

Monitor - Contingency Planning Team

Mid Staffordshire NHS Foundation Trust

Recommendations of the CPT

March 2013

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1. Executive summary

1.1 Introduction

Mid Staffordshire NHS Foundation Trust ('MSFT' or 'the Trust') is a 344 bed acute trust comprising Stafford and Cannock Chase hospitals. It was authorised as a Foundation Trust (FT) on 1st February 2008.

In the following year, the Healthcare Commission called for a review at the Trust because of reportedly high levels of patient mortality and poor standards of care. A number of further reviews followed, including two inquiries, led by Robert Francis QC, into serious failings at the Trust and the commissioning, supervision and regulation of the Trust. These inquiries reported in 2010 and 2013.

In response to these reviews, the Trust has focused on improving the quality of care for patients. It has invested heavily in more staff, leading to significant gains in quality of care. But the Trust increased its spending during a period of tightening financial constraints on NHS organisations. As a result, the Trust has been in financial deficit since 2009 and will require significant external financial support from the Department of Health to pay its debts as they fall due.

Despite repeated attempts to turn itself round, the Trust remains financially challenged. It requires constant financial support to continue operating. For this reason, since March 2009 the Trust has been in significant breach of its terms of authorisation as a Foundation Trust on both financial and governance grounds.

In October 2012, Monitor appointed a Contingency Planning Team (CPT) to assess the sustainability of MSFT and develop a long-term plan to ensure that local patients will continue to receive excellent healthcare services if the Trust proves unsustainable.

The CPT's interim report¹, published by Monitor in January 2013, concluded that, despite the Trust's success in improving clinical performance, its small scale means it is both clinically and financially unsustainable in its current form.

Having established a clear need for the MSFT's form to change, the second phase of the CPT's work has entailed developing an evidence-based plan for reconfiguring local healthcare services that will deliver high quality, sustainable healthcare services to the population served by the Trust. Together with local clinicians, patient representatives, healthcare commissioners and providers, the CPT has generated and considered a wide range of reconfiguration options.

The CPT's recommended that patients would benefit from the establishment of local hospitals in both Stafford and Cannock. This would offer local access to regularly used services, enabling the majority of patients to access most services in the same locality as they access them today. In addition, the CPT is recommending

¹ Mid Staffordshire NHS Foundation Trust sustainability report, Monitor Contingency Planning Team, January 2013

the consolidation of emergency and specialist services into larger more specialist hospitals in the area, and the introduction of services that will support closer integration of acute, community, primary and social care for the population currently served by MSFT. These changes will improve the quality and safety of patient care, whilst ensuring that future services for MSFT patients are both clinically and financially sustainable.

1.2 MSFT must change to ensure sustainable high quality services for patients

The people of Stafford, Cannock and the surrounding areas, rightly expect their local health services to be the very best; with the best standards of care, delivered with compassion by appropriately qualified staff. The CPT acknowledges the performance improvements at MSFT that have been achieved in the last 18-24 months, which reflect both significant financial investment and the hard work and commitment of the Trust's leaders and staff.

In reviewing the options for the local population, the CPT and its Clinical Advisory Group were guided by the need to retain local services whenever possible, but to ensure that the services are safe and appropriately staffed. Therefore, moving services out of the localities of Stafford and Cannock was only considered where necessary to ensure patients can access high quality, safe and sustainable services.

MSFT is a 344-bed acute hospital trust with an annual turnover of about £155m. It is a relatively small acute trust in that it serves a catchment population well below the Royal College guidelines for hospitals providing a full range of acute medical and surgical services. The CPT does not believe that the levels of activity seen at the Trust's two sites are of a sufficient scale to ensure clinical sustainability in the long term. Specifically, the estimated catchment population is c210,000² compared to Royal College guidance for a full emergency service provider of 450,000 - 500,000³ and a minimum for a district general hospital of 300,000. Small hospitals such as MSFT face challenges in meeting Royal College standards and guidelines due to lower patient volumes, and, as a result, lack the ability to support the number of senior staff required to maintain a consultant presence twenty-four hours a day, seven days a week. In addition, MSFT faces material recruitment and retention challenges, with a higher proportion of temporary staff than other trusts. These challenges have a knock-on effect on clinical sustainability.

² Staffordshire Public Health estimated the catchment population to be 190,000 and 212,000 and this was validated by the CPT ('Assessment of Sustainability' MSFT CPT, January 2013)

³ The preferred catchment population size, as recommended in previous reports, for an acute general hospital providing the full range of facilities, specialist staff and expertise for both elective and emergency medical and surgical care would be 450,000-500,000." The Royal College of Surgeons of England. Delivering High-quality Surgical Services for the Future. . March 2006.

The CPT has also found that the Trust is insolvent. It will need more than £70m over the next five years to cover the cost of its operations, whilst at the same time finding efficiency savings of more than 7% each year in order to break even at the end of this period.

NHS providers in financial difficulties have sometimes continued to receive subsidies from the Department of Health and/or local commissioners while they implement a realistic cost improvement plan. However, the CPT believes that delivering cost savings of this magnitude over a period of five years would most likely have a detrimental impact on clinical services and MSFT should not aim to do so. Pressure to introduce drastic cost cuts to services that were already clinically and financially sub-scale was one of the underlying causes of the serious failings in quality of care previously experienced by MSFT patients and must be avoided.

The CPT therefore concluded that MSFT is neither clinically nor financially sustainable and that there is no safe and credible means of making it both clinically and financially sustainable over the next five years in its current form.

1.3 Change at MSFT must involve other local healthcare providers...

The evidence suggests that the future clinical and financial sustainability of services currently delivered by MSFT depends on reconfiguring services across the local health economy. The CPT's analysis suggests that reforming services across the local health economy will enable the local population to continue to receive care locally, where it is most appropriate, whilst having access to high quality specialist care: delivered by the right specialists for their needs; at larger more specialist centres; where there are sufficient resources to deliver this care twenty-four hours a day, seven days a week.

The CPT is recommending that some services currently provided by MSFT should move to other providers and that there should be a fundamental change in the clinical service models in Stafford and Cannock. The CPT is also recommending that there should continue to be hospitals in both Stafford and Cannock.

The CPT has worked with local commissioners and senior leaders from all of the providers in the local health economy since the start of its work. All of these organisations acknowledge they have a role to play in making sure the population of Stafford, Cannock and the surrounding areas continue to receive high quality healthcare services. All parties also acknowledge that the local health economy is currently experiencing many challenges and the CPT's proposed changes cannot happen immediately. Therefore change cannot be isolated to Stafford and Cannock and must take place across the local health economy in order to deliver the changes in services that the patients deserve.

The CPT believes that pursuing the options it proposes will strengthen all the providers in the local health economy and make the local health economy as a whole more sustainable.

1.4 ...and fulfil the intentions of local healthcare commissioners

The CPT's recommendations also need to conform with the commissioning intentions of the commissioners charged with purchasing NHS-funded healthcare on behalf of the local population. To that end, the CPT has worked closely with the Stafford & Surrounds and Cannock Chase Clinical Commissioning Groups (CCGs).

Both CCGs have stated their intention, where appropriate, to shift care away from acute hospitals into community and home based services through their commissioning. 'Care closer to home' has been a recurring theme in recent national health policy and has been judged to "significantly improve patient satisfaction with healthcare services, as well as improving patient attitudes to and knowledge of their individual conditions and treatments"⁴. The local commissioners are already working with local providers to redesign clinical pathways, which will change some elements of where and how patients access the treatment and care they require without having to go to an acute hospital. The CPT believes its recommended reconfiguration will enable commissioners to better fulfil their intentions.

The recommended reconfiguration should also meet regulatory requirements related to commissioning. One of Monitor's new roles, under the Health and Social Care Act 2012, will be to support commissioners to ensure that, in the rare event that a healthcare provider fails, patients will continue to access the care that they need. Monitor has released draft guidance for commissioners concerning their role in securing continued healthcare services for their local population. This guidance explains how a CPT should support commissioners in defining 'protected services' for their local population in circumstances where a local provider is failing financially⁵. The guidance defines 'protected services' as services for which "there is no acceptable alternative" to the struggling provider.

The CPT has supported local commissioners in drafting a list of protected services for MSFT, which is set out in this report. The CPT has taken this list into account in developing and evaluating its options for change and making its recommendations. The CPT's recommended clinical service model for Stafford and Cannock continues to deliver all of the services protected by local commissioners.

1.5 The CPT's recommended clinical service model

The CPT's primary objective is to develop a set of options that are clinically sustainable in the long term, ensuring the people of Stafford, Cannock and the surrounding areas can access the clinically safe and high quality services they rightly expect. Critically, the CPT is looking at long term solutions rather than a short term fix to the clinical sustainability issues it has identified.

⁴ 'Care closer to home' narrative report - Royal College of Physicians, 2012

⁵ The draft guidance ("Ensuring continuity of health services and designating Commissioner Requested Services and Protected Services") is to be finalised in the near future and it is likely that the terminology in the guidance will be updated and that the phrase 'protected services' will be replaced by 'Location Specific Services'. For the purposes of this report, the phrase 'protected services' is retained.

This means that some services would have to be relocated, in order that they can be delivered by specialists in their field, at hospitals with the facilities to deliver the highest quality care and best outcomes possible.

The CPT developed and evaluated options for the clinical service model, unconstrained by the possible organisation form (i.e. who is running the hospital and services) or the costs of transitioning to the new model. The reason for taking this approach was to make sure the CPT met its primary objective of identifying a clinically sustainable service model.

To help the CPT to generate and evaluate a list of options, and to ensure these options had the appropriate clinical input, the CPT formed a Clinical Advisory Group (CAG), comprised of the Medical Directors from all of the providers and commissioners in the local health economy and chaired by an independent clinical advisor, Hugo Mascie-Taylor. This CAG has advised the CPT throughout its work.

This report sets out in detail the process that the CPT followed to evaluate how services could be delivered to patients. This process resulted in the initial identification of 32 options for the clinical service model which have been evaluated to produce a final shortlist of three. These three options are all derivations of a 'Local Hospital' and it is this model that the CPT is recommending should be established in both Stafford and Cannock.

1.5.1 The local hospital

Medicine is becoming increasingly specialised, and there is a national trend towards centralising specialist services in order to improve patient outcomes, patient safety and quality of care. This creates a growing need for local hospitals, to maintain patients' access to more commonly needed and less specialised services, and several local hospitals are developing as a result of reconfigurations elsewhere in the NHS (for example, in NW and SE London, and in Hertfordshire).

The local hospital is consistent with the principles of:

- ▶ "localise where possible" - a local hospital provides access for a local population to a range of services for common conditions that are used frequently, notably some emergency and urgent care services, clinically appropriate outpatient appointments and clinically appropriate day case procedures;
- ▶ "centralise where necessary" - as medicine and surgery gets increasingly specialised, establish or enhance larger more specialised centres of excellence that provide specialist care, delivered by specialist physicians using specialised equipment;
- ▶ "deliver better integration of care" - a local hospital will be part of a clinical network, with close links to the local ambulance service, primary care providers (i.e. GPs), larger more specialised acute providers, community providers (who provide healthcare out of acute hospitals, e.g. district nursing, health centres

and community hospitals) and social care providers. A local hospital creates the opportunity to drive this integration, for example, by co-locating some of these services.

1.5.2 The CPT's recommendations for services within the local hospitals in Stafford and Cannock

The CPT is proposing that local hospitals in Stafford and Cannock provide access for the local population to a range of frequently used services, such as common low risk procedures and outpatient appointments. This means specialised services that require specialist expertise and technology should be moved to appropriate centres within the local health economy.

Although more detailed work needs to be undertaken to finalise the detail for some of the services the CPT's proposal is:

- ▶ Stafford services would include: a clinically appropriate 24/7 Emergency and urgent care service (see Section 1.5.3 for more explanation); specialty outpatient services (including ante and post-natal); clinically appropriate medical and surgical day cases; intermediate care beds; therapies (including physiotherapists and occupational therapists); diagnostics (including ultrasound, plain film X-Ray, MRI and CT scans); and, some clinical support services (including pharmacy and phlebotomy).
- ▶ Cannock services would include: Minor injuries unit; specialty outpatient services (including ante and post-natal); clinically appropriate medical and surgical day cases; therapies (including physiotherapists and occupational therapists); diagnostics (including ultrasound and plain film X-Ray); and, some clinical support services (including pharmacy and phlebotomy).

In addition, the CPT has concluded that retaining clinically appropriate elective inpatient care is likely to be sustainable if consolidated into a single location, but this will require further consideration as part of the TSA process.

The CPT also believes that the two local hospitals could be further developed to be part of a hub, co-located with some primary and community care services (for example, health centres, GP practices, community beds). This has not been evaluated in detail by the CPT, but is an option that the CPT would recommend for further exploration.

1.5.3 The CPT's recommendations for services moving away from Stafford and Cannock

What this does mean, is that some services could move away from Stafford and Cannock, notably those services dependent on critical care.

The CPT has concluded that emergency surgery is not viable in Stafford, due to insufficient general surgeons to cover a 24/7 service. Without emergency surgery

on site, it makes critical care unviable due to the size of the unit that would remain. This has a number of consequences, notably:

- ▶ Any 24/7 Emergency and urgent care service in Stafford would not be an appropriate setting to treat patients with major urgent care needs. The CPT has assessed that at least 50% of the patients currently attending A&E in Stafford would still be appropriate to attend the proposed new service, but those with major needs should be treated at a larger more specialised A&E/trauma centre.

In January 2013, the NHS Commissioning Board commenced a review (being led by Sir Bruce Keogh, the Medical Director of the NHS) into the model of urgent and emergency services in England. The CPT believes this very timely review should significantly inform the final proposals for the service in Stafford and the local health economy.

- ▶ Having no critical care service on site means it would be unviable to operate an obstetrician-led maternity service. Furthermore, the CPT does not believe there will be sufficient activity to support a viable midwifery-led maternity unit. Therefore, the CPT is recommending that the maternity service in Stafford should be limited to non-complex pre and post natal outpatient appointments only.

1.6 Why are the proposed changes better for patients?

The CPT has worked closely with the local clinicians and the CAG to develop solutions that improve care for the local population and deliver better outcomes not only today but also in the future, in line with the standards for high quality services as defined by the Royal Colleges.

Clinical evidence demonstrates that early and consistent input by consultants for non-elective and emergency care enables rapid and appropriate decision making. This ensures that patients receive correct diagnoses; are treated on the right pathway of care; leading to better patient outcomes including reduced mortality rates and improved physical functioning and quality of life⁶.

Larger more specialist centres are able to attract and retain a greater level of consultant cover and associated teams. Greater centralisation of specialist services in such centres allows the consultant cover to extend to seven days a week and up to 24 hours a day which meets the Royal College guidelines⁷. Studies have shown that centres with a higher level of consultant presence achieve better outcomes for patients. At these larger more specialised centres, consultants and their teams see a wider range of patients that provides them with the experience to

⁶ National Confidential Enquiry into patient Outcome and death, 2007. Emergency admissions: A step in the right direction, NCEPOD; London Health programmes, 2011. Adult emergency services: case for change, London Health programmes

⁷ Seven Day Consultant Present Care December 2012. Academy of Medical Royal Colleges

maintain their skills and enables them to invest in the latest technology and treatments.

At MSFT today, the relatively small number of patients⁸ being treated does not provide consultants with the range and frequency of experience they need to maintain their skills and the number of consultants available means that it is often not possible to have seven day a week or up to 24 hours a day specialist consultant presence in many services.

The consolidation of services in Staffordshire has already taken place for some services. Currently patients with symptoms of stroke or heart attack go to UHNS or Wolverhampton, with patients requiring vascular surgery also going to UHNS. This is because both trusts are better placed to provide consultant delivered service on a 24/7 basis and have the necessary expertise and equipment that enables them to save patient lives. The CPT's recommendations are an extension of this, to ensure the population of Stafford and Cannock can continue to get an excellent service at units which are closer to achieving the best practice guidelines.

That said, the CPT recognises that where possible services should be delivered locally. The local hospital models proposed have been developed with this in mind and the CPT has assessed that over 80% of the current patient attendances to either Stafford or Cannock hospitals will remain within the same locality.

In addition, given the needs of the local population, the CPT recognises the need to have access to intermediate care beds locally and to improve the provision of out of hospital care and care integration. Intermediate care is a range of services which are designed to help patients to avoid admission to an acute hospital ('step up'), or to rehabilitate after discharge from an acute hospital ('step down'). Intermediate care services are typically staffed by multi-disciplinary teams, including nurses, physiotherapists, occupational therapists and care assistants. Intermediate care provides more appropriate care to the needs of a growing elderly population than acute hospital care. The introduction of intermediate care services in Stafford and Cannock should reduce the length of time spent in an acute hospital bed.

1.7 The implications of the CPT's recommended clinical model

The CPT has concluded that the proposal of a local hospital in both Stafford and Cannock would be clinically sustainable. In evaluating the clinical service model it has also made the following conclusions:

1.7.1 Access

- ▶ More than 80% of current patient attendances to the hospitals in Stafford or Cannock would be retained in the same locality. The reason for this is that about 55% of current attendances are for adult outpatient appointments, and

over 90% of these would be retained in the same locality under the CPT's proposals.

- ▶ The remaining patient attendances would be at a different location, meaning that patients would sometimes need to travel further to receive the specialist care required. The West Midlands Ambulance Service would therefore be an integral part of any solution and may require additional resources.

In these circumstances:

- Average travel times for those services that are relocated would increase but remain in line with typically used standards. The average ambulance journey time for those living in the Stafford and Surrounds CCG catchment area (from their homes) would increase from 8 to 15 minutes. The average ambulance journey time for those living in the Cannock Chase CCG catchment area would increase from 13 to 14 minutes. Private car travel times would increase, but remain comparatively low.
- Public transport travel times are important drivers of health inequalities and these would increase. This is the primary reason why the CCGs have protected several services, including outpatients. The CPT and the CCGs acknowledge that patient transport services would need to be enhanced in order to mitigate the impact of the changes for patients using public transport. This must be factored into the plans for change.

1.7.2 Finance

- ▶ The operation of local hospitals in Stafford and Cannock can be financially sustainable. However, this can only be achieved with significant reduction of the current cost base and in line with the proposed clinical models.
- ▶ Reducing the current cost base to a sustainable level will require a significant reduction in overheads, including significant remodelling or changes to the current estate. The consequence of reducing the cost base means that it is most likely that these local hospitals would need to be operated by an alternative provider with an established management structure.

1.7.3 Deliverability

- ▶ The assessment of the CPT is that the proposed reconfiguration could make a positive financial contribution to other providers in local health economy - that is the revenue associated with the increase in activity will cover the cost of delivery. It should be stated that improving the financial health of other providers in the local health economy is not a driver for the CPT recommending these changes.
- ▶ There are currently some capacity constraints across the local health economy that would need to be addressed to accommodate the proposed service changes. This additional capacity would need to be developed over time and services moved when the required capacity is available. The timescale would

vary by service, but may take 2-3 years for full implementation, although a detailed implementation plan will need to be developed by the TSA. The CCGs have reflected this by protecting some services until capacity is available.

- ▶ Ideally, much of the required capacity could be created through redesigning services across acute, community, primary and social care, leading both to lower demand and improved length of stay in hospitals. There may also be opportunities for other providers to utilise the MSFT sites for some of their activity, particularly for elective care, although this is not a core assumption. However, it may be necessary for additional capacity to be developed at other sites in order to deliver the recommended changes.

