Office of the
Trust Special Administrator
of MSFT

Mid Staffordshire NHS
NHS Foundation Trust

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

Trust Special Administrators' Draft Report – Volume One (Main report)

July 2013

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

Trust Special Administrators' Draft Report – Volume One (Main report)

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Table of Contents

Foreword 2

1 Introduction 5

2 Trust background 11

3 MSFT performance 26

4 The case for change 32

5 Commissioning in the local health economy 46

6 Providers in the local health economy 53

7 Meeting the TSAs' obligations 58

8 Independent Health and Equalities Impact Assessment 72

9 Developing the draft recommendations 76

10 The TSAs' draft recommendations 108

11 Next steps 157

Appendices and annexes 158

Appendix A: Glossary of terms 159

Appendix B: References 162

Appendix C: Public Health Staffordshire – assessment of catchment population 164

Appendix D: Letter to TSAs from the Regional Director of NHS England, Midlands and East 166

Appendix E: Letter to TSAs from the National Clinical Advisory Group (CAG) 168

Appendix F: Letter to TSAs from the National Nursing and Midwifery Group (NCAG) 172

Appendix G: Letter to TSAs from the Chair of the Stafford and Surrounds CCG 174

Appendix H: Letter to TSAs from the Chair of the Cannock Chase CCG 176

Appendix I: Detailed service model 177

Appendix J: Letter sent from A&E clinical leads in West Midlands 179

Foreword

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

Every patient is entitled to expect high quality and safe health services from the NHS.

This responsibility to local people has underpinned the work of the TSAs of Mid Staffordshire NHS Foundation Trust (MSFT or the Trust).

There is another important responsibility to all taxpayers who rightly expect every pound spent on health services to be spent efficiently.

We are the TSAs appointed by Monitor, the health care regulator, on 16 April 2013 following its decision to use its powers to intervene at MSFT.

We are:

- Professor Hugo Mascie-Taylor, an experienced clinician and medical leader;
- Alan Bloom and Alan Hudson, senior partners at EY, a major consultancy firm.

Some have questioned why the TSAs are undertaking this process at MSFT now, when recent inspections at Stafford and Cannock Chase hospitals show services are safe.

It is important to recognise that the Care Quality Commission (CQC) has recently indicated that the Trust is safe, however, the CQC does not take into account the long term financial and staffing difficulties the Trust has and will continue to experience.

This broader assessment was undertaken by the Contingency Planning Team in 2012/13 when it was asked by Monitor to look at the Trust's future. It concluded the Trust won't be able to provide safe care within the available budget for the foreseeable future and there are shorter term safety issues in certain areas of activity, such as A&E, and medium and longer term safety issues in others.

Following this assessment we were appointed as TSAs to oversee the Trust's current services but importantly to also plan for health services for the long term future.

The process and the objectives of the TSAs, as set out in this report, are set in statute and guidance produced by Monitor.

We would like to take this opportunity to acknowledge the hard work and dedication that MSFT's staff have continued to demonstrate following our appointment while continuing to give patients good care and attention. We thank all staff for their commitment.

We do not wish to dwell on the Trust's difficult history. Instead we are concentrating our efforts on finding a long term solution for the Trust's present problems. These problems are summarised below:

- MSFT provides services to relatively small numbers of patients; some patients in the area are actively choosing to use other hospitals. On a related and important point, this means staff may not see enough cases to maintain and improve their skills and ultimately keep patients safe.
- It is difficult to attract and retain enough doctors and nurses. The Trust therefore has a high number of temporary staff which is very expensive. It has also had to take on extra staff in recent years to improve care levels.
- This means the cost of running the Trust is far too high for the number of patients the hospitals serve compared to similar hospitals. The Trust does not earn enough money to cover its costs, nor will it in the future.

These problems must be solved. To avoid a continuation of the current situation where the Trust is in the impossible position of trying to provide its current range of services safely within its budget, it is essential the difficult job of planning to provide safe, affordable services into the future is done now. This is the task we have undertaken.

Our guiding principle is to ensure the draft recommendations, as described in this document, ensure the local population can access safe services within the budget available, as near to patients' homes as possible, without adversely affecting health inequalities. We expect these draft recommendations, if approved, would be implemented over the next two to three years.

Our proposals involve very close working with other hospitals and success will also be dependent on much better collaboration with GPs and community services.

We recognise that other hospitals in the area currently face their own challenges and would not be able to take on additional patients from MSFT until they are ready to do so.

These draft recommendations have been developed with the input of many, including local people and leading national experts, whom we wish to thank.

Our draft recommendations also have the support of the Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups (the CCGs), who buy health

services on behalf of patients in the area, and NHS England, who support CCGs as well as commission some services directly.

We would also like to acknowledge the hard work, support and openness of many stakeholders, both local and national. Much of our work has required us to gather information from these organisations, often in very short timescales. This is something which they have not been compelled to do, but have done so without question and in full support of the TSAs' efforts to ensure the local public of Stafford, Cannock and the surrounding areas can continue to access high quality and safe healthcare services.

Most people go to Stafford and Cannock Chase hospitals as outpatients or to have diagnostic tests. Our draft recommendations do not impact these services. In fact these services may even be enhanced. Our proposed solution would allow 91% of patient visits to the hospitals to continue in the future.

The publication of this report, and its supporting information, enables the TSAs to commence a formal 40 working-day consultation on Tuesday 6th August 2013.

The TSAs have produced a series of documents to support this period of consultation and have organised multiple public meetings across the catchment area served by MSFT.

The TSAs will fully consider the views of the people, groups and stakeholders who respond before finalising our recommendations. An updated, and expanded, version of this report that sets out the TSAs' final recommendations will be produced for Monitor and then ultimately the Secretary of State for Health.

Professor Hugo Mascie-Taylor

Alan Bloom

Alan Hudson

1 Introduction

1. On Monday 15 April 2013, the parliamentary order '*The Mid Staffordshire NHS Foundation Trust (Appointment of Trust Special Administrators) Order 2013 (SI 2013/838)*' was made by Monitor under section 65D(2) of the National Health Service Act 2006.

2. This order was accompanied by the document '*Mid Staffordshire NHS Foundation Trust: The Case for Appointing a Trust Special Administrator*' which was presented to Parliament under section 65D(6) of the National Health Service Act 2006. This document confirmed Monitor's decision to appoint Trust Special Administrators (TSAs) for Mid Staffordshire NHS Foundation Trust (MSFT or 'the Trust') with effect from 00:01 on Tuesday 16 April 2013. The Trust Board and the Board of Governors of MSFT were both suspended from this point forwards with the TSAs assuming immediate accountability for MSFT.

3. In addition to taking on accountability for the day to day running of the Trust, the TSAs are required to develop, and recommend to Monitor and the Secretary of State, a plan for ensuring that clinically and financially sustainable services can be delivered over the long term for the local population currently served by MSFT. In doing so, the TSAs must ensure that this plan does not undermine the delivery of healthcare services to any other part of the local health economy.

4. This report is a **draft report** that presents the draft recommendations of the TSAs. The sole purpose of this draft report is to support the undertaking of an open public consultation which will be used to inform the preparation of the final report of the TSAs.

1.1 Consulting the public on the TSAs draft recommendations

5. A public consultation will commence at 00:01 Tuesday 6th August 2013 and will conclude at 00:00 on Tuesday 1st October 2013. The TSAs' consultation plan is included as an annex to this draft report (see Annex 1).

6. The TSAs understand and appreciate the strength of interest of local people who use Stafford and Cannock Chase hospitals. Since the TSAs' appointment, local people have held multiple public events to demonstrate their support for the hospitals, have attended public meetings in their hundreds and sent in over 1,500 separate items of correspondence to the TSAs.

7. The focus of the public consultation will be with regards to where and how patients will access the services currently delivered by MSFT. The TSAs are continuing to develop options with regards to the organisations that will deliver these services, the future of MSFT itself, and other consequences of the draft recommendations. This draft report sets out some of these options in support of the draft recommendations.

8. The TSAs' principles and objectives of the public consultation are:

- To make the consultation as accessible as reasonably possible to key people and groups affected;
- To approach and carry out the consultation with an open mind as the TSAs have made draft recommendations without the benefit of much public feedback until the consultation;
- To ensure that those who may be affected by the TSAs' draft recommendations, including patients, staff and the public, have the opportunity to understand and respond to the draft report during the consultation period, which has been extended to 40 working days;
- To ensure that everyone who wants to participate in the consultation will be provided with enough information that they can feedback in an informed way.
- To be as open, transparent and fair as possible in the conduct of the consultation;
- To conscientiously listen to responses to the draft recommendations, ensure that there is a thorough understanding of the issues raised and feedback given;
- To consider fully all responses before finalising the report submitted to Monitor and the Secretary of State; and
- To give confidence to the public and those stakeholders who have responded to consultation, that their views have been accurately received and recorded.

9. A series of eight public meetings have been organised during the consultation period. These meetings were publicised 12 days before the start of the consultation. These meetings take place in Stafford, Cannock, Rugeley and Stone, with a combined capacity in excess of 5,750.

10. The draft recommendations in this report are different to those made by the CPT. This is primarily due to the differences in the remits for the CPT and TSAs, with the TSAs placing a far greater focus on the influence of - and impact upon - the local health economy on the services delivered in Stafford and Cannock. The TSAs have listened to the reaction of the local population to the recommendations of Monitor's

Contingency Planning Team (CPT)[1] and this has also been a factor in the development of the draft recommendations. The TSAs therefore hope that the local population will consider their draft recommendations on their own merit.

1.2 Structure of the draft report

11. This draft report summarises the process the TSAs have undertaken to date, establishes the case for change and presents the draft recommendations of the TSAs. The work of the TSAs is ongoing and the final report will build upon the information presented within this draft report and the outcomes of the public consultation.

12. This draft report is set out as follows:

Volume One

- Section 2: Trust background – presents an overview of the Trust, including the population that it serves and the services that it provides.
- Section 3: MSFT performance – summarises key performance information about the Trust, including some benchmarks against national average performance and local health economy performance.
- Section 4: The case for change – sets out the rationale for why change is essential with MSFT in order to deliver clinically sustainable services.
- Section 5: Commissioning in the local health economy – outlines the role of local commissioners, both in working with the TSAs and in their broader work in commissioning health services for Mid Staffordshire.
- Section 6: Providers in the local health economy – summarises the other healthcare providers in the local health economy and some of the challenges they are facing.
- Section 7: Meeting the TSAs' obligations – sets out the statutory obligations that the TSAs are working within and what the TSAs have done to meet those obligations.
- Section 8: Independent Health and Equality Impact Assessment - describes the formation of an independent steering group that will assess the impact of the TSAs' draft recommendations on the local population.
- Section 9: Developing the draft recommendations – describes the process that the TSAs have followed in order to generate and evaluate options for change.

[1] Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust – Recommendations of the CPT, March 2013.

- Section 10: Draft recommendations – presents the draft recommendations of the TSAs that will form the basis for the public consultation. These draft recommendations are primarily focussed on the clinical service models for Stafford and Cannock.
- Section 11: Next steps – outlines the next steps for the TSA process.
- Appendices:
    - A: Glossary of terms
    - B: References and sources for information/evidence presented in the draft report
    - C: The assessment of catchment population – Public Health Staffordshire
    - D –H: Letters sent to the TSAs from various stakeholders who have worked with the TSAs to help the development of the draft recommendations
    - I: The detailed breakdown of services currently provided by MSFT and what will happen to services in the future
    - J: A copy of the letter from A&E leads in the West Midlands to the Trust Chief Executives and lead commissioners across the region

Volume Two

13. The TSAs have prepared and collated a series of annexes in support of this draft report. These are as follows:

- 1: The TSAs' consultation plan
- 2: MSFT performance summaries
- 3: Local CCG strategies
- 4: TSA governance paper
- 5: TSA stakeholder engagement
- 6: Clinical advisors - terms of reference and meeting notes
- 7: TSAs' financial evaluation
- 8: West Midlands Ambulance Service paper
- 9: Travel times methodology
- 10: MSFT Estate summary

Volume Three

- The scoping report from the Independent Health and Inequalities Impact Assessment (HEIA) steering group.

1.3 Preparing the final report

14. The TSAs will continue to assess the impact of the draft recommendations during the period of the public consultation. This will primarily be through the ongoing Independent Health and Equalities Impact Assessment (see Section 8), and the TSAs continuing work in developing the supporting final recommendations around organisational form, estates, detailed financial analysis and implementation.

15. On conclusion of the public consultation, the TSAs will have 15 working days to finalise their recommendations and prepare their final report for Monitor. These recommendations will be informed by the responses from the consultation and will reflect the ongoing work of the TSAs described above. **The latest date that the final report will be submitted to Monitor is Tuesday 22nd October 2013.**

16. Monitor will review the final report and will consider whether to approve the report for submission to the Secretary of State for Health. Monitor will have 20 working days to complete their review and may ask for further information from the TSAs to support their recommendations. During this period, Monitor will publish the TSAs' final report.

17. If Monitor approves the report, it will be submitted to the Secretary of State **within 20 working days**, who will have up to 30 working days to consider and approve the recommendations of the TSAs.

18. Under section 65KB of the National Health Service Act 2006, once the Secretary of State has received the final report, the Secretary of State must decide if it is satisfied with a number of specific criteria:

- that commissioners have discharged their functions in connection with the administration process;
- that the TSA has carried out the administration duties;
- that Monitor has discharged its functions;
- that the recommendations in the final report would secure the continued provision of the Location Specific Services[2];
- that those recommendations would secure the provision of services of sufficient safety and quality; and
- that the recommended actions would provide good value for money.

