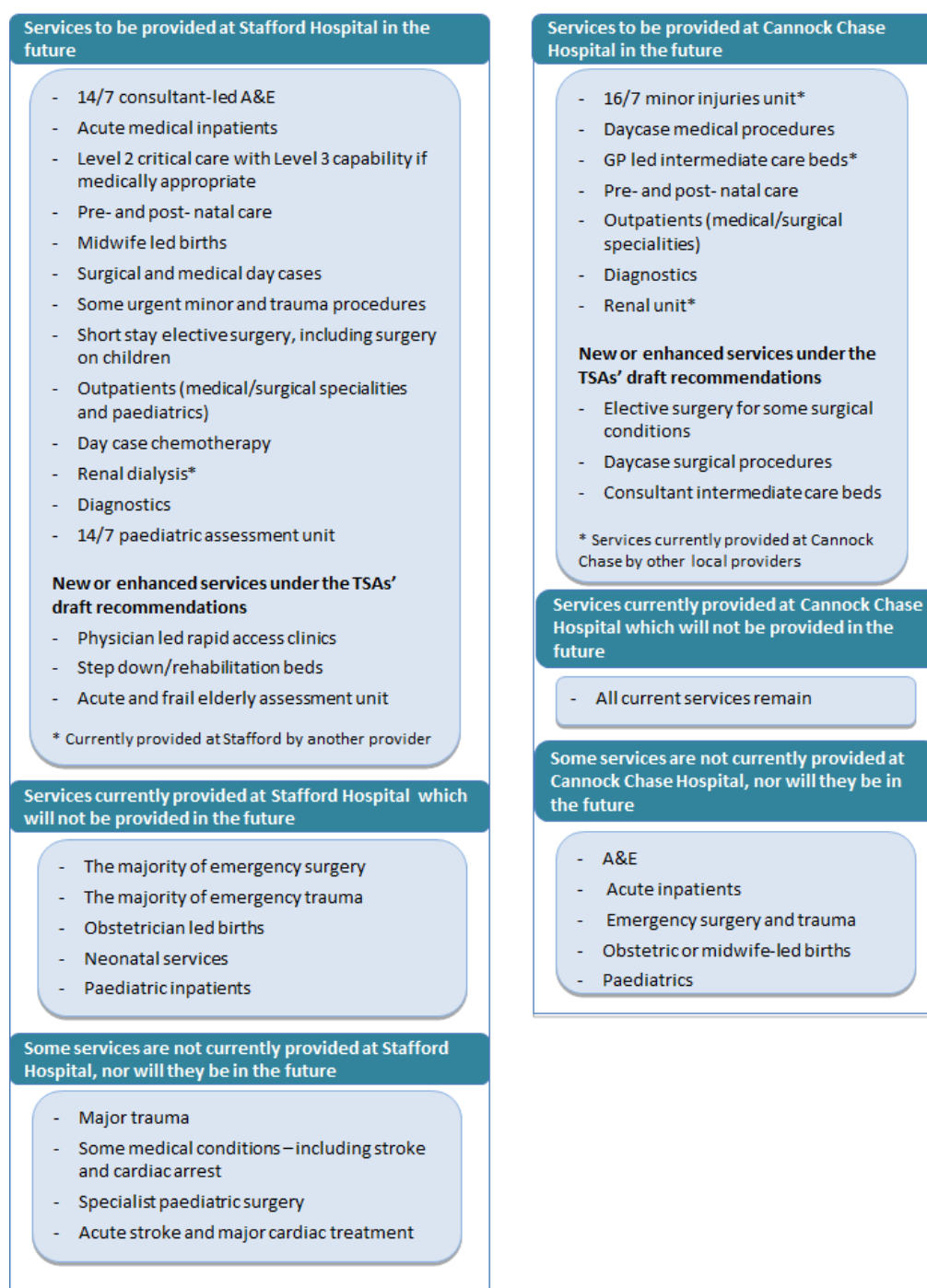
improve the clinical and financial sustainability of running acute services from Cannock Chase Hospital.

598. In the draft report, it was noted that the CAG had reservations about the safety of providing a broader range of elective inpatient surgery at Cannock Chase Hospital due to concerns about the overnight medical cover at the hospital.
599. During the consultation period the provision of elective surgery at Cannock was further discussed with a core group of the relevant CAG members to determine the minimum overnight staffing model which would enable elective surgery to be provided safely. This staffing model is on the basis of a networked arrangement where staff would rotate between Cannock and a larger site.
600. The minimum overnight staffing to support safe inpatient surgery was agreed to be:
- Resident middle grade doctor for Orthopaedics;
  - Resident middle grade doctor for General Surgery;
  - Resident middle grade Anaesthetist; and
  - Resident Medical Officer (non-training grade).
601. The TSAs are satisfied that this staffing model is feasible and that their recommendation with regards to elective surgery is achievable.

### 13.9 The overall impact on patient access of the proposed changes to clinical services

602. Figure 12 summarises the clinical models for Stafford and Cannock Chase Hospitals that the TSAs are recommending.

Figure 12: The TSAs recommended clinical model for Stafford and Cannock



603. In their draft report, the TSAs assessed the proportion of patients who currently access services at Stafford and Cannock Chase Hospitals who would still access services in Stafford or Cannock Chase Hospitals. They concluded that under their draft recommendations 91% of patient attendances to Stafford and Cannock Chase Hospitals would remain at Stafford and Cannock Chase Hospitals.
604. The revisions the TSAs' have made to their recommendations means that more patients will attend Stafford and Cannock Chase Hospitals than would otherwise have done so under the TSAs' draft recommendations. This is because<sup>64</sup>:
- A proportion of the births that currently take place at Stafford Hospital will be retained at the proposed MLU at Stafford Hospital; and
  - A proportion of the patients that have 'level 3' critical care needs will still be treated at Stafford Hospital.
605. It is difficult to predict how many of these attendances would no longer take place at Stafford Hospital under the TSAs' revised proposals because: a) birth location is down to patient choice; and b) the decision whether to treat a 'level 3' critical care patient will be down to medical judgement. However, at present the total number of patient attendances at MSFT for births (ca. 1,800-1,900) or critical care (ca. 425) represent less than 0.5% of total attendances. Therefore, the proportion of patients expected to be retained in Stafford or Cannock Chase Hospitals is higher under the TSAs' final recommendations but will still be 91%.
606. Of the 9% of activity that will no longer take place at Stafford and Cannock Chase Hospitals, recent activity at MSFT shows this is likely to be a near equal split between Stafford and Cannock residents. Table 60 shows the proportion of activity taking place at MSFT based upon the residency of patients.

Table 60: Average attendances to MSFT split between Stafford and Cannock residents

Type of care	Stafford and Surrounds	Cannock Chase
Elective	50.1%	49.9%
Non-elective	55%	45%

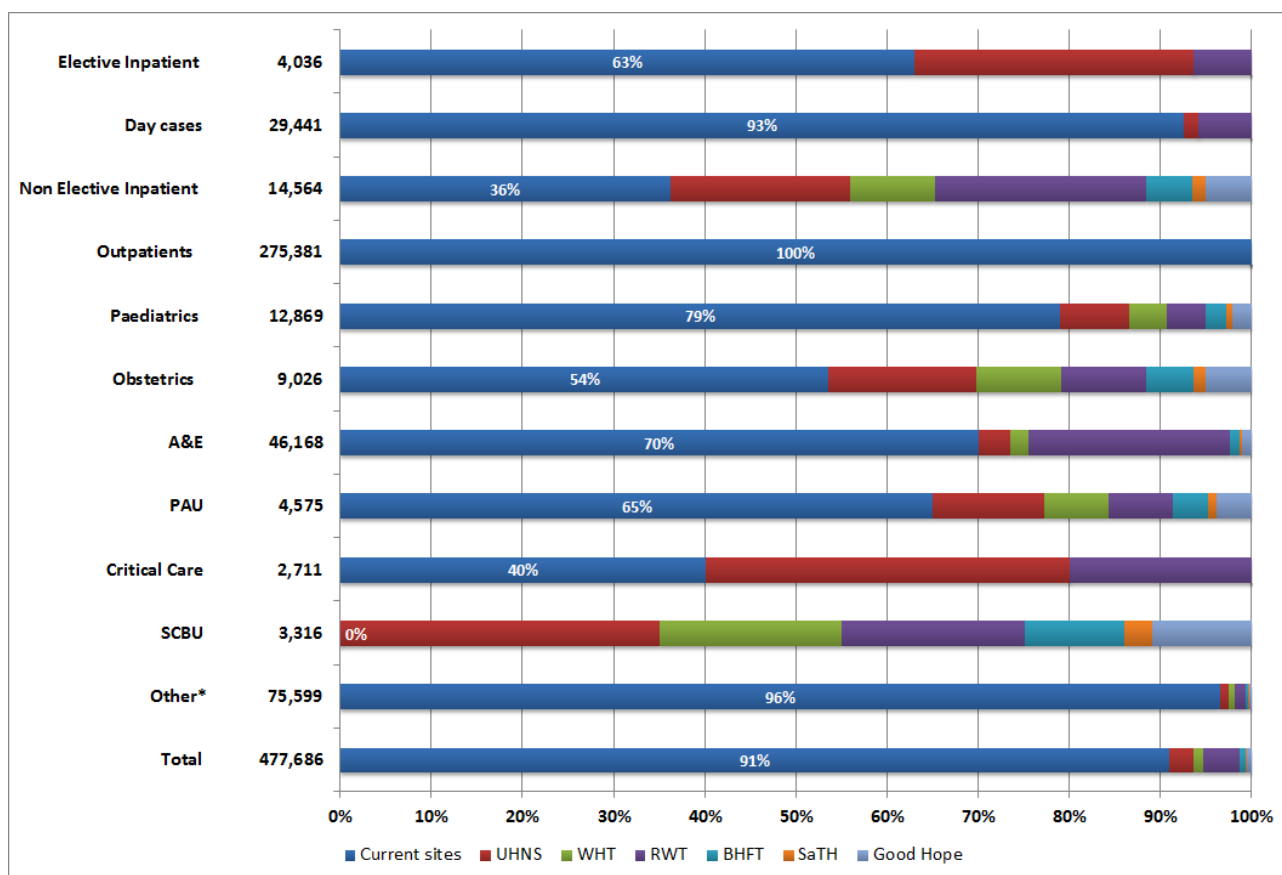
Notes:

- 1: The information is based upon Trust held data.
- 2: This is shown as a proportion of activity for Stafford and Cannock residents. Approximately 5% of MSFT activity is for out of catchment residents and has been excluded from this analysis.
- 3: The elective split is based upon referrals over the period 2010/11 - 2012/13.
- 4: Non elective activity is based upon data for 2012/13.

<sup>64</sup> The changes that the TSAs have made to Recommendation 7 (PAU) relate to the staffing model but would not impact the number or type of patients that the TSAs would proposed attend the PAU.

607. Figure 13 shows the TSAs' assessment of where current MSFT activity will be delivered in 2016/17. This is based upon 2012/13 activity levels and taking into account the TSAs' recommendations, with the exception of the revised changes to maternity and critical care.

Figure 13: The TSAs assessment of activity levels in 2016/17 for those services currently provided by MSFT, and the levels that will no longer be provided in Stafford or Cannock (NB: Does not show impact of the revised recommendations for MLU or critical care)



Source: TSA analysis

Note:

1: Non elective activity is apportioned based upon travel time to an alternative hospital, elective activity is apportioned based upon historic commissioning patterns.

608. In the information presented to date, the TSAs have focussed on patient access for the 9% of patient attendances which would no longer take place in Stafford or Cannock under the TSAs' recommendations. However, the TSAs' recommendations propose that some activity which currently takes place at Stafford Hospital will take place at Cannock Chase Hospital in the future, and vice versa.

609. The intention of the TSAs' proposals is that there is a greater range of elective and day case services in Cannock Chase Hospital in the future and that there would



therefore be a reduction in the need for Cannock Chase residents to travel to Stafford Hospital for treatment. In addition, with the proposal that orthopaedic surgery takes place at Stafford Hospital in the future – for Stafford residents – this would see a reduction of Stafford residents having to travel to Cannock Chase Hospital for orthopaedic surgery.

610. Table 61 summarises an indication of the number of elective and day case procedures that will take place at Stafford Hospital for Stafford residents and Cannock Chase Hospital for Cannock residents where previously the procedure would have taken place at the other hospital. This is based upon MSFT activity in 2012/13.