1.8 Delivering the CPT's recommended clinical model

MSFT is operating within a challenged local health economy. Some local providers are experiencing clinical challenges of their own, others are forecasting significant financial problems for the foreseeable future. This is compounded by local commissioners undergoing a significant (national) restructuring and a county-wide community provider that has recently taken on responsibility for integrating community care with adult social care - an integration exercise that is still ongoing.

The CPT has focussed on developing a solution where the services currently delivered by MSFT can be delivered in a clinically and financially sustainable way in the future. The work of the CPT has therefore primarily focussed on the clinical service model and it is evident change cannot be isolated to just Mid Staffordshire.

Therefore, the CPT has recommended that: given the nature of its preferred solution; the instability in the local health economy; and, the urgency of the case for change, Monitor appoints a Trust Special Administrator (TSA). In a TSA-led restructuring, the TSA assumes the role of the Trust board and accounting office holder for the Trust, whilst preparing their own report for the Secretary of State for Health on how to deliver sustainable services for the public of Mid Staffordshire.

Any changes to services will require a statutory public consultation to be undertaken. If a TSA is appointed, it is expected that this consultation will commence nine weeks after the first day of the administration period and will last 30 days.

1.9 Next steps

The TSA process will take up to six months to complete and will include a public consultation on any proposed changes. The CPT's recommendations will be passed to the TSA, who is at liberty to consider all options, including those ruled out by the CPT.

Some of the changes proposed by the CPT - if adopted by the TSA - could be implemented reasonably quickly after the end of the TSA process. However, the CPT believes implementing its recommendations in full could take up to three years, at an estimated cost that could exceed £60m, subject to: the development of plans for the future use of the estate; the determination of the appropriate organisational form for the future delivery of services; and, excluding the cost of funding the ongoing deficit of MSFT during that period.

The changes proposed by the CPT would require a significant investment of time and money, but are absolutely necessary to ensure high quality, clinically and financially sustainable services for the population of Stafford, Cannock and the local health economy as a whole.

Although the full implementation of the proposed changes would take time, it is imperative that the local public and GPs bear in mind that the CPT has not identified any factors to indicate the current delivery of services is clinically unsafe. The Trust has improved over the last 24 months, is continuing to improve, and the hard work and commitment of the Trust's leaders and staff is not in question. Under a TSA, Stafford and Cannock hospitals will continue to operate as now and patients should continue to use the services as they do now.

2. Introduction and context

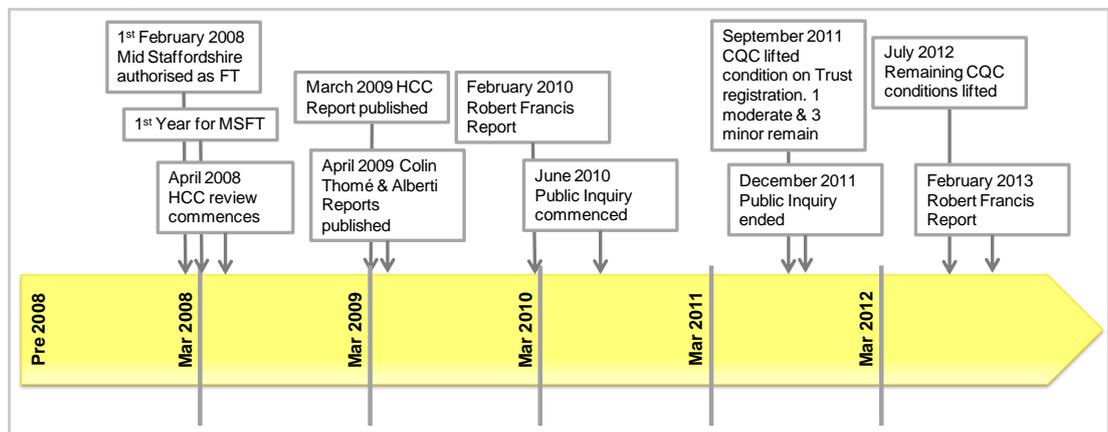
2.1 Mid Staffordshire NHS Foundation Trust

Mid Staffordshire NHS Foundation Trust ('MSFT' or 'the Trust') is a 344 bed acute Trust located on two sites: Stafford Hospital (built in 1984) and Cannock Chase Hospital (built in 1992). MSFT has an annual turnover of about £155m.

The Trust was authorised as a Foundation Trust (FT) on 1st February 2008. In the following year, the Trust was subjected to a review by the Healthcare Commission into reported high levels of patient mortality and poor standards of care.

Following this review there have been three further reviews and a public inquiry that has recently reported. Figure 1 sets out a timeline of these reviews.

Figure 1: High Level MSFT external reviews from 2008 to 2013



In response to the recommendations of these reviews concerning the quality of patient care, the Trust invested significantly in additional staff during 2009 and 2010 at a time when increasing financial constraints were being placed on NHS organisations. The Trust was also affected by decreasing patient referrals over the period, which in turn led to a reduction in the Trust's income.

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, the Trust has reconfigured some clinical pathways with the result that MSFT is not providing certain specialised and/or urgent services on a standalone basis, e.g.

- ▶ Urgent cardiology care (Acute coronary syndrome, or ST elevated myocardial infarction) - provided by UHNS and Wolverhampton;
- ▶ Urgent stroke care - provided by UHNS and Wolverhampton;
- ▶ Vascular surgery - networked with UHNS.

The strategic and tactical changes the Trust has made have had a direct impact on improving both quality and performance. However, the investment in additional resources at a time when revenue is reducing has been one of the primary factors behind the Trust being in a position of financial deficit. The Trust has therefore

required significant external financial support from the Department of Health in order to pay its debts as they fall due.

Despite repeated attempts to turn around its financial position, the Trust remains financially challenged and is expected to require further financial support to continue operating. Accordingly, the Trust has been in significant breach of its terms of authorisation as a Foundation Trust on financial and governance grounds since March 2009.

2.2 Monitor's appointment of the Contingency Planning Team

MSFT 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. The Care Quality Commission (CQC), the quality regulator, has said it no longer has outstanding concerns about the care delivered by MSFT.

However, the Trust is still losing money, and had to be given significant financial support from the Department of Health last year in order to maintain provision of services for patients. These circumstances cannot go on indefinitely.

Under the Health and Social Care Act 2012, Monitor has a primary duty as the new sector regulator to protect and promote the interests of people who use healthcare services. To carry out this new duty, Monitor also acquired new powers to ensure the continuity of services for patients if a provider's financial viability puts them at risk.

In order to ensure the continuity of services for patients, Monitor needs to be assured that the clinical improvements are sustainable for the long-term. It therefore appointed a Contingency Planning Team (CPT), led by Ernst & Young and supported by McKinsey & Company, to develop a plan for the long-term to ensure services are provided for local patients on a sustainable basis.

2.2.1 Objectives of the Contingency Planning Team

The terms of reference for the CPT were published in October 2012 and are available on Monitor's website (<http://www.monitor-nhsft.gov.uk/home/news-events-and-publications/latest-press-releases/terms-reference---contingency-planning-team->).

The core objectives for the CPT are to:

1. make an independent assessment of the financial, clinical and operational sustainability of MSFT in its current form;
2. work with commissioners to identify those services which need to be maintained in the event of provider failure, in order to ensure there is no significant adverse impact on local health or health inequalities;
3. engage with local commissioners and providers to explore the options for the future provision of all of the services currently provided by MSFT;

4. evaluate whether proposed changes should be delivered through solvent restructuring or as part of Monitor's Trust Special Administration framework;
5. make a recommendation on the future configuration of the services currently supplied by MSFT to ensure that they are delivered on a sustainable basis for the benefit of the local population.

The CPT has already assessed the Trust's sustainability (objective 1) and its conclusions are summarised in Section 2.3 below. The rest of this report addresses objectives 2-5.

2.3 Trust sustainability

During the period October 2012 - December 2012, the CPT conducted an independent assessment of MSFT to determine whether there was a plan that, if successfully implemented, would sustain the delivery of services over the short, medium and long term. The focus of this assessment was on the actions that the provider can take that are within its own control.

The CPT assessed sustainability from three perspectives - operational, clinical and financial. Whilst there are clear relationships between the three, the CPT assessed each in isolation and presented separate conclusions from each perspective.

2.3.1 Operational sustainability

The CPT acknowledged that the Trust has made significant improvements in its operational structures and processes over the last 18 to 24 months. This has resulted in improvements in key performance measures, such as CQC ratings, A&E waiting times, Hospital Standardised Mortality Rates (HSMR) and 18-week waiting times. During this period, there has also been significant investment in additional staff.

The CPT concluded that if a plan could be identified to deliver long term financial and clinical sustainability, then the Trust's operating model is fit for purpose. To that extent, the CPT concluded that MSFT is operationally sustainable.

2.3.2 Clinical sustainability

While there have been notable improvements in the quality of care at the Trust, the Trust faces a substantial challenge of scale when comparing the volume of activity at MSFT with other trusts in England. MSFT is a comparatively small trust, for example, it is 132nd out of 150 trusts in England, in terms of A&E attendances, and 135th in terms of births. Due to the size of the catchment population there is limited opportunity for growth, even allowing for predicted demographic and population changes.

Furthermore, with many acute surgical services becoming increasingly specialised, the Trust serves a size of population which is insufficient to provide exposure to enough conditions, treatments and procedures for many of its current complement of specialist consultants to achieve national standards and maintain their professional expertise.

Small hospitals such as MSFT face challenges in meeting Royal College standards and guidelines due to lower patient volumes, and, as a result, lack of ability to support the number of senior staff required to maintain a consultant presence twenty-four hours a day, seven days a week. This is particularly true for acute specialties where consultant presence may be required at short notice any time of the day or week, such as emergency surgery, A&E and maternity.

While many smaller hospitals face similar pressures there are several additional challenges that MSFT faces due to its recent history and reputational issues. In particular, MSFT has faced persistent difficulty in appointing medical staff and the Trust has had to rely heavily on non-permanent appointments. It has also had to pay a premium for the staff it does recruit.

Bearing in mind the available evidence, the CPT has concluded that although there have been substantial clinical improvements to the quality of care over the last three years, the Trust is clinically unsustainable in the long term, especially for emergency care, in light of established national standards.

2.3.3 Financial sustainability

The Trust is forecast to make a deficit for the fourth consecutive year, and required £21m cash support in financial year 2012/13. The Trust is forecast to make a deficit for the foreseeable future.

While MSFT has achieved £16.6m efficiencies in 2011/12 and 2012/13, the efficiencies required to break even by 2018 would be a minimum of 7% each year for the next five years. This level of savings exceeds realistic targets and would still require an estimated £73m in additional support from the Department of Health and local commissioners over the same period.

The CPT has concluded, and the Trust has agreed, that this required level of extra savings and additional income is very unlikely to be delivered and sustained over the five year period

On the basis of the evidence reviewed, the CPT concluded that the Trust cannot achieve financial sustainability within the next five years without significant external intervention. Moreover, without cash support the Trust is unable to pay its debts as they fall due and as such is deemed insolvent. The Trust has needed and will continue to require substantial cash support for the next five years.

2.3.4 Sustainability conclusion

The CPT has therefore concluded that MSFT is neither financially nor clinically sustainable and there is not a credible plan to deliver sustainability over the next five years in the Trust's current form. On this basis, the CPT believes there is a clear and evident case for change with regards to the services currently delivered by MSFT.

<p>CPT Conclusion One:</p> <p>A major acute hospital in Stafford will not be clinically sustainable</p>	<ul style="list-style-type: none"> ▶ MSFT is one of the smallest trusts in the country with the volume of activity below the national average for every service, and in some of the major acute services it is one of the smallest trusts in the country. ▶ MSFT has had a persistent difficulty in appointing career grade medical staff ▶ Even if sufficient career grade, e.g. consultant, medical staff were recruited to operate a 24/7 service in line with Royal College standards, there is insufficient volumes of activity to maintain their skills and capabilities
<p>CPT Conclusion Two:</p> <p>A major acute hospital in Stafford will not be financially sustainable</p>	<ul style="list-style-type: none"> ▶ MSFT will need to achieve over 7% efficiency for the next five years to break even ▶ MSFT will also need over £70m of financial support to fund its deficit during this period ▶ Employing the number of consultants required for 24/7 cover would worsen the financial position of the Trust

2.4 Structure of this report

This report presents the CPT's recommendations to Monitor on what changes it has assessed will ensure the sustainable delivery of the health services currently delivered by MSFT to the population of Stafford, Cannock and the surrounding area. The remainder of this report is structured as follows:

- ▶ **Section 3 - The local health economy:** Describes the local health economy for the population of Stafford, Cannock and the surrounding area.
- ▶ **Section 4 - Protecting services currently delivered by MSFT:** Provides an overview of the process and the outputs of the process that the CPT has facilitated with local commissioners to define protected services in Stafford and Cannock.
- ▶ **Section 5 - Developing options for change:** Provides an overview of the process the CPT has followed for establishing a shortlist of options for the future service configuration in Stafford and Cannock.
- ▶ **Section 6 - Evaluating the short list of options:** Presents the outcomes of the clinical evaluation of service configuration options.
- ▶ **Section 7 - The CPT's recommendations:** Details the recommendations on the service configuration and the implications for patients.
- ▶ **Section 8 - The financial evaluation of the CPT's recommendations:** Provides an overview of the financial evaluation conducted by the CPT.

- ▶ **Section 9 - How the recommended solution should be implemented:** Sets out an evaluation of the restructuring mechanism most likely to succeed in implementing the CPT's recommendations.
- ▶ **Section 10 - Delivering the recommended solution:** Outlines the considerations that will need to be taken into account in delivering the recommended solution.
- ▶ **Section 11 - Conclusion and next steps:** Briefly explains the next steps for Monitor and MSFT.

3. The local health economy

Every hospital operates within a local health economy (LHE). This includes 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.

Having determined that there is no course of action that MSFT could pursue on its own to deliver sustainability in its current form, it is necessary and appropriate for the CPT to explore options for change across the LHE.

There are two primary reasons for doing so:

1. The CPT must identify services that could be delivered across the LHE to ensure the sustainable delivery of services for the population of Stafford, Cannock and the surrounding areas.
2. Any changes made to the delivery of services in Stafford and Cannock will have effects on other providers in the LHE, both positive and negative. It is essential that the CPT understands any potential negative effects of its recommendations across the LHE so that any risk to another provider is mitigated.

This section therefore provides an overview of the LHE, the health providers and commissioners and the views of key stakeholders within the LHE as to the changes that could be undertaken.

3.1 Defining the local health economy

The CPT has worked on the basis that the LHE was the:

1. health commissioners who currently purchase the majority of the services for their local population from MSFT;
2. health providers that were likely to be directly and significantly affected by changes to the services delivered in Stafford and Cannock.
3. health commissioners who currently purchase a significant amount of services from other providers who may be directly impacted (e.g. Stoke, North Staffordshire, Wolverhampton)

3.1.1 Commissioners in the local health economy

Approximately 95% of the activity for MSFT is for patients in the catchment area of the former South Staffordshire PCT. From April 2013 the PCT will cease to exist and is being replaced by four Clinical Commissioning Groups (CCGs). Of the four, the Stafford and Surrounds CCG (S&S CCG) and the Cannock Chase CCG (CC CCG), commission the majority of the activity historically provided by MSFT.

General Practitioners (GPs) within these two CCGs made over 18,000 new referrals to MSFT in 2010/11, although the volume of referrals had dropped by >7% since 2008/09 (see Table 1) as patients have chosen to have their care delivered by an alternative provider.

Table 1: MSFT referrals from primary CCG catchment areas during 2008-11

Year	2008/09	2009/10	2010/11
S&S CCG new referrals	20,476	19,273	18,939
% of S&S CCG total referrals that go to MSFT	85%	80%	78%
CC CCG new referrals	20,497	19,099	18,624
% of CC CCG total referrals that go to MSFT	82%	75%	73%

3.1.2 Healthcare providers within the LHE

At the start of the CPT's work, it was necessary to form a hypothesis and then agree on which other providers should be deemed as within the LHE of MSFT.

The CPT started with the hypothesis that up to seven NHS Acute Hospitals could form part of the LHE⁹, in addition to the Staffordshire and Stoke-on-Trent Partnership NHS Trust, (which runs community and social care services across Staffordshire) and the West Midlands Ambulance Service.

It then followed a three step process to rule in or rule out each of these hospitals as acceptable potential alternative providers of services to patients currently served by MSFT, should the need arise.

Step One: Travel times

The CPT has used detailed travel time analysis¹⁰ to assess its recommendations, including by ambulance, private car and public transport (see Section 7.2 for details on this analysis). However, for the initial determination of which hospitals could belong in the LHE, the CPT used private car travel times from Stafford and Cannock hospitals.

The rationale for this was that the majority of the population served by MSFT live in Stafford or Cannock and those other providers within a reasonable driving distance of these towns are likely to be impacted by any changes to services in Stafford and Cannock.

⁹ UHNS, Stoke-on-Trent; New Cross, Wolverhampton; Manor Hospital, Walsall; Queens Hospital, Burton; The Royal Derby Hospital; Heart of England, Birmingham; Princess Royal, Telford.

¹⁰ Based upon post code blocks (the first four/five characters of a postcode)

There are three other hospitals within 30 minutes¹¹ of either Stafford or Cannock Hospitals (the travel time between Stafford and Cannock Hospitals being 20 minutes). These were UHNS, Stoke-on-Trent; New Cross Hospital, Wolverhampton; and Manor Hospital, Walsall.

Step Two: GP referring behaviour

It was previously noted that the majority of referrals from the catchment areas of Stafford and Surrounds CCG and Cannock Chase CCG were to MSFT, but that these referrals were reducing as a consequence of patient choice. The CPT therefore analysed these referral patterns to determine which alternative hospitals patients had chosen to attend. It would be reasonable to assume that any changes to the services at MSFT could see a similar drift of patients to other hospitals which would directly affect these providers.

On the basis of this analysis the CPT noted that four hospitals had received a significant increase in referrals from GPs in the Stafford and Surrounds CCG and Cannock Chase CCG catchment areas. These were the three hospitals noted in Step One, plus Queen's Hospital, Burton. This is likely to be the patients in the eastern region of the catchment area where Burton is the closest hospital after MSFT.

Step Three: Initial engagement with the providers

The CPT spoke with the senior leaders for each of the seven hospitals it considered. The purpose of these conversations was to ascertain whether they considered changes in services at MSFT would have a significant impact on their hospital. Bearing in mind the overnight closure of the A&E unit at Stafford Hospital, these hospitals had a recent and credible experience that could be drawn upon to determine whether they would be affected.

On the basis of these conversations, Heart of England, Birmingham and The Royal Derby Hospital concluded that they would not be significantly affected.

UHNS (Stoke-on-Trent), New Cross Hospital (Wolverhampton), Manor Hospital, (Walsall), and, Queen's Hospital (Burton) stated they believed they would be affected by any changes to services at MSFT - the latter also noting that it ran the Community Hospitals in Lichfield and Tamworth which could be affected.

Shrewsbury and Telford Hospitals NHS Trust, stated that the Princess Royal in Telford may be affected by certain changes to MSFT, especially as it is planning to consolidate a number of services, notably all maternity services, into Telford.

Therefore, the CPT has worked on the basis that the LHE comprises the following NHS Trusts:

¹¹ There is no set standard for what is a 'reasonable travel time'. However, 30 minutes has been used by other reconfiguration programmes (for example, the London Stroke and Trauma service reconfiguration) as a reasonable travel time for Ambulance transfers between hospitals. The CPT therefore worked on the basis that a 30 minute travel time limit for private car journeys - which take longer than ambulance transfers - was reasonable.