19. Of these criteria, the first three relate to processes or functions during the administration, and the last three relate specifically to the recommendations made

[2] Location Specific Services have been developed by local commissioners and are those services whose withdrawal, in the absence of alternative local provision, would be likely to have a significant adverse impact on health or significantly increase health inequalities.

by the TSAs in the final report. If the Secretary of State is dissatisfied with the compliance of any one of the six criteria, it must give reasons to the TSAs. The Secretary of State would then require the TSAs to rework and re-submit the report to address the criteria on which the Secretary of State was not satisfied.

20. The Secretary of State will make a final decision on the TSAs' recommendations. If Monitor and the Secretary of State take the full complement of days to complete their reviews then the final decision will be made by **31st December 2013** at the latest.

2 Trust background

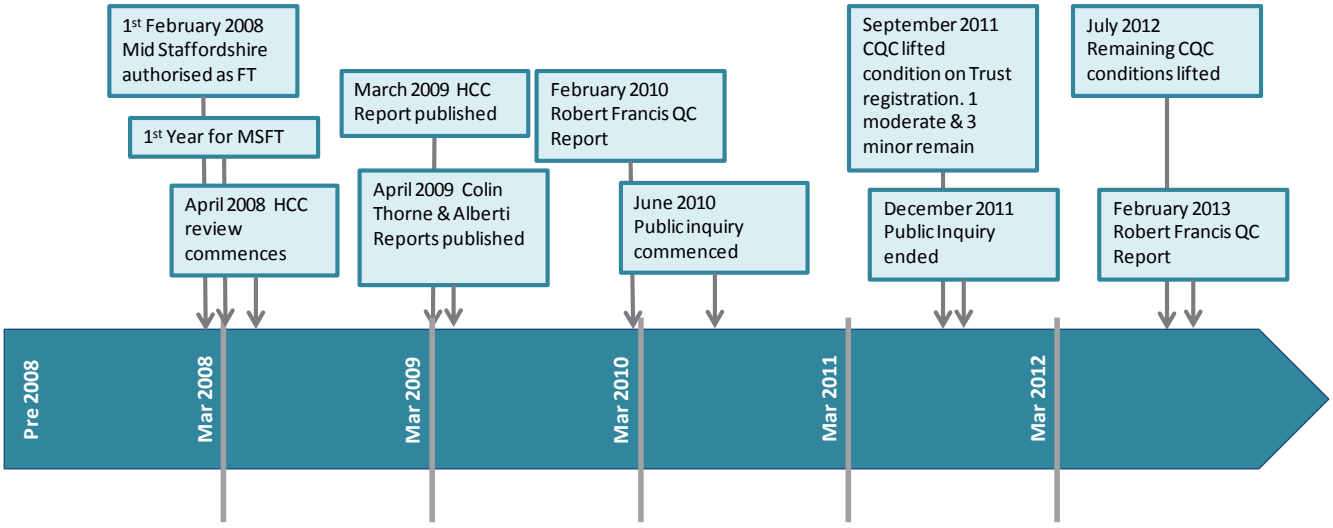
2.1 Mid Staffordshire NHS Foundation Trust

21. MSFT is a 344-bed acute Foundation Trust located on two sites: Stafford Hospital (opened in 1983) and Cannock Chase Hospital (opened in 1991), and provides services to the populations of Stafford, Rugeley, Stone, Cannock and the surrounding areas[3].

22. In 1993, shortly after the opening of Cannock Chase Hospital, the two hospitals were brought together into a single NHS Trust – the Mid Staffordshire General Hospitals NHS Trust. The Trust was awarded Foundation Trust status on 1st February 2008. The Trust currently employs ca. 3,000 staff and has an annual income of ca. £155m. In 2012 this made MSFT the 144th largest trust, by income, in the country out of a total of 167 trusts[4].

23. Shortly after achieving FT status in 2008, the Trust was subjected to a review by the Healthcare Commission (HCC) into reported high levels of patient mortality and poor standards of care. Following this review there have been three further reviews, an independent inquiry and a public inquiry – the two inquiries being headed by Robert Francis QC. A timeline of these reviews/inquiries is shown in Figure 1.

Figure 1: A summary timeline of reviews/inquiries into MSFT



24. The most significant of these reviews are the two inquiries led by Robert Francis QC[5]. The report of the second inquiry sets out the series of events behind the

[3] www.midstaffs.nhs.uk

[4] Laing's Healthcare Market Review 2011/12, Laing and Busson.

[5] The results of these inquiries can be found at http://www.midstaffspublicinquiry.com/.

documented issues[6]. The TSAs have worked on the basis that these public inquiries were open, forensic and comprehensively documented. Reviewing and commenting in detail on the evidence is outside of the remit of the TSAs.

2.2 The catchment population of MSFT

25. There are various statements that have been put forward about the catchment population for MSFT. The MSFT website states that they serve a population of 276,500, which is a reasonable position to take as the registered population of Stafford and Surrounds and Cannock Chase CCGs – their primary commissioners – is 276,500.

26. The website also states, on the same page, that the Trusts is '...serving a local population of around 320,000' (see Figure 2 below). This is the previously reported figure and was based upon the registered population of the South Staffordshire PCT (prior to its replacement by the CCGs as the lead commissioner for MSFT in April 2013).

Figure 2: A screenshot from the MSFT website that shows two different values for the population served by MSFT

27. The Francis Report quoted the Healthcare Commission report (2009) which also stated that the population served was 320,000[7] – it is likely that this information was taken from the MSFT published figures as there is no evidence of a separate assessment into the population being undertaken.

[6] *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, February 2013, Executive summary, London: The Stationery Office, p. 11.

[7] http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf (Page 141)

28. In 2012, Public Health Staffordshire (PHS) – part of Staffordshire County Council – conducted an evaluation of MSFT's catchment population and this analysis was presented by the CPT in their report into sustainability[8]. The key factor in this analysis was the distinction between the **catchment population** and the **population of the catchment area**.

29. PHS have subsequently updated their analysis on the basis of the volume of admissions to MSFT in 2012/13. Their updated assessment paper is included as an appendix to this document (Appendix C). The key messages from their analysis are as follows:

> *"Catchment areas are usually different to catchment populations. Catchment areas relate to the geographical area as a whole, whereas the catchment population refers to the people who would use the hospital if they needed treatment. The catchment area for Mid Staffordshire NHS Foundation Trust (MSFT) is higher than the catchment population."*
>
> *"Many factors, such as the type and size of a hospital, its proximity to other hospitals, characteristics of the population, reputation and patient choice affect a hospital's catchment population."*
>
> *"The catchment population for MSFT for all admissions was estimated to be 226,300 in 2009. Locally derived information indicates a decline in the catchment population from 2009/10 onwards. Public Health Staffordshire's (PHS) estimate, based on all hospital admissions between 2010/11 and 2012/13, suggest that the catchment population has fallen by around 11% to 204,400 with a likely range between 192,000 and 217,000."*

30. Information held by the Trust indicates that total patient first attendances have dropped in the last five years (see Table 1). The two significant reductions in patient attendances were in 2009/10 and 2012/13. Both of these years saw extended media coverage of Stafford Hospital (2009 – Healthcare Commission review; 2012 – Overnight closure of A&E, Francis Report and the interventions by Monitor). Patient attendances did stabilise and marginally rise from 2010 – 2012, but these levels have dropped in the period April 2012 – March 2013.

Table 1: Attendance levels into MSFT for the period 2008/09 – 2012/13

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

[8] Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust – Assessment of Sustainability, January 2013.

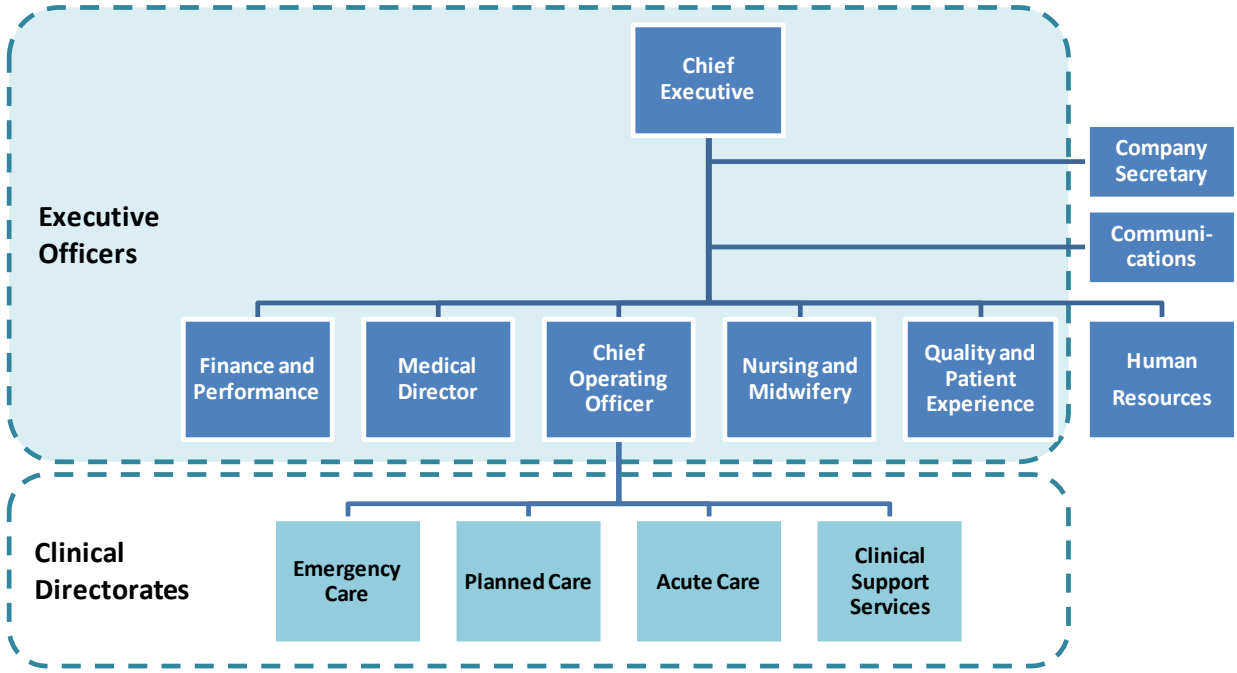
31. The TSAs consider that the numbers presented by PHS are a reasonable estimate of the population of people who would consider MSFT to be their acute hospital of choice.

32. It is evident from the analysis by PHS that if the decline in patient referrals into MSFT were to cease and patient referrals to increase back to 2008/09 levels then the 'catchment population' of MSFT would increase to nearer the estimate from 2009 (226,300).

2.3 MSFT organisational structure

33. Figure 3 presents a high level view of the organisational structure.

Figure 3: An overview of the MSFT organisational structure



2.4 Services delivered in Stafford and Cannock

34. MSFT provides a broad range of acute services, with some of the more complex and hyper-acute services being provided by the larger, more specialised hospitals in the region. Figure 3 presents a high level view of the organisational structure. The range of services currently provided by the Trust is spread across four clinical directorates:

- The **Planned Care** directorate contains a range of wards, departments and staff primarily focussed on managing the admission and in situ care needs of patients referred into MSFT.

- The **Acute Care** directorate contains a range of wards and departments, primarily concerned with the ongoing care and treatment of unplanned patient activity.
- The **Emergency Care** directorate primarily focuses on the immediate treatment and management of patients attending MSFT in an emergency. The directorate also manages paediatric care.
- The **Clinical Support Services** directorate provide a range of integral and essential clinical support services to the other directorates.

35. The majority of non-elective/unplanned care is delivered at Stafford Hospital. Ambulances do not take emergency patients to Cannock Chase Hospital; all non-elective surgery takes place on the Stafford site; and the critical care service is provided in Stafford Hospital.

36. Table 2 outlines the range of services that are delivered at the two sites. A full breakdown of services is provided in Appendix I.

Table 2: A summary of the services provided at each of MSFT's hospitals

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

37. 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 services with the result that MSFT is not providing certain specialised and/or urgent services on a standalone basis. Table 3 sets out the services that are not wholly provided by MSFT.

Table 3: A summary of services provided at Stafford and/or Cannock by providers other than MSFT

Service	Provided by	Site(s)	Description
Opthalmology	Jointly with The Royal Wolverhampton NHS Trust (RWT)	Stafford and Cannock	RWH provides consultants, staff grade and nursing staff for ophthalmology outpatient services for new and follow-up patients in MSFT

Service	Provided by	Site(s)	Description
Vascular surgery	University Hospital of North Staffordshire (UHNS)	UHNS (Stoke)	All patients from Mid Staffs region are referred directly to UHNS.
Ear, Nose and Throat	Jointly with UHNS	Stafford and UHNS	Two visiting consultant from UHNS provide assessment and treatment for a range of conditions. The Consultants are accompanied by specialist Registrars for each outpatient and theatre session from UHNS. On-call rota shared between UHNS and MSFT. Suspected Head and Neck cancer referrals, are treated at UHNS.
Cancer	UHNS and RWT	Stafford and Cannock	Provide a range of cancer services in Stafford and Cannock
Renal	UHNS and RWT	Stafford and Cannock	Service operated out of Stafford by UHNS and Cannock by RWT
Maxillofacial	Jointly with UHNS	UHNS (Stoke) and Stafford	UHNS provides dental lab services at UHNS. UHNS provide visiting consultants for outpatient and theatre services in Stafford
Plastics	UHNS	Stafford and Cannock	UHNS provide visiting consultants for outpatient and theatre services in Stafford
Cardiology	UHNS and RWT	Stafford and Cannock	UHNS and RWT provide care for ptients with acute coronary syndrome, or ST-elevated myocardial infarction
Minor Injuries Unit	SSOTP	Cannock	SSOTP run the MIU in Cannock
MRI	Alliance Medical	Cannock	Alliance Medical run the MRI unit in Cannock
General Surgery	Jointly with UHNS	Stafford and UHNS (Stoke)	The surgical alliance between UHNS and MSFT enables a partnership between UHNS and MSFT to deliver a range of services between MSFT and UHNS. Consultant appointments enable the delivery of this service primarily at MSFT with support being provided by UHNS. The visiting consultants from MSFT will provide services for the treatment of a range of conditions.
Littleton Ward	SSOTP	Cannock	SSOTP run Littelton ward at Cannock which are GP and Nurse led beds for patients who are stepped down from Acute Care

38. In addition to these services, UHNS also provides consultant input into the general surgery, gynaecology, neurosurgery and orthodontics services delivered by MSFT.