Table 61: Patient attendances for elective and day case procedures that will move to the patient's local hospital

	Stafford and Surrounds residents at Stafford Hospital	Cannock Chase residents at Cannock Chase Hospital
Elective/day case procedures per year	888	941

Source: TSA analysis of HES data 2012/13

Notes:

1: Stafford figure is based upon day case and elective orthopaedic procedures undertaken at Cannock Chase Hospital for patients registered with GPs in the Stafford and Surrounds CCG

2: Cannock figure is based upon day case and elective procedures for Breast surgery, Ear, Nose and Throat and Urology specialities, at Stafford Hospital for patients registered with GPs in the Cannock Chase CCG

## 14 The affordability of the TSAs' recommendations

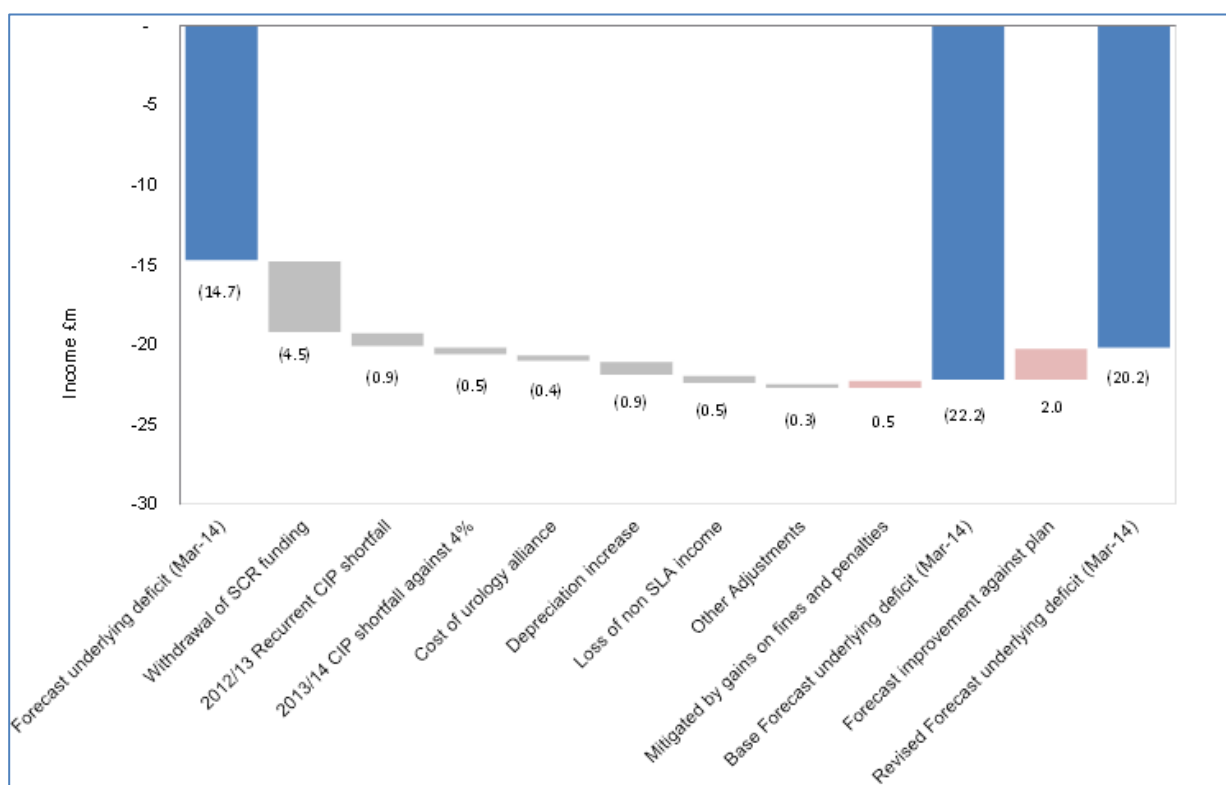
- 611. The TSAs' recommendations will deliver a substantial reduction in the annual running costs for the services currently provided by MSFT. Indeed, the savings identified (£34.4m) over the next three years will exceed the current deficit of MSFT (£14.7m at the end of the last financial year) and the forecast deficit for the end of the current financial year (forecast to be ca. £20m).
- 612. However, the impact of additional cost inflation over the next three years would mean that the MSFT deficit, if no changes were made, would total £42.5m. This means that the level of savings identified would not fully address the forecast deficit as it stands at the end of a three year transition period in April 2017.
- 613. However, the TSAs' extensive and ongoing analysis is currently indicating that the proposed changes will not deliver sufficient levels of savings to address the expected impact of cost inflation in the delivery of healthcare over the period April 2014 – March 2017.
- 614. The TSAs have concluded that, in all probability, there is no solution which focuses solely on the reconfiguration of MSFT services which will reduce the forecast financial deficit to zero. The TSAs are satisfied that their analysis shows that their recommendations provide the best balance of clinical sustainability and realisable financial savings, whilst maintaining local access to services.
- 615. The TSAs have continued to work with multiple parties to develop further detail and consensus on the expected gap in funding from April 2017 and how this gap will be funded. This is the single reason an extension was granted to the TSAs for the period allotted to develop their final report.
- 616. Annex 3.4 presents the TSAs financial analysis in detail, including the assumptions used in preparing this analysis. This section presents a brief summary of the outcomes of this analysis.

### 14.1 The forecast financial position for MSFT by March 2017

- 617. At the end of FY13 (March 2013), MSFT reported a closing deficit position of £14.7m. This included the benefit of non-recurrent funding of £4.5m, so the underlying deficit of the trust was £19.2m. The financial plan for MSFT for 2013/14 initially showed a forecast deficit position of £22.2m. This was due to a combination of CIP shortfalls in the previous as well as a number of SLA adjustments.

618. However, the TSAs' latest forecast position for March 2014 is a deficit of £20.2m, due to the anticipated improved performance of the activity plan and a resulting increase in income seen in Q1 of 2013/14. The TSAs have therefore based their financial evaluation on the year end position being £20.2m. The financial movements from April 2013 – March 2014 are shown in Figure 14.

Figure 14: The forecast movements in MSFT financial performance for the current financial year



619. Like all NHS trusts and other NHS organisations, MSFT will continue to be faced with additional financial pressures which are driven by both annual tariff deflation and cost inflation. Monitor publishes financial planning assumptions which all foundation trusts, and aspirant Foundation Trusts, must build into their financial forecasting. These are outlined in Table 62.

Table 62: Monitor's financial planning assumptions

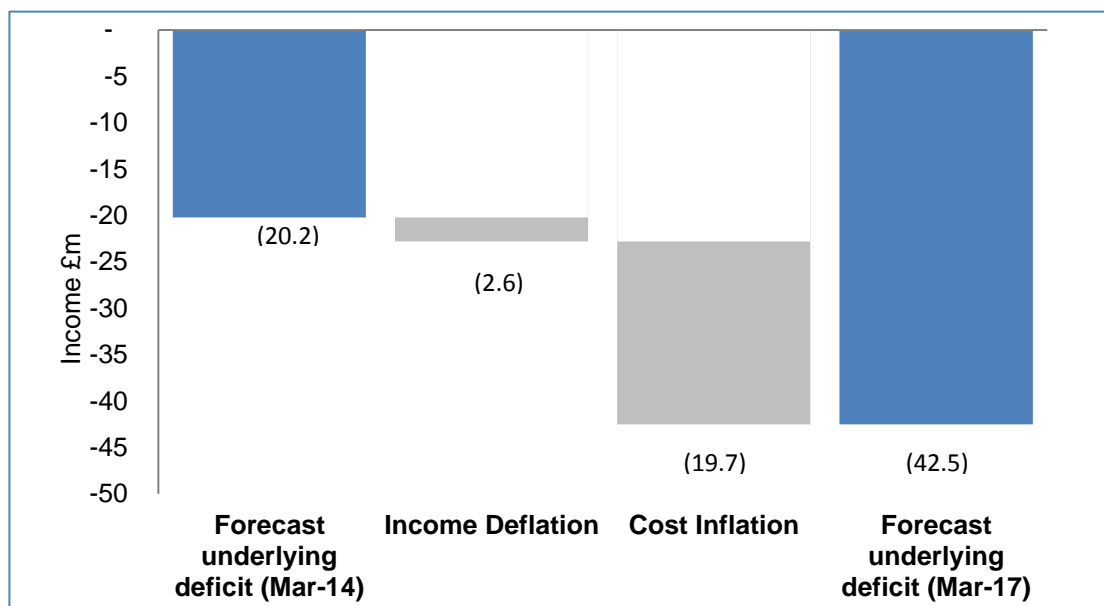
Assumption	13/14	14/15	15/16	16/17
Tariff inflator/ deflator	-1.30%	-1.30%	-0.20%	-0.20%
Cost inflation	3.70%	3.70%	4.00%	4.00%

Source: Monitor

620. MSFT would need to deliver annual savings of 4-5% every year just to address these pressures and maintain their current deficit level of ca. £20m. If no savings were made then MSFT's forecast deficit for March 2017 would be £42.5m (as shown in

Figure 15). This means that savings of greater than £42.5m need to be identified if the deficit associated with the activity currently provided by MSFT is to be fully addressed.

Figure 15: Forecast deficit for MSFT in March 2017



## 14.2 Changes to the TSAs' financial assumptions as a result of the consultation feedback

621. The TSAs' draft report set out a financial evaluation that the TSAs conducted into three potential clinical models:
- 1: A model based solely on retaining the Location Specific Services in Stafford and Cannock;
  - 2: A model based upon the recommended clinical model of the Contingency Planning Team; and
  - 3: A model based upon what were to become the TSAs' draft recommendations.
622. The evaluation demonstrated that the Draft TSA model (Model 3) was the most cost effective clinical model to implement.
623. The TSAs received feedback from multiple parties with regards to their financial analysis and underpinning assumptions. The TSAs also determined that their proposed clinical model should be modified (as set out in Section 13). This has led the TSAs to refine their financial analysis in the following ways:
- Introducing the MLU – An MLU will attract a different tariff (relating to birth without complications) than the existing unit. The TSAs have modelled 357



births, which is the number of births needed at an MLU in order for it to break even.

- MAU – The TSAs have revised their staffing assumptions upwards in the financial model based upon further discussions with local providers.
- Capital assumptions – The capital assumptions have been refined to reflect the ongoing work undertaken to assess the capital requirements associated with implementing the TSAs' recommendations.
- Productivity – The TSAs have revised their productivity assumptions following their ongoing discussions with local providers.
- Excess bed days (XBD) - Excess bed day income is the payment received when a patient's length of stay in a hospital bed is longer than expected. If the productivity assumptions are achieved then the excess bed day income currently received for the provision of the services retained in Stafford and Cannock would decrease.
- Other income adjustment – Other income has been updated to remove non recurrent income and those income streams that are expected to cease.
- Paediatric premium – A review of guidance has resulted in the TSAs providing a greater level of nursing cover for Paediatric inpatient services at other provider sites than was previously included in the model.
- Clinical Nurse Specialists (CNS) – Following discussions with local providers, the TSAs have incorporated a greater level of CNS presence on the Stafford and Cannock sites.
- Finally, the impact of each of these movements on the overall inflation position has been accounted for within the forecasts for the models.

624. These revisions to the financial assumptions have had an impact on the range of savings that the TSAs presented in their draft report.

625. In their draft report, the TSAs indicated there were potential additional savings that could be delivered and that further work would be undertaken. At this point in time, the TSAs cannot attribute any additional savings to any of these opportunities for the following reasons:

- Further reductions in productivity: This is still a possibility in the future but the TSAs are not confident, at this point in time, that it would be appropriate or realistic to target further productivity savings;
- Demand management: The TSAs do not have sufficient evidence to indicate that the proposed demand management schemes will deliver further savings; and

- Improved Local Health Economy integration: The TSAs believe this could deliver savings (this is also the position of the local CCGs in their response to the TSAs), but are clear that it is beyond their remit to investigate such opportunities.

### 14.3 Investment required to deliver TSAs' recommendations

626. As noted in Section 4, there has been minimal recent investment in capital improvements at Stafford and Cannock Chase Hospitals and there is currently a maintenance backlog of ca. £69.8m.
627. The TSAs' recommendations will require investment in Stafford and Cannock Chase Hospitals in order to address the maintenance backlog and to reconfigure the hospitals to deliver the changes in the proposed service models. The TSAs' recommendations also call for investment in other hospitals in the Local Health Economy in order to establish additional capacity (details of which are covered in Section 15), as set out in Table 63.