- ▶ University Hospital of North Staffordshire NHS Trust (UHNS), Stoke-on-Trent;
- ▶ The Royal Wolverhampton NHS Trust (RWT);
- ▶ Walsall Healthcare NHS Trust (WHT), which runs Manor Hospital;
- ▶ Burton Hospital NHS Foundation Trust (BHFT), which runs Queen's Hospital;
- ▶ Shrewsbury and Telford Hospitals NHS Trust (SaTH), which runs Princess Royal Hospital;
- ▶ Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSoTP), which runs community and social care services across Staffordshire;
- ▶ West Midlands Ambulance Service NHS Foundation Trust (WMAS).

The CPT notes that there is one private hospital - Rowley Hall, Stafford - within the catchment area of S&S CCG and CC CCG. The CCGs do commission some services from Rowley Hall, but at only 14 beds, the CPT concluded that for the purposes of its work it would not be a significant contributor to the potential solutions that the CPT would be evaluating.

3.1.3 Other commissioners across the LHE

The CPT spoke with leaders of other commissioning groups across the LHE. This includes Stoke on Trent, North Staffordshire and Wolverhampton. The purpose of these discussions was to ensure that their perspective and concerns were taken into consideration regarding the impact of any changes to services.

3.2 Delivery of healthcare within the MSFT's local health economy

The CPT has engaged with the healthcare providers and commissioners across the LHE throughout its work. This engagement has included:

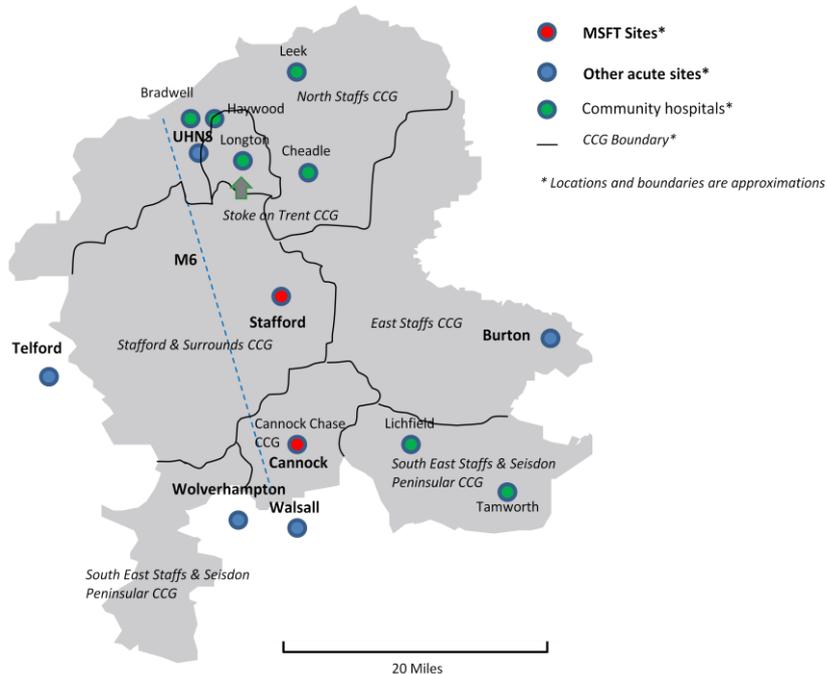
- ▶ Multiple meetings with the senior executives in each Trust;
- ▶ Regular involvement of medical directors and strategy directors of each trust, as well as clinical chairs of the CCGs with their participation in the Clinical Advisory Group¹²;
- ▶ In addition, representatives from the local CCGs, and Staffordshire LINKs, formed the Protected Services Definition Group;
- ▶ Finance and operating directors from trusts and CCGs in the Operations and Finance Group;
- ▶ Gathering data from each of the Trusts to support the analysis of the CPT.

The general consensus from all of the Trusts is that there needs to be change across the LHE in order to improve the delivery of services not just for the population served by MSFT, but the broader population of Staffordshire. The remainder of this section provides an overview of each of the providers and some of the issues and ideas concerning better delivery of services that are recognised across the LHE.

3.2.1 An overview of the LHE's providers

The map of Staffordshire in Figure 2 shows the location of the providers and the CCGs within the local health economy. The map shows Stafford is centrally located within the county, but there are other providers to the north, south, east and west.

Figure 2: The local health economy for MSFT



¹² See Section 5.1 for full details of the working groups established by the CPT.

Tables 2-8 present an overview of the other providers in terms of the size and type of services they provide:

Tables 2-8: A summary of the other NHS providers in MSFT's local health economy

Mid Staffordshire NHS Foundation Trust (MSFT)				
2011/12 Turnover	2011/12 Surplus/(Deficit)	2012/13 Surplus/(Deficit) forecast	Number of staff	Number of beds
£155m	(-£19.9m)	(-£15m)	3,000	350
Mid Staffordshire NHS Foundation Trust provides general acute Hospital services for the populations of Stafford, Cannock and the surrounding areas. It provides services from two main sites: Stafford and Cannock Hospital. Stafford hospital provides the full range of acute services whereas Cannock does not receive emergency inpatients but provides some elective surgery and rehab beds.				
University Hospital of North Staffordshire NHS Trust (UHNS)				
2011/12 Turnover	2011/12 Surplus/(Deficit)	2012/13 Surplus/(Deficit) forecast	Number of staff	Number of beds
£426m	£3m	(-£23m)	7,000	1,000
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 and opened in 2012. It provides specialist treatment such as major trauma and neurosurgery to the local populations of Newcastle under Lyme and Stoke on Trent and to the wider population of Staffordshire and South Cheshire and Derbyshire.				
Burton Hospital NHS Foundation Trust (BHT)				
2011/12 Turnover	2011/12 Surplus/(Deficit)	2012/13 Surplus/(Deficit) forecast	Number of staff	Number of beds
£171m	(-£5.3m)	(-3.5m)	2,500	420
Burton Hospital 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. As well as hosting services at these sites the Trust provides a range of outpatient and inpatient services from there.				

Walsall Healthcare NHS Trust (WHT)				
2011/12 Turnover	2011/12 Surplus/(Deficit)	2012/13 Surplus/(Deficit) forecast	Number of staff	Number of beds
£227m	£3.6m	£3.7m	5,000	500
<p>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.</p>				

The Royal Wolverhampton NHS Trust (RWT)				
2011/12 Turnover	2011/12 Surplus/(Deficit)	2012/13 Surplus/(Deficit) forecast	Number of staff	Number of beds
£374m	£8.7m	£4.5m	6,500	800
<p>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 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.</p>				

Shrewsbury and Telford Hospitals NHS Trust (SaTH)				
2011/12 Turnover	2011/12 Surplus/(Deficit)	2012/13 Surplus/(Deficit) forecast	Number of staff	Number of inpatient beds
£300m	£0.05m	£1.9m	5,000	720
<p>Shrewsbury and Telford Hospitals NHS Trust is a 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 West 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.</p>				

Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSoTP)				
2011/12 Turnover	2011/12 Surplus/(Deficit)	2012/13 Surplus/(Deficit) forecast	Number of staff	Number of inpatient beds
£204m	£1.5m	£2m	6,000	300 (community)
<p>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.</p>				

3.3 Commissioning within the local health economy

Health commissioning is the function which exists to ensure that high quality healthcare services are provided for the local population. To undertake this function, commissioners act as advocates for patients and communities to secure a range of high-quality healthcare services for the local population. In securing these services, commissioners are also the custodian of tax-payers money, placing on them a requirement to secure the best value healthcare services that they can find within their budget, which is based on the size and characteristics of the population they serve.

Commissioning across the NHS is being significantly restructured, with Primary Care Trusts (PCTs) and Specialised Commissioning Groups (SCGs) being replaced by local Clinical Commissioning Groups (CCGs) and regional 'Local Area Teams' (LATs) who will work under the strategic direction of the NHS Commissioning Board (NHS CB). This report does not dwell on the details of the changing commissioning bodies, other than to note that the CPT has been actively engaged with the individuals and organisations who will commission the significant majority of services at MSFT from April 2013.

The CPT has been working closely with the Stafford and Surrounds CCG and Cannock Chase CCG to develop the options presented in this report. Both CCGs are represented on the Clinical Advisory Group and Protected Services Definition Group (see Section 5.2 for further details on these groups). The CPT has also had regular meetings with both the CCGs and the PCT cluster (and the future Local Area Team) during the development of options presented in this report.

This section presents a high level outline of current commissioning intentions and sets out the process and conclusions of the process to define protected services.

3.3.1 Local commissioning intentions

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. They accept that the scope, style and scale of these services may be significantly different in the future. 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.

Specifically, Stafford and Surrounds CCG intentions are to:

- ▶ Commission a 24/7 Emergency and Urgent Care Service in Stafford;
- ▶ Ensure that services are provided as locally as possible but centralised where necessary in order to deliver highest quality of care;
- ▶ Ensure that services are clinically and financially sustainable in the future;

- ▶ Commission services which shift the pattern of care away from hospitals into community and home based services;
- ▶ Redesign several pathways to deliver better care, including long term condition, elderly care, Ear Nose and Throat (ENT), musculoskeletal services, colorectal surgery, general surgery, oral surgery, plastics, urology, gynaecology, cardiology and gastroenterology.

Specifically, Cannock Chase CCG intentions are to:

- ▶ Ensure that services are provided as locally as possible but centralised where necessary in order to deliver highest quality of care
- ▶ Continue commissioning a Minor Injuries Unit (MIU) in Cannock. (Note: The current MIU is operated out of Cannock Hospital by the Staffordshire and Stoke-on-Trent Partnership NHS Trust and as such is not part of the CPT review)
- ▶ Redesign several pathways to deliver better care, including long term conditions, elderly care, Ear Nose and Throat (ENT), ophthalmology, musculoskeletal services and end of life care.

The CPT's recommendations have sought, where possible, to reflect these intentions.

3.4 Stakeholder views on what change could look like

During the course of its work, the CPT has engaged with a wide range of stakeholders in addition to the commissioners and providers in the local health economy.

The CPT has attended multiple stakeholder forums to brief on the CPT process and to give stakeholders an opportunity to ask questions and discuss their views. These forums have included:

- ▶ Briefings with the Board of Governors of MSFT;
- ▶ MSFT staff briefings;
- ▶ Public meetings organised by the Trust;
- ▶ The Staffordshire Health Scrutiny Committee;
- ▶ The Staffordshire Health Wellbeing Board;
- ▶ Local MP working groups;
- ▶ CCG patient forums.

The CPT has also received formal submissions on the views from the:

- ▶ Working group set up by the MP for Stafford;
- ▶ Board of MSFT;
- ▶ Governors of MSFT.

This section summarises the most commonly expressed views and addresses two proposed solutions that have been consistently raised with the CPT as a means of managing the sustainability challenges faced by the Trust.

3.4.1 Common stakeholder views

Whilst there is a wide range of stakeholder views, there is also a lot of commonality in some of the views expressed. The following views have been stated by multiple stakeholders; however, this not an exhaustive list of opinions, nor indeed does every opinion have universal support.

- ▶ Change is needed at MSFT, and the driver for change should be to secure clinically viable services and consistently good patient outcomes.
- ▶ As many services as possible currently delivered by MSFT should be retained locally, especially emergency care provision, maternity services and care of the elderly.
- ▶ If services are to be moved to another provider - and several stakeholders do not wish any services to move - it should only be those that are highly specialised, and then only to providers that deliver services to the same standard as currently delivered by MSFT.
- ▶ If services are to be moved, they should be the right size, sustainable in the long term and must not destabilise the operations or finances of another trust.
- ▶ Stafford needs a 24/7 'Accident and Emergency' department, rather than a department that shuts overnight as the current service does - although some stakeholders do accept that it may not be possible to treat patients with highly complex needs.
- ▶ Some services must be retained in Cannock, although the majority of stakeholders accept that these services do not need to be provided by MSFT.
- ▶ The use of clinical networks with other providers should be used to enable as many services to be retained in Stafford and/or Cannock, taking advantage of the clinical skills of staff employed by other providers, but using the local facilities.
- ▶ Any proposal to move services to another provider raises concerns for those individuals reliant on public transport. Some stakeholders cannot see a resolution to this issue, whilst others are calling for a modernisation to patient transport services and an increase in capacity within the West Midlands Ambulance Service.
- ▶ There should be an aspiration to move to a more integrated model of care across acute, primary, community and social care, either through co-location of services in the same site or through redesigned care pathways. This is qualified by the view of several stakeholders that local community and social care services need to be significantly redesigned and performance improved before this aspiration can be fulfilled.

- ▶ There is a general unease/lack of confidence about the other providers in the local health economy, especially in light of recent news of mortality rates and the financial position in some of the local providers.
- ▶ Any change must be properly managed, but cannot be allowed to drag on for a lengthy period of time. There is widespread concern that delaying change will lead to a drop in standards due to staff leaving and patients choosing to be treated elsewhere.
- ▶ Many stakeholders are clear that they do not want these changes to be used as an excuse to introduce private sector providers, although when challenged, very few stakeholders can explain why they hold this view.

Engagement with stakeholders has been a key part of the CPT process and due consideration has been given to their range of views and opinions in arriving at its conclusions. However, the CPT has had to balance a range of inputs to the process, not all of which will be reflected in the final recommendation.

3.4.2 Considering solutions with the existing service model

Before presenting the work the CPT has conducted, it is important to address two solutions that have been consistently suggested to the CPT by a variety of stakeholders.

The CPT understands why these solutions may seem obvious, but it does not believe that either solution is feasible or likely to solve the challenge of MSFT's sustainability.

1. ***If there is spare capacity/empty wards within Cannock Hospital why can't MSFT bring in more activity and consequently more revenue? Would this not help solve the financial problems?***

Hospitals within the NHS can only deliver the services that health commissioners choose to purchase from each health provider. Just because there may be capacity within any single given trust and a waiting list for some services, does not mean there is the demand from the commissioners or the money to pay for those services, or for that matter, demand from patients, who have the choice of where to be treated for non-urgent (elective) care. The commissioners across Staffordshire and neighbouring counties have a finite amount of money to spend on purchasing health services and choose to spend that money in the manner and at the location they consider most appropriate

It should also be noted that if MSFT were to operate more services at either site - assuming commissioners were able and willing to pay for those services - then it would need to bear the cost of providing those services. It is quite conceivable that, especially in light of the higher than average cost base, these services would cost more money to operate than the revenue the Trust would receive - which would worsen the Trust's financial problems.

2. *Why can't MSFT close and/or sell Cannock Hospital and consolidate services into Stafford Hospital?*

During the sustainability review, the CPT considered this possibility, but concluded that consolidating sites alone will not create a clinically or financially sustainable solution, without significant service reconfiguration as well. Consolidating sites would not address the issue that both the catchment population and activity levels across both hospitals are lower than those recommended by the Royal College Standards for an acute general hospital providing the full range of facilities, including specialist staff and expertise for both elective and emergency medical and surgical care.

The commissioners have also made it clear that they wish to commission services in both Stafford and Cannock. The CPT has therefore worked on the basis that it will try to identify a service configuration that retains some services in both localities, and would only consider consolidating onto a single site if an alternative sustainable solution was not identified.

4. Protecting services currently delivered by MSFT

Under the new Healthcare Act when a provider becomes, or is likely to become, unable to pay its debts as they fall due, Monitor will place the provider in special administration. In the event that MSFT is placed under trust special administration, commissioners have a responsibility for ensuring that the local population continues to have access to key NHS services in their local areas. Monitor has issued draft guidance for commissioners on the designation of 'protected services' ("Ensuring continuity of health services and designating Commissioner Requested Services and Protected Services"). Monitor is currently working on finalising the guidance for publication and based on stakeholder feedback and the terminology of 'protected services' is likely to change to 'location specific services'. However, for the purposes of this report the CPT will use 'protected services' terminology and refer to the published draft guidance which was used by the commissioners throughout the process.

The guidance defines 'protected services' as services for which "there is no acceptable alternative provider and would need to be kept running if the provider were to fail". If designated as protected, these services will have **extra regulatory protection under a trust special administration**. 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 attractive alternatives or because commissioners believe they can commission it without extra regulatory protection.

Based on the draft guidance, the two CCGs have prepared **draft** lists of protected services for their respective localities, which have been signed off by their respective CCG membership boards. Both Stafford and Surrounds CCG and Cannock Chase CCG have confirmed that they support each other's draft list. It is important to note that the CCGs currently operate in the 'shadow' form until April 1. In the meantime the PCT cluster has been providing necessary assurance and support for the CCGs in their decision making.

It is the responsibility of the CCGs to define protected services, supported by the CPT. Therefore, this report sets out the process followed and the conclusions that the CCGs have made. This informs the basis of the options development and evaluation that is then covered in the rest of this report.

In preparing the draft list of protected services there are four criteria to consider:

Table 9: The criteria used when evaluating whether a service should be protected

Criteria	Question being addressed
Access to alternative providers	Do alternative providers of a similar service exist? Is the distance (travel time) to alternative providers acceptable? Are these services of 'equivalent' quality?
Available capacity at alternative providers	Would alternative providers have the capacity and capabilities to deliver the services? Could new capacity be created - either by existing providers or by new entrants - over a reasonable time period?
Impact on Health Inequalities	Would withdrawing a service have a disproportionate impact on disadvantaged groups, who have lower health outcomes? Are there any unique and hard to replicate relationships with patient groups or other public services?
Inter-dependencies between services	Are there any services which need to be protected because they are interdependent with services already selected for protection?

The CPT has supported the local commissioners in preparing a draft list of protected services. This has been through the establishment of, and support to, a 'Protected Services Definition Group' (PSDG), chaired by the CPT's independent clinical advisor (see Section 5.2 for further description). The CPT provided the analysis and information necessary to enable the PSDG to assess the options available to them, as follows:

Criterion One: Identifying acceptable alternative providers of services

In order to identify alternative providers that were acceptable to commissioners, the PSDG considered travel times and clinical quality. The CPT used detailed travel time analysis to assess which alternative providers are within a reasonable travel time. The CPT analysed blue light, private car and public transport times at both peak and off peak times.

Criterion Two: Determining capacity at alternative providers

The CPT gathered data from all the relevant providers on activity and capacity. Through the Operating and Finance Group (OFG) assumptions on demographic growth, demand management and operational improvements such as average length of stay were agreed, allowing the CPT to forecast capacity requirements. The CPT then modelled these changes over time to assess what relevant capacity would be available both immediately and in 2015/16. The CPT's estimates, assumptions and outputs were tested with all relevant providers in the region through one-on-one discussions.

Criterion Three: Impact on health inequalities

In order to assess the impact on disadvantaged groups and health inequalities the CPT considered the increase in public transport times to alternative providers and the existence of unique relationships with patient groups or public services that would be hard to replicate elsewhere. The PSDG were concerned with the increased public transport times due to the rural nature of the area. As a result some of the more frequently used services were designated protected.

Criterion Four: Service interdependencies

The CPT tested all services classified as protected to assess if there were interdependent services, for example, if general surgery was protected, anaesthetics would also need to be protected as the services are interdependent.

In preparing the draft list of protected services there are two considerations that must be taken into account:

1. The CCGs have undertaken the process for drafting protected services using draft guidance that Monitor has been consulting on and has yet to be finalised. Any changes to the guidance could impact on the final list of protected services;
2. The draft list of protected services is only relevant in the context of an appointment of a Trust Special Administration (TSA) who will go through the final confirmation of the protected services.