39. In December 2011, a decision was taken, on clinical grounds, to close the A&E department between the hours of 22:00 (10pm) and 08:00 (8am). This closure was

initially intended to be temporary to enable a series of remedial actions to be put in place to enable the service to re-open. Although the Trust implemented a series of remedial actions, the leadership of the Trust and local commissioners were not satisfied that the service could be safely operated on a 24 hours a day / 7 days a week basis and have not restarted the overnight service.

40. The TSAs believe the decision of the Trust and commissioners was correct. There are only six A&E consultants (two substantive and accredited A&E consultants, two junior grade doctors 'acting up' in consultant roles, and two locums) available to the Trust to operate the 14/7 A&E service. This is significantly below national guidance of 10 consultants being required to operate a safe 24/7 A&E rota[9].

41. This has had a consequent impact on the numbers of A&E attendances at MSFT, although it has not had a consequent impact on the number of non-elective spells. Table 4 summarises the full year activity levels for all services, including A&E and non-electoive spells, provided by MSFT over the last three years.

Table 4: Number of patients treated at MSFT over the period 2010/11 – 2012/13

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

Source: Trust data

[9] Emergency Medicine Taskforce - Interim Report (Dec 2012) – The College of Emergency Medicine.

2.5 Overview of the Trust's staff

42. Table 5 gives a breakdown of the Trust's average staffing for FY11, FY12 and FY13. The staff numbers are expressed as whole time equivalents (WTEs). Staffing levels (including temporary staffing) have reduced by c3.5% from FY11 to FY13.

Table 5: A summary of MSFT's staffing for the last three financial years

WTEs[10]	FY11[11]	FY12	FY13
Clinical staff, including scientific and therapeutic staff	1,806	1,702	1,736
Non-clinical staff	807	807	753
Total non-agency staff	**2,613**	**2,509**	**2,489**
Agency staff	**159**	**176**	**177**

43. A significant proportion of the staff deployed by MSFT are temporary staff, costing almost £10 million per annum. The amount of temporary staffing has increased by 11% since 2010, partly due to issues with recruitment.

44. When compared with the ten trusts most similar in size (based upon income), MSFT is one of the highest spenders on temporary staff (see Table 6).

Table 6: The proportion of expenditure spent on temporary staff as a percentage of Trust turnover (in 2011/12), at MSFT and the ten most similar trusts in England, based upon annual income

Trust	Income (2011/12, £m)	Bank, agency and non-permanent staff spend (2011/12, £m)	Bank, agency and non-permanent staff spend as proportion of income (%)
Dartford & Gravesham NHS Trust	168.09	11.15	6.64%
Tameside Hospital NHS Foundation Trust	143.56	9.06	6.31%
Mid Staffordshire NHS Foundation Trust	155.74	9.44	6.06%
West Middlesex University Hospital NHS Trust	148.94	8.27	5.55%
James Paget University Hospitals NHS FT	167.17	8.74	5.23%
Southport and Ormskirk Hospital Trust	178.18	7.10	3.98%
Barnsley Hospital NHS Foundation Trust	160.89	6.23	3.87%
Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	165.02	5.89	3.57%
Harrogate and District NHS Foundation Trust	168.63	3.10	1.84%
Dorset County NHS Foundation Trust	148.02	2.44	1.65%
Burton Hospitals NHS Foundation Trust	171.53	1.70	0.99%

Source: Trust Annual Reports 2011/12

[10] Source: Trust data

[11] The financial year in the NHS runs from 1 April to 31 March. FY11 is the period 1 April 2010 – 31 March 2011.

2.6 Overview of the Trust's estate

45. The Trust provides services from two sites, Stafford and Cannock, with the majority of acute services being provided at Stafford. Neither site has any PFI commitments. Table 7 presents an overview on the Trust's estate. More detail on the estate is provided in Annex 10.

Table 7: A summary of the estate at MSFT's hospitals

Estate	Stafford Hospital	Cannock Chase Hospital
Site Area (ha)	14.64	3.35
Net Internal Area (m2)	31,788	18,190
Car Par Spaces	907	337
Age	31 years	23 years
Net Book Value (£m) / Value of the asset	61.656	31.506

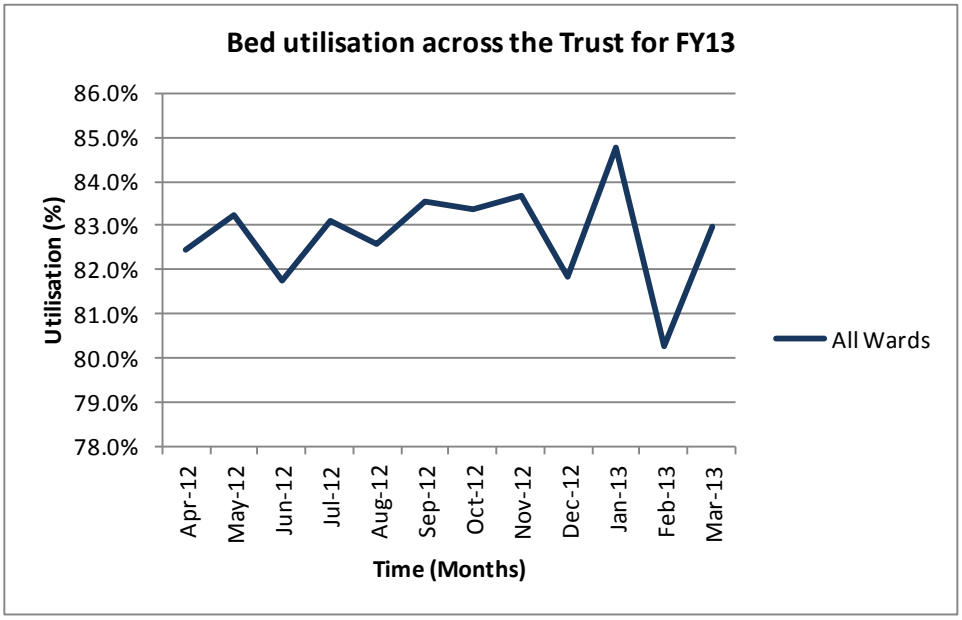
46. In November/December 2012 the Trust commissioned an estates review that was conducted by an external party – Strategic Healthcare Planning. The review identified that 43% of the space at Cannock Chase Hospital was occupied by MSFT, 37% by third party providers and 20% was not utilised. Most of the third party utilisation is taken up with short term leases.

47. At Stafford there are fifteen ward-based areas, including Paediatrics and Maternity. One of these wards remains empty and is currently being used as spare clinical space to facilitate general improvements to the others. Cannock has nine available wards, of which only three are used: two wards run by the Trust and a ward run in collaboration with the local Community Trust (Staffordshire and Stoke-on-Trent Partnership NHS Trust).

48. Figure 4 shows that average bed utilisation across 2012/13 was less than 82.3% - within the target range for bed utilisation as when occupancy rates rise above 85% it can 'start to affect the quality of care provided to patients and the orderly running of the hospital'[12].

[12] Bagust (1999). Dynamics of bed use in accommodating emergency admissions: stochastic simulation model www.bmj.com/content/319/7203/155

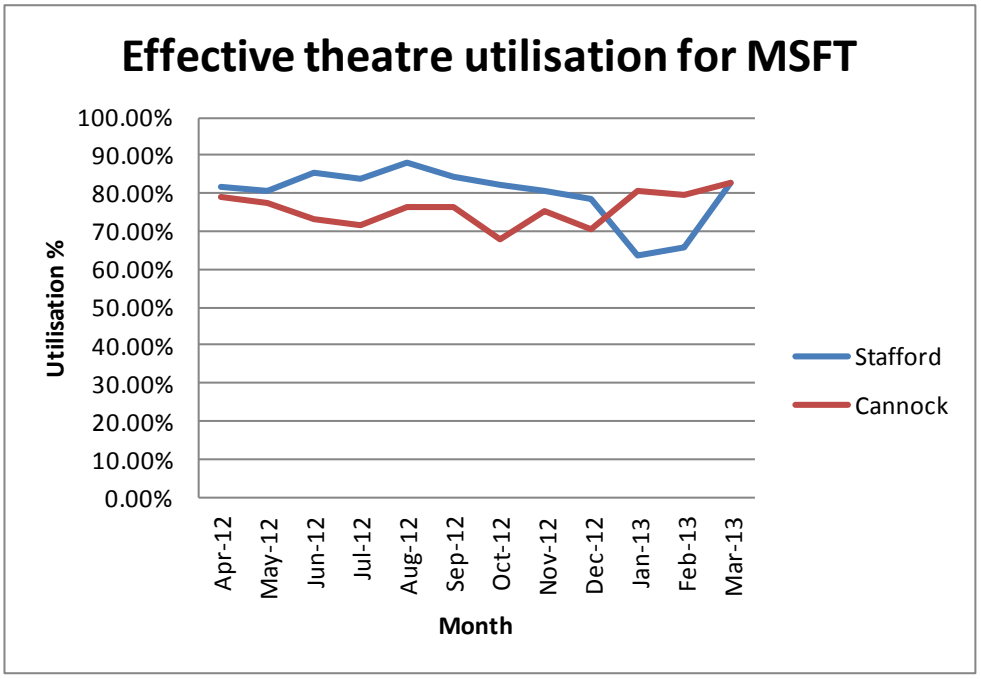
Figure 4: Average bed utilisation at MSFT for FY13



Source: MSFT Trust data

49. There are seven theatres in use at Stafford and five at Cannock. Theatre utilisation, shown in Figure 5, is lower than should be expected, indicating either: over capacity of theatre space in relation to bed capacity; inefficient use of theatre; or insufficient demand for theatres. (NB: the drop in theatre utilisation in early 2013 was due to an outbreak of Norovirus that led to ward closures at Stafford Hospital).

Figure 5: Average theatre utilisation at MSFT for FY13



Source: MSFT Trust data

50. In February 2012, a comprehensive condition appraisal of the estate was completed by NIFES Consulting Group. There has been a relatively low level of investment in the estate over the last five years (see Annex 10). This has led to a significant backlog of maintenance (as set out in Table 8) of ca. £6.9m, the majority of which is for Cannock Chase Hospital. With neither hospital having undergone any recent major functional reconfigurations there is also over £20m of investment required to bring the functional configuration of the estate in line with latest standards[13].

Table 8: Estimated cost of the maintenance backlog at MSFT's hospitals

Estate – estimated cost (£)	Stafford Hospital	Cannock Chase Hospital
Physical Condition	1,220,285	3,152,766
Space	n/a	n/a
Quality	268,881	552,375
Statutory	860,851	409,551
Environmental	332,200	67,200
Sub total	**2,682,217**	**4,181,892**
Functional Suitability	16,526,475	4,222,435
Total	**19,208,692**	**8,404,327**

51. The costs associated with managing the Trust's estates are more than £10million (6%) of its annual income, which compares with a national average of less than 1% for all trusts and just over 1% for all foundation trusts[14]. The primary reason for this is the Trust having to manage the estate costs associated with two district general hospitals – something that is very unusual for trusts the size of MSFT. Some costs associated with running a hospital estate are linked to patient volumes (e.g. linen, catering) whilst others are related to the size of the estate. The three largest cost categories are all related the size of the estate:

- Energy management = £2.75m
- General estates expenses = £1.43m
- Estate electronics = £1.00m

[13] 'NHS EstateCODE – Department of Health

[14] Department of Health: QIPP national workstream: Back office efficiency and management optimisation

2.7 Overview of the local health economy

52. Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups (CCGs) commission services for a combined population of 276,500. Their main acute provider is MSFT; and c95% of hospital activity at the Trust comes from these CCGs. The CCGs were formed in 2012 and have been authorised as statutory bodies from 1st April 2013. Within the area covered by the CCGs:

- There are 41 general practices, employing approximately 160 General Practitioners and approximately 125 practice nurses.
- There are approximately 45 dental practices and approximately 50 community pharmacies.
- Out of hours care is provided by Badger Healthcare.