Table 63: The TSAs' assessment of capital expenditure required

TSA assessment	
Stafford	£35.8m
Cannock	£7.0m
Other locations	£83.6m
IT	£3.8m
<b>Total</b>	<b>£130.2m</b>

628. Any capital expenditure will attract annual costs in the form of:
- Depreciation costs associated with any investment; and
  - Public Dividend Capital (PDC), which is effectively the finance charge to the organisation associated with the capital expenditure.
629. Table 64 sets out the annual cost of depreciation and PDC for each of the models, based on the estimated capital investment above. These costs would be proportionally allocated to the providers that receive the capital investment at their current sites and, in addition, to those providers that run Stafford and Cannock Chase Hospitals in the future.

Table 64: The annual financial impact of the proposed investment

TSA assessment	
Depreciation	£4.0m
PDC dividend	£2.9m
<b>Total annual cost</b>	<b>£6.9m</b>

630. Indicative costs were provided by the West Midlands Ambulance Service (WMAS) for inclusion in the TSAs' draft analysis. This cost is estimated at £1.2m per annum and has not changed since the TSAs' draft report.

## 14.4 Potential savings

631. The TSAs have identified a range of savings associated with the implementation of their recommendations. As noted above, these savings have been adjusted following feedback during the consultation. The detail of how these savings were assessed is in Annex 3.4. Table 65 summarises the level of savings that the TSAs have assessed.

Table 65: A summary of the assessed savings associated with implementing the TSAs' recommendations

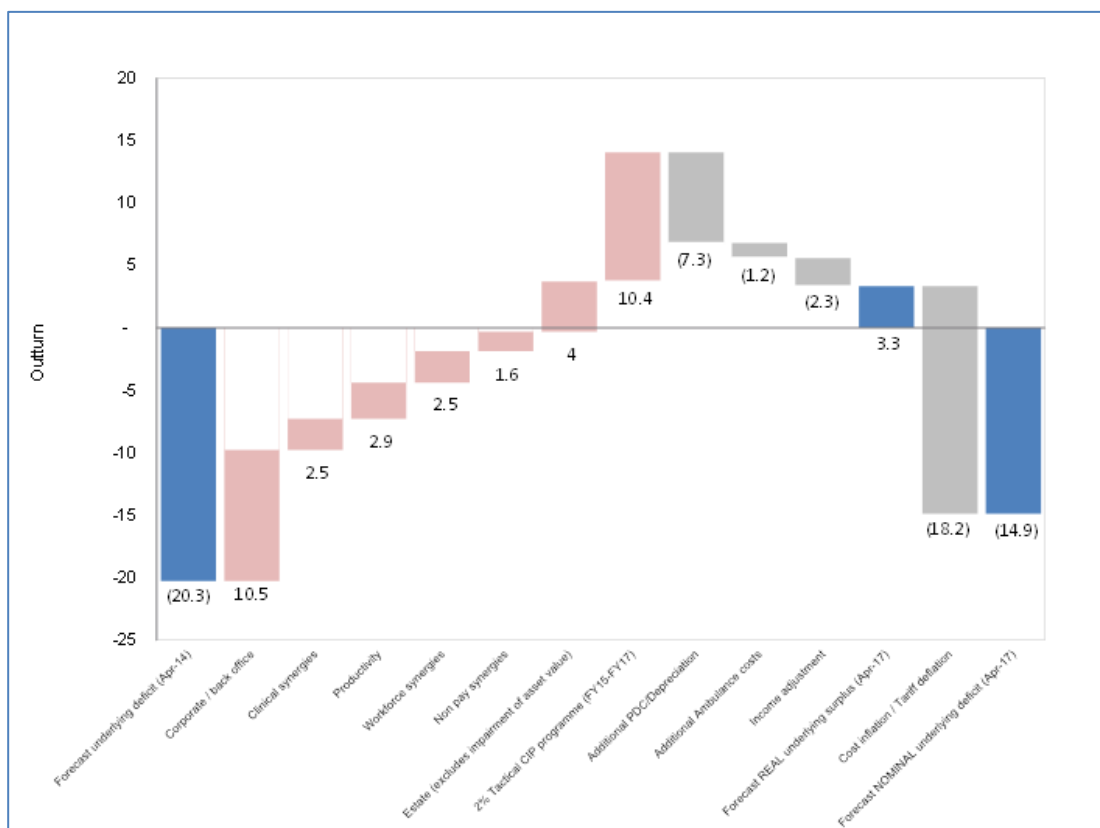
Category	Assessment	Assessed saving
Corporate/back office savings	The current cost is significantly higher than typical back office costs. The savings are based upon alignment with average back office and corporate costs and the removal of duplicate functions if MSFT as an organisation no longer exists.	£10.5m
Clinical synergies	The reduction in duplicate clinical costs associated with the services in Stafford and Cannock being run by existing alternate providers.	£2.5m
Productivity savings	Reduction in ward costs due to reducing average length of stay for inpatients to the national average.	£2.9m
Workforce synergies	The reduction in temporary staff costs, the removal of some duplicate positions and the alignment of staff structures to NHS standards that would be possible through the networking with other providers. This is reduced from the draft report based upon the new assumptions for the MAU.	£2.5m
Non pay synergies	The reduction in non-pay costs that would be possible through the closer networking with other providers.	£1.6m
Estate savings	Reduction of estate costs to nearer the average for the NHS.	£4m
Efficiency improvements	All NHS providers are expected to deliver 4-5% efficiency improvements every year – to counter the rising cost of service delivery. The TSAs have assumed MSFT would deliver 2% of tactical cost improvements each year as they believe delivering 4% alongside the rest of the changes taking place during transition would be unrealistic.	£10.4m
<b>Total</b>		<b>£34.4m</b>

632. This is a reduction in forecast savings from the £40.8m presented in the TSAs' draft report.

#### 14.5 The forecast position for March 2017

633. As stated above, the TSAs forecast deficit at the start of April 2017 (at what would be the first year of the TSAs' proposed reconfiguration) if no savings were achieved would be £42.5m. Taking into account the forecast savings and the additional PDC/depreciation associated with the capital investment required would leave a deficit of ca. £14.9m.
634. Figure 16 shows a summary of the forecast financial movements between April 2014 and March 2017 associated with implementing the TSAs' recommendations.

Figure 16: The Forecast financial movements associated with the TSAs' recommendations





635. The TSAs have made similar assessments for the CPT and LSS models for comparison purposes. The forecast positions for March 2017 under each model are shown in Table 66.

Table 66: The forecast position in March 2017 for the LSS and CPT models

	LSS	CPT	TSA
Forecast position	(£18.4m)	(£17.8m)	(£14.9m)

## 14.6 Reducing the gap further

636. The TSAs' recommendations are limited to assuring the safe and sustainable delivery of the services currently provided by MSFT. Local CCGs, providers and central bodies all recognise that there are further opportunities to reduce costs that fall outside of the scope of work undertaken by the TSAs. The responses from both local CCGs and NHS England state that they believe there are additional cost saving measures:

**Extract from CCG response to the consultation (30 September 2013)<sup>65</sup> – see Appendix D**

*“The fact is that services could be commissioned, provided and costed differently, underpinned by the drive to integrate services. The CCGs believe this different approach could deliver a more financially sustainable solution.”*

*“Commissioners would wish to validate and test these assumptions using different costing models which promote service integration”*

*“In conjunction with other CCGs in Staffordshire they [member practices] will continue to lobby central government about funding for South Staffordshire”*

*“What the CCG wishes to do is to ensure that acute services should be seen in the round alongside community provision.”*

*“The CCG as the responsible commissioner would wish to commission and procure services which are financially affordable through working differently with providers on costing and risk sharing which is reflected in contracts with these providers.”*

**Extract from NHS England letter to TSAs (11 December 2013) – see Appendix B**

*“We believe that there are a number of measures that could be applied to the recommended service model that would mitigate the current estimates of excess cost. We recognise that some of these may need further engagement or consultation with local stakeholders. These measures include;*

- 1. The integrated use of North Staffordshire community beds to increase overall system productivity and reduce reliance on new capital spend at UHNS.*
- 2. The refurbishment of spare capacity at Bradwell Community Hospital, to avoid capital expenditure on the acute site.*
- 3. The requirement for all new capital expenditure to have a signed off business case that takes full account of commissioning capacity plans - thus ensuring all new capital spend is*

<sup>65</sup> The CCG response was written prior to the latest letter sent to the TSAs by NHS England.



*genuinely unavoidable.*

*4. Without changing the TSA recommended clinical model, commissioners will review case mix and patient flow to determine whether the proposed provider specification is necessary at all sites (for example with regard to the number of single rooms and requirement for operating theatre upgrades)*

*5. The TSA model is currently based on current income levels - this will need to be updated to reflect future commissioning intentions and QIPP plans.*

*6. The CCGs taking responsibility for the negotiation of revision to the ambulance contract and patient transport with a view to minimising the impact on patients and reducing the ambulance services proposed cost increase.*

*7. Cannock Chase Hospital being subject to a placed based scheme developed with the local authority to fully explore the possibility of a landmark regeneration scheme that fully exploits the current site.*

*8. The implementation of the TSA recommendations will need to reflect CCG responsibilities and enable them to exercise their commissioning intentions through service procurement where appropriate.*

*9. We view the TSA clinical model as a start point for a wider-ranging Strategic Review that will ensure that both commissioning and provision across Staffordshire is placed on a clinically and financially sustainable footing for the long term.*

*10. NHS England, Monitor and the NHS TDA will need to review proposed capital spend to ensure the most appropriate accounting treatment is consistently applied.*

*11. All parties will need to be incentivised through the implementation arrangements to secure best value for money for the taxpayer.*

*We recognise that all of these actions will need extensive further engagement and we will work with local commissioners to support and help them develop these plans."*

637. The TSAs are not in a position to comment as to the likely impact of either the CCG or NHS England proposals, but do welcome the commitment of local and national commissioners and other stakeholders to build upon the work and recommendations of the TSAs.

#### **14.7 Transition costs, capital costs and funding requirements**

638. In calculating the transition costs the TSAs have assumed that the implementation of the TSAs' recommendations will start in April 2014 and will take no longer than three years. The TSAs are aware that some stakeholders believe that the transition period will/should take longer, but the TSAs have based their analysis on a three year period.
639. Table 67 outlines the estimated costs during this transition period associated with implementing the TSAs' recommendations, including depreciation of £26.3m. The transition costs associated with implementing LSS are assessed to be higher than this (see Annex 3.6).

Table 67: Estimated transition funding

	TSA model
Forecast deficit for three years	£58.7m
Less: Depreciation	(£26.4m)
<b>Forecast deficit for three years (excluding depreciation)</b>	<b>£32.3m</b>
Transaction costs	£18m
Redundancy costs	£5.3m
Double running costs	£8m
<b>Total transition costs</b>	<b>£63.6m</b>

Notes:

- Assumptions are estimated based on experience from other hospitals that have recently undergone reconfiguration.
- The three year deficit funding figures under each model are based on the forecast outturn position for each of the three years (2014/15, 2015/16 and 2106/17). Costs are reflective of the model forecasts detailed above with cost reduction phased over a three year period. The anticipated cumulative savings are 20% in year one, 40% in year two and 40% in year three.
- Implementation costs are estimated to be £18m across the transition period, based on an average of £500k per month for the 36 months.
- Double running costs of £8m are profiled at £3m in year two and £5m in year three, with zero double running costs anticipated in year one.
- Redundancy costs are estimated at £5.3m assuming that where activity moves to different sites, employees TUPE to the new organisation.

640. Capital charges will be incurred relating to reconfiguration of the estate to deliver each the proposed clinical model and to maintain the existing assets. The TSAs have assessed these amounts as shown in Table 68.

Table 68: Total transition costs

	TSA model
Capital expenditure to deliver TSA model	£130.2m
Maintenance during transition period	£26.4m
<b>Total transition costs</b>	<b>£156.6m</b>

641. The TSAs' have had extensive discussions with local providers throughout the period since the draft report was published in relation to both the operational and capital costs associated with the TSAs' draft recommendations. The TSAs' have also consulted with NHS PropCo. The TSAs' conclusions with regards to capital investment are made in light of these discussions and external advice. However, it should be noted that the other providers have some reservations as to the TSAs' forecasts and capital investment conclusions.

642. Taking into account the estimated level of capital investment, maintenance charges and transition funding the TSAs are therefore estimating that the total funding requirement will be £220.2m. This is shown in Table 69.