Table 10 sets out the high level draft list of protected services.

Table 10: The draft list of protected services

Stafford & Surrounds CCG	Cannock Chase CCG
<p>At Stafford:</p> <p>On the basis of Health Inequalities:</p> <ul style="list-style-type: none"> • Outpatients • Patient facing diagnostics • Day case chemotherapy • Pre-natal and post-natal care • Step down beds <p>On the basis of capacity and protected only until alternate capacity is available:</p> <ul style="list-style-type: none"> • Current 14/7 A&E¹³ • Routine Obstetrics • Selected Emergency (Non Elective) admissions/inpatients¹⁴ • Select elective admissions for a range of medical specialties <p>On the basis of service interdependency and only protected for as long as the interdependent service is protected:</p> <ul style="list-style-type: none"> • High dependency services commensurate with services on site • Sufficient neonatal resuscitation to support services on site • Adult Anaesthetics <p>At Cannock: No services are protected</p>	<p>At Stafford: No services are protected</p> <p>At Cannock:</p> <p>On the basis of Health Inequalities:</p> <ul style="list-style-type: none"> • Outpatients

<p>CPT Conclusion Three:</p> <p>Services will be retained in both Stafford and Cannock</p>	<ul style="list-style-type: none"> ▶ Commissioners wish to retain access to services in both Stafford and Cannock, particularly <ul style="list-style-type: none"> • In Stafford: Outpatients, diagnostics, pre and post natal care, step down beds • In Cannock: Outpatients ▶ Commissioners wish to commission 24/7 emergency and urgent care service in Stafford
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¹³ Noting that the commissioning intentions (as per Section XX) are to redesign the services and commission 24/7 Emergency and Urgent Care service

¹⁴ 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.

5. Developing options for change

Having determined that MSFT at present is neither clinically or financially sustainable, the CPT was required to develop a 'contingency plan' to develop, for Monitor, a series of recommendations about changes that could be made in order to ensure that the population of Stafford, Cannock and the surrounding areas have access to high quality healthcare services, including those services currently delivered by MSFT.

This contingency plan sets out where and how the population can expect to access services taking into account: commissioning intentions; the draft list of protected services, and an assessment of the impact on the local health economy.

This section sets out how the CPT developed a long list of options for the future of clinical services at Stafford and Cannock and surrounding hospitals and the process it went through to reduce the long list to a short list for detailed evaluation before selecting a preferred option for the contingency plan itself.

5.1 CPT advisory groups

The CPT established three working groups to support the development of options. These working groups met on multiple occasions and were chaired by senior independent advisors to the CPT. An overview for each of the three groups is presented in Table 11.

Table 11: An overview of the three working groups that have been established to support the CPT

Protected Services Definition Group (PSDG)		
Chair	Membership	Purpose
Professor Hugo Mascie-Taylor <i>Clinical Advisor to CPT and Medical Director for NHS Confederation</i>	<ul style="list-style-type: none"> Accountable Officer for Stafford and Surrounds and Cannock Chase CCGs Chairs, clinical leads, Exex board members from Cannock Chase CCG, Stafford and Surrounds CCG Clinical Governance Director, CC CCG Primary Care Director, CC CCG Director, CC CCG Medical Director, Staffordshire Cluster General Manager, Stafford and Surrounds CCG Representatives from Staffordshire LINK 	<p>The PSDG met five times to:</p> <ul style="list-style-type: none"> follow the process outlined in Monitor's consultation on Guidance for Commissioners. agree 'protected services' - the services for which, should MSFT fail, there is no acceptable alternative provider. review the availability of alternative provider services for the local populations served by Stafford and Cannock hospital, understanding alternative provider capacity, capability and willingness to deliver services advise on, or identify questions to be raised, at the Clinical Advisory Group on the clinical viability of services that are proposed as being protected

Clinical Advisory Group (CAG)		
Chair	Membership	Purpose
<p>Professor Hugo Mascie-Taylor <i>Clinical Advisor to CPT and former Medical Director for NHS Confederation</i></p>	<ul style="list-style-type: none"> • Chair, Stafford and Surrounds CCG • Clinical Chair, Cannock Chase CCG • Medical Directors or their delegated representative and Strategy directors from: MSFT; University Hospital of North Staffordshire; Burton Hospital; The Royal Wolverhampton NHS Trust; Walsall Healthcare NHS Trust; Shrewsbury and Telford NHS Trust; Staffordshire and Stoke-on-Trent Partnership Trust; Cluster of Staffordshire PCTs; West Midlands Ambulance Trust. 	<p>The CAG met four times to:</p> <ul style="list-style-type: none"> • provide clinical advice to the programme, ensuring the programme develops robust clinical proposals • make clinical recommendations to the CPT • set out quality standards for clinical services • review and agree the clinical evidence base supporting proposed models of care • review future activity and capacity assumptions • provide clinical input into the development of potential options for change • provide expert clinical advice on CPT outputs - as and when requested
Operating and Finance Group (OFG)		
Chair	Membership	Objectives
<p>Bob Alexander <i>Director of Finance, NHS South. From April 2013, the Director of Finance for the NHS Trust Development Authority</i></p>	<ul style="list-style-type: none"> • Directors of Finance, and Directors of Operations or their delegated representatives from: MSFT; University Hospital of North Staffordshire; Burton Hospital; The Royal Wolverhampton NHS Trust; Walsall Healthcare NHS Trust; Shrewsbury and Telford NHS Trust; Staffordshire and Stoke-on-Trent Partnership Trust; Cluster of Staffordshire PCTs; West Midlands Ambulance Trust. 	<p>The OFG met four times to:</p> <ul style="list-style-type: none"> • provide financial leadership advice to the programme, ensuring the programme develops financially robust proposals • agree future activity, finance, productivity and capacity assumptions to be used by the CPT • provide financial input into the development of potential configuration options

5.2 The process for developing a short list of options

The CPT's primary objective is to develop a set of options that are clinically sustainable in the long term. The CPT focused on how clinical services currently provided in Stafford and Cannock could be delivered in future to ensure high quality care, unconstrained by estates or organisational implications. This ensured that there was a full debate and evaluation of the type and nature of services that could be delivered in the Stafford and Cannock localities.

It is important to be aware of the fact that, throughout this section any reference to future services in Stafford or Cannock does not mean that these services are guaranteed to be delivered at the existing Stafford and Cannock Hospitals. Once the clinical model is finalised, a separate assessment should be undertaken on the effectiveness and value for money associated with retaining/redeveloping the existing sites or developing new facilities.

The development of the options was regularly tested by and developed with the Clinical Advisory Group, and analysed using information developed with the Operating and Finance Group.

The primary considerations that were taken into account when developing the range of options were: the commissioning intentions of the two CCGs; the views of local stakeholders; national guidance on clinical standards; access to services based on the emerging outputs from the Protected Services Definition Group; and the range of services that are currently delivered by other providers in the local health economy.

The CPT has not looked in detail at the delivery of primary, community, social care and mental health services for the population of Stafford, Cannock and their surrounding areas, as these are provided by organisations other than MSFT. The CPT has worked on the basis that effective provision of these services is essential to underpin the successful delivery of any revised model of hospital care.

The CPT has followed a process for generating potential options for change:

- ▶ **Step One:** Assess the potential service configuration models that could deliver services in Stafford and in Cannock;
- ▶ **Step Two:** Develop and validate a long list of options for clinical service models across Stafford and Cannock based upon the potential hospital types identified in Step One;
- ▶ **Step Three:** Conduct a high level evaluation of these options in order to establish a short list of options for detailed evaluation.

In doing so, a long list of thirty-two options was developed, which was reduced to an initial shortlist of eight options for detailed evaluation and a final shortlist of three (see Section 6).

The remainder of this section details how these shortlisted options were determined.

5.3 Step One: Potential service configuration models

The CPT worked very closely with the CAG to consider what service configuration models are possible for Stafford and Cannock.

The CPT and CAG agreed that there were a range of options for Stafford and Cannock, based upon variations of the traditional acute hospital model or the local hospital model that are emerging within the NHS. The CPT looked first at the options for meeting local needs for local and non-elective care.

5.3.1 Acute hospitals

The traditional hospital model is the general acute hospital providing a broad range of services. Acute hospitals can range in size from larger more specialist tertiary centres and teaching hospitals (e.g. UHNS), down to smaller district general hospitals (e.g. Stafford Hospital). It should be recognised that in describing different types of hospital models there is a spectrum from a “community hospital” to a “major acute”. For the purpose of the options development described in this report the CAG defined hospitals providing a full range of acute services (including emergency surgery, critical care and unselected medical admissions) as “major acute hospitals”.

Recent service reconfigurations in the NHS have led to some district general hospitals providing a reduced range of non-elective/emergency services. For example, this may include the decommissioning of their emergency surgery service while retaining some acute medical services. These hospitals are often referred to as ‘warm sites’. These hospitals are often part of an established clinical network with one or more major acute hospitals.

Stafford Hospital currently offers a range of core emergency services, i.e. A&E, emergency surgery and an unselected medical take. It has set up some networking with UHNS, but this is at a relatively early stage.

The CPT and CAG agreed that both a major acute hospital and a warm site should be considered on the long list of options for Stafford Hospital.

The CPT and CAG noted that the characteristics of Cannock are more similar to the local hospital model described in the next section than that of a full acute hospital. Given the close proximity of Cannock Hospital to Walsall and Wolverhampton, it was therefore agreed that the option of an acute hospital (either major acute or warm site) in Cannock should not be considered.

5.3.2 A ‘local hospital’

Other recent service reconfigurations in the NHS have seen the emergence of the concept of the ‘local hospital’ which is distinctly different to the traditional acute hospital model, and closer, although different, to what is often called a “community hospital”.

The concept of a local hospital is consistent with the principles of “centralise where necessary” and “localise where possible” and the drive towards better integration of care across primary, secondary and community services.

There is a national trend towards greater centralisation of specialist services onto fewer sites to improve safety and quality of care by ensuring the availability of fully trained specialists and equipment on a seven day a week basis, up to 24 hours a day. This creates a greater need for local hospitals to maintain access to more commonly needed and less specialised services. This has been reflected in the recommendations for recent healthcare reconfigurations e.g. in NW, SW and SE London and in Hertfordshire.

In addition, there are clearly stated commissioning intentions for improving the integration of clinical pathways across primary, community and acute care. A local hospital creates the opportunity to drive this integration, for example, by co-locating some of these services.

While it is informative to look at other examples, it is critical that the range of services at a local hospital should be tailored to the needs of the local population it serves. The following are some desirable characteristics of the services delivered by a local hospital:

- ▶ A local hospital provides access for a local population to a range of services for common conditions that are, therefore, used frequently;
- ▶ A local hospital is part of a clinical network, i.e. there are close links with:
 - i) Acute providers in the local health economy. For example, the acute provider is commissioned to provide an acute service for patients in the catchment of the local hospital, but all of the outpatient appointments and basic diagnostics associated with the patient’s treatment are delivered at the local hospital;
 - ii) Local community providers, especially in care pathways associated with care of the elderly and patients suffering from long term conditions.

The services within a local hospital could include some of the following:

- ▶ Emergency and Urgent Care service. This is not a full Accident and Emergency department, but a non-admitting unit such as a Minor A&E, an Urgent Care Centre or a Minor Injuries Unit. It is often desirable to integrate GP out of hours services in order to provide a coherent 24/7 service;
- ▶ Some emergency and urgent care services can be supplemented by facilities allowing short stay admissions of low-risk patients requiring some inpatient support who are then discharged back into the community. These patients may require access to medical cover which can be provided through a clinical network with a neighbouring acute hospital;

- ▶ Outpatient services for the local population including pre and post natal appointments;
- ▶ Diagnostic services, as part of the outpatient service, and for GP direct referrals;
- ▶ Intermediate care inpatient beds that can act as a step down facility for other providers in the Local Health Economy, particularly for patients from the local area. These are often frail elderly patients who need ongoing inpatient care and/or rehabilitation before returning to their normal place of residence;
- ▶ Provision of minor procedures such as diagnostic investigations, day case procedures or outpatient procedures.

In many ways, Cannock Hospital is currently very similar to a local hospital, so the CPT and CAG agreed that the local hospital model should be considered for both Stafford and Cannock Hospital.

5.4 Step Two: Developing the long list of options

Having determined the potential service configuration models for local and non-elective care that should be considered in Stafford and Cannock, the CPT and CAG also considered elective care. This included whether there were clinical and/or financial benefits associated with consolidating elective inpatient services onto only one of the sites. In addition, the CPT and CAG looked at the case for delivering some elective work currently done by other providers at one of the MSFT sites (an “elective centre”).

Taking this into account, it was agreed that there were 32 possible options for meeting local needs for local, non-elective and elective care that could be considered on the basis of the various combinations of hospital type in Stafford and Cannock¹⁵. These options are shown in Figure 3.

Figure 3: The long list of 32 options

		Options for services in Stafford								
		1. Major Acute hospital	Acute hospital ('warm site')			Local hospital			8) No services / site closure	
			2) + IP elective centre	3) + IP elective care	4) No IP elective	5) + IP elective centre	6) + IP elective care	7) No IP Elective		
Options for services in Cannock	Local hospital	A) + IP elective centre	1A	2A	3A	4A	5A	6A	7A	8A
		B) + IP elective care	1B	2B	3B	4B	5B	6B	7B	8B
		C) No IP elective	1C	2C	3C	4C	5C	6C	7C	8C
	D) No services / site closure	1D	2D	3D	4D	5D	6D	7D	8D	

¹⁵ This conclusion was reached during Phase One of the CPT, so at the time the range of 32 options included the possibility of closing one or both of the hospitals as this was being evaluated as part of the sustainability review.

Notes

- 1) An elective centre implies that the site would deliver additional elective activity, currently delivered at other trusts in the region; elective care refers only to the elective activity currently delivered by MSFT.
- 2) Options 4 and 7 for Stafford, and option C for Cannock, include the provision of day case elective procedures that would be appropriate to the range of on-site support services (Options 7 and C being restricted to simple day case procedures and no critical care provision).

5.5 Step Three: Establish a shortlist of options

Having established a long list of 32 options, the next step was to reduce this list to a short list of options that could be taken forward for a detailed evaluation during Phase Two of the CPT. Based upon the information gathered and analysis undertaken during Phase One, the CPT excluded 25 options from the long list of options. The rationale for excluding options is as follows.

5.5.1 Excluding options on clinical and financial sustainability grounds

The CPT concluded that MSFT as a trust is clinically unsustainable. As was discussed earlier, the standards set out by the Royal Colleges imply that small hospitals struggle to recruit and retain sufficient senior medical staff to provide care on 24/7 basis. Even if it were possible to afford and recruit such doctors they would not have sufficient on-going work to maintain their skills and capabilities.

The CPT also concluded that the current services, which are effectively those of a sub-scale major acute hospital, are unsustainable financially. On this basis, the CPT has concluded that a major acute hospital in Stafford (option 1) is not a realistic option (as per CPT Conclusions One and Two - Section 2.3). Accordingly, the alternatives under option 1 have been excluded. This further reduced the number of options from 32 to 28.

5.5.2 Excluding options on commissioning grounds

The local commissioners, in developing their draft list of protected services, determined they wished to retain access to outpatient services in both Stafford and Cannock (as per CPT Conclusion Three - Section 4). Therefore, the alternatives for option 8 and option D were excluded. This reduced the long list of options from 28 to 21.

5.5.3 Excluding options on clinical grounds

The collective opinion of the CAG was that a site with a reduced set of acute services or a "warm site" option for Stafford was not desirable, due to the close interdependencies between different non-elective and emergency services, and complex elective services - in particular the requirement for on-site critical care. Exclusion of all warm site options would have further reduced the number of remaining options from 18 to 9.

However, at the request of the Chairs and Chief Executives of the providers across the Local Health Economy, the CPT agreed to re-assess the clinical rationale for two specific warm site options - 3C and 4C - in depth with the CAG.

It was agreed to split option 3C into two variants:

- ▶ Variant 1: An 'unselected acute medical take with critical care but not emergency surgery'. This means that patients needing, or possibly needing, emergency surgery, are taken to an alternative site.
- ▶ Variant 2: A 'selected acute medical take with no emergency surgery and no critical care'. This means that patients needing, or being at risk of needing, critical care are taken to an alternative site.

Adding these three warm site options (3Cv1, 3Cv2 and 4C) increased the number of options back to 12.

No definitive conclusions were drawn on warm site options until the detailed evaluation.

5.5.4 Excluding options on the basis of activity levels

If a local hospital was established in Stafford this would be within 10 miles of the local hospital in Cannock. As previously mentioned, operating inpatient beds means that there needs to be consultant, anaesthetist and resuscitation cover overnight.

The CPT and CAG has concluded that with the current levels of demand for low risk inpatient elective care it would not make clinical or financial sense for both sites to operate inpatient beds. Therefore options 5A, 6A, 5B and 6B were excluded. This reduced the number of options being evaluated from 12 to 8.

<p>CPT Conclusion Four:</p> <p>Consolidate inpatient elective activity on one site</p>	<ul style="list-style-type: none"> ▶ Clinically appropriate inpatient elective work could be run from either Stafford or Cannock ▶ However, this work should be consolidated onto one site to benefit from economies of scale to support appropriate overnight cover.
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5.5.5 Finalising the shortlist of service configuration models

In summary, the initial shortlist therefore comprises eight options, as illustrated in Figure 4. Appendix A provides a high level overview of the services included for each of these options.

Figure 4: The shortlist of service configuration models

			Options for services in Stafford							
			1. Major Acute hospital	Acute hospital ('warm site')			Local hospital			8) No services / site closure
				2) + IP elective centre	3) + IP elective care	4) No IP elective	5) + IP elective centre	6) + IP elective care	7) No IP Elective	
Options for services in Cannock	Local hospital	A) + IP elective centre							7A	
		B) + IP elective care							7B	
		C) No IP elective			3C v1 3C v2	4C	5C	6C	7C	
	D) No services / site closure									

6. Clinically evaluating the shortlist of options

The eight shortlisted options were evaluated against four criteria starting with clinical sustainability and quality. Only options that passed this evaluation were then further assessed in terms of patient access and financial sustainability. Table 12 sets out the high level criteria used:

Table 12: The evaluation criteria used to evaluate the short list of options

Evaluation test	Criteria
1: Clinical sustainability, quality of care and patient safety	<ul style="list-style-type: none"> • What would be needed for this to be a viable model of care? • Does the option improve clinical sustainability, by moving closer to national standards for provision of acute and emergency services for the population of Stafford and Cannock? • Does the option improve clinical effectiveness of elective treatment services for the population of Stafford and Cannock?
2: Access for the population of Stafford and Cannock	<ul style="list-style-type: none"> • How many potential patient trips will be affected by the changes? • What is the impact on patient travel times?
3: Financial sustainability	<ul style="list-style-type: none"> • Is the option financially sustainable? • What is the financial impact of the option on other providers?

The remainder of this section sets out the clinical evaluation before presenting the CPT's recommended clinical model. Section 7.2 outlines the likely impact on patients and the financial evaluation is presented in Section 8.

6.1 Clinical evaluation

The CPT's primary objective has been to develop a set of options that are clinically sustainable, ensuring the local population can access clinically safe and high quality services, with as many of services delivered locally as possible. The CPT and CAG assessed each of the eight shortlisted options on the basis of clinical sustainability, quality of care and patient safety.