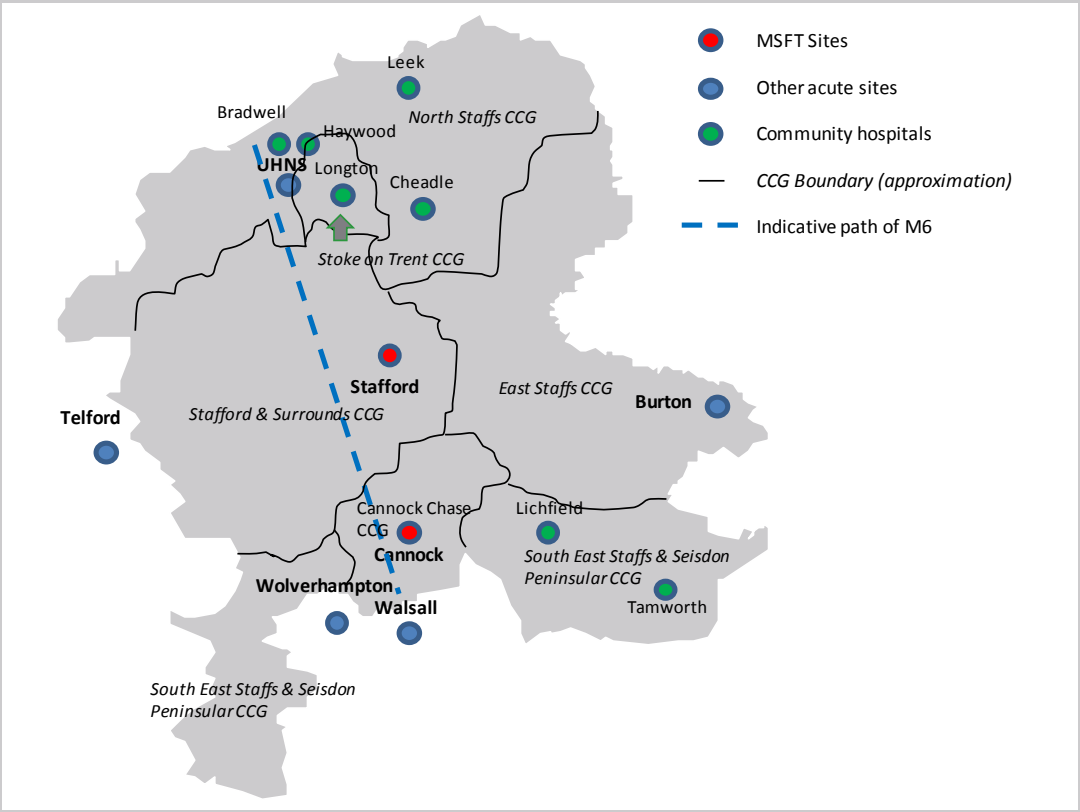
53. Across Staffordshire:

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

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

55. Figure 6 shows the location of the providers and the CCGs within the local health economy.

Figure 6: The geography of the local health economy



56. As can be seen, Staffordshire is bisected by the M6 and there are a number of other acute providers within 20 miles of either Stafford or Cannock Chase Hospitals, as follows:

- To the North - University Hospital of North Staffordshire NHS Trust (UHNS), Stoke-on-Trent;
- To the South – The Royal Wolverhampton NHS Trust (RWT), which runs New Cross Hospital, and Walsall Healthcare NHS Trust (WHT), which runs Manor Hospital;
- To the East - Burton Hospitals NHS Foundation Trust (BHFT), which runs Queen's Hospital and the community hospitals in Lichfield and Tamworth;
- To the West - Shrewsbury and Telford Hospitals NHS Trust (SaTH), which runs the Princess Royal Hospital, Telford.

57. A summary of the size and scale of each Trust is provided in Table 9.

Table 9: A summary of providers in the local health economy

Trust	2012/13 Turnover	Number of staff	Number of beds[15]
UHNS	£459m	ca. 6,700	1,045
BHFT	£173m	ca. 2,500	482
WHT	£225m	ca. 5,000	489
RWT	£376m	ca. 6,500	812
SaTH	£309m	ca. 5,000	752
SSoTP	ca. £369m	ca. 6,000	303 (community)

58. Each of these trusts in the local health economy has undergone, and in most cases is still undergoing, challenges of their own. These challenges include some trusts operating financial deficits, some with issues in their clinical services, and others in the process of reconfiguring their services/sites/organisational form. In Section 6, a more detailed overview is presented on each of these trusts and the issues they are facing.

2.8 Historic attempts to transform services

59. As previously noted, there have been multiple reviews undertaken at MSFT. Each of these reviews has led to some form of change, but the majority of changes have been relatively small scale and have not led to significant changes in the service model. One example of this would be the move of vascular surgery from MSFT to UHNS, as a consequence of recommendations that some services should be consolidated into specialist centres.

60. The one exception to this is the Clinical Service Implementation Programme (CSIP) that was established in 2011. CSIP was a joint initiative between MSFT, local commissioning groups (South Staffordshire Primary Care Trust and the two embryonic CCGs) and Staffordshire County Council. The objective of the programme was to redesign major care pathways in line with evolving commissioning intentions and resulted in a series of recommendations aimed at delivering improved clinical and financial sustainability. Whilst some of the recommendations were implemented – notably within MSFT itself – the programme did not deliver the full range of anticipated improvements. There are several factors behind the limited success of the programme, the most notable being the challenges posed by the planned integration of community and social care into a single organisation (SSOTP) during the implementation period for the CSIP recommendations.

[15] Source: NHS England: Bed Availability and Occupancy Data (January to March 2013)

2.9 Monitor's intervention to deliver sustainable service for the local population

61. The Trust has been working closely with Monitor to improve its performance in recent years, and has made significant improvements in the clinical care provided for patients. However, the Trust is still losing money, and had to be given significant financial support (ca. £21m) from the Department of Health (DH) in 2011/12 in order to maintain provision of services for patients.

62. In October 2012, Monitor appointed a Contingency Planning Team (CPT) to assess the sustainability of MSFT (clinically, financially and operationally) and, in the event that it was deemed to be unsustainable, to develop an initial high-level plan which would enable services to be provided for local patients on a sustainable basis. 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-).

63. The CPT's work was carried out in two phases: 1) Assessing MSFT's sustainability and 2) Developing a contingency plan to deliver sustainability. The outcomes of the first of these phases are outlined in Section 4 and are directly relevant to the appointment of the TSAs. The scope of the CPT, in developing its recommendations, was different to the scope of the work undertaken by the TSAs in developing their recommendations. The TSAs have been required to take into account the influence of and the impact upon the local health economy when formulating their recommendations.

64. The TSAs' work has been informed by some of the analysis presented by the CPT and supported by some of the established stakeholder relationships. However, Monitor and the TSAs are satisfied that the work undertaken during the CSIP, and subsequently by the CPT, has demonstrated that changes focussed on Mid/South Staffordshire alone will not fully address the problems faced by MSFT. This observation is one of the central tenets of the case for change set out in Section 4.

3 MSFT performance

65. MSFT has delivered improvements over the last 1-2 years in clinical outcomes – notably in its mortality rates and hospital acquired infection rates. It has also been subjected to recent Care Quality Commission (CQC) inspections that have reported no areas for concern.

66. This section provides a summary of recent performance. Further details on recent performance are presented in annexes to this draft report.

3.1 Recent clinical performance

67. As previously noted, the TSAs have been determined to not expend time or effort reviewing, restating or commenting upon the well documented issues associated with the Trust during the middle to latter part of the last decade. The TSAs are of the view that it would be disingenuous to directly link the case for change to the reported problems of this period of history and that the local population would not welcome any attempts to do so. The only observation that the TSAs would make is that there have been indirect reputational consequences of these events that have, in part, caused both clinical and financial challenges for the Trust.

68. The assessment undertaken by the CPT concluded that *'it has not identified any evidence that the Trust is currently delivering unacceptable standards of care'*[16]. The TSAs want to reiterate that statement and acknowledge the continuing hard work and commitment of the Trust's leaders and staff to deliver the best possible care for all patients that attend the two hospitals.

69. Recent CQC unannounced inspections of both Stafford and Cannock Chase Hospitals have confirmed that both hospitals are meeting expected standards[17].

70. Against some standard clinical metrics – notably mortality rates – the Trust is currently performing well, whilst against others (4 hour A&E waits and 18 week referral to treatment rates) the Trust has been doing less well - although it should be noted that the Trust has invested in the last 12 months to improve the referral to treatment rates.

71. Annex 2 is a summary paper of MSFT's KPIs and performance against other Trusts (including the data sources for this analysis). The following tables summarise some

[16] Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust – Assessment of Sustainability, January 2013, P14.
[17] CQC – Inspection Report (Stafford Hospital), 6 March 2013; CQC – Inspection Report (Cannock Chase Hospital), 23 April 2013.

of these KPIs and how the Trust is performing against other trusts nationally and within the local health economy.

Table 10: Summary of performance against the 4 hour A&E target

4 Hour A&E (This shows the percentage of patients who were seen and either admitted, transferred or discharged within 4 hours)				
	2009/10	2010/11	2011/12	2012/13
Mid Staffordshire NHS Foundation Trust	96.0%	87.6%	88.3%	93.8%
Peer group average	96.6%	94.1%	93.8%	95.5%
National average	95.8%	94.6%	94.5%	95.9%
Burton Hospitals NHS Foundation Trust	96.3%	97.6%	96.8%	94.0%
Shrewsbury and Telford Hospitals NHS Trust	87.8%	89.2%	91.5%	90.6%
The Royal Wolverhampton NHS Trust	98.8%	98.2%	97.1%	95.8%
University Hospital of North Staffordshire NHS Trust	96.7%	93.8%	88.1%	89.9%
Walsall Healthcare NHS Trust	97.2%	94.9%	96.0%	95.0%

Table 11: Summary of performance against the 18 week referral to treatment target

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

Table 12: Summary of performance for the MRSA rates

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

Table 13: Summary of performance for C.diff rates

C.diff rate (This indicator summarises how many Clostridium difficile infections were acquired by patients over the age of 65 whilst an inpatient in an acute trust – expressed as the number of patients affected per 100,000 bed days) NB: C diff rates for 2012/13 not yet published	2009/10	2010/11	2011/12	2012/13
Mid Staffordshire NHS Foundation Trust	105.4	80.5	80.5	-
Peer group average	93.2	72.0	70.2	-
National average	90.8	77.5	64.2	-
Burton Hospitals NHS Foundation Trust	89.9	59.3	69.7	-
Shrewsbury and Telford Hospital NHS Trust	80.7	71.4	52.2	-
The Royal Wolverhampton Hospitals NHS Trust	96.5	84.8	104.2	-
University Hospital of North Staffordshire NHS Trust	154.3	118.9	59	-
Walsall Hospitals NHS Trust	73.5	116	97.4	-

72. Tables 14 and 15 summarise how the Trust is performing against other trusts within the local health economy with regards to two of the commonly used mortality rate measures (the 'Hospital Standardised Mortality Rates (HSMR)' and Summary Hospital-level Mortality Indicator (SHMI)).

73. Mortality rates are measures that assess the ratio between the actual number of patients who die following treatment at a trust and the number that would be expected to die. The number expected to die is derived from average figures in England and takes into account the characteristics of the patients treated at each hospital.

74. The SHMI takes into account all patients treated at the Trust that die during their stay at the hospital or within 30 days of discharge. The HSMR takes into account deaths in a large range of diagnosis groups.

75. These figures are published for information purposes only and will not be commented upon further in this report. NB: Information for 2012/13 not yet published.

Table 14: Summary of performance for HSMR

Hospital Standardised Mortality Rates (HSMR)		
	2010/11	**2011/12**
Mid Staffordshire NHS Foundation Trust	90	84
Burton Hospitals NHS Foundation Trust	112	112
Shrewsbury and Telford Hospital NHS Trust	115	100
The Royal Wolverhampton Hospitals NHS Trust	112	100
University Hospital of North Staffordshire NHS Trust	116	104
Walsall Hospitals NHS Trust	106	117

Table 15: Summary of performance for SHMI

Summary Hospital-level Mortality Indicator (SHMI)		
	2010/11	2011/12
Mid Staffordshire NHS Foundation Trust	0.99	0.93
Burton Hospitals NHS Foundation Trust	1.12	1.01
Shrewsbury and Telford Hospital NHS Trust	1.12	1.07
The Royal Wolverhampton Hospitals NHS Trust	1.11	1.03
University Hospital of North Staffordshire NHS Trust	1.03	1.06
Walsall Hospitals NHS Trust	1.06	1.13

76. Whilst acknowledging the improved performance of the Trust and commending the staff, it should be noted that a range of acutely sick patients are not treated at MSFT

(notably a large cohort of patients with the signs and symptoms of cardiac and stroke conditions). As such, some of the performance measures for the Trust can be misleading when used in comparison with other trusts. A notable example of this is a recent report into the survival rates of patients experiencing a cardiac arrest across hospitals in the West Midlands. Stafford Hospital was the best performing hospital of those assessed, but it should be noted that MSFT does not treat a large cohort of local patients who are initially diagnosed with cardiac symptoms; these patients are taken to either UHNS or RWT.

3.2 Recent financial performance

77. The Trust has had an underlying financial deficit since 2008 and at the end of the last financial year (April 2012 – March 2013), the deficit reported was £14.74m.

78. During this period the Trust delivered Cost Improvement Plans (CIPs) equating to £10.4m, which is equivalent to 6% of expenditure (£172m) and 100% of budget (£10.4m). The year position is set out in Table 16.

79. MSFT received £21m of subsidy funding, over and above activity related income, from the Department of Health in FY12 and a further £21.3m in FY13. Local commissioners also provided the Trust with £2.4m in 2012 and £4.5m in 2013 (shown as Strategic Change Reserve). Without these funds the Trust would have been unable to pay its staff and suppliers.

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

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

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

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

80. When the CPT conducted their review, the Trust was forecasting a year end deficit (in March 2013) of £15m. The Trust's final deficit reported at year end was £14.7m.