Table 69: Estimated total funding requirement

	TSA assumptions on capital			
	Y1	Y2	Y3	Total
Deficit funding	£17.4m	£11.4m	£3.5m	<b>£32.3m</b>
Implementation costs	£6.0m	£6.0m	£6.0m	<b>£18.0m</b>
Redundancy costs	£1.3m	£1.3m	£2.7m	<b>£5.3m</b>
Double running costs	-	£3.0m	£5.0m	<b>£8.0m</b>
<b>Total transition costs</b>	<b>£24.7m</b>	<b>£21.7m</b>	<b>£17.2m</b>	<b>£63.6m</b>
CAPEX	£45.6m	£65.1m	£19.5m	<b>£130.2m</b>
Maintenance during transition	£7.2m	£8.6m	£10.6m	<b>£26.4m</b>
<b>TOTAL FUNDING</b>	<b>£77.5m</b>	<b>£95.4m</b>	<b>£47.3m</b>	<b>£220.2m</b>

Note: Capital costs have been split based on 35% spent in year one, 50% in year two and 15% in year three and is indicative only. This split will be assessed in more detail during the implementation phase.

643. The TSAs have calculated the Net Present Value (NPV) and conducted a range of sensitivity analysis that is summarised in Annex 3.4.

## 14.8 Source of funding

644. Total funding for transition costs, capital and time-limited ongoing deficit funding from 2017/18 onwards will be provided by a combination of financing from the Department of Health and income from NHS England paid via the CCGs.
645. As stated in the 11 December 2013 from NHS England, *'I can confirm that NHS England would be prepared to fund a maximum of £8m of the implementation costs where these can be demonstrated to fall within our Provider Support Policy, with the balance being provided by the Department of Health. Your final report will also identify an ongoing funding gap for these services of £14.87m from 2017/18 onwards. I can also confirm that NHS England would be prepared to provide time-limited commissioner support of up to £14.87m per annum from 1/4/17 whilst local commissioners work through putting in place a more financially sustainable set of service arrangements in the County. For the sake of clarity, NHS England will not accept any liability for any costs over and above the sums set out above and neither would we expect local CCGs to do so.'*



646. The letter from NHS England is also clear that any capital investment will have to be supported by a robust business case: *'The requirement for all new capital expenditure to have a signed off business case that takes full account of commissioning capacity plans - thus ensuring all new capital spend is genuinely unavoidable.'*

## 15 Stafford and Cannock Chase Hospitals

647. Annex 3.6 contains an analysis of the current estate and the potential costs associated with addressing the maintenance backlog, improving the functional standards of the two hospitals in line with NHS standards, and investment in the estate in line with the TSAs' recommendations. This section is a brief summary of that analysis and summarises:

- an overview of the estate;
- the current condition of the estate; and
- an assessment of the investment needed at Stafford and Cannock Chase Hospitals.

### 15.1 Overview of the estate

648. The Trust's estate consists of two sites, one in Stafford and one in Cannock, with a total land area of 17.99 hectares.

649. The Trust does not have any PFI commitments and owns the land and buildings apart from the exceptions noted below.

#### Stafford Hospital

650. Stafford Hospital opened in 1983; 72% of the current buildings were built between 1977 and 1984 and 22% between 1985 and 1994; the remainder was built since 1994. Some parts of the estate are not owned by the Trust including:

- Main reception - leasehold expires 2017;
- Medical records area - leasehold expires 2024; and
- Post Graduate Medical Centre - leasehold expires 2092.

651. At Stafford there are fifteen ward-based areas, including paediatrics and maternity. One of these wards remains empty and is currently being used as spare clinical space to facilitate general improvements to the others. There are seven theatres in use at Stafford. The current amount of estate allocated to clinical administration/hospital administration/FM services/plant is ca. 23%.

### Cannock Chase Hospital

652. Cannock Chase Hospital (on the current site) formally opened in 1991, with the majority (96%) of the building built between 1985 and 1994. 43% of the space is occupied by MSFT, 37% by third party providers and 20% is not utilised. With regards to the areas leased out, the majority end in September 2014, with the exception of:
- MRI - lease expires 24 March 2022 with Alliance Medical; and
  - BPAS - lease expires 2015.
653. The current amount of estate allocated to clinical administration/hospital administration/facilities management (FM) services/plant is ca. 23% for Stafford and ca. 14% for Cannock Chase.

## 15.2 The current condition of the estate

654. The Trust has maintained and upgraded the estate where necessary, however, there has been relatively low investment in the estate over the last few years, although investment was significantly higher in the last financial year.
655. Given the relatively low investment in the past, a comprehensive condition appraisal (six facet survey) of the estate was completed by NIFES Consulting Group dated February 2012. The appraisal was undertaken in accordance with NHS 'Estatecode' and associated guidance and identified an estimate of the costs of bringing the estate up to 'Condition B', meaning the estate is sound, operationally safe and exhibits only minor deterioration and complies with the relevant guidance and statutory requirements.
656. In November 2012 the Trust also commissioned an estates review conducted by an external party - Strategic Healthcare Planning (SHP). SHP has subsequently been working with the TSAs to review the estate requirements.
657. As a part of the SHP review, the need for investment was identified at both sites to enable improvements in patient pathways, clinical efficiencies and estate utilisation. Many of the costs requirements identified were over and above those identified in the six facet survey.
658. Table 70 outlines the investment identified for Stafford and Cannock Chase Hospitals.

Table 70: The range of assessments on investment needed at Stafford and Cannock Chase Hospitals

Assessment	Stafford Hospital	Cannock Chase Hospital	Total
A: Total works backlog to bring estate up to 'Condition B' - at February 2012	£36m	£8.3m	£44.3m
B: Investment required to improve functional performance – at December 2012,	£18m - £34m	£9m - £19m	£27m - £53m
C: Investment required to bring estate up to 'Condition B' and improve functional performance – at October 2013.	£56.3m	£13.5m	£69.8m

NOTES:

- 1: The figures presented relate to separate assessments.
- 2: Assessment B includes some investment identified in Assessment A.
- 3: Assessment C includes: Factoring in maintenance works undertaken since Assessment A; taking into account cost inflation over investment period; all fees and project costs; VAT.

659. Regardless of any investment needed to support the TSAs' recommendations, it is evident that both hospitals require significant investment to bring them in line with more modern facilities.

### 15.3 Investment needed at Stafford and Cannock Chase Hospitals to deliver the TSAs' recommendations

660. The TSAs have been working, during the consultation period, with SHP to refine the investment requirements at Stafford and Cannock Chase Hospitals that were stated in the draft report. The investment requirements have been broken down into four levels of investment:
- A: Backlog maintenance costs (five facet) excluding any functional/quality costs;
  - B: Investment Level A **plus** refurbishment/reconfiguration costs associated with delivering the TSAs' recommendations, using the current ward/bed structure where possible;
  - C: Investment Level B **plus** additional costs required if bed facilities were refurbished to provide enhanced quality standards associated with patient privacy and dignity; or
  - D: Investment Level C **plus** additional costs identified by other providers associated with delivering additional services that the provider Trusts could consider to Stafford/Cannock Chase.



661. Table 71 sets out the estimated costs for each of the levels of investment, including the TSAs' assessment of investment at other sites in the Local Health Economy that would be needed to deliver the TSAs' recommendations.

Table 71: Estimated levels of capital Investment

	Updated six facet analysis	A	B	C	D
Stafford	£56.3m	£21.7m	£35.8m	£48.9m	£55.2m
Cannock Chase	£13.5m	£4.8m	£7.0m	£11.4m	£30.5m
Other provider sites			£83.6m	£83.6m	£74.6m
IT costs			£3.8m	£3.8m	£3.8m
Total	£69.8m		£130.2m	£147.7m	£164.1m

NOTES:

- 1: Includes investment costs associated with the MLU
- 2: For the purposed of the TSAs' financial evaluation it has assumed that Investment level B would be a minimum requirement.
- 3: The backlog maintenance element of this spend is £23.6m across Stafford and Cannock Chase Hospitals

662. Under Investment Level B, ca. 62.5% of Stafford Hospital and ca. 72% of Cannock Chase Hospital would be occupied. Site drawings for the proposed reconfiguration of Stafford and Cannock Chase Hospitals are included in Annex 3.6.
663. The TSAs' have had extensive discussions with local providers throughout the period since the draft report was published in relation to both the operational and capital costs associated with the TSAs' draft recommendations. The TSAs' have also consulted with NHS PropCo. The TSAs' conclusions with regards to capital investment are made in light of these discussions and external advice. However, it should be noted that the other providers have some reservations as to the TSAs' forecasts and capital investment conclusions.
664. In the letter from NHS England dated 11 December 2013, any requirement for new capital expenditure will need a signed business case that takes full account of commissioning capacity plans, therefore ensuring all new capital spend is genuinely unavoidable. This process will be undertaken during the implementation phase.



665. In addition, NHS England, in this letter, have identified other opportunities which could potentially reduce the requirement for new capital spend, including; the integrated use of North Staffordshire community beds to increase overall system productivity, the refurbishment of spare capacity at Bradwell Hospital and developing Cannock Chase Hospital with the local authority to fully explore the possibility of regenerating the current site. These opportunities will need to be reviewed further during the implementation phase, recognising that these actions will need extensive further engagement.
666. In assessing the estimated capital expenditure cost as part of the financial evaluation, the approach was taken that, where possible, the existing facilities will be retained in their current configuration, with no modification to improve standards (with the exception of any backlog maintenance), unless relocation of the department is required to achieve site rationalisation.

## 16 Implementing the final recommendations

667. Following the Secretary of State's final decision in respect of the TSAs' recommendations, it is envisaged that implementation of those recommendations will take up to three years. Until MSFT is dissolved, it is expected that the TSAs will continue to lead the implementation of the approved recommendations. Thereafter, it will be the responsibility of the receiving providers, in conjunction with the CCGs, to oversee the transition of any subsequent clinical and operational changes.
668. The TSAs recognise that the CCGs have commissioning freedom and will build on the TSAs' recommendations as part of ongoing commissioning processes. However, in order for the TSAs to fulfil their objective to secure continued provision of essential local services, the TSAs propose their recommendations are implemented quickly and they are aiming for dissolution and transfer on 1 October 2014.
669. A detailed implementation methodology will need to be developed to ensure both the continuing provision of safe clinical services to patients during the implementation phase, and that clinical, operational and financial sustainability is achieved following this. It is important that there is minimal day to day disruption to patient care throughout this process.
670. This section summarise some of the key principles the TSAs would use in developing their implementation plan. Further detail is presented in Annex 3.7.

### 16.1 Implementation programme

671. The implementation approach should focus on five key areas of work to carry out planning, preparation and implementation of the recommendations over the course of the transition period. The TSAs will play a key role in this transition until MSFT is dissolved and its activity moves to other providers. The TSAs will work with local and national stakeholders to ensure the appropriate approach, risk appraisal, management and governance structure is put in place to ensure stability over the transition period.
672. In order to achieve a stable transition, the implementation approach should be divided into five connected workstreams:
- Managing the Trust (operational, financial and clinical)
  - Separation and Integration (i.e. the separation of Stafford and Cannock Chase Hospitals, the clinical transformation/redesign and integration with receiving providers)



- Managing the Transaction process
- PMO
- Communications

673. More detail on each of these workstreams is set out in Annex 3.7.

674. The implementation programme will be carried out alongside and in conjunction with Trust staff, engaging other key individuals and stakeholders from across the local health economy. An experienced Transition Director will be appointed to manage change within the Trust in order to provide oversight and support to staff during the transition period, working alongside the TSAs, Chief Executive and other senior Trust staff.

675. The local CCGs, as well as NHS England, will be closely involved throughout the implementation period. In managing the implementation and transition of assets and services to receiving providers, in parallel to the CCGs wider work, the TSAs will ensure continued close cooperation with the CCGs as part of the delivery and governance of the plan.

## **16.2 Managing risk**

676. As part of the approach to implementation, a full risk assessment will be undertaken prior to the transfer of services. This will ensure the safe and sustainable transition and delivery of services, should Secretary of State approval be received. This will cover all aspects of governance and operations at the Trust and should include detailed planning, written processes, experiences and lessons, workforce engagement and patient pathway work when developing the new organisational and service options for the Trust.

677. Whilst the TSAs have current responsibility for the Trust, and will do during the transition, it is envisaged that UHNS in relation to Stafford and RWT in relation to Cannock Chase will own the risks associated with the development, implementation and operation of those services following dissolution. It is anticipated these organisations will use an approved risk assessment methodology (e.g. the NHS Litigation Authority risk management methodology) in order to carry out a thorough risk assessment.