The primary conclusions of this assessment were:

- ▶ A 'warm site' in Stafford would be clinically undesirable.
- ▶ Therefore, the local hospital model provides the best opportunity for the local commissioners to fulfil their commissioning intentions and meet national standards for emergency care.
- ▶ Maintaining current elective work at MSFT is clinically sustainable, but current caseload should be reviewed for clinical appropriateness in a local hospital

model and inpatient work should be consolidated on one of the two sites to capture economies of scale.

- ▶ There does not appear to be a compelling clinical case for the establishment of an elective centre in Stafford or Cannock. However this option should be explored further in the next stage of work (see Section 10.1).

6.1.1 The evaluation of a warm site

The CAG deemed that the “warm site” option in Stafford, (i.e. keeping a reduced selection of current non-elective (emergency) services) was clinically undesirable on the grounds set out in Table 13.

Table 13: The rationale for ruling out the warm site options

<p>CPT Conclusion Five:</p> <p>Emergency Surgery is not viable</p>	<ul style="list-style-type: none"> ▶ A 24/7 emergency surgery service should have 8-9 general surgeons on the general surgery take, with one consultant (ideally capable of conducting laparoscopic surgery) available on site within 30 minutes, any day or time and available immediately by telephone ▶ MSFT has five general surgical posts, of which only two are covered by substantive consultants. Only one of the staff is laparoscopically trained
<p>CPT Conclusion Six:</p> <p>Critical care therefore becomes unviable</p>	<ul style="list-style-type: none"> ▶ 39% of critical care beds are used for non-elective surgery today (55% for non-elective medicine, 6% for elective surgery) ▶ If non-elective surgery is no longer delivered, only 4-6 beds would be required ▶ Staffing and maintaining clinical skills at a very small unit is extremely difficult and unviable in the long term
<p>CPT Conclusion Seven:</p> <p>Without critical care, an unselected medical take and a consultant-led obstetrics service becomes unsustainable</p>	<ul style="list-style-type: none"> ▶ An unselected medical take without critical care, or emergency surgery on site introduces clinical risk and therefore is not desirable ▶ Consultant-led obstetrics service cannot be supported in a unit without critical care
<p>CPT Conclusion Eight:</p> <p>A selected medical take is high risk and reduces viability of a consultant-led A&E service</p>	<ul style="list-style-type: none"> ▶ A selected acute medical take adds complexity in the process for assessment of emergency patients,, which is high risk and undesirable ▶ The lack of an on-site critical care service would be unsafe even for a selected acute medical take, in the event that patients deteriorate rapidly ▶ A selective consultant-led A&E will see significantly reduced activity, compounding existing problems with consultant cover ▶ A service that only manages a small medical take will struggle to attract staff, due to the lack of opportunities to train and maintain experience for serious emergency cases

The CAG and CPT therefore excluded options 3Cv1, 3Cv2 and 4C from further evaluation, reducing the shortlist of options to five.

Local commissioners have determined that they wish to protect a clinically appropriate 24/7 Emergency and urgent care service in Stafford. One consequence of the conclusions around critical care is that Stafford would not be a clinically appropriate setting to treat patients with major urgent care needs. This means that some patients currently treated at Stafford A&E would need to be taken to an alternative provider. The CPT's initial assessment is that approximately 50% of the patients currently attending A&E in Stafford would still be appropriate to attend any proposed new service that is not supported by critical care.

In January 2013, the NHS Commissioning Board commenced a review (being led by Sir Bruce Keogh, the Medical Director of the NHS) into the model of urgent and emergency services in England. The CPT believes this a very timely review, which should significantly inform the final proposals for the service that should be established in Stafford.

6.1.2 Is midwife-led unit feasible in Stafford?

Standalone midwife-led units (MLUs) can provide a viable alternative to an obstetric unit for lower risk women/babies. The CAG considered the option of a standalone MLU. The conclusion of the CAG was that it would likely not be viable as a standalone unit in Stafford, which is already amongst the smallest obstetric units in England. The CAG were concerned about the viability of a very small midwifery-led unit and noted that it would need to be staffed with very senior and experienced community midwives, which could be challenging to recruit. The CAG therefore thought it unlikely that there would be sufficient demand at Stafford to ensure a clinically and financially viable unit.

The CPT has gathered information to validate the view of the CAG and has concluded that a stand alone midwifery-led unit is unlikely to be viable (see conclusion below).

<p>CPT Conclusion Nine:</p> <p>A stand alone midwifery-led unit is unlikely to be viable</p>	<ul style="list-style-type: none"> ▶ Estimates from national studies¹⁶ suggest that between 50-60% of pregnancies are classed as low risk. ▶ However, experience from MLUs across the country shows that only 10-12% of women actually choose to give birth in a midwife-led unit (co-located or standalone)¹⁷ where previously there was an obstetric unit. This is likely because epidural anaesthesia is not available and due to the possibility of an estimated 22% of women needing to be transferred during labour due to a complication. ▶ The current number of births in Stafford is around 1,900 and therefore in a standalone MLU births there could be as few as 200 births per year. ▶ Given that any standalone midwife-led unit requires at least two midwives to be present at all times, a complement of around 16 WTE midwives would be needed. ▶ This would mean each midwife could expect to deliver as few as 13 babies a year - a number which is too low to maintain skills and capabilities - and is also a very expensive service model.
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6.1.3 Is an elective centre clinically desirable and is it feasible?

The CAG reviewed the options for elective care including an elective centre, whereby some of the elective surgical activity that is currently delivered at other trusts in the region could be drawn into a dedicated unit at Stafford or Cannock. This assessment is split into three parts: elective day cases, elective inpatient work currently undertaken at MSFT, and elective inpatient work currently undertaken at other sites.

The CAG identified the following considerations:

- ▶ The CAG and CCGs both concluded that clinically appropriate day cases currently undertaken at Stafford and Cannock should remain there. The exact percentage requires further clinical audit, but is estimated to be a large proportion of current MSFT day case work (~95%).
- ▶ The CAG and CCGs also concluded that clinically appropriate elective inpatient work currently undertaken at Stafford and Cannock was viable as part of a local hospital model for each site. However, this work should be consolidated onto

¹⁶ Hollowell J et al. The Birthplace national prospective cohort study: perinatal and maternal outcomes by planned place of birth. Birthplace in England research programme. Final report part. NIHR Service Delivery and Organisation programme; 2011

¹⁷ Hospital Episode Statistics maternity data 2011/12 report that 12% of all births occurred in both types of midwifery units, (alongside midwifery units and free standing midwifery units)

one site to benefit from economies of scale to support appropriate overnight cover.

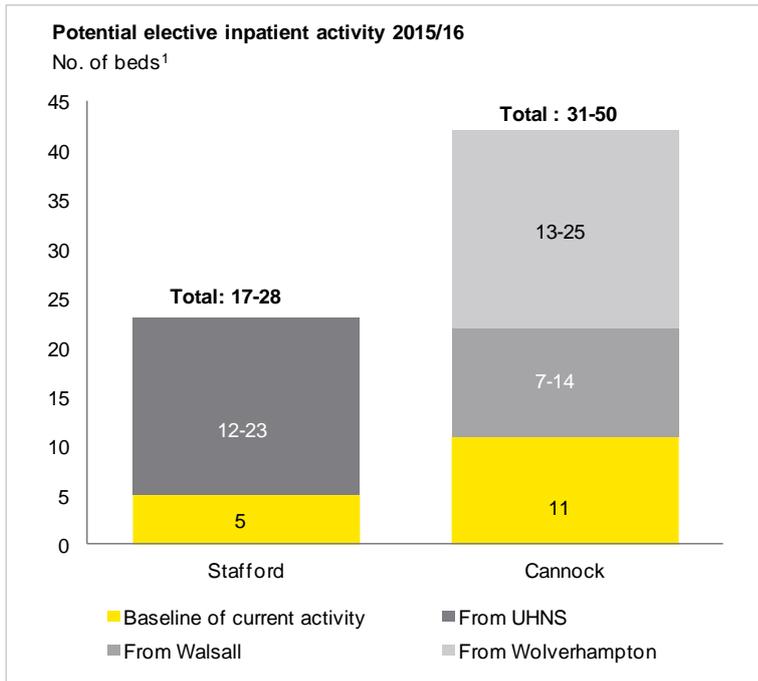
- ▶ A centre dedicated to elective care across a broader area of the LHE could bring benefits, in terms of reduced hospital acquired infection rates and reduced cancellations. However:
 - Practically, an elective centre works best if located very close to critical care and other acute facilities. A “remote” elective centre model would require either a very low risk patient population, or at least level 2 critical care on site. The CPT has modelled the former based on CAG advice.
 - Transfers are smoothest if the acute site and elective centre are part of the same organisation, or have a joint ownership structure (e.g. a Joint Venture of participating trusts)
 - Working across multiple sites increases complexity, therefore it is desirable to have limited number of specialities that have a critical mass on site
 - Overnight surgical cover is needed for an elective inpatient service, which requires sufficient scale in the relevant services at the site
 - Orthopaedics would most likely be the single largest specialty at an elective centre, accounting for ~ 50% of activity. Orthopaedic surgery should preferably be performed in a theatre that uses a laminar flow ventilator, which reduce the chance of post-operative infection. The majority of laminar flow theatres within MSFT are located in Cannock Hospital.

In addition to these clinical considerations, there is a significant question of whether there is sufficient demand from patients, GPs or other providers to support an elective centre in either Stafford or Cannock. MSFT has lost elective market share in recent years. Whilst this could potentially be turned around using a new approach to service provision, it does not suggest a significant amount of currently unmet patient/GP demand.

If an elective centre was situated in Stafford or Cannock then it could provide a service for patients currently treated at other hospitals. This might be one approach to resolving bed capacity shortages across the local health economy, but clinical considerations rather than capacity management should drive this decision.

On the basis that the core specialities suitable for an elective centre include orthopaedics, urology, gynaecology and general surgery, Figure 5 illustrates the CPT’s assessment of potential activity in 2015/16 if an elective centre was located in either Stafford or Cannock (expressed in terms of the number of beds required). This assessment includes only those inpatient procedures that are deemed suitable to be conducted in a centre without critical care level 2 or higher.

Figure 5: The forecasted levels of potential elective inpatient activity in 2015/16



The CPT has therefore concluded that there is not a compelling case for an elective centre in Stafford or Cannock, but this should be finalised during detailed design.

<p>CPT Conclusion Ten:</p> <p>There is no rationale to include an elective centre in either of the proposed local hospitals</p>	<ul style="list-style-type: none"> ▶ There is not a compelling clinical or demand based rationale at this stage to make an elective centre part of the core options. ▶ Therefore, the CPT did not evaluate in further detail the elective centre options 7A and 6C. ▶ However, further work should be undertaken on this once the core service model has been finalised.
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6.1.4 The conclusion of the clinical evaluation

The three core options remaining are all variations of a local hospital in both Stafford and Cannock and are shown in Figure 6.

Figure 6: The remaining three options that have been evaluated further.

		Options for services in Stafford							
		1. Major Acute hospital	Acute hospital ('warm site')			Local hospital			8) No services / site closure
			2) + IP elective centre	3) + IP elective care	4) No IP elective	5) + IP elective centre	6) + IP elective care	7) No IP Elective	
Options for services in Cannock	Local hospital	A) + IP elective centre							
		B) + IP elective care	●					7B	
		C) No IP elective					6C	7C	
	D) No services / site closure								

7. The CPT's recommended clinical model

Having developed and evaluated a series of options for the clinical configuration of services in Stafford and Cannock. This section summarises:

- ▶ the recommended clinical model;
- ▶ the CPT's assessment on the implications of this model for patients.

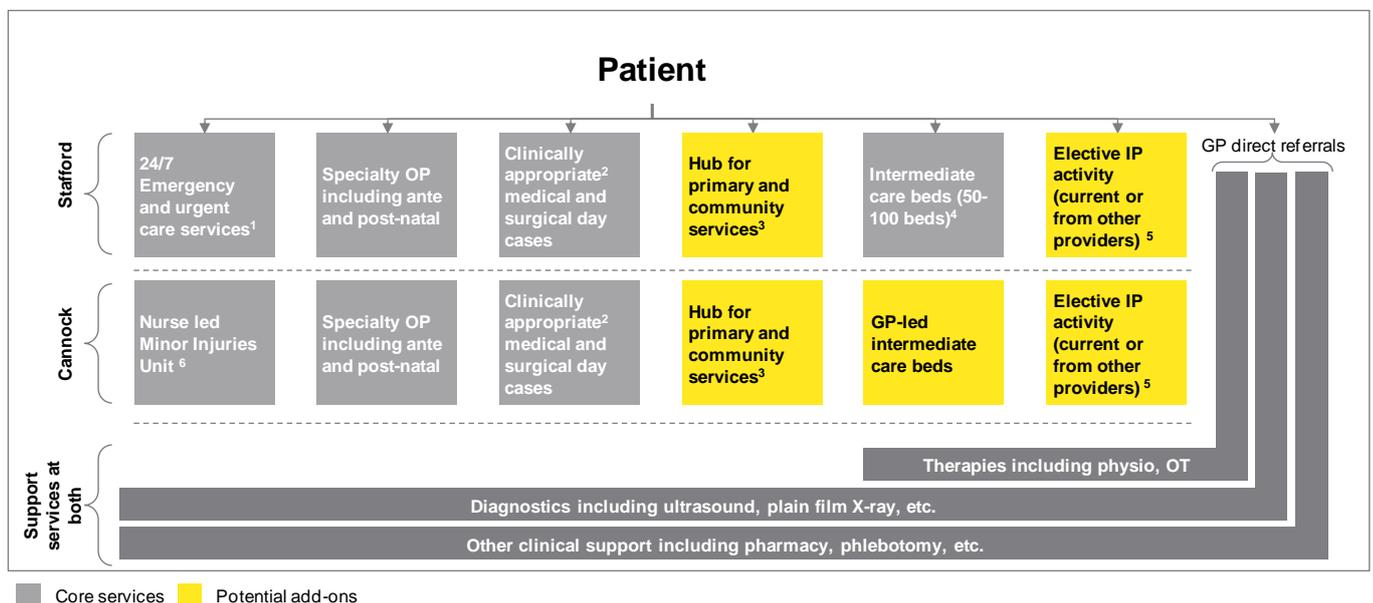
7.1 The recommended clinical service model for Stafford and Cannock

The CPT is recommending the establishment of a local hospital in Stafford and a local hospital in Cannock. There are still a number of elements of the hospitals in each locality to be refined if these recommendations are taken forward.

The clinical service model has seven types of service in each locality. In Stafford, five of these are considered to be core elements with two further types of service to be considered during the detailed design of the reconfiguration. In Cannock, four of these service types are core with three to be considered further.

The elements are outlined in Figure 7, with the core elements shown in grey.

Figure 7: The elements of the proposed local hospitals in Stafford and Cannock



Notes

1. Incorporates GP out of hours services. Staffed by a multidisciplinary team, likely to include advanced nurse practitioners with prescribing rights, GPs and emergency medicine specialists, with access to specialist input, 999 and non-emergency transport. MSFT A&E has ~800 attendances a week today. If 50% of activity is retained, this will be ~400 attendances a week, or 50-60 attendances a day;

2. Current MSFT work that can be safely performed without critical care support; day cases requiring theatres/ dedicated suites to be kept as is, if financially feasible, else consolidated on a single site;
3. Potentially includes a wide range of health and social services, including ambulatory care for long term conditions;
4. These beds are to be led by elderly care physicians or GPs. CPT initial estimates are that there will be the need for 50-100 beds in Stafford. These beds are likely to be provided in conjunction with UHNS and will alleviate some of the capacity pressures at UHNS;
5. The financial evaluation has indicated that elective care beds in one locality will deliver a larger surplus than having no elective care at either locality. However, the case for whether elective activity is retained in Stafford and Cannock needs further exploration;
6. The MIU in Cannock is currently operated by SSoTP. The CPT has not recommended changing the current MIU, but has not assessed whether SSoTP is the best placed to continue to provide this service.

As stated above, there are a number of elements that need more detailed design following Monitor's decision on how the CPT's recommendations are taken forward. Section 10.1 outlines the further work that is required.

7.2 What are the implications of this recommendation for patients?

The CPT believes that local hospitals in both Stafford and Cannock will secure the sustainable delivery of high quality health services for the local population.

Effective clinical networks with local acute hospitals supported by enhanced ambulance services will ensure that patients can access higher quality, more highly specialised services whilst still maintaining the vast majority of hospital attendances at their local hospital.

The CPT also believes that this presents an opportunity to deliver a much more integrated approach across acute, primary, community and social care. This will be especially critical in treating an ageing population and patients with long term conditions who are typically treated in all four types of care provision.

The CPT conducted a series of assessments to understand the impact on patients, especially access to care. These analyses were aimed to address the following questions:

- 1) Why are the proposed changes better for patients?
- 2) How many potential patient trips will be affected by the changes?
- 3) For services that would be relocated, what is the impact on patient travel times, assuming they travel to the nearest alternative provider of the service?
- 4) What does this mean in practice for patients?

This section outlines the outcomes of these assessments.

7.2.1 Why are the proposed changes better for patients?

The CPT has worked closely with the local clinicians and the CAG to develop solutions that improve care for the local population and deliver better outcomes not only today but also in the future. In doing so the CAG reviewed standards for high quality services as defined by the Royal Colleges.

While recognising that best practice guidelines may not be achievable in all cases, the CAG agreed that these guidelines should define the aspiration for healthcare services for the local population, and any proposed models should move services closer to these aspirations.

Clinical evidence demonstrates that early and consistent input by consultants for non-elective and emergency care enables rapid and appropriate decisions. This ensures that patients receive correct diagnoses and are quickly on the right pathway of care, leading to better patient outcomes including reduced mortality rates and improved physical functioning and quality of life¹⁸.

Larger more specialist centres are able to attract and retain a greater level of consultant cover and associated teams. Greater centralisation of specialist services in such centres allows the consultant cover to extend to seven days a week and up to 24 hours a day which meets the Royal College guidelines¹⁹. Studies and reports have shown that centres with a higher level of consultant presence achieve better outcomes for patients who are looked after by more experienced staff. At these larger more specialist centres consultants and their teams see a wider range of patients that provides them with the experience to maintain their skills and enables them to invest in the latest technology and treatments. In a broad range of services - from vascular surgery to cancer care to acute cardiac care as well as critical care and emergency surgery - larger centres with more consultants are able to deliver better quality care resulting in fewer adverse events (deaths or complications) and better functional abilities for patients.

At MSFT today, the relatively small number of patients²⁰ being treated does not provide consultants with the range and frequency of experience they need to maintain their skills and the number of consultants available means that it is often not possible to have seven day a week or up to 24 hours a day specialist consultant presence in many specialities. A good example of this is in emergency surgery where a high quality service would have at least 8 - 9 consultant general surgeons on the general surgery take so that one of them can be available 24 hours a day seven days a week - and where the majority are trained in the latest surgical techniques such as laparoscopic surgery. This is not feasible at MSFT where the

¹⁸ National Confidential Enquiry into patient Outcome and death, 2007. Emergency admissions: A step in the right direction, NCEPOD; London Health programmes, 2011. Adult emergency services: case for change, London Health programmes

¹⁹ Seven Day Consultant Present Care December 2012. Academy of Medical Royal Colleges

²⁰ Mid Staffordshire NHS Foundation Trust sustainability report, Monitor Contingency Planning Team, January 2013

numbers of patients being treated is too small to enable such numbers of surgeons to be trained and maintain their skills.