81. This final position included £4.5m of income from local commissioners from their Strategic Change Reserve (SCR). Following the transition of commissioning to the local CCGs from April 2013, SCR funding will no longer be available. Taking this, and other minor factors into account, the TSAs are forecasting that the deficit at the end of the current financial year (March 2014) will be ca. £20.2m. This is summarised in Annex 7.

4 The case for change

82. The first task of the Contingency Planning Team (CPT) was to assess the sustainability of MSFT. In January 2013, Monitor published the CPT's report into the future sustainability of MSFT.

83. This section outlines the reason why changes to the current model for delivering healthcare services are absolutely necessary. It summarises the key conclusions from the CPT's sustainability report and builds upon these conclusions to set out why change is needed in Mid Staffordshire and across the local health economy. It also highlights the consequences of not delivering change in the way services are currently delivered. The CPT sustainability report[18] sets out in detail why the Trust was deemed unsustainable from a clinical and financial perspective.

4.1 Why MSFT is not sustainable in its current form

84. The CPT concluded that MSFT, in its current form, was neither clinically nor financially sustainable. The TSAs have been appointed on the presumption that the CPT's analysis and conclusions with regards to sustainability were reliable. For this reason, the TSAs have only assessed limited additional information with regards to the sustainability of the Trust in its current form, notably:

- Public Health Staffordshire's refresh of the catchment population assessment – see Section 2.2.
- An update to the forecasted financial deficit, to take into account the latest financial position of the Trust - see Section 3.2.

85. On the basis of this information, the TSAs have found no reason to dispute the CPT's conclusions with regards to the sustainability of the Trust, which are:

- The Trust's clinical performance is currently sound, and against some measures it is performing very well;
- It is achieving this performance at an average cost that is significantly higher than most other trusts in the country – this has caused the Trust to operate with a significant financial deficit for the last four years;
- The major factors behind this financial deficit are:
    - the investment in additional staff to address the clinical issues of the past, whilst at the same time income has significantly reduced due to a reduction in patient numbers;

[18] Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust – Assessment of Sustainability, January 2013.

  - incurring the costs of running two 'district general hospitals' whilst receiving a level of income typically associated with a small hospital trust operating a single site; and
  - using a high volume of temporary staff when compared to similar trusts, which incurs a higher cost than permanently contracted staff.

- The Trust has experienced recruitment and retention issues, due to a combination of factors: national shortages in some clinical specialities; the preference of clinical staff to work in large hospitals; and reputational issues.
- Despite investing in additional clinical staff, the Trust is currently operating some clinical services (notably A&E, emergency surgery and paediatric services) with consultant numbers that are significantly below Royal College guidelines.
- This is largely due to the fact that MSFT is one of the smallest trusts in the country and activity levels do not justify an increase in consultant levels – even if funding were available – because there would be insufficient patients treated to maintain the essential clinical skills of the workforce.
- If the Trust were to deliver cost savings to bring it in line with the average cost of delivery of NHS services, it would undoubtedly adversely affect clinical outcomes.
- For these reasons the Trust has been deemed neither clinically nor financially sustainable.

86. Further detail on each of these points is provided below.

87. It is important to understand that the conclusion around sustainability is an assessment of MSFT, as the current provider of services in Stafford and Cannock. It does not mean that services cannot be delivered in a sustainable manner in Stafford and/or Cannock and it is therefore the TSAs' responsibility to:

- determine how the Location Specific Services ('LSS' - see Section 5.5) can be delivered in Stafford/Cannock on a sustainable basis;
- assess whether any additional services can be delivered alongside the LSS in Stafford/Cannock on a sustainable basis; and
- determine how those services that cannot be delivered on a sustainable basis in Stafford/Cannock can be delivered on a sustainable basis in other locations, whilst not creating health inequalities for the populations of Stafford or Cannock.

4.2 Why MSFT is not clinically sustainable

88. As previously noted, the Trust's recent performance has improved in the last 12-18 months. However, there is a clear distinction between current performance levels (the 'here and now') and the question of clinical sustainability (the medium to long term delivery of clinical services). In determining that the Trust is not sustainable, it is not a judgement on the current staff and how they are delivering services, it is a judgement on whether the Trust is likely to be able to deliver acceptable levels of care into the future.

89. The core factor in determining that the Trust is clinically unsustainable is the scale of services and consultant levels in key specialities being significantly below Royal College guidelines.

90. MSFT is a small trust. As previously noted it ranks 144th out of 167 trusts in terms of income. With regards to patient activity, the CPT noted that:

> *"In all services, the volume of activity at MSFT is below the national average and it is evident that, in some services MSFT is one of the smallest trusts in the country:*
>
> - *For maternity births, MSFT ranks 135th out of 148 services in England.*
> - *For A&E attendances, MSFT ranks 132nd out of 150 services in England.*
> - *For non-elective (emergency) surgical spells, MSFT ranks 133rd out of 166 services in England.*
> - *For paediatric spells over 1 day, MSFT ranks 116th out of 167 services in England."*

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

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

Table 17: Attendances into MSFT for the period 2008/09 – 2012/13

Row Labels	2008-09	2009-10	2010-11	2011-12	2012-13
Total first attendances	**146803**	**138706**	**140540**	**141381**	**133514**
+/- change (year on year)	-	-5.5%	1.3%	0.6%	-5.6%
+/- change (from 08/09)	-	-5.8%	-4.3%	-3.7%	-9.1%

93. This reduction in patient attendances has had a consequent impact on the assessed catchment population for MSFT – that being the population of people who choose to use MSFT. As noted in Section 2.2 and Appendix C, Public Health Staffordshire (PHS) have estimated that the **catchment population** for MSFT is c204,400 and this has reduced since 2009 due to the reducing volume of patient referrals.

94. The Royal College of Surgeons have previously produced guidelines that a population of 450,000 – 500,000 would be an appropriate catchment population for "an acute general hospital that provides the full range of facilities for both elective and emergency medical and surgical care" and that the minimum catchment population should be 300,000[19]. Neither the PHS estimation nor the Trust's stated population (276,500) fall within these guidelines.

95. The TSAs are aware that the local population is forecast to increase:

- New housing developments are being planned for Stafford. Stafford Borough Council have given permission for 2,911 new dwellings to be built within Stafford over the next six years. This is consistent with the stated planning provision of up to 500 new dwellings per year[20].
- There is a planned relocation of some of the UK armed forces based in Germany by the end of 2015. From the TSAs' discussions with the MoD, the current estimates are that an additional 1,040 troops and c420 families will be relocated to MoD Stafford. Whilst this is not likely to include many older people – the largest users of acute hospital services – it may increase the number of births in the area. It is not possible to accurately predict how many additional births this may bring into the catchment area, but is unlikely to exceed 100 per annum.

96. If the trend for reducing referrals into MSFT were to be reversed, and taking into account the predicted growth in local population, then it is possible that the catchment population may increase to nearer 300,000 over the next ten years, but, working on the basis of the PHS assessment of catchment population, it would still be significantly below the preferred population size recommended for a full scale acute general hospital by Royal College of Surgeons' guidelines.

97. What this means in practice is that small hospitals, such as MSFT, face challenges in deploying the appropriate number of consultants in key specialities to ensure there is the appropriate presence twenty four hours a day, seven days a week. This is particularly true for acute specialties such as A&E, emergency surgery, paediatrics

[19] This was originally stated in 'Provision of Acute General Hospital Services, Royal College of Surgeons of England, 1998'; but has subsequently been restated in other reports including 'Delivering High Quality Surgical Services for the Future, the Royal College of Surgeons, 2006'.

[20] http://www.staffordbc.gov.uk/the-plan-for-stafford-borough

and obstetrics where consultant presence is required at short notice any time of the day or week. The CPT noted that:

> *"As it stands, MSFT is unable to meet the relevant Royal College standards for the number of consultants required to deliver twenty four hour, seven days a week cover across a number of services, including A&E, Emergency Surgery and Paediatrics (see table below)."*

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

* Numbers revised to show most up to date staffing numbers.

99. If the number of consultants were increased to be nearer to Royal College guidelines – assuming funding were available – the Trust would then be faced with a disproportionately large cohort of highly skilled consultants who would most likely not be treating the volume of patients needed to maintain their specialist skills. This would deter many consultants from applying to work at MSFT.

100. Furthermore, MSFT already faces a challenge in recruiting. This is primarily due to national shortages of consultants in certain specialities meaning there are more positions available in some specialities than there are available consultants. In addition, the CPT noted that MSFT is often seen as a less attractive employer, due to it being a small trust with low patient volumes and with historic and well publicised reputational issues.

101. The leadership of MSFT recognised some of these challenges over the last two to three years and took steps to mitigate the impact, notably for non-elective and specialist care, through:

- The continuing overnight closure of A&E due to insufficient consultant cover to enable a safe 24/7 service.
- The cessation of treatment for patients: with cardiac or stroke signs or symptoms; or, who have suffered a major trauma. These patients are now treated at UHNS or RWT. From September 2013, urology patients will also be treated at UHNS or RWT. It is current practice, where the West Midlands Ambulance Service are called to attend patients with such symptoms they take these patients directly to either UHNS or RWT.
- The establishment of a clinical network with UHNS to deliver some services, e.g. vascular surgery.

4.3 Why MSFT is not financially sustainable

102. MSFT has been operating at a financial deficit since 2009. The level of the deficit reported in April 2013 is £14.7 million. The deficit is expected to deteriorate in the current financial year due to the withdrawal of the local commissioners 'Strategic Change Reserve' which provided MSFT with £4.5m of non-activity related income in 2012/13. In order to continue operating (i.e. paying staff and suppliers), the Department of Health (DH) has had to provide £21 million of additional subsidy to MSFT in FY13. A similar subsidy was provided by DH in FY12. Without these ongoing subsidies from DH, MSFT would be insolvent.

103. Put into simple terms it costs approximately £15-20m more per year to operate MSFT than it receives in income. Either costs are too high, or income is insufficient – or both.

104. The primary source of income is associated with payments for treating patients. Providers of NHS services are paid a tariff for the patients they treat. These tariffs are set nationally and are based upon an assessment of the average cost to deliver each specific treatment. Inevitably, providers that consistently deliver the majority of their services at above the average national cost are likely to be in a position where the tariff does not cover the cost of delivery. Local commissioners have the discretion to modify some tariffs, but they are obliged to do this in the context of a fixed budget. Therefore, if they agree to pay above tariff for one or more specific services, there is a reduced budget available to pay for other services. In the context of MSFT, the two local CCGs are in deficit and have stated that they are not in a position to pay above tariff for the delivery of acute based services.

105. The Department of Health has used the tariff system to try and influence changes to working practices in order to reduce the number of emergency admissions:

- In the 'Payment by Results' guidance for 2010/11[21] - the payment for emergency admissions which exceeded 2008/09 levels was reduced to "*provide an added incentive for closer working between providers and commissioners, to support the shift of care out of hospital settings and keep the number of emergency admissions to a minimum.*"
- In the 'Payment by Results' guidance for 2011/12 - the payment for emergency readmissions within 30 days of discharge was removed to "*ensure that hospitals are responsible for patients for the 30 days after discharge.*"

106. However, MSFT does not have comparatively high level of emergency admissions, so it is unlikely that these 'incentives' are the root cause of the financial problems faced.

107. The root cause is far more likely to be the cost of delivering services is too high. The CPT noted:

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

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

109. The only conclusion from this can be that the root cause of the financial issues at MSFT is not the income/tariff system, but the costs associated with MSFT.

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

[21] The Department of Health's tariff framework.

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

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

112. However, there is no evidence that demonstrates any NHS provider in the UK has been able to deliver such a level of cost reductions over a five year period. The CPT concluded, and the TSAs agree, that if any attempt was made to do so, **it would have a significant and detrimental impact on front line services and clinical outcomes.** As such, the TSAs do not currently believe it can be commended as an appropriate course of action.

4.4 Broader issues within the NHS

113. There is an evident case that MSFT in its current form is not sustainable, and that changes are needed. However, there are a range of well publicised issues which are prevalent across the NHS in general and which are broader than the questions of clinical and financial sustainability. The TSAs' draft recommendations have not been developed in ignorance of these issues.

114. Three notably relevant issues to MSFT have been summarised in this sub-section.

Widespread pressure in secondary care

115. Increasing pressure is being placed upon secondary care providers, notably in unprecedented levels of A&E attendance and delays in discharging patients. In the period since the TSAs were appointed for MSFT, there has been widespread reporting on the unsustainable levels of attendances to A&E. This is both a national problem and a local problem.

> ***Key considerations***
>
> In May 2013, the clinical leads of A&E departments across the West Midlands wrote to the acute trust chief executives and CCGs about the recent issues in A&E (Appendix J): *"Following a winter and spring of sustained, extraordinary pressures throughout the EDs in the region, we now believe we are in a state of crisis which needs to be more*

widely acknowledged and moreover urgently addressed."