678. A range of implementation risks and mitigations have been identified by the TSAs. These are set out in Annex 3.7.

### 16.3 Governance of the implementation programme

679. In order to ensure a seamless transition into implementation, and to draw these stakeholders together, further work will be undertaken on the appropriate governance structure to manage the implementation process.
680. The TSAs propose the following groups to form part of this governance structure:
- **Oversight group:** comprising representatives from relevant central government bodies to facilitate an integrated approach to implementation and timely resolution of any issues that arise.
  - **Transitional Services Board (successor of the Sustaining Services Board):** The TSAs created a Sustaining Services Board (SSB – see Section 3) to promote system accountability and oversee the identification and management of system-wide risks associated with the delivery of patient care during the TSAs tenure. This board includes Chief Executive and senior Director membership from the Trust and all adjacent provider organisations. We anticipate the SSB will transform into the Transitional Services Board (TSB) who act as the implementation ‘steering group’.
  - **‘Executive Transition Management Team’:** This group, consisting of the TSAs, Chief Executive and Trust senior Director membership, would act as a successor of the current MSFT Senior Management Team. It would include a ‘Transition Director’ and act as a forum for the Trust’s Executive team to continue to manage the Trust, ensuring continuity of patient care in light of the ongoing changes.
  - **Project Steering Group:** This group would act as a forum to report on the TSAs’ progress, enabling the TSAs to report to Monitor (and DH). Project steering group meetings should be held on a regular basis, drawing together updates on the five workstreams outlined by the TSAs.

### 16.4 Other considerations during transition

681. A number of key stakeholders that have expressed views on additional considerations that need to be developed as a part of the transition and implementation approach.
682. The development of the detailed transition and implementation plans should take into account all appropriate proposals and mitigations raised during the TSAs work to date. This includes responses to the consultation, proposals from the HEIA steering group and the letters from the CCGs and NHS England.

683. Table 72 summarises some of the key areas that have been raised and should be considered as part of implementation.

Table 72: Areas for consideration during implementation

Area	Details
Royal College and professional bodies guidance	The TSAs acknowledge all comments received from the Royal Colleges and professional bodies and would expect those responsible for implementation to take on board all of these comments.
Risk assessment	The TSAs would expect full operational risk assessments to be conducted during the implementation period.
Education and training	The healthcare providers and education providers will need to review the education and training opportunities at Stafford and Cannock Chase Hospitals to ensure they are fully taken advantage of.
Continuity of care	Communication within and between services is vital to ensure continuity of care for patients. Commissioners and providers should ensure services are delivered in a way which promotes continuity of care.
Building capacity	Ensuring this additional investment and capacity is established within the other providers and WMAS to support the service model.
Infrastructure	The appropriate level of supporting infrastructure; additional transport schemes, car parking and accommodation should be identified and planned for.
Monitoring delivery	A set of metrics should be established with all future providers, aligned with the TSAs' final recommendations to Monitor, which addresses the areas of public and staff concern.
Capital spend	New capital expenditure will need a signed business case that takes full account of commissioning capacity plans, therefore ensuring all new capital spend is genuinely unavoidable.
Other opportunities	The other opportunities presented by NHS England will need to be reviewed further during the implementation phase, recognising that these actions will need extensive further engagement.

## Appendices and annexes

A series of appendices and annexes have been presented in support of the TSAs' report. The appendices are included alongside the main report in Volume One and the annexes are presented across Volumes 2, 3 and 4. These appendices and annexes are as follows.

### Appendices (included in this volume):

- A: Glossary of terms
- B: Letters to the TSAs from NHS England
- C: Letters to the TSAs from clinical advisory groups
- D: Letters to the TSAs from local CCGs
- E: The assessment of catchment population - Public Health Staffordshire
- F: A copy of the letter from A&E leads in the West Midlands to the Trust Chief Executives and lead commissioners across the region

### Consulting on the draft recommendations (Volume 2):

### Supporting analysis and information (Volume 3):

### The Independent Health and Equality Impact Assessment (Volume 4)

## Appendix A: Glossary of terms

Term	Description
2006 NHS Act	Sets out, in Chapter 5A, the NHS failure regime – which is subsequently amended in the Health and Social Care Act 2012
A&E	Accident and Emergency
Acute Care	A pattern of health care in which a patient is treated for a brief but severe episode of illness, an urgent medical condition, or during recovery from surgery
BHFT	Burton Hospitals NHS Foundation Trust
BPAS	British Pregnancy Advisory Service
CCGs	Clinical Commissioning Groups
CCU	Coronary Care Unit
CHC	Continuing Health Care
CIPs	Cost Improvement Plans
Clinical Networks	Organisations used to deliver locally integrated services across a number of providers, usually where there is benefit in sharing specific expertise or resources to improve outcomes for patients.
CNS	Clinical Nurse Specialists
CPT	Contingency Planning Team
CQC	Care Quality Commission
CRG	Clinical Reference Group
Critical Care	Encompasses a range of units (including High Dependency Units (HDUs), Intensive Care Units (ICUs)), which concentrate special equipment and specially trained personnel for the care of seriously ill patients requiring immediate and continuous attention.
CSIP	Clinical Service Implementation Programme
DH	Department of Health
Draft TSA model	Draft clinical model
EDs	Emergency Departments
Elective Surgery	A planned, non emergency surgery procedure
ENT	Ear, Nose, and Throat
EPAU	Early Pregnancy Assessment Unit
EUCC	Emergency, Urgent and Critical Care
FAQs	Frequently Asked Questions
FEAU	Frail and Elderly Assessment Unit
FM	Facilities Management
FT	Foundation Trust
FTN	Foundation Trust Network
FY13	Financial Year 2013
GI Surgery	Gastrointestinal Surgery
GP(s)	General Practitioner(s)





GUM	Genito Urinary Medicine
HCC	Healthcare Commission
HDU	High Dependency Unit
HEIA	Health and Equality Impact Assessment
HEIA SG	Health and Equality Impact Assessment Steering Group
HSMR	Hospital Standardised Mortality Rates
HTCS	Healthcare Travel Costs Scheme
ICU	Intensive Care Unit
ITU	Intensive Therapy Unit
KPIs	Key Performance Indicators
LATs	Local Area Teams
Level 2	High Dependency Care
Level 3	Intensive Care
LHE	Local Health Economy
LSS	Location Specific Services
MAU	Medical Assessment Unit
MIU	Minor Injuries Unit
MLU	Midwifery Led Units
MoD	Ministry of Defence
Monitor	The independent regulator of foundation trusts and responsible body for the CPT
MP	Member of Parliament
MRI	Magnetic Resonance Imaging
MSFT	Mid Staffordshire NHS Foundation Trust
CAG	National Clinical Advisory Group
NHS Propco	NHS Property Services
NICE	The National Institute for Health and Care Excellence
NMAG	National Nursing and Midwifery Advisory Group
NDA	Non-Disclosure Agreements
NHS	National Health Service
NHS TDA	NHS Trust Development Agency
NPV	Net Present Value
OFT	Office of Fair Trading
ONS	Office of National Statistics
Outpatient	A patient who attends a hospital for a scheduled appointment but does not require admission.
PAU	Paediatric Assessment Unit
PDC	Public Dividend Capital
PFI	Private Finance Initiative

PHS	Public Health Staffordshire
PIU	Paediatric Inpatient Unit
PMO	Programme Management Office
Primary Care	The collective term for all services which are people's first point of contact with the NHS, e.g. GPs, dentists.
Protected Services	Protected services are defined by local commissioners as those services provided by a healthcare provider that is likely to fail, where there is no alternative acceptable provider of those services.
Providers	A hospital, clinic, health care professional, or group of health care professionals who provide a service to patients.
QIPP	Quality, Innovation, Prevention and Productivity
RCI	Reference Cost Index
RCM	Royal College of Midwives
RCN	Royal College of Nursing
RCOG	Royal College of Obstetricians and Gynaecologists
RCPCH	Royal College of Paediatrics and Child Health
RCS	Royal College of Surgeons
Royal Colleges	The professional bodies working to improve the quality of healthcare by ensuring the highest standards of care for the population
RWT	Royal Wolverhampton NHS Trust
S&S	Stafford and Surrounds CCG
SaTH	Shrewsbury and Telford Hospitals NHS Trust
SAU	Surgical Assessment Unit
SCBU	Special Care Baby Unit
SCR	Strategic Change Reserve
SHMI	Summary Hospital-level Mortality Indicator
SHP	Strategic Healthcare Planning
SLA	Service Level Agreement
SSB	Sustaining Services Board
SSoTP	Staffordshire and Stoke-on-Trent Partnership NHS Trust
the Trust	Mid Staffordshire NHS Foundation Trust
TSA(s)	Trust Special Administrator(s)
TUPE	Transfer of Undertakings (Protection of Employment) Regulations 1981
UCC	Urgent Care Centre
UHNS	University Hospitals of North Staffordshire NHS Trust
UPR	Unsustainable Provider Regime
VTs	Voluntary Transport Schemes
WHT	Walsall Healthcare NHS Trust
WMAS	West Midlands Ambulance Service
WTE	Whole Time Equivalent
XBD	Excess Bed Days



## Appendix B: Letters to TSAs from NHS England

### Letter in response to the proposed amendments to the TSAs' recommendations (11 December 2013)

**NHS  
England**

NHS England, Midlands & East  
2 – 4 Victoria House  
Capital Park  
Fulbourn  
Cambridge  
CB21 5XB

Tel: 01223 597 561

Our Ref: PW/jd

By e-mail:

Alan Bloom, Joint Trust Special Administrator  
[abloom@uk.ey.com](mailto:abloom@uk.ey.com)

11 December 2013

Dear Alan

Re: TSA Final Report

**Statement under S 65G of the National Health Service Act 2006 in respect of your final report on Mid Staffordshire NHS Foundation Trust (the Trust)**

Pursuant to S65G of the National Health Service Act 2006, NHS England confirms that the recommendations in your draft report to Monitor, as varied after the consultation period by the recommendations set out in your final report on the Trust, would achieve the objectives set out in Section 65DA of the National Health Service Act 2006.

Specifically, following our discussions with you and your team, in which you outlined the amendments you will be making to your draft report in the final report, we confirm that those proposals, as varied, would achieve the objective of the TSA to secure the provision of the Location Specific Services identified by the local CCGs.

We understand that your final report will make recommendations to Monitor and the Secretary of State that the Trust should be dissolved and its services transferred to specified local providers. The report will also recommend to commissioners and other stakeholders in the local health system a service model reflecting the consultation carried out by the TSA as proposals were developed, with some modifications following responses to the public consultation. If the recommendations are accepted by Monitor and the Secretary of State, the local CCGs will be responsible for working with providers to take forward this work and we will ensure appropriate arrangements are put in place. We will also work with the TDA and Monitor to ensure that appropriate joint oversight arrangements are also put in place.

The final report will identify transaction/implementation costs over a three year

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period 1/4/14 to 31/3/17. I can confirm that NHS England would be prepared to fund a maximum of £8m of the implementation costs where these can be demonstrated to fall within our Provider Support Policy, with the balance being provided by the Department of Health. Your final report will also identify an ongoing funding gap for these services of £14.87m from 2017/18 onwards. I can also confirm that NHS England would be prepared to provide time-limited commissioner support of up to £14.87m per annum from 1/4/17 whilst local commissioners work through putting in place a more financially sustainable set of service arrangements in the County. For the sake of clarity, NHS England will not accept any liability for any costs over and above the sums set out above and neither would we expect local CCGs to do so.

We believe that there are a number of measures that could be applied to the recommended service model that would mitigate the current estimates of excess cost. We recognise that some of these may need further engagement or consultation with local stakeholders. These measures include;

1. The integrated use of North Staffordshire community beds to increase overall system productivity and reduce reliance on new capital spend at UHNS.
2. The refurbishment of spare capacity at Bradwell Community Hospital, to avoid capital expenditure on the acute site.
3. The requirement for all new capital expenditure to have a signed off business case that takes full account of commissioning capacity plans - thus ensuring all new capital spend is genuinely unavoidable.
4. Without changing the TSA recommended clinical model, commissioners will review case mix and patient flow to determine whether the proposed provider specification is necessary at all sites (for example with regard to the number of single rooms and requirement for operating theatre upgrades)
5. The TSA model is currently based on current income levels - this will need to be updated to reflect future commissioning intentions and QIPP plans.
6. The CCGs taking responsibility for the negotiation of revision to the ambulance contract and patient transport with a view to minimising the impact on patients and reducing the ambulance services proposed cost increase.
7. Cannock Chase Hospital being subject to a placed based scheme developed with the local authority to fully explore the possibility of a landmark regeneration scheme that fully exploits the current site.
8. The implementation of the TSA recommendations will need to reflect CCG responsibilities and enable them to exercise their commissioning intentions through service procurement where appropriate.
9. We view the TSA clinical model as a start point for a wider-ranging Strategic  
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Review that will ensure that both commissioning and provision across Staffordshire is placed on a clinically and financially sustainable footing for the long term.

10. NHS England, Monitor and the NHS TDA will need to review proposed capital spend to ensure the most appropriate accounting treatment is consistently applied.

11. All parties will need to be incentivised through the implementation arrangements to secure best value for money for the taxpayer.