The consolidation of services in Staffordshire has already taken place for some services. Currently patients with stroke, heart attack or vascular surgery go to UHNS because the Trust is better placed to provide consultant delivered service on a 24/7 basis and has the necessary expertise and equipment that enable them to save patient lives. The CPT's recommendations are an extension of this, to ensure the population of Stafford and Cannock can continue to get an excellent service at units which are closer to achieving the best practice guidelines.

While some of the proposed changes call for centralisation where it is necessary to deliver better care for the local population, the CPT recognises that where possible (i.e. where clinically and financially sustainable) services should be delivered locally. Over 80% of the current patient attendances to either Stafford or Cannock hospitals will remain within the same locality (Section 7.2.2 for further detail). In addition, given the needs of the local population, the CPT recognises the need to have access to intermediate care beds locally and to improve the provision of out of hospital care as well as care integration. This will provide more appropriate care to a growing elderly population, avoiding admission to an acute hospital bed where it is not necessary.

7.2.2 How many potential patient trips will be affected by the changes?

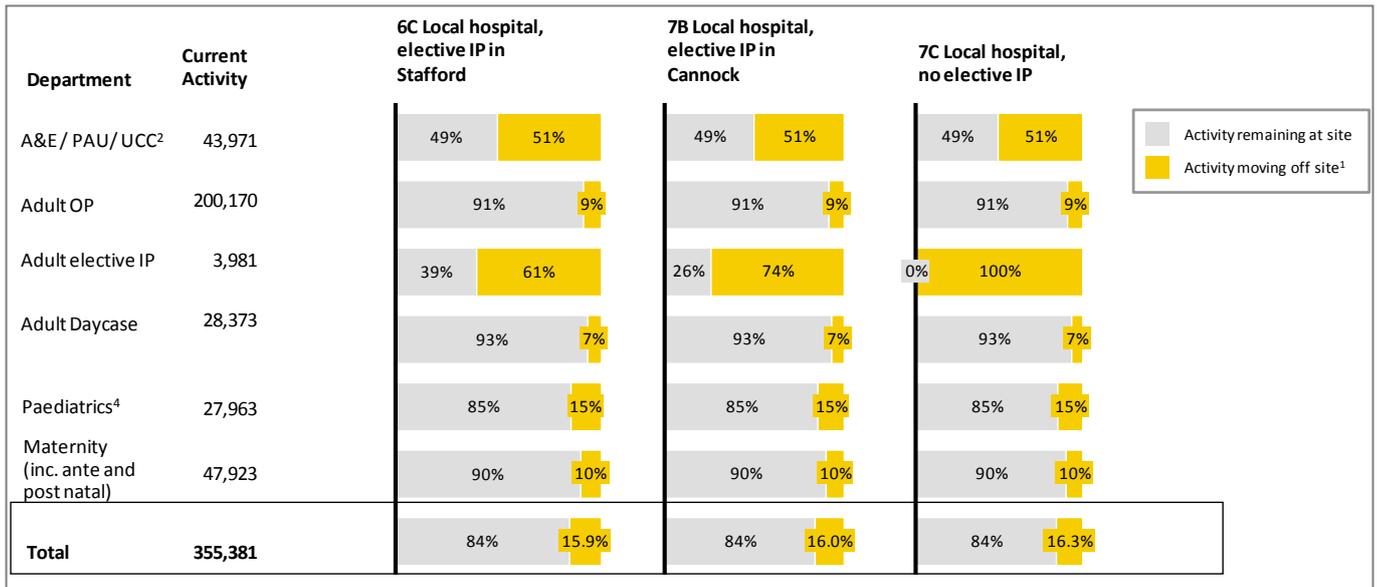
In all of the remaining options, some acute services currently delivered by MSFT will need to move to an alternative provider.

Bearing in mind commissioner intentions to provide as much care as possible close to home, outpatient clinics will remain in Stafford and Cannock, minimising patient journeys elsewhere. Currently, over 55% of all patient trips to Stafford and Cannock Hospitals are for outpatient appointments.

These can be delivered safely through a local hospital model. Therefore, it is highly desirable to keep these in the current locality, as reflected in the draft list of protected services from the CCGs. Similar considerations apply to urgent care, pre and ante natal maternity services, and the majority of paediatric visits and elective day cases.

Figure 8 presents movements of services by type of patient trip, concluding that the total number of trips moving as a result of the proposed changes is about 16%.

Figure 8: The forecasted impact on patient access to services



Notes

- 1) Activity moving from one MSFT site to the other is counted as a move to an alternative site
- 2) These figures do not include the impact of intermediate care beds, which would increase the amount of activity retained for 'Adult elective inpatients' in all scenarios. These numbers have not been assessed as the intermediate care beds are a service not currently provided.
- 3) Non-elective inpatients are included in the A&E numbers as this is the point of access
- 4) Paediatrics includes elective, day cases and out patients. Non-elective is included within the A&E figure

<p>CPT Conclusion Eleven:</p> <p>The majority of patient attendances (>83%) will stay within the same locality in all of the options considered.</p>	<ul style="list-style-type: none"> ▶ For maternity services ~ 90% of patient visits will stay at MSFT under a local hospital model, as all non-complex ante- and post-natal outpatients would still be delivered in the current locality. ▶ For paediatrics ~ 85% of patient visits (outpatients, day cases) will stay in the same locality under the local hospital model. ▶ For A&E, it is estimated that at least 50% of attendances (those that are currently discharged with no/ GP follow up) could stay locally, but this will depend on the nature of the Emergency and Urgent Care service that is delivered in Stafford.
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Section 7.2.4 presents some examples of the impact on patients of these recommendations

In addition, two further areas are not reflected in the numbers above:

- ▶ “Step up” intermediate care beds could accommodate some of the current attendances. This requires further clinical audit of caseload in the next phase of work. But as a broad indication, this might involve 10-15 beds with an average stay of 2 days accounting for potentially 20% of current A&E admissions, particularly for the frail elderly.
- ▶ “Step down” intermediate care beds at Stafford would accommodate the post-acute rehabilitation part of the hospital stay of acute medical admissions moving to another trust. This would comprise 50-100 beds (ideally at the lower end of this range) accounting some of the current acute medical bed days at Stafford.

7.2.3 What is the impact on patient travel times?

The CPT’s analysis of the three local hospital models concluded that approximately 16% of current patient visits will no longer be delivered in the same locality if a local hospital is established in both Stafford and Cannock.

The analysis also showed that approximately half of the attendances that are relocated are emergency cases and the other half are planned elective attendances.

The CPT assessed the impact on patient travel times for those attendances that are likely to be relocated. The assessment of travel times is based upon the average time to travel during peak traffic periods from each postal code area within the catchment areas of Stafford and Surrounds CCG and Cannock Chase CCG to the nearest alternate provider.

In making these assessments, the following assumptions were made:

- ▶ Patients attending a hospital in an emergency case are likely to travel either by ambulance or in a private car.
- ▶ Patients attending a hospital for a planned elective attendance are likely to travel in either private car or by using public transport.

In either situation, patients travel to the nearest alternative provider. This is likely to be true in emergency cases, although for elective care, patients may choose to travel to providers that are further away.

The results of this analysis are shown in Table 13.

Table 13: The estimated impact on average travel times

Type of attendance	Proportion of current attendance affected	Mode of travel	Stafford and Surrounds CCG population		Cannock Chase CCG population	
			Travel time today (mins)	Travel time with local hospital model (mins)	Travel time today (mins)	Travel time with local hospital model (mins)
No change in access	84%	No change				
Emergency / non-elective with change in access	8%	Ambulance/ Blue light	8	15	13	14
		Private car	13	23	20	21
Elective planned care with change in access	8%	Private car	13	23	9	21
		Public transport	40	66	29	62

<p>CPT Conclusion Twelve:</p> <p>Travel for non-elective (emergency) care will increase, but it is within acceptable standards</p>	<p>For travel for non-elective (emergency) care at peak times, on the assumption that these journeys are conducted by ambulance or private car:</p> <ul style="list-style-type: none"> ▶ For Stafford and Surrounds CCG, the average blue light travel time increases from 8 minutes to 15 minutes, and private car travel time increases from 13 minutes to 23 minutes; ▶ For Cannock Chase CCG, the average blue light travel time increases from 13 minutes to 14 minutes, and private car travel time increases from 20 minutes to 21 minutes. ▶ The CPT analysis also indicates that the maximum blue light ambulance travel time would be less than 25 minutes. ▶ Therefore, overall travel times for Cannock residents would not change significantly while for Stafford they would increase, but remain relatively low compared to many if not most parts of the NHS. <p>For example, the London Health Programme determined that 30 minutes should be the maximum ambulance travel time to the nearest hospital for patients who have suffered a major trauma or are showing symptoms of having suffered a stroke²¹.</p>
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²¹ <http://www.londonhp.nhs.uk/wp-content/uploads/2011/03/Travel-Times-Ambulance-Coverage-Analysis.pdf>

<p>CPT Conclusion Thirteen:</p> <p>Travel for elective care, especially by public transport, is higher than commissioner aspirations, has led to the protection of some local regularly accessed services, and may require revised commissioning of patient transport services</p>	<p>For travel for elective care at peak times, on the assumption that these journeys are conducted by private car or public transport:</p> <ul style="list-style-type: none"> ▶ For Stafford and Surrounds CCG, the average private car travel time increases from 13minutes to 23 minutes, and public transport travel time increases from 40 minutes to 66 minutes ▶ For Cannock Chase CCG, the average private car travel time increases from 9 minutes to 21 minutes, and public transport travel time increases from 29 minutes to 62 minutes ▶ 17% of the Stafford population (9,742 households) and 20% of Cannock population (8,213 households) do not have access to private cars. While the number of patients potentially affected is a small part of MSFT's total patient population, the analysis has shown there is a significant rise in travel times for this group. ▶ The local commissioners recognise the impact that this could have on health inequalities and expect that any move to a local hospital model will need to be supported by an appropriate change to patient transport services to address the needs of this segment.
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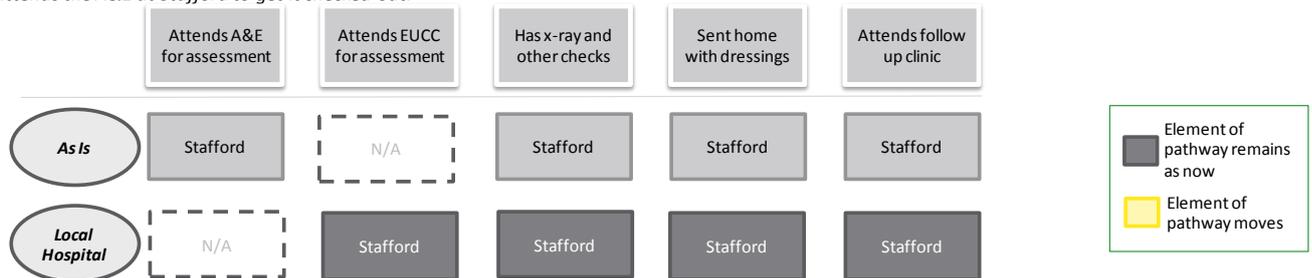
7.2.4 What does this mean in practice for patients?

The proposed options will improve the quality of care by ensuring increased compliance with national standards for emergency care while delivering the majority of services locally. The CPT has not assessed the impact on every care pathway, but for illustrative purposes, the following diagrams indicate how the recommended changes will impact three common patient pathways.

Illustrative case study 1: A paediatric case with a minor injury. The 24/7 emergency and urgent care centre, in the local hospital model, would replace the 14/7 A&E which may previously have been used:

Figure 9: A minor paediatric case study

Pathway for urgent paediatric: An 8 year old girl hurts her finger playing football. She has some discomfort and suspects it may be dislocated. She attends the A&E at Stafford to get it checked out.



Illustrative case study 2: A non complex maternity case. Patients will receive their ante and post natal care (check-ups and scans etc.) in Stafford or Cannock but will have their birth at another hospital of their choice:

Figure 10: A non complex maternity case study

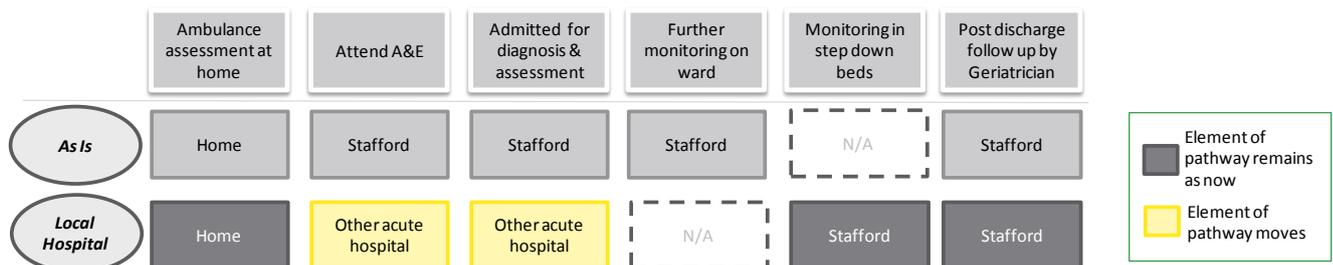
Pathway for maternity care: A 27 year old woman who is receiving regular ante natal care at Stafford and plans to have her baby at Stafford Hospital. She has had some minor complications during her pregnancy and is under the care of the Consultant Obstetrician.



Illustrative case study 3: An elderly patient who needs a hospital admission. The patient will initially go to another hospital in the area but will be transferred back to Stafford for rehabilitation and monitoring:

Figure 11: A care of the elderly case study

Pathway for care of the elderly: A 82 year old women has been off her feet for a few days. She has had a fall and was found by a neighbour who called an ambulance. On arrival at A&E she was confused and unstable. She was admitted for 14 days under the care of the geriatricians.



8. The financial evaluation of the CPT's recommended clinical model

The financial evaluation has assessed the potential implications for the three options, in terms of the income and expenditure associated with delivering the options. The CPT used the same data and information provided by MSFT for the sustainability report. The following steps were taken:

1. Establish a financial and activity baseline for 2015/16 based upon MSFT delivering the same range of services as today, making assumptions about efficiency benefits that could feasibly be delivered;
2. Assess the impact on the baseline income and expenditure directly associated with the changes in the clinical service model for each of the three options;
3. For each of the three options, assess the impact on the baseline costs following a reduction in indirect costs and an estimation of the potential savings through collaboration and/or outsourcing;
4. For each of the three options, assess the further impact on costs following an estimation of the potential savings that could be achieved through a change to the organisational form.

The financial evaluation does not include the cost of implementing the solution or any capital requirements associated with the proposed reconfiguration.

8.1.1 Setting the 2015/16 baseline

To forecast the 2015/16 financial and activity baseline (see Table 14) the CPT used the same information and activity dataset that was used to assess MSFT's sustainability in Phase One of the CPT.

The CPT used forecasts based on the financial and activity datasets provided by MSFT which were then projected forward to determine a full year financial position for 2012/13. The 2015/16 financial baseline was calculated using income, cost and activity growth assumptions agreed by the Operating and Financial Group.

Efficiency benefits were capped at 4% and were applied equally to all areas of spend at a cost centre and account code level. This enabled the CPT to estimate costs associated with each service and point of delivery.

Current income associated with rental of premises and high cost drugs was removed from the baseline so that the CPT could evaluate the sustainability of the core service model.

The same dataset was used to forecast the activity and income values. The financial and activity evaluation has been based on known activity but sensitivities must be considered during the detailed design.

Table 14 shows the movement from 2012/13 baseline to the 2015/16 baseline for core services.

Table 14: The forecasted financial baseline for 2015/16

	Base Case £m
Income 12/13	158
Tariff deflator	-2
Non-tariff deflator	-1
Non-recurrent	-3
Non Core income	-2
Pass through	-16
Income 15/16	135
Expenditure 12/13	173
CIP Efficiencies	-23
QIPP	-5
Pay and Non-pay Inflation	13
Activity moves	3
Depreciation	8
PDC	1
Non-recurrent	-1
Pass through	-16
Non-core cost	-1
Expenditure 15/16	152
Surplus/(Deficit)	-17

8.1.2 Assessing the impact of changes to the clinical service model

The CPT assessed the financial impact of changes to the clinical service model. For the purposes of this assessment the CPT looked at the income associated with clinical activities, and the costs directly associated with delivering those services e.g. doctors, wards, theatre sessions, diagnostics.

It is important to note that despite the areas of good performance demonstrated in the sustainability report e.g. high utilisation of beds driven in part by a low mean length of stay (3.7 days) compared to its peers, the Trust maintains a high reference cost index. This means that there are some inherent inefficiencies throughout the organisation leading to a high cost base for the amount and type of activity. The method used to evaluate the options includes the cost impact of some of these inefficiencies e.g. theatre and out-patient productivity. However, it is anticipated that once the final clinical model is fully determined and the new pathways of clinical care are understood, greater efficiencies in both productivity and cost could be realised. At this point a detailed, bottom-up costing and

workforce plan would need to be undertaken with additional efficiencies explicitly identified.

The movement of the income associated with the changes in activity followed the principle laid out in the 2012/13 Payment by Results rules that payment will follow the activity.

Costs were assumed to fall into one of three categories and were treated as follows:

- ▶ **Variable** - an increase or decrease in income/cost occurs for every increase or decrease in activity, e.g. the trust is paid for each person that is treated. This value can go up or down depending on how many patients are treated;
- ▶ **Stepped** - the cost incurred increases or decreases in increments, e.g. the cost of a 28 bedded ward will be the same up to the point when 29 beds are needed at which point another ward is needed; and
- ▶ **Fixed** - these costs are not linked directly to movements in activity and remain the same until a decision is made that directly increases or decreases the cost.

The CPT assessed every cost centre and account code and allocated direct costs to each service and, by using a standard apportionment methodology consistent with that of the NHS reference cost submissions, split out the direct costs to the appropriate point of delivery, i.e. outpatients or inpatients.

The CPT assessed the impact of changes in activity levels to understand where there were step cost implications. Step costs are typically applied where surgical activity is linked to the number of theatre sessions and where the number of bed days required dictates the number of wards needed to meet demand.

All assumptions were applied consistently to all options and Table 15 outlines this assessment.

Table 15: The assessment of the impact of changes to the clinical service model

£ 000	Base case	Option 6c	Option 7b	Option 7c
Income	122,942	69,758	70,425	63,901
Other Income	11,798	6,270	6,255	5,058
Total Income	134,740	76,029	76,679	68,959
Clinical Services Expenditure	84,635	39,968	41,476	37,680
Support Services Expenditure	15,365	11,268	11,264	11,281
Total Exp	100,000	51,237	52,740	48,961
Margin (£)	34,740	24,792	23,939	19,998
<i>Margin (%)</i>	26%	33%	31%	29%

<p>CPT Conclusion Fourteen:</p> <p>The local hospital models will deliver a better financial margin than the forecasted margin for the base case scenario</p>	<ul style="list-style-type: none"> ▶ Each option was found to improve the financial position of MSFT by up to 7% from the base case forecast, achieving a margin of up to 33% before overheads and capital charges. ▶ In particular, the figures indicated that the financial impact of the service changes was improved when elective inpatient care was maintained in addition to medical and surgical day case activity (options 6c and 7b).
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8.1.3 Assessing the potential for savings on overheads, cost of capital and benefits due to collaboration, outsourcing and changes to the organisational form

The CPT reviewed the remaining overhead costs not directly associated with service delivery to determine which costs could be reduced. This included:

- ▶ Examining the overheads in the same way as the direct costs to determine those costs that could be reduced as a consequence of reducing activity, e.g. linen or patient meals; and
- ▶ Determining which costs could be reduced further through financial efficiencies associated with outsourcing or collaboration; and
- ▶ Whether or not the cost would be reduced further should there be a change in organisational form.