In June 2013, the Foundation Trust Network released the results of a survey into the pressures in A&E[22]. 72% of FTN member trusts indicated they thought A&E was near to or at a 'tipping point'. The report noted: "*The emergency care system has been under huge pressure over the last few months and although recent weeks have seen performance stabilise, there is a danger the system will fail unless each local health economy plans effectively for the coming winter. It is important that any actions taken to stabilise the system in the short termshould be consistent with the longer term changes that are needed, as this a complex,whole health and social care system, issue."*

The survey showed that member trusts thought delays in transfer of care was a key reason behind the issues in A&E. It identified five 'strong themes' emerged as reasons:

- Lack of integration
- Excessive beaurocracy
- Issues with hospital capacity
- Issues with social care capacity
- Lack of funding

The King's Fund noted in February 2013[23] that although delayed discharges have reduced since 2008, 63% of NHS Finance Directors reported that "*delays had got worse in the last 12 months".*

An NHS Confederation paper in September 2012[24] stated that *"Delayed transfers in care currently cost the NHS £545,000 per day (approx. £200 million per year). They are distressing for patients and, without action, the situation will get worse."*

Delivery of care to an ageing population

116. An ageing population places increasing demands on the NHS, with mounting evidence that acute hospitals are not the best care setting for many conditions associated with the ageing population. This is driving a move to closer integration of care across health and social care providers.

Key considerations

The Economic and Social Research Council stated in March 2013[25]: *"The pressure on the health service is set to increase dramatically over the next decades. The number of people aged over 65 is estimated to increase by 51 per cent between 2010 and 2030, and the number of people over 85 will double over the same period... This trend could lead to a 50 per cent increase in people suffering from arthritis, coronary disease or*

22 'Emergency care and emergency services 2013, view from the frontline.' Foundation Trust Network, June 2013

23 Quarterly monitoring report, The King's Fund, February 2013.

24 'Papering over the cracks: the impact of social care funding on the NHS', NHS Confederation, September 2012

25 http://www.esrc.ac.uk/impacts-and-findings/features-casestudies/features/25376/future-nhs-funding-squeeze-highlighted-by-ifs-research.aspx

strokes, and an 80 per cent rise in people with dementia - to almost two million."

In January 2012, The King's Fund reported[26]: *"Integrated care is essential to meet the needs of the ageing population, transform the way that care is provided for people with long-term conditions and enable people with complex needs to live healthy, fulfilling, independent lives... In all of the successful integrated care projects we examined, additional and improved services outside hospital were required – shining a light on the lack of current capacity and capability in community services to deliver care co-ordination and more intensive care in the home environment."*

In March 2012, Rand Europe, The Nuffield Trust, the University of Cambridge and Ernst & Young published a report into their independent evaluation of the Department of Health's Integrated care pilots. The report concluded that integrated care can improve quality of care if: *"well led and managed, and tailored to local circumstances and patient needs".* The majority of the pilots evaluated involved the 'horizontal integration' of services across community and social care providers, very few included 'vertical integration' between these providers and acute hospital providers.

In May 2013, the government announced that a series of 'pioneer' projects will be launched in 2013 that, amongst other objectives, will seek to reduce delays in discharging patients from hospitals. In making the announcement, the Care and support minister, Norman Lamb, stated: *"Unless we change the way we work, the NHS and care system is heading for a crisis."*

Increasing sub-specialisation in medicine and surgery

117. Increasing numbers of junior doctors are specialising at the outset of their careers. Aligning this with advances in medical technology and the impact of the European Working Time Directive, means that establishing regional centres of excellence in certain conditions is having a positive impact on survival for patients who attend these larger more specialised hospitals. This is in part due to the increased levels of consultant led care that consolidation of specialised (and scarce) resources can enable – a clear challenge for the clinical sustainability of MSFT – which has a demonstrably positive impact for certain patient groups.

Key considerations

There is growing evidence that concentrating some clinical services into larger specialised hospitals improves patient outcomes. In 2012, the Academy of Royal Colleges released a report[27] into the benefits of increasing consultant led care – something that larger more specialised hospitals are able to deliver – noting that: *"Numerous reviews by expert clinicians have concluded that patients have increased morbidity and mortality when there is a delay in the involvement in their care of*

[26] 'Integrated care for patients and populations: Improving outcomes by working together' The King's Fund, January 2012
[27] 'The benefits of consultant led care', The Academy of Royal Colleges, 2012

consultants across a wide range of fields including in acute medicine and acute surgery, emergency medicine, trauma, anaesthetics and obstetrics."

In January 2013, The Royal College of Surgeons of England released a report[28] on the reconfiguration of services, noting: *"With specialist resources and equipment in fewer locations, and a higher volume of patients with the same surgical conditions, staff will have more experience and expertise to ensure the highest patient safety levels."*

However, this trend needs to be balanced by the need to ensure rapid intervention is available for certain emergency patients, notably those with respiratory problems. A paper in the Emergency Medical Journal in 2007[29] noted: *"There is good evidence for some groups of emergency patients that care provided in specialist centres improves outcomes... In these cases we can be reasonably confident that with appropriate pre-hospital care and at distances typical in the UK, the benefits of specialist care, which is only available in certain centres, would outweigh any detriments resulting from the increased travel distances to the centres... Our data suggests that any changes that increase journey distances to hospital for all emergency patients may lead to an increase in mortality for a small number of patients with life-threatening medical emergencies... it is not certain that it would be acceptable to trade an increased risk for some groups of patients, such as those with severe respiratory compromise, for a reduced risk in other groups such as those with myocardial infarction."*

4.5 Change is required across the local health economy

118. The remit for the TSAs is to ensure the services currently delivered by MSFT can be delivered into the future in a sustainable manner. The TSAs have not put forward any draft recommendations with regards to other providers in the local health economy. However, it is evident that delivering sustainable services will require cooperation with local providers.

119. This presents a challenge to the TSAs because there is not one single provider in the local health economy that is not experiencing challenges of its own. Section 6 presents an overview of the local providers and outlines these issues. These issues have been widely reported and the local population of Stafford and Cannock are very aware of them.

120. One immediate challenge is that there is currently little available capacity at any of these providers to be able to deliver some of the services that may no longer be delivered in Stafford or Cannock. This lack of capacity differs between providers and by services, but regardless, it is inconceivable that changes could be made to MSFT services without:

[28] 'Reshaping surgical services: Principle for change', The Royal College of Surgeons of England, 2013

[29] 'The relationship between distance to hospital and patient mortality in emergencies: an observational study', Nichol et al, 2007

- increasing the capacity for certain services at one or more of the other local providers; and/or
- reducing the demand being placed upon acute services across the local health economy; and/or
- reconfiguring the way in which services are delivered across the local health economy.

121. The TSAs have been in regular contact with the leaders of the local providers. The TSAs are confident that all parties: recognise the challenges in their own organisation and the local health economy overall; are determined to address these issues in order to strengthen the local health economy; and, are committed and willing to work in new ways which will support the delivery of the TSAs' draft recommendations.

4.6 What are the consequences of doing nothing

122. MSFT as an NHS provider is not sustainable. If nothing is done to address the clinical and financial issues in a planned programme of transformation, it is inevitable that the Trust will need to make piecemeal changes in order to address clinical safety issues and reduce costs. The potential consequences of 'doing nothing' are likely to include some or all of the following. It should be noted that this is not an exhaustive list and is based upon a reasonable assessment of the challenges that MSFT faces.

- Despite commissioner expectations that services are retained in Stafford and Cannock, it is likely that MSFT would need to close one of the two hospitals. This alone would not address the financial challenges the Trust faces, but would deliver a reasonable reduction in operating costs.
- Some of the major clinical services are likely to continue to operate at significantly below the recommended level of consultant cover. It is therefore likely that these services would need to reduce the level of service offered, including:
    - The levels of emergency practitioners currently working within the A&E are at the bare minimum required to deliver a 14/7 service. Any changes to the staffing levels, e.g. through illness or staff leavers will mean the unit could be unsafe to operate a 14/7 service. Any further reduction of service in Stafford will place additional pressures on the already struggling A&E units across the region.
    - 24/7 emergency surgery is unlikely to be maintained as there is insufficient surgical cover to operate safe 24/7 rosters. Indeed, in 2011 a

local review of the emergency surgery provision concluded that the service was unviable in its current form.

- Low volume services may need to be decommissioned as the patient volumes will make the service unviable. This would mean that patients would need to travel to receive all elements of this service – including outpatient appointments.
- Cost improvements would still need to be delivered. This would certainly impact front line services, although the changes outlined above would deliver some cost improvements.
- Any unplanned or piecemeal changes to the services in Stafford would mean a drift of patient activity to other providers in the local health economy – some of whom are having capacity issues.
- Funding from local commissioners and the Department of Health would need to be provided to ensure the Trust remains solvent. These funds come from a finite CCG/NHS budget, which means that other services would need to be rationalised in order to generate these funds.
- The Trust would not have funds available to invest in capital/estate improvements, the latest medical technologies or medicines.

123. Some of these potential outcomes would be triggered due to the need to make savings. If the current level of subsidy (ca. £20m per annum) were made available to the Trust indefinitely then some of these outcomes are less likely. However, the Trust would still:

- be one of the smallest in the country;
- operate a number of critical services with staffing levels significantly below royal college guidelines;
- have the same challenges around recruitment and retention of staff; and
- be understaffed in certain specialities.

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

4.7 Change must be delivered as quickly as possible

125. The draft recommendations made by the TSAs are complex – there is no one single solution – and will require change across many organisations. Consequently these draft recommendations will take a reasonable period of time to implement.

126. The uncertainty about the future of services in Stafford and Cannock has been challenging for the staff. In the last six months a number of staff have left, or have indicated they are planning to leave, the Trust. Several have cited the ongoing uncertainty as a factor in their decision to leave. If, because of delay in implementing change, further staff leave the Trust, or patients exercise their right to attend another provider, there is a significant risk that services will be adversely affected. It is therefore essential that changes are clearly communicated, thoroughly planned and are executed as quickly as possible.

5 Commissioning in the local health economy

127. Commissioning across the NHS has undergone a significant change in the last 1-2 years. The traditional commissioning bodies (Primary Care Trusts and Specialised Commissioning Groups) have been replaced by local Clinical Commissioning Groups (CCGs) and regional 'Local Area Teams' (LATs) who will work under the strategic direction of NHS England. These new commissioning bodies took over responsibility for commissioning healthcare services in April 2013.

128. The CPT and more recently the TSAs have been working closely with local CCGs (primarily Stafford and Surrounds and Cannock Chase CCGs) and this section presents a high level outline of current commissioning intentions, the finalisation of Location Specific Services (LSS), the need for commissioners to deliver financial balance in the local health economy and the steps the CCGs are taking to reduce the demands being placed in secondary care providers.

5.1 Commissioners in the local health economy

129. Stafford and Surrounds and Cannock Chase Clinical Commissioning Groups (CCGs) commission services for a registered population of 276,50030 and for a large proportion of this population (estimated by Public Health Staffordshire to be ca. 204,400) their main acute provider is MSFT. Indeed c95% of GP referrals at MSFT comes from referrals from within the Stafford and Cannock CCGs.

130. GPs within these two CCGs made over 40,000 new referrals to MSFT in 2012/13 and whilst the volume of referrals reduced during the period 2009/10-2011/12 from the 2008/09 levels, the referral numbers (from local GPs) in 2012/13 are almost back to 2008/09 levels (see Table 18). However – as noted in Section 2.2 – total referrals into MSFT are 10% lower than 2008/09 levels (other referral routes being A&E referrals and hospital consultants).

Table 18: MSFT referrals from local CCGs

Year	2008/09	2009/10	2010/11	2011/12	2012/13
S&S CCG new referrals[31]	20,476	19,273	18,939	18,033	20,889
CC CCG new referrals[29]	20,497	19,099	18,624	19,061	19,812

[30] NB: As per Section 2.2, this is distinctly different to the catchment population for MSFT.

[31] Data from South Staffordshire PCT referrals have been used to estimate referrals numbers prior to the formation of the CCGs

131. Stafford and Surrounds CCG and Cannock Chase CCG are committed to ensuring that services are delivered as locally as possible and centralised where necessary in order to ensure that the local population receives the highest possible standards of care. This is reiterated in their letters to the TSAs that give their support to the draft recommendations being put forward for consultation (see Appendices G and H).

132. The CCGs accept that the scope, style and scale of these services may be significantly different in the future and they also understand and support the need for local health services to be both clinically and financially sustainable. On this basis, the CCGs have acknowledged that the services currently delivered by MSFT will need to change and this means that some services may need to shift away from Stafford and/or Cannock.

5.2 Commissioning intentions (provided by Stafford & Surrounds and Cannock Chase CCGs)

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

134. Each CCG was sent a data benchmarking pack by the Department of Health as they were authorised in April 2013. The information in these packs suggests that the two CCGs have higher levels of acute activity than the national average, as summarised in Table 19.

Table 19: Admission rates for MSFT vs. national average

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

135. The CCGS have a particular focus on patients who have ambulatory care sensitive conditions, where evidence[32] indicates that patients with these conditions can and should be managed outside of acute hospitals.

136. Future services need to be clinically safe and affordable and be tailored to meet specific population needs. Therefore beds at Stafford and Cannock need to be

[32] Source, NHS Institute: The Directory of Ambulatory and Emergency Care for Adults.

particularly focused on provision for the frail elderly and people with life-long chronic conditions. It is the CCGs' desire that in the future many more people with chronic conditions will be effectively managed in Primary Care and Community Services and admission to hospital for this group will be the exception rather than the rule.

137. The commissioner aspirations are for a more integrated provider landscape which reduces service fragmentation and care pathways spread across multiple organisations, ultimately reducing acute interventions as a consequence of a failing system of care. More specifically, commissioners wish to ensure that:

- Emergency and Urgent Care is adequate to meet most population needs whilst being safe and affordable (this includes enhancing the provision of minor injuries at Cannock, which would have been designated as a location specific service had the service been provided by MSFT);
- Planned care pathways are robust enough to safely manage patients effectively in Primary Care for longer through the use of new interventions; and
- The provision of new services using technological advances in healthcare is maximised.