We recognise that all of these actions will need extensive further engagement and we will work with local commissioners to support and help them develop these plans.

Alongside this work on the final costs for the delivery of the new service model we note the recognition in your report, of the unaffected ongoing role of commissioners to consider further developments in service models and new commissioning initiatives. We will continue to work with local commissioners to support those initiatives.

We recognise the challenges the TSAs have faced in producing their final report. While all parties want to achieve a long term solution to the well documented issues that the Trust has faced, NHS England supports the important first steps that the TSAs have proposed in their report. We will continue to support the work of local commissioners with providers to develop those long term solutions, while also supporting them in the interim as they work to deliver immediate and necessary improvements in services for the people of Stafford and Cannock.

Yours sincerely

**Dr. Paul Watson**  
Regional Director (Midlands and East)

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Office of the  
Trust Special Administrator  
of MSFT

## Letter in response to the consultation (1 October 2013)

Our Ref: PW/jd



NHS England  
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CB21 5XB

By e-mail:

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Alan Bloom, Joint Trust Special Administrator  
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Hugo Mascie-Taylor, Joint Trust Special Administrator  
[hugo@mascie-taylor.org](mailto:hugo@mascie-taylor.org)  
Mid Staffordshire NHS Foundation Trust

1 October 2013

Dear Alan and Hugo

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

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

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

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**3. Accounting treatment for capital spend**

It is unclear whether this is feasible, and the magnitude of any resulting mitigation has not been calculated.

**4. Changes to the CCG allocation formula**

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

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

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

Yours sincerely

**Dr. Paul Watson**  
Regional Director (Midlands and East)

**Paul Baumann**  
Chief Financial Officer, NHS England

c.c. David Flory, Chief Executive, NTDA

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## Letter in support of move to consultation (23 July 2013)



NHS England, Midlands & East  
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Fulbourn  
Cambridge  
CB21 5XB

Tel: 01223 597 561

Our Ref: PW/jd

By e-mail:

Alan Bloom, Joint Trust Special Administrator  
Hugo Mascie-Taylor, Joint Trust Special  
Administrator  
Mid Staffordshire NHS Foundation Trust

23 July 2013

Dear Alan and Hugo

I am writing on behalf of NHS England in response to your letter dated 19 July to David Bennett where you request an NHS England perspective on the TSA proposal for Mid-Staffordshire

The TSA has carried out extensive work to identify a service proposal that is designed to meet the twin requirements of clinical and financial sustainability. In doing so, the current service proposal moves well beyond the LSS defined by local CCGs and envisages a much wider range of services being maintained on both the Stafford and Cannock sites. This has been proposed in order to mitigate the impact on other hospitals of implementing the original LSS and because a networked service model has been developed to overcome the clinical staffing challenges of maintaining A&E and acute medicine on the Stafford site.

We would support the clinical model and the intent to maintain a wider range of services in the Stafford and Cannock sites, subject to further assurance that financial sustainability can be secured without a tariff premium for commissioners. The high level financial assumptions that have led to the conclusions that this would be the more financially attractive option have been shared with us, but not at a level of detail that would allow us to provide independent assurance. We would like to discuss these assumptions with you in more detail in parallel with the consultation process.

We note that the TSA has evaluated the residual gap to be £5.4m and a number of options are presented to resolve this including further CIP, downward pressure on Capex and demand management. Whilst we would accept that there has been insufficient time for a full solution to this gap to be described, we would note that it has yet to be demonstrated exactly how this remaining gap will be bridged. We would encourage the TSA to carry out further work on this during the consultation. We are assuming that the detailed solution will not include a tariff premium for commissioners.

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The implementation costs of the proposal are significant. Again, the high level financial assumptions have been shared with us but not at a level of detail that would allow us to give independent assurance. We understand from Monitor that these transitional costs would need to be funded directly from the Department of Health and would not be a call on NHS England or CCG funds. Our support for the TSA proposal is based on the assumption that transitional costs will be treated in this way.

The TSA proposal envisages the removal of emergency surgery, in-patient paediatrics and obstetrics from the Stafford site. Whilst we can see the clinical arguments for doing this, we would encourage you to ensure that the consultation document sets out very clearly why the networked assumption being proposed for A&E and general medicine cannot be applied to these services. Likewise, it would also be helpful if the rationale for excluding a midwife-led delivery unit is clearly set out.

In summary, the TSA has tackled a very difficult service issue and has worked constructively with partners on developing these proposals. With the provisos set out above, we would support the current proposals being put forward for public consultation.

Yours sincerely

**Dr. Paul Watson**  
Regional Director (Midlands and East)

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## Appendix C: Letters to TSAs from their clinical advisory groups

### Letter from the CAG in response to the proposed amendments to the TSAs' recommendations (21 October 2013)

**ACADEMY OF  
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COLLEGES**

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Professor Hugo Mascie-Taylor  
Mid Staffs Foundation Trust Special Administrator

21 October 2013

Dear Hugo,

**Clinical Advisory Group**

I am writing to you following the joint meeting of the Medical and Nursing Clinical Advisory Groups on 8 October. This followed the close of the public consultation exercise on the TSA proposals for the future of services currently provided by MSFT.

At the meeting we heard from you on proposed amendments the TSA would wish to make on its original recommendations in the light of the consultation. We also heard proposals from clinical groups from MSFT in respect of critical care, paediatric and maternity services in accordance with the process set out in my letter of 24 Sept 'CAG – Final Stage Terms of Engagement'.

We were extremely grateful to the clinicians from MSFT coming down to meet us and impressed by the clear passion of their commitment to provide high quality services for patients in Mid-Stafford.

You reported to us that most of the original proposals set out in your recommendations remained unchanged. The view of the CAG in respect of those services therefore would remain as set out in our letter to you of 22 July.

The three areas of proposed amendments to the original proposals were:

**Obstetrics/midwifery**

The TSA is now proposing the inclusion of a Midwife Led Unit at Stafford. The TSA view, based on feedback from the consultation, is that more women will choose a MLU than the TSA originally stated and this would make the unit financially sustainable as well as it being clinically sustainable. In our earlier discussions the CAG had been clear, on the advice of the Royal College of Obstetricians and Gynaecologists and the Royal College of Midwives, that MLUs for low risk births provide a safe model of care. That continues to be our view.

Local clinicians proposed a model of an alliance with the neighbouring trust to continue to provide obstetrician and midwife delivered care. The CAG felt that there was not sufficient detail to fully understand the implications of their proposals. The view of the CAG was that, in line with RCOG guidance, there are risks if units seek to provide for all births without full consultant presence.

**Critical care**

The TSA originally stated that any patients requiring Level 3 critical care would be transferred out after 4-6 hours. This recommendation has been revised to say Level 3



patients will be transferred based on clinical need and not based solely on a time limit. If there is the capacity and capability to manage a Level 3 patient in Stafford then they will be kept in Stafford and not unnecessarily transferred.

Local clinicians proposed maintaining the current Level 3 critical care service but providing rotation of staff with units at North Staffs.

The CAG welcomed the more flexible approach of the TSA and stressed that the principle should be that Level 3 patients are treated at the original location for as long as there is sufficient capacity and capability to treat them effectively and safely. If it is anticipated that staffing of the correct capacity and capability will not be available patients must then be transferred.

With the local clinicians' proposals the CAG was pleased to see that rotation with North Staffs was proposed because it previously had concerns that the activity of the unit would not in itself provide the environment to maintain a proper learning and developmental environment.

The view of the CAG was that assuming the principle above was strictly followed, both the TSA and the local clinicians' proposals would be clinically safe.

#### **Paediatrics**

The TSA recommendation on the Paediatric Assessment Unit has been revised to describe fully the level of Paediatrician cover on site to support the PAU. The 14/7 unit will be staffed by paediatric trained nurses with 14/7 support from paediatric trained A&E consultants. There will be Paediatric Consultant hot clinics and outpatient clinics a minimum of 5 days per week and these clinicians would be available on site to support the PAU if requested.

Local clinicians proposed models dependent on whether maternity services would or would not be retained.

The CAG felt that both models would be clinically safe.

#### **Conclusion**

As we stated in our original letter, it is always likely that there can be more than one model of clinically safe provision. Equally the CAG was clear that in expressing its views it was not formally endorsing any specific individual provider or proposal. That remains the position. The CAG was never invited to design proposals and was specifically asked to give an opinion on safety and sustainability of those services which providers were willing to support.

We hope the TSA can take assurance from our opinion on the clinical safety of possible service models but recognise that there are also other considerations out with our terms of reference in regard to costs, sustainability and provider requirements which the TSA will have to take into account.

Yours sincerely

Professor Terence Stephenson,  
Co-Chairman National Clinical Advisory Group  
Chairman Academy of Medical Royal Colleges



## Letter from the CAG in support of move to consultation (22 July 2013)

**ACADEMY OF  
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Professor Hugo Mascie-Taylor  
Mid Staffordshire Foundation Trust Special Administrator  
22 July 2013

Dear Hugo,

**OPINION OF THE MSFT NATIONAL MEDICAL CLINICAL ADVISORY GROUP**

I am writing to give you the views of the medical Clinical Advisory Group (CAG) on the Mid-Staffordshire Trust Special Administrators' (TSAs) recommendations for the future of services currently provided by Mid-Staffordshire NHS Foundation Trust. These are shortly going out for public consultation as part of the Monitor Trust Special Administration process.

**Background and Terms of Reference**

The TSAs asked the Academy of Medical Royal Colleges to facilitate a national Clinical Advisory Group of senior medical consultants nominated from medical Royal Colleges to provide them with independent advice.

The Academy and Colleges were very willing to accept the invitation to work with the TSAs because we believe it is essential that any changes to the configuration or provision of health services should be informed by clinical expertise and do not reduce clinical standards and safety.

As a group of independent doctors we had to be very clear about our role in relation to this process and what could or could not be expected of the CAG. This was set out in the published terms of reference that were agreed for the CAG.

It was not the role of the group to devise its own proposals for services currently provided by Mid-Staffordshire Foundation Trust. Neither was it our role to make judgements or recommendations on the relative costs and benefits of proposals.

We were asked to provide advice on the basis of available evidence, standards and current practice in the UK for ensuring the safety and quality of clinical services for the benefit of patients.

Specifically the CAG was asked to review three proposals presented by the TSAs and comment on:

- The clinical safety of proposed schemes
- The extent specific proposals would or would not support the recruitment, retention, training and continuing professional development of appropriate medical staff
- Whether or not proposals move services closer to College clinical standards.

In considering the proposals the CAG was clear that, in general, safety is not definable as a simple choice between safe and unsafe. In many, but not all areas,



there is a sliding scale of gradation of safety. If therefore, we state that one set of arrangements is safer than another that does not automatically imply that the second proposals are unsafe.

However, whilst examining individual speciality services in turn, our considerations have also taken due note of the interdependence of many acute services on other disciplines. The important relationships of cross and inter-disciplinary working contribute to safe and high quality services and are an important feature of modern medical practice, thus influencing our assessment.

We know the TSAs have worked very hard to identify a solution that is clinically sustainable and which seeks to retain, where possible, local services for the local population. The TSAs have engaged with the CAG through a series of meetings and discussions. I believe the CAG has advised and challenged the TSAs, in keeping with our remit, as they have developed their recommendations.

#### **Proposed models**

We considered three separate proposals put to us by the TSAs. As this was how we referred to them during our discussions I am calling these:

- The Trust Special Administrator (TSA) model which is what is now being recommended
- The "Local Specified Services" (LSS) model which contained the minimum requirement identified by the local CCGs
- The Contingency Planning Team (CPT) model suggested by the CPT following its review of the Mid-Staffs services.

#### **The TSA Model**

We have commented on proposals that are broad in nature and we recognise that there is more detail to be developed over the coming weeks. It is important that the CAG is satisfied that the detailed proposals do not bring up any unexpected problems which would raise concerns about safety. We would therefore expect the opportunity to comment on the detailed proposals in due course.

The CAG is, however, satisfied that the proposals the TSAs have recommended are founded upon principles that should deliver a clinically safe and sustainable solution for services at Stafford and Cannock hospitals for patients and staff.

We believe that if medical staff are properly deployed as part of a rotating network between the Mid-Staffordshire and another large secondary care site(s) as appropriate this would provide improved opportunities for the recruitment and retention and continuing development of doctors.

If the proposed arrangements for medical staffing are to include doctors in training it must be ensured that they provide the required learning and experience and that supervision is compliant with the GMC standards.

We believe that, if implemented fully and effectively, the proposals taken as a whole would bring services in the local area more in keeping with College clinical guidelines and standards.