It should be noted that if the collaborating parties are not part of the same organisation then potentially only a share of these savings could be claimed.

Even taking the cost efficiencies into account, the retained overheads are significantly higher than would be expected if the organisation was designed from scratch. This is due to the legacy of having a cost base linked to the estate, infrastructure, operating structure and cost of capital associated with an acute

general hospital that has been running at a deficit for over four years. The CPT's sustainability report demonstrated that the cost base was comparatively higher than national averages as a percentage of turnover in areas such as HR&T, Quality and Risk, IM&T and Estates. Further work would be required to go through these legacy costs in detail to understand which would need to be retained and which could be reduced to reflect the revised clinical model.

With these legacy costs retained, the CPT view is that delivering the services in Stafford and Cannock through a standalone organisation would not be possible as the current cost base could not be reduced to a level sufficient to break even. The CPT therefore also looked at the potential benefits of changes to organisational form.

At this stage the CPT assumed that part of the overhead cost base would no longer be required if the services were run by another organisation as there would be duplication of effort that could be removed and organisational synergies that could be realised. The analysis focused on removing functions such as the Trust Board and the removal/reduction of some management roles and administrative functions, e.g. Finance, Human Resources and Procurement.

Again, the impact of collaboration with other providers and restructuring would need to be determined once the clinical model is finalised through a detailed, bottom-up costing of the infrastructure and estate footprint to confirm the removal of the legacy inefficiencies and reduce the high cost base.

This assessment is outlined in Table 16.

Table 16: The assessment of the potential for savings associated with changes to the organisational form

£ 000	Base case	Option 6c	Option 7b	Option 7c
Income	122,942	69,758	70,425	63,901
Other Income	11,798	6,270	6,255	5,058
Total Income	134,740	76,029	76,679	68,959
Clinical Services Expenditure	84,635	39,968	41,476	37,680
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Total Exp	100,000	51,237	52,740	48,961
Margin (£)	34,740	24,792	23,939	19,998
<i>Margin (%)</i>	<i>26%</i>	<i>33%</i>	<i>31%</i>	<i>29%</i>
Overheads	41,072	25,203	25,368	21,722
Cost of Capital	10,775	7,162	7,138	7,046
Potential benefits through collaboration and changes to organisational form	(5,958)	(9,089)	(9,129)	(8,949)
Total Surplus/(deficit)	(11,148)	1,516	563	179

CPT Conclusion Fifteen:	
The local hospital models have been assessed to be financially sustainable	The CPT estimated potential savings that would improve the financial position to such an extent that, for each of the options, there is the possibility that a small surplus could be delivered.

8.1.4 Key assumptions

It is important to note that in any forecasting there is an element of inherent risk and uncertainty and that a number of assumptions must be made. The key assumptions used within this evaluation are:

- ▶ Assumptions around demand management (reducing the number of patients needing hospital care through prevention and primary/community care interventions) are achieved and that both demographic and non-demographic growth will materialise;
- ▶ All projections and forecasts are based on the actual activity levels for months 1-6 of 2012/13;
- ▶ The baseline cost assumes that the target 4% cost efficiencies are achieved in FY14,15, and 16 and that these savings are delivered equally across all areas of spend;
- ▶ Commissioners will only pay for activity at the tariff rate;
- ▶ The costs and income do not include some of the elements of the model of care which are significantly different to the current services. This includes the intermediate care beds, the Urgent Care Centre, MIU, or the associated cost impact of future capital investment. Further refinement of these costs and models is required following the detailed design of the solution.

The inherent risks and uncertainty associated with forecasting have been mitigated as best as possible through detailed analysis of the individual cost centres and through the validation of data and assumptions with the OFG, and the information and finance team at MSFT during Phase One of the CPT programme.

The methodology for modelling the activity and finance data used a top-down approach for most of the costing scenarios with the exception of where stepped costs were assumed to occur. This method was used in order present a realistic picture of the challenge faced and the scale of the changes required to deliver financial sustainability. However, the CPT was concerned that the detailed analysis could be misleading and would inherently include some current cost inefficiencies that were not identified. To validate the conclusions reached, the CPT produced a bottom-up model which estimated the cost of delivering and then managing the proposed options as an entirely new entity operating out of a purpose-built facility. When compared, the results of the bottom-up and top-down assessments were found to be not materially different and therefore the CPT is confident that the conclusions reached through the financial evaluation are credible.

9. How should the preferred solution be implemented?

The CPT has considered the restructuring alternatives capable of delivering our recommendation, ensuring the continuity of high quality patient care during the transition and into the future. Of the three options available, our recommendation to Monitor is to appoint a Trust Special Administrator. This section explains each option and our reasons for choosing the recommended option.

9.1 Options for restructuring

There are three options for how the restructuring could be taken forward: Trust-led, commissioner-led, and TSA-led. It should be noted that regardless of who is given the mandate, there will be a requirement to develop a detailed implementation and consultation plan. Each of these three options is described below with the following section outlining the CPT's recommendation.

9.1.1 Trust-led restructuring

In a Trust-led restructuring, the current Trust board is the accountable body and decision maker on any changes carried out. The CPT's preferred option has a substantial impact on the local health economy.

Therefore to govern decisions on changes needed outside of Trust, a local area decision-making body would need to be established. In addition to this local area decision-making body, additional support would be required from regional and national bodies, e.g. the NHS Trust Development Authority, NHS Commissioning Board (NCB) or its Local Area Teams (LATs)²² to arbitrate where there is no consensus on change.

In this capacity, the Board would appoint the programme delivery team, which would probably require external support/resources to deliver the transition. As the CPT's preferred solution requires the reconfiguration of local services, the Board would also require local commissioners to run the 90 day public consultation.

9.1.2 Commissioner-led restructuring

In a commissioner-led restructuring, local commissioners would be the accountable body and ultimate decision makers. CCGs have been set up across England primarily to commission healthcare to the extent they consider necessary to meet the reasonable requirements of: (i) patients registered with the GP practices who are members of the CCG; and (ii) people who usually live within the CCG's defined

²² The main aim of the NHS CB is to improve the health outcomes for people in England by empowering and supporting clinical leaders at every level of the NHS through clinical commissioning groups (CCGs), networks and senates, in the NHS CB itself and in providers, and helping them to make genuinely informed decisions, spend taxpayers' money wisely and provide high quality services (adapted from <http://www.commissioningboard.nhs.uk/about/#info>). LATs aim to achieve a sustainable solution that establishes the definitive local presence of the NHS CB (adapted from *NHS Commissioning Board: Local area teams*, Department of Health, June 2012, p. 3).

geographic area who are not registered with any GP practice (except where regulations prescribe otherwise)²³.

In this option, the current Trust board would be retained and would have responsibility to deliver changes under the direction of the commissioners. As noted above, the CPT's recommended option has a substantial impact on the local health economy. Therefore to ensure that change is delivered across providers in multiple CCGs, the LAT would need to arbitrate.

Local commissioners would appoint a programme delivery team; again this would probably need external support/resources. In this option, the commissioners themselves would run the 90 day public consultation.

9.1.3 TSA-led restructuring

In a TSA-led restructuring, the TSA assumes the role of chief executive and accounting officer holder for the Trust. This means that the Trust's Board is suspended, and the TSA would be the ultimate decision maker, with Monitor and the Secretary of State for Health retaining accountability for the final decision.

Monitor would manage the process of identifying and appointing the TSA and the TSA would draw upon Monitor-appointed external support/resources to deliver the programme - which could be jointly procured alongside the TSA.

The TSA would operate to a strict timetable and after 45 working days would present its plan for restructuring to the Secretary of State for Health. The TSA would then run a 30 day public consultation before taking a further 15 working days to refine the recommendations to Monitor and the Secretary of State.

²³ The Functions of Clinical Commissioning Groups, Department of Health, June 2012, p. 8.

9.2 Recommendation on restructuring approach

Although a Trust-led restructuring is one potential option for Monitor, the likelihood that the recommended solution could involve the de-authorisation and dissolution of MSFT the CPT has concluded that a Trust-led restructuring is not feasible.

9.2.1 Assessment of a preferred option

The CPT has proposed a series of criteria to assess whether a commissioner-led or TSA-led option is the most applicable. Table 17 outlines the assessment against these criteria.

Table 17: The advantages and disadvantages of commissioner vs. TSA led restructuring

Criteria	Commissioner-led restructuring		TSA led-restructuring	
	Advantages	Disadvantages	Advantages	Disadvantages
Capability to deliver change in the Trust	<ul style="list-style-type: none"> As budget holders, CCGs will have the ability to influence the Trust 	<ul style="list-style-type: none"> CCGs are newly established and have not done this before, raising significant questions on ability to lead change in the LHE Likely to need agreement by committee (if multiple CCGs are the lead commissioners) 	<ul style="list-style-type: none"> TSA will be appointed solely to deliver the change required for patients, and could do so without compromise 	<ul style="list-style-type: none"> TSA may not have the remit for delivering the solution, which would separate decision-making from implementation
Capability to deliver change across LHE	<ul style="list-style-type: none"> CCGs have an in-built incentive to demonstrate value for money achieved with the overall budget CCGs can construct contracts which provide "levers for change" 	<ul style="list-style-type: none"> Will need support from other CCGs to influence the LHE, which may lead to compromise on a solution May need considerable oversight if consensus is not achieved on key decisions 	<ul style="list-style-type: none"> TSA will have the ability to quickly elicit support from NTDA / NCB in order to deliver the change 	<ul style="list-style-type: none"> TSA will not have the remit to deliver change across the LHE
Likely to deliver radical change	<ul style="list-style-type: none"> Provides opportunity to deliver commissioning intentions (the shift from acute to community care) 	<ul style="list-style-type: none"> CCGs may seek to avoid radical change in their early days as they establish themselves 	<ul style="list-style-type: none"> TSA will take decisions in support of the best outcome for patients, regardless of how radical the changes are 	<ul style="list-style-type: none"> TSA will not have remit to deliver change across LHE
Ability to source centrally held funds for transition	<ul style="list-style-type: none"> None 	<ul style="list-style-type: none"> CCGs have competing demands for funding 	<ul style="list-style-type: none"> TSA able to make an objective assessment of funding needed 	<ul style="list-style-type: none"> None
Maintains performance in the Trust	<ul style="list-style-type: none"> Changes will not take up as much capacity in Trust management, allowing them to focus on Trust performance 	<ul style="list-style-type: none"> May lead to disputes between commissioners and Trust about the root cause of poor performance (with the Trust blaming the commissioners change programme) 	<ul style="list-style-type: none"> TSA will have remit to ensure performance is maintained, but will be able to create a separation between TSA and the day to day delivery of care 	<ul style="list-style-type: none"> Appointment of TSA may see staff leave which could undermine service delivery (although this risk is equally associated with CPT)

Other relevant factors have been identified:

- ▶ The local CCGs are newly authorised and going through a period of significant change as the PCT is dissolved. It is highly unlikely that the CCGs will have the capacity at this stage to deliver the scale of change that is likely to be required;
- ▶ Multiple stakeholders across the LHE have indicated their preference for the appointment of a TSA;
- ▶ The changes required will require the support and cooperation from providers outside the direct influence of the two primary CCGs in Stafford, Cannock and the surrounding areas.

CPT Conclusion Sixteen:

The appointment of a TSA represents the strongest chance of delivering a successful restructuring

Whilst a TSA appointment represents the strongest chance of delivering a successful restructuring it should be noted that there are multiple challenges the TSA will need to overcome if it is to succeed:

- ▶ The TSA does not have the remit to enforce change across the other providers within the local health economy. Any solution will require the TSA to work with other providers and central bodies (such as Monitor, NTDA, NCB) to arrive at a consensus decision for the best way forward;
- ▶ The providers in the local health economy are neither individually nor collectively in positions of strength. Should the appropriate incentives be in place, there is no guarantee that the providers will be able to effectively implement the recommended changes;

10. Delivering the recommended solution

Delivering transformational change across health economies whilst maintaining standards of care is always challenging and it is anticipated that delivering the CPT's recommended solution would be no different.

As has been previously described, the recommended solution will involve significant change at Stafford and Cannock Hospitals as well as an increase in flow of patients to other providers within the health economy. It will also involve the development and implementation of new models of care (e.g. in the form of intermediate care) which will require significant input from clinicians across the health economy to ensure that patients can be cared for in the most appropriate way in the most appropriate setting. This will require much closer working between the various components of the health economy, which could be challenging given some of the current issues across the local health economy.

10.1 Elements of the recommended solution requiring further development

Given the scale of the changes proposed for the delivery of services for the population of Stafford and Cannock, there are inevitably some key areas where additional engagement with stakeholders is required to further develop elements of the recommended option. In particular, there are three areas that need further development, of which the first two are discussed in more detail below:

- (i) the detailed specification of the clinical services to be delivered at Stafford and Cannock;
- (ii) the organisational form and non-clinical support that will be required to ensure that these services are delivered in a clinically effective manner;
- (iii) the timetable for implementation.

10.1.1 Detailed specification of clinical services

The CPT has undertaken a significant amount of work to define the recommended clinical solution, however, further work is required to fully develop certain elements that will be continue to be delivered at Stafford and Cannock. In particular, the following areas need further consideration:

- 1) Core emergency and urgent care services at Stafford;
- 2) Intermediate care beds;
- 3) Alignment with the finalised list of protected services;
- 4) Clinically appropriate day cases;
- 5) The presence of an elective centre;
- 6) Clinical support services.

The first two elements are especially critical as they have not been included in the CPT's financial evaluation. This is because they are both new services, without precedent in the local health economy and will require the commissioners to establish an appropriate tariff for the delivery of these services. These elements and their associated tariffs will need to be designed in such a way as to ensure they do not compromise the financial sustainability of the local hospitals.

Each of these is discussed below.

1) Core emergency and urgent care services at Stafford

The working assumption for the CPT's recommended solution for the provision of urgent care services at Stafford is that c 50% of current A&E attendances (60-80 attendances per day) are clinically appropriate to be retained at Stafford. In addition, audits of patient throughput have found that c 40-50% of A&E activity could be handled by primary care. Further work is required to understand exactly what type of patients could be seen by primary care, which require an urgent care service and what is the most appropriate setting for the different patient groups to be seen.

It is proposed that the retained emergency and urgent care services at Stafford will form part of a suite of services which will enable access to treatment, advice and support from the most appropriate clinicians, including access to specialist opinion where required. Further work is required to understand how this core service fits in with other emergency and urgent care services to deliver a coherent "24/7" service. Other services that could form part of the broader suite of services include: A&E departments at other providers, GP urgent care, GP out of hours, and existing intermediate care teams.

Based on current A&E attendance activity levels, between one and four clinicians would need to be available from multidisciplinary teams at any given time and at least one of these clinicians should have prescribing rights. However further work is required to understand what staffing skills mix is required, at what location(s), and with what supporting infrastructure.

2) Intermediate care beds

The CPT is proposing that intermediate care beds should be available at Stafford and/or Cannock as described earlier in this document. However, the precise groups of patients who will use these beds and the type of services to be offered are as yet to be agreed. It is likely that the 'step down beds' would be used by patients from the locality who have had acute treatment at other providers and could rehabilitate / recover at Stafford. Further work is required with local clinicians and commissioners to understand how many of these 'step down beds' would be required.

The step up beds will be used for low risk admissions, or for patients who can be conclusively diagnosed, or for those needing to be kept in for observation. Again,

further work is needed to understand the number of beds required for this patient group.

Part of the process of deciding which patient groups could be admitted to an intermediate care facility will be an assessment of the types of staff (in particular clinical staff), facilities and services that are available on site. There will also be a very strong dependency on linkages with primary, community and social care services that could support a seamless transfer of patients from acute care to intermediate care and then home.

3) Alignment with the finalised list of protected services

If a TSA is appointed, the CCGs will be required to finalise their list of protected services. If the finalised list differs from the current draft list, further work will be required to assess the impact on the clinical model and revisions may be necessary.

4) Clinically appropriate day cases

For day cases, a specialty-by-specialty review will be needed to ensure that there is a sufficient volume of activity to deliver financially viable rotas, theatres and other associated infrastructure across both local hospitals and to ensure that they are clinically appropriate given the other services that will be retained on site. It is noted that the commissioner preference would be to retain day cases on both sites, but it may not be feasible to do so.

5) Elective centre

Section 6 set out the arguments for an elective centre in either Stafford or Cannock. The CPT has not made a recommendation on whether or not an elective centre should be part of its preferred solution and there is more work to be done with the other providers in the local health economy to determine whether this is a feasible option.

6) Clinical support services

Further work is required to understand what clinical support services are required. It is likely that access to specialist consultation by phone, 999 and non-emergency transport; basic on-site radiology; a "24/7" pharmacy; and sufficient blood tests to support the services offered will all be required.

10.1.2 Specification of the organisational form and non-clinical support

Once the final clinical service model has been determined, the organisational form and associated non-clinical support services will need to be finalised. The CPT's recommendations have been developed to be neutral of organisational form, although the financial evaluation has indicated that reductions in management overheads will need to be achieved in order to ensure financial sustainability.

In addition to organisational form, there should be consideration for non-clinical support that will include:

- ▶ the level of administrative support necessary to support operations;
- ▶ the “back office” capacity needed to support operations (e.g. functions such as estates, HR and IT).

The financial evaluation of the proposed options has demonstrated that consideration should also be given to collaboration or outsourcing of clinical and non-clinical support services.

10.1.3 Alignment of estate and infrastructure

Once the final clinical model is determined, it will be necessary to consider whether the current estate and infrastructure is clinically and financially appropriate. Redeveloping the current estate is likely to cost less in the short term than building new facilities in Stafford and/or Cannock, but consideration should be given as to whether this allows for a facility that is fit for purpose and presents value for money in the mid to long term.

10.2 Transition costs

The transition to the new models of care described in this report will require investment to ensure that patient care continues to be safely delivered during the period of the transition. Investment is also required to upgrade facilities so that they are fit for purpose; this means investment not only at both Stafford and Cannock, but potentially at other providers in the local health economy.

The three final options that were evaluated are derivations of a local hospital model, so it has been assumed that the cost of transition does not significantly differ between the three options - which is why the transition costs were not used as a differentiating factor on the options evaluation.

The transition costs have been split into four broad categories, as follows.

1) Staff costs

The changes proposed in this document will have a substantial impact on the staff currently working at MSFT. The staff transition costs relate to the need to ensure that staff are treated fairly, and in compliance with HR policies.

It is likely that an outcome of this reconfiguration will be that some staff and staff groups could be either relocated to work elsewhere in the local health economy or put into a redundancy situation. This could affect all staff groups, but at this stage it is not possible to determine who could be affected and how many could be affected.

2) Double-running costs

To ensure that the quality of patient care is maintained during the transition requires a period when services continue to be provided, but ramped down, at MSFT whilst being introduced/ramped up at another provider". This requires double running costs to cover the provision of staff, facilities and equipment across the two sites.

3) Implementation costs

The cost of implementing organisational change during the transition includes allowances for the complexities of a TSA (if one is appointed), an implementation team to oversee the transition programme, and infrastructure redesign (e.g. IT, electronic patient records) to merge/migrate systems where necessary. The implementation costs have been calculated based on assessment of previous NHS mergers and reconfigurations and adjusted for the size and complexity of the current proposal.