138. The commissioning prospectus for each CCG is included in Annex 3 and the detailed CCGs commissioning intentions can be found at: www.cannockchaseccg.nhs.uk and www.staffordsurroundsccg.nhs.uk.

5.3 Affordability of commissioned services

139. The primary responsibility for CCGs is to commission a broad range of high quality, safe services to meet the healthcare needs of their local population.

140. In achieving this objective, CCGs are going to be measured against a broad set of outcomes, which are aggregated under five headings[33]:

- Preventing people from dying prematurely;
- Enhancing quality of life for people with long term conditions;
- Helping people to recover from episodes of ill health or following injury;
- Ensuring that people have a positive experience of care; and
- Treating and caring for people in a safe environment and protecting them from avoidable harm.

141. These measures are all – quite rightly – quality indicators, rather than financial indicators. However, CCGs operate with finite financial resources and commission

[33] Source: The CCGs outcomes indicator set 2013/14 – NHS England.

healthcare services from multiple healthcare providers, including those delivering secondary (acute) care, metal healthcare and community care.

142. It is the responsibility of CCGs to ensure that these financial resources are used to deliver the highest positive impact for the local population. Spending money on financially inefficient services deprives other parts of the local health economy from funding, funding which – in the CCGs' assessment – may be more effective at meeting their commissioning outcomes.

143. Table 20 outlines the broad split of how the two CCGs spend their budgets.

Table 20: Allocation of CCG funds

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

5.4 Managing the demand for acute services

144. Demand for healthcare services is rising and putting many parts of the healthcare system under increasing pressure. Initiatives that seek to reduce demand for acute hospital services are typically known as 'demand management' initiatives. It is essential that commissioners and providers work together on demand management in order to:

- Reduce the volume of patients that need healthcare interventions;
- Reduce the volume of patients that are referred to or self-present at acute hospitals; and
- Reduce the volume of patients that re-attend acute hospitals for further treatment (whether through readmissions or through excess follow-up appointments).

145. In 2013/14, the CCGs have established plans to deliver a range of demand management targets:

- Outpatients – both CCGs are aiming to reduce first outpatient appointments by 5%, through improvements in care pathways and better GP to consultant communications;

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

146. In addition to these plans, the commissioners are considering additional interventions in order to manage demand in the system. The TSAs have summarised these interventions in Section 10.7.

5.5 Location Specific Services (LSS)

147. The Failure Regime for Unsustainable NHS Providers, as set out in Chapter 5A of the 2006 National Health Service Act (the failure regime), is intended to ensure the continued provision of healthcare services in the event that a healthcare provider fails.

148. As part of this regime, one of the obligations of the CPT was to work with local commissioners to draft a list of 'protected services'. The process undertaken aligned with Monitor's draft guidance on "Ensuring continuity of health services and designating Commissioner Requested Services and Protected Services".

149. This guidance has now been finalised, with some minor modifications to the process and the language – notably the change in terminology to 'Location Specific Services' or 'LSS'[34].

150. Location Specific Services are those services which, if withdrawn, and in the absence of alternative local provision, would be likely to lead to:

- a significant adverse impact on the health of persons in need of the service or significantly increase health inequalities; or
- a failure to prevent or ameliorate either a significant adverse impact on the health of such persons or a significant increase in health inequalities.

151. The guidance sets out that, during the first 45 working days of the TSA process[35], local commissioners are required to reconsider and formally sign off the list of Location Specific Services that was drafted during the CPT phase of work.

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

152. Moreover, the TSA is expected to only consider options for changes in services that, at a minimum, provide for the continued provision of Location Specific Services for up to ten years following the cessation of their appointment at the trust[36]. All options should ensure that the provision of such services satisfies the principles of effectiveness, efficiency and economy. In addition, the TSA may make recommendations relating to Location Specific Services that impact upon organisations other than the provider in trust special administration (i.e. other than MSFT). Such recommendations should be, over the medium-term, financially sustainable and improve or maintain clinical standards, and these must be in line with clinical commissioning intentions[37].

153. It is important to note that only services provided by the 'failing' provider can be protected and that only services that currently exist can be protected. In addition, if a particular local service is not designated for protection, this does not mean it is not required or that it will not be commissioned. When a service is not protected, this is either due to availability of feasible alternatives or because commissioners believe they can commission it without extra regulatory protection[38].

154. In preparing the list of Location Specific Services, four criteria were considered:

Table 21: The criteria used when nominating LSS

Criterion	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?

[35] Where an extension is granted, as it was in this instance, this would be within 75 working days.
[36] Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts, 5 April 2013, London: Monitor.
[37] Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts, 5 April 2013, London: Monitor.
[38] Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust Recommendations of the CPT, March 2013.

155. The TSAs have confirmed with the CCGs an agreed list of the LSS; they are set out in Table 22.

Table 22: The confirmed list of Location Specific Services

Stafford & Surrounds CCG	Cannock Chase CCG
At Stafford: Services identified as an LSS on the basis that not doing so would impact Health Inequalities: • Outpatients • Patient-facing diagnostics • Day case chemotherapy • Pre-natal and post-natal care • Step down beds ***These are the 'Core LSS' for Stafford.***	**At Cannock:** Services identified as an LSS on the basis that not doing so would impact Health Inequalities: • Outpatients (including pre-natal and post-natal care) • Patient facing diagnostics ***These are the 'Core LSS for Cannock'.***
At Stafford: Services identified as an LSS on the basis that there is currently insufficient capacity at alternate providers: • Current 14/7 A&E [39] • Routine Obstetrics • Selected Emergency (Non Elective) admissions / inpatients [40] • Select elective admissions for a range of medical specialties ***Each service will cease to be identified as an LSS when CCGs are content that suitable alternate capacity is available.***	
At Stafford: Services identified as an LSS on the basis that they are interdependent with another service that is identified as an LSS: • High dependency services commensurate with services on site • Sufficient neonatal resuscitation to support services on site • Adult Anaesthetics ***Each service will cease to be identified as an LSS if/when the interdependent service is no longer an LSS.***	
At Cannock: No services are identified as LSS in Cannock by S&S CCG	**At Stafford:** No services are identified as LSS in Stafford by CC CCG

[39] Commissioning intentions are to redesign the services and commission 24/7 Emergency and Urgent Care service

[40] 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

6 Providers in the local health economy

156. Every hospital operates within a local health economy (LHE) comprising a range of health commissioners, healthcare providers, social care providers and public health programmes that seek to positively influence, manage and treat the healthcare needs of a local population.

157. In developing the draft recommendations presented within this report, the TSAs have had to be aware of:

- the influences that the LHE have upon MSFT;
- the impact that any changes proposed for MSFT will have on other organisations within the LHE; and
- how possible changes in these other organisations will impact the delivery of healthcare services to the local population of Stafford and Cannock.

158. This section provides an overview of the other main healthcare providers within MSFT's local health economy. It summarises: the key characteristics of each provider; some of the key parameters associated with each provider (e.g. income, number of staff); and, most pertinently, the key challenges each provider is currently facing.

6.1 Overview of providers in the LHE

159. The following tables present an overview of the other providers in terms of the size and type of services they provide (*summarised from the CPT report, with updated figures based upon information published by the Trusts*):

Table 23: A summary of UHNS

University Hospital of North Staffordshire NHS Trust (UHNS)					
2011/12 turnover	2011/12 surplus/ (deficit)	2012/13 turnover	2012/13 surplus/ (deficit)	Number of staff	Number of beds
£426m	£3m	£470m	£0.2m[41]	ca. 6,700	1045
University Hospital of North Staffordshire is a major acute trust providing services predominantly from the City General Hospital in Stoke-on-Trent. The City General Hospital was redeveloped under a PFI scheme in 2012. It provides specialist treatment such as major trauma and neurosurgery to not only the local populations of Newcastle under Lyme and Stoke on Trent but to the wider population of Staffordshire and South Cheshire and Derbyshire.					

[41] This small surplus was delivered by *"receipt of significant sums of non recurrent funding and the additional payments negotiated for the activity delivered above the originally contracted levels."* – June 2013 Board papers

Table 24: A summary of BHFT

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

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

Table 25: A summary of WHT

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

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

Table 26: A summary of RWT

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

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

Table 27: A summary of SaTH

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

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

Table 28: A summary of SSoTP

Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSoTP)					
2011/12 turnover	2011/12 surplus/ (deficit)	2012/13 turnover	2012/13 surplus/ (deficit)	Number of staff	Number of beds
£204m	£1.5m	ca. £369m (planned)	£2m	ca. 6,000	303 (community)

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

6.2 Immediate challenges faced by the local providers

160. There are a range of challenges for the providers across the local health economy. In some cases these challenges are significant and increasing.

161. From a financial perspective, both UHNS and BHFT (along with MSFT) are reporting financial deficits – although in both cases the level of deficit (in relation to turnover) is somewhat lower than the 10% deficit at MSFT.

- BHFT reported a deficit of £3m (2% of turnover) at the end of the last financial year, an improvement of over £2m from the previous year.
- In May 2013, the auditors at UHNS wrote to the Secretary of State reporting a forecasted deficit for the end of the current financial year of greater than £30m (which would be ca. 7% of turnover). The latest board report at UHNS (June 2013) reported:

> *"The letter outlines the financial position for 2012/13, whereby financial balance was only achieved through the receipt of significant sums of non recurrent funding and the additional payments negotiated for the activity delivered above the originally contracted levels.*
>
> *The current position for 2013/14 is summarised in the letter, whereby the provisional plan forecasts a shortfall of income over expenditure of £31.4m, subject to the outcome of the ongoing discussions with the NTDA."*

162. In addition to the financial challenges faced by some providers, many trusts in the LHE face significant challenges at being able to sustain the current quality of care and access levels particularly within A&E and emergency admissions.

163. In May 2013, the clinical leads for the 18 A&E departments in the West Midlands wrote a joint letter to the CCG leads and Trust Chief Executives. The letter sought to highlight the recent challenges that have been prevalent and widely reported across all parts of the NHS (the full letter is presented in Appendix J):

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

164. In the last 12 months, A&E performance has, in general, deteriorated across England. In response NHS England have asked all hospital trusts and CCGs to develop specific plans for reducing demand on each A&E within the country.

165. All NHS Trusts should be working towards achieving FT status. To become FTs, each provider will have to demonstrate sustained good performance in clinical operations, governance and financial management. MSFT and BHFT are the only current FTs in the local health economy.

166. As noted in Section 2, MSFT has undergone recent inspections by the CQC who have not reported any concerns with the quality of care at MSFT. All of the other providers in the LHE have also undergone recent inspections and no major concerns have been reported at any of these providers (see Table 29).

Table 29: A summary of CQC inspections across the local health economy

Provider	Date of last inspection	Number of standards the Trust was measures against	Compliant	Minor concerns	Moderate concerns	Major concern
BHT	Jul 12	6	5		1	
SaTH	Nov 12	6	6			
RWT	Mar 13	5	5			
UHNS	Sep 12	9	9			
WHT	Aug 12	7	6	1		

Source: www.cqc.org.uk

167. The two concerns noted in this table are:

- At its last full inspection in July 2012 BHT had a moderate concern related to medicine management. At a follow up visit in December 2012 BHT were found to be compliant in this area.
- WHT received a minor concern for its record keeping at its routine visit in August 2012. The Trust was re-assessed against this in December 2012 and received a minor concern still in this area.

7 Meeting the TSAs' obligations

168. This section presents an overview of the responsibilities of the TSAs and the approach the TSAs have taken in order to develop this draft report. It presents an overview of the statutory obligations of the TSAs, the timetable that the TSAs are working towards and the governance structure of the TSAs and the 'Office of the TSAs'. The latter part of this section then explains the work that the TSAs are currently undertaking alongside the consultation process in order to finalise the recommendations that the TSAs will make to Monitor and the Secretary of State for Health.

7.1 The statutory obligation of the TSAs

169. On 16th April 2013, Monitor appointed Joint Trust Special Administrators to MSFT under the National Health Service Act 2006, as amended by the Health and Social Care Act 2012. This is the first time that Monitor has appointed a Trust Special Administrator to take over the running of a Foundation Trust (FT).

170. The TSAs have been appointed to meet a series of obligations and processes established in the National Health Service Act 2006 and they are required to have regard to the guidance issued by Monitor ('Statutory guidance for Trust Special Administrators appointed to NHS Foundation Trusts' - 5 April 2013). In setting out the role of the TSA, the guidance states:

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

171. The process being followed by the TSAs involves a time limited statutory timetable[42], during which:

- Monitor must determine whether it is satisfied that the recommended action fulfils the objectives of special administration and that the TSAs have carried out their duties; and
- If Monitor is satisfied, the Secretary of State for Health must determine whether he intends to exercise his limited grounds for veto. This will avoid prolonged periods of uncertainty and clinical and/or financial underperformance.

172. Based on this time limit, the TSAs have developed a high-level plan for delivering its recommendations to Monitor, as seen in Figure 7.

173. The legal framework allows for Monitor to extend the 145 working day timetable 'in exceptional circumstances', through the extension of the periods for the draft report, consultation or report finalisation.

174. In this instance, and at the request of the TSAs, the period for the production of the TSAs' draft recommendations was extended from 45 working days to 75 working days. The period for the public consultation was also extended from 30 working days to 40 working days (Annex 5 includes the TSAs' published 'Questions and Answers' which outline the reasons for this extension).

Figure 7: The TSA timeline

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

[42] *Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts*, 5 April 2013.