It will be essential to develop and follow very clear protocols across specialties in terms of when it will be safe to provide care at Stafford or Cannock and when the safe solution would be to transfer or refer patients to larger centres.

#### **The LSS and CPT models**

We had a number of comments that applied to both these models.

##### ***Safety and capacity of services in the health economy***

Both models propose to considerably reduce services in Mid-Staffordshire particularly with the closure of A&E. The CAG has considerable concern about the implications on other providers who would have to pick up this work. From what we have heard we have serious doubts that there is the capacity in the system for other local providers simply to absorb this emergency and acute medicine activity. We would therefore have concerns about the safety of care in other local areas if these models were adopted without significant support for those providers expected to take on activity no longer occurring in Mid-Staffordshire.

The CAG felt that services would be further from rather than closer to College clinical guidelines and standards with these two models, albeit recognising that such standards are mainly aspirational rather than absolute.

##### ***Recruitment and retention of medical staff***

The CAG felt that the LSS and CPT models in overall terms would make it harder to recruit and retain consultants at Mid-Staffordshire because the range of the posts and services would be less attractive. There were also concerns as to whether the required middle grade (i.e. non trainee) doctors would be readily available. The CAG did, however, recognise that the removal of A&E services would also remove the recruitment/retention issue for those staff in Stafford. It might therefore make recruitment and retention easier at surrounding hospitals.

Our comments on the specific models were:

##### ***LSS Model***

We had concerns at the proposal for a stand-alone geriatric unit at Stafford without acute care back-up. With a "Step-Down" facility the selection of appropriate patients becomes crucial – and potentially subject to dispute. To be safe senior medical staffing would have to be provided on a networked basis.

With the proposals for Cannock there was considerable concern about how night-time cover and support would be provided. The Group was clear that no ASA (American Society of Anaesthesiologists) Level 3 cases should be handled. The Group was also clear that the services should not be dependent on trainees.

The management of transition to this model would be crucial.

##### ***CPT Model***

In respect of services at Stafford, there was greater concern about the "enhanced intermediate care" ("Step-Up") for elderly patients without availability of 24 hours acute back-up. The selection of patients would be complex and subject to disagreement.

There should be a limited rather than a full range of day cases offered otherwise it is impossible to guarantee that there will not be a requirement for admission when the



level of back-up available would not be adequate. In addition there should be clinical staff available with details of the individual patient's specific case to advise if discharged patients have complications and ring for advice. Advice should not be provided by a different centre without knowledge of the individual case.

The CAG had real doubts about the operational viability of the 5 day ward model. There would be a clear need for consultant availability to handle surgical complications.

In essence, increasing the level of activity beyond the routine and straightforward requires there to be a level of interdependent back-up services that are not proposed in this model.

The concerns over the CPT proposals for services at Cannock were the same as those with the LSS model proposed for Cannock

#### Conclusion

In conclusion the CAG was clear that both in respect of the services that would be provided at Stafford and Cannock and also because of their implications for other organisations the CPT and LSS models were intrinsically less safe than the TSA model. As stated earlier we believe, on the evidence that we have seen, that if implemented properly the TSA model should deliver a clinically safe and sustainable solution for services at Stafford and Cannock hospitals for patients and staff.

Finally, the CAG felt that whilst the proposal we supported appears clinically safe these are not the only options that could provide clinically safe services. The Group was also clear that in expressing its views it is not formally endorsing any specific individual provider or organisation.

The local population of Mid-Staffordshire rightly expects to have access to high quality, clinically sustainable healthcare services. That is why I, and my colleagues on the CAG, are fully committed to continuing to work with the TSAs over the coming weeks as they consult the residents of Mid-Staffordshire and develop their final recommendations.

Yours sincerely

Professor Terence Stephenson  
Co-Chairman National Clinical Advisory Group  
Chairman Academy of Medical Royal Colleges



## Letter from the NMAG in support of move to consultation (26 July 2013)

26 July 2013

Professor Hugo Mascie-Taylor  
Trust Special Administrator  
Office of the TSA  
Stafford Hospital  
Weston Road  
Stafford  
ST16 3SA

Dear Hugo,

Re: MSFT Nurse Clinical Advisory Group (NCAG)

On behalf of the members of the NCAG I am writing to you to confirm the views expressed by the group from the process we have undertaken with the TSA. The remit of the group was established with the following terms of reference:

- Comment, on the basis of the information available, on the clinical safety of proposals presented to the Nurse CAG by the TSA rather than recommend ideal services which no organisation has offered to provide
- Comment on any aspect of the clinical safety of proposals for example
  - Whether a proposal appears clinically safe or unsafe exactly as it is
  - What adjustments or amendments would be required to make a proposal clinically safe
  - the circumstances in which a proposal would or would not be clinically safe
  - the evaluation required on an on-going basis to judge whether the proposals remain clinical safe
  - Whether they move services closer to designated College clinical standards
- Comment on the extent it believes specific proposals would or would not support the recruitment, retention, training and continuing professional development of appropriate staff

As a group of senior nurses representing a cross section of the profession we have provided you, in good faith, our views on the proposals presented to us and on the information available. Detailed below is a summary of our views of each model presented to us to review. First of all is the TSA model which has the groups support as the preferred option for the TSAs draft recommendations and in our opinion will deliver the most amount of sustainable services for both Cannock and Stafford. Our views on the LSS and CPT models are also summarised:

TSA Model	<b>Safety</b>
	<ul style="list-style-type: none"><li>• There are no significant safety concerns made about this model</li><li>• There needs to be appropriate protocols in place to ensure the safe transfer of patients when needed</li></ul>
	<b>Recruitment and retention</b>
	<ul style="list-style-type: none"><li>• A networked model will not have a significant impact on recruitment and retention as a lot of the nursing roles will not be suitable for rotation</li><li>• There may be issues of recruiting paediatric nurses to the PAU</li></ul>





**LSS model**

**Safety**

- There are no significant safety concerns made about this model
- The provision of step down beds at Stafford need to be supported by clear protocols which ensure that the appropriate patients end up there. Appropriate medical cover would also be required overnight. A nurse led service may be more appropriate for this model

**Recruitment and retention**

- Recruitment for the standalone service would be difficult under the current model unless it was made more dynamic. One way to do this would be to just have a nurse and therapy led unit
- Career progression is an important factor for recruiting quality staff. This may be limited at Stafford and Cannock with the limited range of services provided
- It is important in this model that there is strong nurse leadership for it to function properly as there is a limited amount of other support on site

**CPT model**

**Safety**

- We have concerns about step up provision particularly if it is to be located on site without other services co-located as it needs specific specialist input
- This could also increase the volume of transfers to other sites which would not be desirable for the elderly population
- The provision of elective surgery in a standalone unit either at Stafford or Cannock would need appropriate cover as well as patient selection. Without this it would pose some clinical sustainability issues.

**Recruitment and retention**

- The same issues noted for the LSS model apply for the CPT model as well
- Career progression is an important factor for recruiting quality staff. This may be limited at Stafford and Cannock with the limited range of services provided
- It is important in this model that there is strong nurse leadership for it to function properly as there is a limited amount of other support on site

Whilst we would support the TSA model as the draft recommendations of the TSA this is only based on the information provided to us at the time. Any refinements to this model would need further clinical scrutiny and review to ensure safety is maintained. We would all welcome the opportunity to support the TSA on the further development of its recommendations.

Yours sincerely,


Elizabeth McManus

On behalf of the Nurse Clinical Advisory Group



## Appendix D: Letters to TSAs from the local CCGs

### Letter from Stafford and Surrounds CCG in response to the consultation (30 September 2013)

  
**Stafford and Surrounds  
Clinical Commissioning Group**

30 September 2013

Alan Bloom,  
Trust Special Administrator  
Mid Staffordshire Hospitals Trust

Greyfriars Therapy Centre  
Unit 12 Greyfriars Business Park  
Greyfriars  
Stafford  
ST16 2ST  
Telephone: 01785 221051

Dear Alan

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

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

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

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

**Comments on the process and the draft report**

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


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

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

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

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

Stafford & Surrounds CCG Chair: Dr Anne-Marie Houlder      Accountable Officer: Andrew Donald





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

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

#### **Comments on the Proposals and the Draft Report**

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

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

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

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

#### **Comments on the Clinical and Financial Sustainability Question**

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

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

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

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





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

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

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

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

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

The CCG therefore proposes that:-

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

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

In conclusion the CCG confirms the following:

1. The CCG believes the TSA has delivered its functions under the act and the Mid Staffordshire Hospitals Foundation Trust should be dissolved at a point when it is clear who will provide the future services.
2. The CCG proposes a five year transitional timescale
3. The CCG notes the clinical model for future reference but further work through local commissioners now needs to take place.
4. The CCG believes a potentially larger piece of work with a wider remit is undertaken to ensure clinical and financial sustainability can be delivered.
5. The CCG wishes to see specific transitional costs allocated to commissioners for transition
6. The CCG notes the three models and the deficit outlined in each. The CCG confirms that it will not be responsible for any outstanding debts at the end of the transitional period.



Office of the  
Trust Special Administrator  
of MSFT

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

Yours sincerely

Dr Anne Marie Houlder  
Chair


Andrew Donald  
Chief Officer

CC Alan Hudson  
Professor Hugo Mascie-Taylor



Office of the  
Trust Special Administrator  
of MSFT

## Letter from Cannock Chase CCG in response to the consultation (30 September 2013)

  
**Cannock Chase**  
**Clinical Commissioning Group**

30 September 2013

Alan Bloom  
Trust Special Administrator  
Mid Staffordshire Hospitals Trust

Greyfriars Therapy Centre  
Unit 12 Greyfriars Business Park  
Greyfriars  
Stafford  
ST16 2ST  
Telephone: 01785 221051

Dear Alan

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

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

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

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

**Comments on the process and the draft report**

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

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


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

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

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

As CCGs understand it the TSA final report will be submitted to Monitor, who will confirm whether the TSA have completed the programme of work. If this is confirmed then the report will be submitted to

Cannock Chase CCG Chair: Dr Johnny McMahon      Accountable Officer: Andrew Donald







the Secretary of State for Health. As the CCG understands the legislation the only decision for the Secretary of State is whether the Trust should be dissolved or not, this would be alongside any agreement to transitional funding.

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

#### **Comments on the Proposals and the Draft Report**

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

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

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

#### **Comments on the Clinical and Financial Sustainability Question**

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

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

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

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

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

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



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

The CCG is of the view that with a different approach to pricing, an extension of the timescale for financial sustainability to five years and with appropriate transitional support to build community based services that it may be possible to reduce the present financial gap. Furthermore the CCGs proposed procurement process for services will also commission further efficiencies which drive out unnecessary costs.

The CCG therefore proposes that:-

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

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

In conclusion the CCG confirms the following:

1. The CCG believes the TSA has delivered its functions under the act and the Mid Staffordshire Hospitals Foundation Trust should be dissolved at a point when it is clear who will provide the future services.
2. The CCG proposes a five year transitional timescale
3. The CCG notes the clinical model for future reference but further work through local commissioners now needs to take place.
4. The CCG believes a potentially larger piece of work with a wider remit is undertaken to ensure clinical and financial sustainability can be delivered.
5. The CCG wishes to see specific transitional costs allocated to commissioners for transition
6. The CCG notes the three models and the deficit outlined in each. The CCG confirms that it will not be responsible for any outstanding debts at the end of the transitional period.

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

Yours sincerely

Dr Johnny McMahon  
Chair


Andrew Donald  
Chief Officer

CC Alan Hudson  
Professor Hugo Mascie-Taylor





## Letter from Stafford and Surrounds CCG in support of the move to consultation (24 July 2013)

**Stafford and Surrounds  
Clinical Commissioning Group**

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

Telephone: 01785 221043

24 July 2013

Mr Alan Bloom  
The Trust Special Administrators  
Mid Staffordshire NHS Foundation  
Trust  
Stafford Hospital  
Weston Road  
Stafford  
ST16 3SA

Dear Mr Bloom,

I am writing an initial letter in conditional support of the work undertaken by the TSA, on behalf of Monitor, to explore the options for reconfiguration of services at MSFT.

Early in the process the two CCGs were asked to work with the CPT to define the Protected Services which absolutely had to remain within Stafford and Cannock communities. The definition of Protected Services, now renamed as Location Specific Services (LSS) is tightly defined by Monitor and this definition constrained the considerations of the CCG.

Nonetheless, Stafford and Surrounds CCG were able to identify a core of LSS which we agreed with the Contingency Planning Team. These LSS were to be supplemented by further services as defined in the CCG commissioning intentions.

We are aware that the TSA considered three models for the provision of future services. All satisfied the requirements of LSS however, the consultation document which has now been prepared by the TSA Office outlines the TSA preferred option. This option addresses not only the provision of the LSS but a more comprehensive range of service provision which is clinically more attractive to the CCG than the LSS model alone.