4) Capital costs

It is likely that the local hospitals proposed for Stafford and Cannock will not need to occupy the full footprint of the current hospitals in each town. It will be necessary to consider whether the best option for the long term is to redevelop the existing hospitals or to commission a new - fit for purpose - facility. In either case there will be a requirement for capital funding.

Once the service model is finalised in detail, it may be necessary for there to be some capital investment in other providers in the local health economy to accommodate the changes in activity.

10.2.1 Total transition costs

The CPT has made an initial assessment of indicative total transition costs and has estimated them to be in the range of £60-70m²⁴. These costs will need to be fully developed as part of the detailed design.

10.3 Managing the transition to the new clinical model

Transitioning to any new models of care needs to be clearly planned and communicated, and requires significant clinical and managerial leadership and time.

The transition also needs an approach that is integrated across the local health economy and which manages interdependencies between the various local implementation plans of the providers involved - including alignment with those providers' own change programmes.

²⁴ This estimate excludes the cost of funding the MSFT deficit during the transition period.

Some of the considerations that will be required include:

- ▶ The establishment of organisational development plans will be required to integrate services into their new host organisation(s), including but not limited to:
 - Operational changes such as job and rota planning; changes to clinical teams' ways of working; establishing new and revised outpatient clinic templates and theatre sessions;
 - HR frameworks to provide a transparent approach, in line with relevant policies, for transitioning staff;
 - IT frameworks to ensure that systems support the revised clinical requirements.
- ▶ The changes to the service models will need to be agreed and contracted with the local CCGs, which could potentially include revisions to payment tariffs where new or revised services are being introduced;
- ▶ A strong Programme Management Office (PMO) will be needed throughout the complex transition process to report progress to local and national stakeholders. The PMO will need to be supported by a clear governance structure and escalation processes.

10.4 Management of the risks and challenges

The implementation of the CPT's recommendations will not be straightforward and the CPT has identified several risks and challenges, not least the fact that MSFT is operating in a local health economy that itself is facing several challenges.

The new clinical models of care (including care provided in non-acute settings) need to be clearly defined and mapped with the close involvement of key local, regional and national stakeholders. This definition and mapping must be done with a clear understanding of where potential adverse impacts are likely and how to mitigate these, as well as identifying key metrics and governance to allow safe transition to new models of care.

Particularly critical is the involvement of GPs and CCGs in creating the care models for the UCCs and clarity on paediatric care and ensuring continuity of care during the transition, especially for vulnerable groups.

Ensuring that the displacement of activity does not destabilise the LHE will be essential. This is a time when there are issues across the entire LHE.

Table 18 outlines the main risks and challenges associated with the CPT's recommendations, with some additional moderate level risks outlined in Appendix B.

Table 18: The main risks and challenges associated with the CPT's recommendations

Challenge/Risk	Impact	Key mitigations	Risk rating
The impact on the stability of the LHE	<ul style="list-style-type: none"> ▶ Any poorly planned or unplanned movements of activity to other providers in the LHE could further destabilise the operational and financial position of one or more providers. 	<ul style="list-style-type: none"> ▶ Establish a local oversight group that monitors any changes to activity flows into each provider in the LHE to assess if the programme of changes centred on MSFT is impacting the operational and financial stability of the LHE. ▶ This should be supported by escalation protocols to commissioners, Monitor and potentially the NCB and NTDA 	High
Primary and community care responding to the new models of care	<ul style="list-style-type: none"> ▶ Length of stay goes up from delayed discharges ▶ Bed capacity reduces ▶ The cost to the system is increased as patients are treated in more in acute settings ▶ The model for care of the elderly will not be delivered 	<ul style="list-style-type: none"> ▶ Develop and agreed model of care for the LHE ▶ Develop a new focus on admissions for specific interventions and not because it is the only option ▶ Provision of step down beds and community geriatricians ▶ Close working between secondary and community providers and CCGs 	High
Capacity at other providers and leadership to deliver the change	<ul style="list-style-type: none"> ▶ The development of suitable capacity at other providers is critical to deliver the programme to ensure the performance at these providers will not be adversely affected ▶ Patient experience will worsen from deteriorating performance 	<ul style="list-style-type: none"> ▶ A detailed plan will be developed with other providers which identifies the capacity needed and the actions needed to develop the capacity. Capital expenditure will be needed in some areas ▶ A focus on creating capacity through efficiencies will be needed to ensure the projections on LOS are delivered 	High
Intermediate beds are inappropriately used	<ul style="list-style-type: none"> ▶ Beds are inappropriately used ▶ Length of stay is increased ▶ Risk to patients sitting in step down beds as an outlier 	<ul style="list-style-type: none"> ▶ Develop access criteria for the beds ▶ Clear management protocols 	High
Staff will find alternative employment during the transition	<ul style="list-style-type: none"> ▶ Services will not have critical mass of staff to run safe service ▶ Patient care may suffer ▶ Transition costs will increase from the use of additional temporary staff 	<ul style="list-style-type: none"> ▶ Rapidly understand the skills mix required and the ability of the current workforce to deliver them ▶ Rapidly implementing HR frameworks to provide a transparent approach 	High
Patients 'switch' to other providers before the transition is completed	<ul style="list-style-type: none"> ▶ Other providers do not have the capacity to cope with unplanned increase in activity ▶ Other providers receive higher than expected activity which may trigger the marginal rate ▶ Increase transition costs 	<ul style="list-style-type: none"> ▶ Current board and TSA must continue to message it is business as usual in Stafford and Cannock ▶ Ensure patients are kept abreast of the changes ▶ Rebase A&E activity with providers if needed 	High
Patients inappropriately attend a local hospital	<ul style="list-style-type: none"> ▶ Patient will require blue light transfer to appropriate department leading to potential delay in emergency treatment ▶ Increase pressure and cost to the ambulance service ▶ Potential risk to patient outcomes 	<ul style="list-style-type: none"> ▶ Develop transfer protocols with ambulance trust ▶ Ensure clinical protocols are developed ▶ A clear engagement plan will be developed for patients so they understand when to use the EUCC and when to go to a neighbouring A&E 	High

11. Conclusion and next steps

The people of Stafford, Cannock and the surrounding areas, rightly expect their local health services to be the very best; with the best standards of care, delivered with compassion by appropriately qualified staff.

The CPT's primary objective has been to develop a set of options that are clinically sustainable, ensuring the local population can access clinically safe and high quality services. Critically, the CPT has looked at long term solutions rather than a short term fix to the clinical sustainability issues have been identified.

The CPT believes that the clinical and financial sustainability of the services currently delivered by MSFT is dependent on a reconfiguration of services in the local health economy. The CPT is therefore recommending that some services currently provided by MSFT should move to other providers and that local hospitals should be established in Stafford and Cannock.

11.1 What happens now

The CPT presented their recommendations to Monitor on 27th February 2013. Monitor has agreed to consult with stakeholders on the appointment of a TSA to deliver the recommendations of the CPT.

If a TSA is appointed, it will be passed the CPT's report for consideration. The TSA should consider the CPT's recommendations, but will have the licence to explore alternative options for change.

Any decision that is taken in future to propose any changes to the current pattern of services would be subject to a statutory public consultation.

In the meantime it is therefore essential that the leaders and staff of the Trust and the local commissioners focus on 'business as usual' activities at MSFT.

Appendix A: Outline of the services included in the shortlisted options.

	Option	Stafford services	Cannock services
Acute Hospital / 'Warm site' in Stafford options	<p><u>Option 3C v1</u></p> <p>Stafford: Warm site (As now but with no emergency surgery)</p> <p>Cannock: Local hospital</p>	<p><u>Acute/Emergency services</u> Consultant led MAU and A&E with unselected medical take + ward support; ITU level 2+; PAU + ward support; Obstetrics and NICU level 2+;</p> <p>(No emergency surgery; No PICU)</p> <p><u>Elective services</u> Outpatients, Elective inpatients, day cases, diagnostics</p>	<p><u>Acute/Emergency services</u></p> <p>Primary care led Minor Injuries Unit</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases</p>
	<p><u>Option 3C v2</u></p> <p>Stafford: Warm site (As now but with no emergency surgery, ITU, obstetrics, paediatrics)</p> <p>Cannock: Local hospital</p>	<p><u>Acute/Emergency services</u> MAU and clinically appropriate EUCC with selected medical take + ward support; outpatients, PAU;</p> <p>(No emergency surgery; No critical care; No PAU ward support; No Obstetrics)</p> <p><u>Elective services</u> Outpatients, Elective inpatients, day cases, diagnostics.</p>	<p><u>Acute/Emergency services</u></p> <p>Primary care led Minor Injuries Unit</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases</p>
	<p><u>Option 4C</u></p> <p>Stafford: Warm site (As now but with no emergency surgery, ITU, obstetrics, paediatrics, elective inpatients)</p> <p>Cannock: Local hospital</p>	<p><u>Acute/Emergency services</u> MAU and clinically appropriate EUCC with selected medical take + ward support; outpatients, PAU; elective day cases</p> <p>(No emergency surgery; No critical care; No PAU ward support; No Obstetrics, No inpatient elective)</p> <p><u>Elective services</u> Outpatients, Elective inpatients, day cases, diagnostics.</p>	<p><u>Acute/Emergency services</u></p> <p>Primary care led Minor Injuries Unit</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases</p>
Local Hospital options	<p><u>Option 5C</u></p> <p>Stafford: Local hospital plus elective centre</p> <p>Cannock: Local hospital with no elective inpatients</p>	<p><u>Acute/Emergency services</u> Clinically appropriate EUCC; intermediate care beds</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases and inpatients (including referrals from outside of catchment area)</p>	<p><u>Acute/Emergency services</u></p> <p>Primary care led Minor Injuries Unit</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases</p>
	<p><u>Option 6C</u></p> <p>Stafford: Local hospital retaining current MSFT elective inpatients</p> <p>Cannock: Local hospital with no elective inpatients</p>	<p><u>Acute/Emergency services</u> Clinically appropriate EUCC; intermediate care beds</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases and inpatients (referrals from catchment area)</p>	<p><u>Acute/Emergency services</u></p> <p>Primary care led Minor Injuries Unit</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases</p>

	Option	Stafford services	Cannock services
Local Hospital options	<p><u>Option 7A</u></p> <p>Stafford: Local hospital with no elective inpatients</p> <p>Cannock: Local hospital plus elective centre</p>	<p><u>Acute/Emergency services</u> Clinically appropriate EUCC; intermediate care beds</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases</p>	<p><u>Acute/Emergency services</u> Primary care led Minor Injuries Unit</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases and inpatients</p>
	<p><u>Option 7B</u></p> <p>Stafford: Local hospital with no elective inpatients</p> <p>Cannock: Local hospital plus current MSFT elective inpatients</p>	<p><u>Acute/Emergency services</u> Clinically appropriate EUCC; intermediate care beds</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases</p>	<p><u>Acute/Emergency services</u> Primary care led Minor Injuries Unit</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases and inpatients (referrals from catchment area)</p>
	<p><u>Option 7C</u></p> <p>Stafford: Local hospital with no elective inpatients</p> <p>Cannock: Local hospital with no elective inpatients</p>	<p><u>Acute/Emergency services</u> Clinically appropriate EUCC; intermediate care beds</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases</p>	<p><u>Acute/Emergency services</u> Primary care led Minor Injuries Unit</p> <p><u>Elective services</u> Outpatients; diagnostics; Elective day cases and inpatients (including referrals from outside of catchment area)</p>

Appendix B: Additional risks associated with the CPT's recommendations.

Challenge/Risk	Impact	Key mitigations	Risk rating
Insufficient patient transport services (PTS)	<ul style="list-style-type: none"> ▶ Patients will choose not to access services if insufficient transport arrangements are in place ▶ Delayed transfers for patients ▶ Restricted access for families 	<ul style="list-style-type: none"> ▶ The biggest demand for PTS is for outpatients. These will be remaining therefore the current provision remains ▶ Cost of the additional PTS will be scoped ▶ Alternatives will be actively sought and developed through the other sectors 	Medium
Under utilisation of the UCC from patient choice	<ul style="list-style-type: none"> ▶ Spare capacity will exist in the UCC ▶ The UCC may not be financially sustainable ▶ Increase activity at other providers 	<ul style="list-style-type: none"> ▶ A clear engagement plan will be developed for patients so they understand when to use the UCC and when to go to a neighbouring A&E 	Medium
Length of stay reductions are not realised both from providers and commissioners	<ul style="list-style-type: none"> ▶ Additional capacity is not delivered ▶ Current performance will deteriorate at providers ▶ Additional capital expenditure required to create capacity 	<ul style="list-style-type: none"> ▶ Assumptions have been tested with providers and commissioners 	Medium
Actual patient flows to other providers are different to the assumed numbers	<ul style="list-style-type: none"> ▶ Attendances at other providers is more than expected ▶ Adverse impact on performance in areas ▶ Additional costs of seeing this activity 	<ul style="list-style-type: none"> ▶ Assumptions have been tested with providers and commissioners ▶ Assumptions based on current flows 	Medium
Establishing an appropriate payment mechanism for the step down beds	<ul style="list-style-type: none"> ▶ There could be an increased cost to commissioners ▶ Providers may not be adequately funded 	<ul style="list-style-type: none"> ▶ An early options appraisal on the potential payment mechanisms will be undertaken ▶ The options appraisal will look at ways to potentially split the tariff or propose locally agreed tariffs for the spells as they stand 	Medium

APPENDIX C: Glossary of terms

A&E / EUCC	Accident and Emergency / Emergency and Urgent Care Centre, the latter to be fully defined as part of the Sir Bruce Keogh review into urgent care services.
Acute care / acute hospital	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 - in an acute hospital .
Attendances (patient)	Each discrete patient visit to a hospital. Could be 1 hour in duration for an outpatient appointment, or several days/weeks for an inpatient stay.
BHFT	Burton Hospital NHS Foundation Trust
CAG	Clinical Advisory Group - formed by CPT and defined in detail in Section 5.1.
Catchment area vs catchment population	Catchment area is the defined area covered by an organisation - in this instance MSFT. Population of a catchment area is the number of people living in the catchment area. Catchment population is the number of people who choose to use that organisation.
CCG	Clinical Commissioning Group - a group of local clinicians responsible for commissioning and monitoring effectiveness of health services. From April 2013, CCGs will be responsible for commissioning healthcare services in the NHS.
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.
Clinical pathways	A pre-determined course of care for patients with a specific condition or disease process. The care pathway can often cross organisational boundaries (i.e. some of the pathway delivered by an acute hospital and the rest delivered by community care.
Clinical service model	An overarching design for the provision of health care services that is shaped by a theoretical basis, evidence based practice and defined standards which broadly define the way health services are delivered.
'Clinically appropriate' care	Care that is provided in an appropriate clinical location by appropriately trained clinical staff that does not compromise the quality of care provided to the recipient of the care. For example, it would be clinically appropriate to treat a major trauma in a location supported by critical care. It would be clinically inappropriate if there was no access to critical care.
Community hospital / community care	Typically, small hospitals that provide a range of clinical and rehab services. Normally do not have resident or 24/7 consultant cover and are mainly staffed by nurses, physiotherapists, OTs and care assistants (may have some GP or community physician led services). Community care is provided by the NHS and social services to assist people in

their day to day living at home. Many community staff are attached to GP practices and to health centres.

CPT	Contingency Planning Team
CQC	The independent regulator of health and social care. From April 2009, the CQC brought together the work of the Commission for Social Care Inspection (CSCI), the Healthcare Commission and the Mental Health Act Commission.
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.
Day case	A patient admitted for planned treatment, generally a surgical procedure, who is expected to return home the same day.
Elective vs non-elective care	Elective care is that which is planned to take place in an agreed location at an agreed time, almost exclusively following a GP referral for that episode of care, Non-elective care is care which is unplanned
FT	Foundation Trust - NHS hospitals that are run as independent, public benefit corporations, which are both controlled and run locally.
Inpatient	A patient who stays in hospital for more than 24 hours; may have been a planned or emergency admission.
Intermediate care	The range of services which are designed to help patients to avoid admission to an acute hospital ('step up'), or to rehabilitate after discharge from an acute hospital ('step down').
KPI	Key performance indicators - Financial and non-financial metrics used to quantify objectives to reflect strategic performance of an organization.
Local hospital	The CPT is proposing local hospitals for Stafford and Cannock (see Section 7 for more detail on the CPT's recommendations).
Locality vs location	Locality is a term meaning a general region whereas location a specific place within a locality. For the context of this report, locality refers to the towns of Stafford and Cannock.
LTC	Long term condition - conditions, such as diabetes, asthma and arthritis that cannot currently be cured, but whose progress can be managed and influenced by medication and other therapies.
Medical vs surgical care	Medical treatment is the diagnosis and management of patients using medicine and minimally invasive interventions (e.g. endoscopy). Surgical treatment is the diagnosis and/or management of patients using invasive surgery.
MIU	Minor Injuries Unit - A self-referral unit for injuries such as cuts, eye injuries, simple fractures, sprains, minor head injuries, minor burns and scalds.
Monitor	The independent regulator of foundation trusts and responsible body for the CPT.
MSFT or the Trust	Mid Staffordshire NHS Foundation Trust

NHS CB	NHS Commissioning Board - The NHS CB's overarching role is to ensure that the NHS delivers better outcomes for patients within its available resources. The NHS CB would play a vital role in providing national leadership for improving outcomes and driving up the quality of care.
NHS TDA	NHS Trust Development Authority - From April 2013, the role of the NHS TDA will be to provide governance and accountability for NHS trusts in England and delivery of the foundation trust pipeline.
OFG	Operating and Finance Group - formed by CPT and defined in detail in Section 5.1.
Outpatient	A patient who attends a hospital for a scheduled appointment but does not require admission.
PCT	Primary Care Trust - NHS body with responsibility for commissioning health care services and delivering health improvements to their local areas. Will cease to exist in April 13 and their function will be largely taken over by CCGs.
PDC	Public Dividend Capital
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.
PSDG	The Protected Services Definition Group - formed by CPT and defined in detail in Section 5.1.
Royal colleges	The professional bodies working to improve the quality of healthcare by ensuring the highest standards of care for the population. Includes colleges for GPs, Obstetricians and Gynaecologists, Paediatrics and Child Health, Physicians, Radiologists, Surgeons and Medicine.
RWT	The Royal Wolverhampton NHS Trust
SaTH	Shrewsbury and Telford Hospitals NHS Trust
SSoTP	Staffordshire and Stoke-on-Trent Partnership NHS Trust
Sustainability	In the context of the CPT's work, sustainability is as follows: <i>'The Trusts can be said to deliver services in a sustainable manner if those services meet the needs of the present and there is assurance that these services can be appropriately maintained to meet the needs of the future'</i> .
Sustainability report	The CPT's interim report, published in January 2013, that concluded that MSFT is neither clinically or financially sustainable.
Tertiary care / tertiary hospital	Highly specialised treatment, that takes place in specialist tertiary hospitals, typically for patients drawn from a wider catchment area than those that attend the hospital for acute

care.

TSA	Trust Special Administration
UHNS	University Hospital North Staffordshire NHS Trust
Warm site	Recent reconfigurations in the NHS have seen the establishment of 'warm site' hospitals that are acute hospitals offering a reduced range of non-elective/emergency services, often typified by the decommissioning of emergency surgery.
WHT	Walsall Healthcare NHS Trust.
WTE	Whole time equivalent - the equivalent one full time post.