We have had initial sight of the financial calculations which back this proposal, and whilst on superficial inspection, they appear to be more favourable than the financial implications of the LSS as a standalone service, we must emphasise that our CFO has not yet had opportunity to consider the TSA proposals in depth.

The CCG has been unable to undertake a detailed due diligence of the underpinning financial implications and we will be working with the TSA over the next few weeks to fully understand the financial breakdown and consequences. The financial bridge appears to demonstrate how the LHE position (for the services currently provided by MSFT) can be brought back into surplus. The CCG recognises that additional capital is very likely to be needed to provide the extra capacity for the service changes required to implement the TSA preferred option but this would be even higher for LSS and CPT models.

It is also important to emphasise that owing to the extremely tight timescale, the Membership Board and the Governing Body of the CCG have not had opportunity to consider these proposals. Further discussion is needed at several levels within the CCG and the organisation will feed its comments into the wider consultation process.

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Office of the  
**Trust Special Administrator**  
of MSFT

We recognise that this draft report is only one step in the wider TSA process and that the recommendations may change as a result of the consultation feedback. However we feel that the TSA draft report now contains sufficient detail to allow the TSA to go to consultation on its initial recommendations.

Yours sincerely

**Dr Margaret Jones**  
Chair, Stafford & Surrounds CCG

**Cc Graham Urwin**  
Director, Area Team

Stafford & Surrounds CCG Chair: Dr Margaret Jones

Accountable Officer: Andrew Donald





Office of the  
Trust Special Administrator  
of MSFT

## Letter from Cannock Chase CCG in support of the move to consultation (22 July 2013)

  
**Cannock Chase**  
**Clinical Commissioning Group**  
Greysfriars Therapy Centre  
Unit 12 Greysfriars Business Park  
Greysfriars  
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ST16 2ST  
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22 July 2013

Mr Alan Boom & Professor Mascie  
Taylor  
The Trust Special Administrators  
Mid Staffordshire NHS Foundation  
Trust  
Stafford Hospital  
Weston Road  
Stafford  
ST16 3SA

Dear Mr Bloom and Prof Mascie - Taylor

I write to advise you that Cannock Chase CCG support the recommendations made by the Trust Special Administrator concerning services to be provided in the Stafford and Cannock areas, in that it fulfils the requirements of the Locality Specific Services, namely those services that the CCG insist have to be provided within Cannock Chase.

I can also advise you that the TSA model is clinically more attractive to our population, offering more services than originally required by the CCG in such a way that is considered safe by the National Clinical Advisory Group.

From the figures we have to date, it would appear that the TSA is offering a financially sustainable model to the local and neighbouring health economies. However, due to the short time frame we have been unable to carry out detailed due diligence. The CCG would expect only to pay for services at tariff, and not a premium, and would not expect any provider deficit to be at extra cost to the commissioner. Whatever the proposed organisational form, the CCG would expect to have lead commissioner, and not associate commissioner, status with any new major provider.

Thus, the CCG supports the TSA recommendations subject to the above conditions and provided agreement is secured from our members during the consultation process

You have the full support of the CCG to go out to public consultation

Yours sincerely



**Dr Johnny McMahon**  
Chair, Cannock Chase CCG

Cc Graham Urwin  
Director, Area Team

Cannock Chase CCG Chair: Dr Johnny McMahonAccountable Officer: Andrew Donald





## Appendix E: Public Health Staffordshire – assessment of catchment population



### Catchment population – Mid Staffordshire NHS Foundation Trust

#### Hospital catchment areas and populations

Catchment areas are usually different to catchment populations. Catchment areas relate to the geographical area as a whole whereas the catchment population refers to the people who would use the hospital if they needed treatment. The catchment area for Mid Staffordshire NHS Foundation Trust (MSFT) is higher than the catchment population.

#### Calculating hospital catchment populations

There are many ways to calculate catchment populations. In the method used here there is a direct relationship between hospital usage and the size of the catchment population.

#### Factors that affect the catchment population

Many factors, such as the type and size of a hospital, its proximity to other hospitals, characteristics of the population, reputation and patient choice affect a hospital's catchment population.

#### Mid Staffordshire NHS Foundation Trust's catchment population

There is no such thing as a single catchment population for a hospital - it varies by specialty, type of admission and can change over time. The catchment population for MSFT for all admissions was estimated to be 226,300 in 2009. Locally derived information indicates a decline in the catchment population from 2009/10 onwards. Public Health Staffordshire's (PHS) estimate, based on all hospital admissions between 2010/11 and 2012/13, suggest that the catchment population has fallen by around 11% to 204,400 with a likely range between 192,000 and 217,000.

#### What is an appropriate catchment population?

Guidelines suggest the catchment population size for an acute general hospital providing the full range of facilities for both elective and emergency medical and surgical care would be 450,000 – 500,000 and that the minimum should be 300,000. Just over 50% of NHS trusts have catchment populations under 300,000. MSFT has a higher proportion of older people and fewer children than England in their catchment population and this is fairly consistent with the age profile of Cannock Chase and Stafford and Surrounds clinical commissioning groups.

The resident population of Cannock Chase and Stafford combined is 228,300 and the population served by Stafford and Surrounds and Cannock Chase clinical commissioning groups is around 276,500. The Association of Public Health Observatories (APHO) produced hospital catchment population estimates for English trusts and Table 1 shows how the catchment area compares with the catchment population.

**Table 1** Mid Staffordshire NHS Foundation Trust catchment area and catchment population

Catchment area			Catchment population	
Resident population of Cannock Chase and Stafford <sup>1</sup> (2011)	Registered * population of Stafford and Surrounds CCG and Cannock Chase CCG (2012)	MSFT Website (2012)	Association of Public Health Observatories (APHO) (2006-07 to 2008-09)	Public Health Staffordshire (2010/11 to 2012/13)
228,300	276,500	276,500	226,300	204,400

Source: Population estimates - 2011 mid-year population estimates, Office for National Statistics, Crown copyright, 2012 GP registered populations, South Staffordshire PCT and North Staffordshire PCT, Catchment populations - Association of Public Health Observatories

<sup>1</sup> Resident population: People who live within the geographical boundaries of Cannock Chase Borough and Stafford District

<sup>2</sup> Registered population: People who are registered with GPs who are part of the Stafford and Surrounds or Cannock Chase Clinical Commissioning Groups (CCGs)



## **1 Factors that affect the catchment population**

Many factors affect the catchment population - these include:

- The type and size of hospital: A district general hospital with a full range of services will probably have a larger catchment population than a smaller unit with fewer services;
- Level of specialisation;
- Proximity to other hospitals;
- Accessibility;
- Patient choice;
- Reputation;
- Relationships with referring GPs;
- Population characteristics - levels of deprivation, proportion of elderly people, morbidity.

For the same hospital the catchment population will vary depending on which specialty, disease group or admission type is being investigated and the catchment population could change over time. If, for example, more people chose to have treatment at a neighbouring hospital then the catchment population would reduce.

## **2 Mid Staffordshire NHS Foundation Trust's catchment population**

It is important to note that there is no such thing as a single catchment population for a hospital - there are separate catchment populations for each specialty and for elective and emergency admissions for example. However, effective service planning requires the provision of estimates that aim to quantify the population that is actively served or potentially served by a hospital. The Association of Public Health Observatories (APHO) estimated that for all admissions between 2006-07 and 2008-09 the catchment population for MSFT was 226,300, more recent estimates produced by Public Health Staffordshire estimate the catchment population to be 204,40.





## Appendix F: Transcript of letter sent from A&E clinical leads in West Midlands

In May 2013, the following letter was sent from the clinical leads of the A&E departments across the West Midlands to acute hospital chief executives and CCGs in the West Midlands.

*FAO: CEOs of Acute Trusts and heads of Clinical Commissioning Groups in West Midlands region*

*Dear Colleague,*

*We write as a group of Service Leads for Emergency Medicine in the West Midlands, representing Emergency Medicine consultants in the region, with responsibility for eighteen of the region's twenty one Emergency Departments (EDs). The EDs of the region manage in excess of 1.5 million patient attendances annually, in a region with a population of 5.36 million. This represents 8.5% of all ED attendances in England.*

*Following a winter and spring of sustained, extraordinary pressures throughout the EDs in the region, we now believe we are in a state of crisis which needs to be more widely acknowledged and moreover urgently addressed. This issue has in recent days and weeks been highlighted by NHS England, the Care Quality Commission, the Royal College of Nursing and the College of Emergency Medicine; we echo the sentiments of these organisations and highlight the fact that this crisis has been particularly and intensely felt throughout the West Midlands and surrounding region. It has come to a point where we must voice our most pressing concerns regarding the safety and quality of care currently being delivered in EDs across the region.*

*All of our EDs have been under immense pressure for the last few months. This pressure has been unprecedented and relentless, and felt by every ED in the region. All have shown inexorable rises in attendance rates, year on year, coupled with increasing intensity in workload, as we care for a rapidly aging population with complex needs. There is toxic ED overcrowding, the likes of which we have never seen before. Nurses and doctors are forced to deliver care in corridors and inappropriate areas within the ED, routinely sacrificing patient privacy and dignity and frequently operating at the absolute margins of clinical safety.*

*We regularly see our EDs overwhelmed with patients, with all cubicles occupied, and no egress into the hospital forthcoming, while patients continue to pour through the doors. Our departments are simply not equipped to safely care for such numbers of patients, an increasing proportion of whom are elderly and frail with complex medical, nursing and social needs. All of the available evidence demonstrates that in-hospital mortality is increased when the ED is overcrowded and patients have to wait excessively for beds. Such overcrowding is now the norm in our EDs. In addition, we are seeing an inevitable and unsurprising increase in serious clinical incidents and complaints, as well as delays and deficiencies in care. And for every incident reported, we know there are multiple examples of substandard care that go under the radar. We and our staff are carrying a huge burden of clinical risk which no other agency seems willing or able to share.*

*While matters have recently come to a head, this situation has been in the making for a*



*number of years, as evidenced by the fact that the recruitment of doctors to Emergency Medicine is in a state of national crisis, and our region has not escaped the problem. The Herculean burden of work, responsibility and clinical risk is so obvious to junior doctors that they are unwilling to join us in the practice of what we once considered the most rewarding areas of clinical medicine, and instead opt for more attractive and sustainable careers. There is institutional exhaustion amongst ED staff, at all levels, across nursing, medical and clerical. We appear to be the only healthcare workers in our organisations who are expected to work under these conditions, and it is not sustainable. Recruitment is almost impossible, and retention is becoming hugely challenging. The relentless volume of work, coupled with a perceived lack of clinical support from outside the EDs is demoralising and destructive.*

*Recent developments such as the introduction of 111 and financial penalties for holding ambulance crews in ED are touted as solutions to the crisis: however we as ED physicians recognise that these measures will actually make the problem worse instead of better, and evidence is already emerging to support our opinions. Furthermore the unilateral and dictatorial manner in which these and other policies have recently been introduced have only served to compound the problems in our departments.*

*The position is such that we can no longer guarantee the provision of safe and high quality medical and nursing care in our EDs. It is not a case of standards slipping, but the inevitable consequence of being forced to work in sub-standard conditions. The aforementioned issues have led to us routinely substituting quality care with merely safe care; while this is not acceptable to us, what is entirely unacceptable is the delivery of unsafe care; but this is now the prospect we find ourselves facing on too frequent a basis.*

*As a group of committed clinicians, we have worked hard to improve safety, quality, efficiency and timeliness of care in our departments, but have now exhausted all of our own resources. The pressures in ED and the ambulance service reflect an overall emergency system failing to cope –a coordinated system -wide response is now urgently needed. We know there is no simple answer to this conundrum; however as things have continued to escalate in this unrelenting fashion with detrimental effects on patients and staff alike, it would be unethical of us not to highlight this to our Executive teams and Clinical Commissioning Groups. Furthermore, we firmly believe and strongly recommend that ED leads should be intimately involved with and consulted on the commissioning of Emergency services in the region, as well as other related emergency care changes-such as 111. He that wears the shoe knows where it pinches; it is imperative that the experts in delivering Emergency Care- i.e. ourselves and our colleagues, are an integral part of its development and reconfiguration.*

*We reiterate our profound distress with the state of EDs in the region; and, while not wishing to apportion blame or devolve ourselves of responsibility, we call urgently on behalf of our patients and our staff for a radical Health Economy-wide response to the urgent care needs of the population of the Midlands. We furthermore call for our EDs to be suitably staffed and supported whilst under such pressure and while longer term solutions are put in place.*

*Yours sincerely*