175. The draft report (this document) must set out a series of draft recommendations 'on how to provide high quality services in a sustainable way'[43]. These draft recommendations could propose to reconfigure services within the current foundation trust or to propose moving towards the dissolution of the foundation trust. In the latter case, the TSAs may propose that the assets and liabilities of the foundation trust are merged with another trust, transferred to the Secretary of State (for provision by a provider that is not a foundation trust), or a combination of both.

176. In drafting this report – and prior to the formal public consultation – the TSAs were obliged to engage with a range of stakeholders as set out below:

- the Care Quality Commission (CQC) to ensure the proposed changes meet with the CQC's registration requirements;
- NHS England with regards to the commissioning of services;
- Local commissioners to confirm Location Specific Services and to support the development of any proposed reconfiguration of services;
- any other person that Monitor instructed the TSAs to engage with. In the instance of the TSAs for MSFT, Monitor expected the TSAs to engage with:
    - Local providers in order to assess the impact of any proposed changes to services on these providers;
    - Clinical experts to ensure that patient safety and clinical sustainability is the priority in determining any proposed changes to services;
    - Monitor and the NHS Trust Development Agency (NHS TDA) to ensure they understand and endorse any proposed changes that may impact other foundations trusts and NHS trusts (respectively);
    - The Department of Health if the proposed changes are likely to require additional funding for implementation or long term financial support.

177. The TSAs have held regular meetings with Monitor to ensure these obligations were being met.

178. The TSAs have engaged with all of these stakeholders. Appendices D-H are copies of correspondence received by the TSAs from NHS England, the local CCGs and the two national clinical advisory groups formed by the TSAs. This correspondence indicates the level of engagement that the TSAs have had with each group and their observations on the TSAs' draft recommendations. Annex 5 summarises the meetings the TSAs have had with a range of stakeholders since their appointment.

[43] Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts, 5 April 2013.

7.2 Governance of the programme

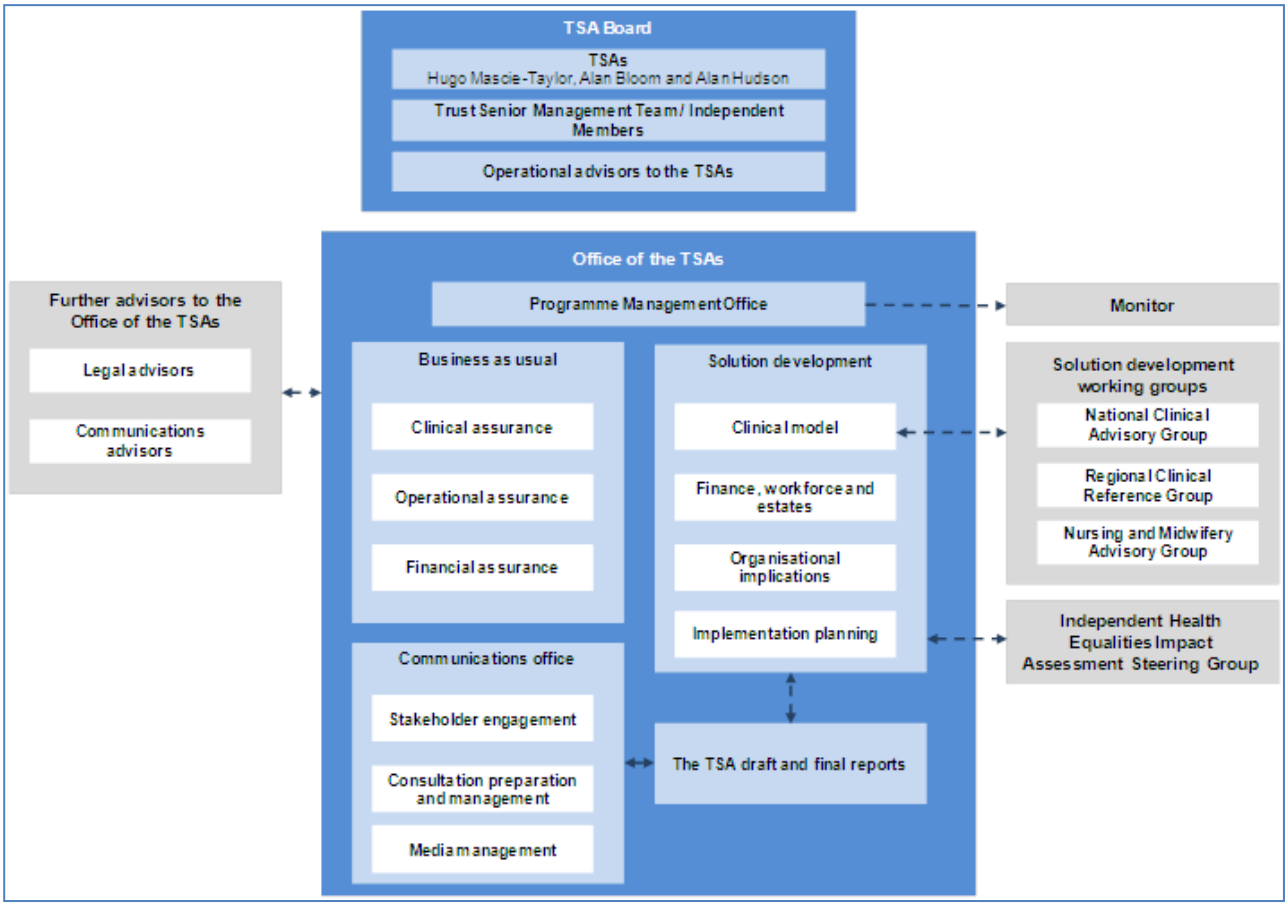
179. Following the appointment of the TSAs, the Trust Board (Executive and Non-Executive Directors, including the Chairman) and Council of Governors were suspended from office. Alan Bloom immediately took on the role of Accountable Officer for the Trust and the TSAs took on the functions of the Governors, Chairman and Directors of the Trust .

180. As the Accountable Officer for MSFT, Alan Bloom is accountable to Monitor in their role as regulators. Monitor must be satisfied that the TSA has carried out certain administration duties under the Act.

181. Although the TSAs are accountable to Monitor, with regards to the development of draft recommendations for the future provision of services, the TSAs are operating independently of Monitor, the Department of Health, the Secretary of State for Health and any other government entity. The draft and final reports will be formally submitted to Monitor in line with the timetable set out in Section 7.1.

182. Figure 8 shows a summary of the governance structure of the TSAs.

Figure 8: The governance structure of the TSAs



183. Key elements of the governance structure are:

- The TSAs have been working closely with the Trust's senior management. Although their Executive powers have ceased, Trust senior management still have day to day responsibility for running the Trust;
- The TSAs have been advised on a day to day basis by a former Chief Executive of an NHS Trust, with regards to assuring 'business as usual' from an operational, clinical and financial perspective;
- This is the first Trust Special Administration of a Foundation Trust, therefore the TSAs have been taking regular legal advice;
- The TSAs have been regularly updating Monitor on the progress of the work being undertaken, and Monitor have been reviewing compliance with the guidelines for TSAs;
- Two clinical advisory groups have been established, see Annex 6;
- An independent Health and Equality Impact Assessment steering group (HEIA) has been established (see Section 8);
- There have been five primary workstreams within the 'Office of the TSAs':
    - The 'Programme Management Office (PMO)' has managed the day to day progress and administration of the TSAs, including reporting to Monitor, regular risk assessments and programme coordination;
    - The 'business as usual' leads have been working with the senior management of the Trust to oversee the day to day operations of the Trust;
    - The 'solution development' team is an ongoing workstream focussed on developing the draft recommendations of the TSAs;
    - The 'communications office' has coordinated all stakeholder engagement activities and managed activities associated with external enquiries, correspondence, media briefings and social media. The communications office will also be overseeing the public consultation; and
    - 'The TSA reports' workstream is the smallest element of the Office of the TSAs and is overseeing the writing of this draft report, the consultation documentation (with the communications office) and the final report to Monitor – after the public consultation. The majority of the information for the TSA reports is coming from the 'solution development' work.

7.3 Governance of the Trust

184. The appointment of the TSAs has not affected the Trust's executive directors' employment status and, as expected, the executive directors have formed the Trust's

'Senior Management Team' with responsibility for the day to day running of the Trust.

185. The Chief Executive of the Trust on the date of the TSAs appointment was Lyn Hill-Tout who has subsequently retired (this was announced prior to the appointment of the TSAs). Maggie Oldham (previously the Chief Operating Officer) has been appointed as the Interim Chief Executive.

186. The TSAs would like to put on the record their recognition for the transformation that Ms Hill-Tout has overseen in her time at the Trust. Her commitment to honesty, compassion and positive public engagement – during a period of intense scrutiny – is of particular note.

187. Immediately upon taking office, the TSAs ordered a full review of the governance and committee structures in place within the Trust. The purpose of these reviews was to: a) assure the TSAs that the governance structures were fit for purpose; b) ensure there are appropriate revisions to the governance structure to enable the Chief Executive to raise matters requiring approval from the TSAs; c) assess if the suspended non-executive directors and governors would and should continue to work with the Trust as 'Independent Members' and 'Public Representatives' of the Trust – something the TSAs have full discretion to determine.

188. These reviews were overseen by the operational advisor to the TSAs. The outcomes of this review were, in summary:

- The legacy governance structure was onerous and had effectively served its purpose over the last two years in driving the Trust to deliver progress regarding clinical and operational performance. The review recommended minor refinements in order to provide assurance to the TSAs though the Senior Management Team;
- The suspended Chair agreed to support the TSAs as an independent member. This support is primarily through the chairmanship of the Senior Management Team meetings.
- Those suspended non-executive directors who did not resign their posts prior to the appointment of the TSAs have agreed to serve as independent members on the Quality, Integrated Audit and Assurance, and Charitable Funds committees.
- The suspended governors continue the role they previously undertook in carrying out announced and unannounced visits to the hospital. They were asked to do this as 'Public Representatives' and have agreed to do so. The Chair of the Governors has also agreed to provide an independent challenge to the TSAs work.

189. The governance review is included as an Annex to this draft report (see Annex 4).

190. As well as undertaking the detailed governance review the TSA has taken steps to assure itself of the safety of the services currently provided. The TSAs operational advisor is a member on the Quality Committee and provides a direct link from the TSA into the scrutiny of any clinical quality issues.

191. The TSA has also overseen a review of all of the actions identified from the recent reports undertaken at the Trust. This review has shown there are no significant actions that are outstanding and importantly the CQC reports have not identified any concerns.

192. The TSA has also been receiving regular reports from the Senior Management Team at the Trust on particularly vulnerable services such as A&E.

193. From these actions which are currently being undertaken the TSAs have been assured that the services are currently being delivered in a safe manner. As well as the assurance on current service provision the TSAs have the necessary mechanisms in place to identify issues going forward.

7.4 Stakeholder engagement

194. The TSAs are obliged to formally consult with a range of stakeholders, both during the development of draft recommendations (as outlined in Section 10), and through the public consultation that will commence on Tuesday 6th August 2013. This engagement is integral to the programme of work being undertaken by the TSAs. However, the statutory guidance for TSAs also sets out the requirement to informally engage with patients, the local population, staff and other parties, prior to the start of the formal consultation.

195. This informal engagement is essential, most especially so that the local population are given the opportunity to understand the rationale for the appointment of the TSAs, the process that the TSAs are undertaking, and how the public will be formally consulted. The TSAs have embarked on a wide range of stakeholder engagement and communications activities, in line with and beyond the requirement set out in the statutory guidance issued by Monitor.

196. Shortly after being appointed, the TSAs held a series of public meetings in Stafford and Cannock. These meetings were not part of the formal consultation and were used primarily as an opportunity to provide information to the public on the process the TSAs were following. Given the timing of the meetings, the TSAs were not in a position to comment on the future of services. The public consultation is the

opportunity for the public to ask these questions and the TSAs will be holding a further series of public meetings during the consultation to answer questions on the draft recommendations contained within this report.

197. Annex 5 presents detailed information on the stakeholder engagement activities undertaken by the TSAs to 26th July 2013. In summary, these are:

- The TSAs have received in excess of 1,650 letters, 250 emails and 100 telephone calls from members of the public. The Office of the TSAs have responded to every letter, email and telephone call received;
- The TSAs have hosted three public meetings, two in Stafford and one in Cannock – as outlined above. Unedited recordings of these meetings are available to view on the TSA's website (http://tsa-msft.org.uk/video-gallery/)
- The TSAs have held 10 meetings with the clinical advisory groups established to support the TSAs;
- The Office of the TSAs have held 84 meetings and 72 telephone calls with organisational stakeholders;
- The TSAs have conducted 11 ward and departmental visits, have held 10 staff briefing sessions and 7 staff drop-in sessions;
- The TSAs have issued six stakeholder bulletins, all of which are available on the TSAs' website (http://tsa-msft.org.uk/latest-news/);
- The TSAs have produced and regularly updated a series of Frequently Asked Questions (FAQs). Many of these questions are based upon themes of questions posed at the public meetings and through the various correspondence received by the TSAs. These FAQs are available on the TSAs' website (http://tsa-msft.org.uk/faqs/) and are captured in the stakeholder engagement summary (Annex 5);
- The TSAs have also met with the local authorities, local Members of Parliament, CCGs from across the local health economy and healthcare providers from across the local health economy.

198. The TSAs recognise that the Trust's staff will know the patients and services best and therefore it would be invaluable to consult with staff regularly throughout the process.

199. Following appointment, the TSAs addressed staff on Wednesday 17 April 2013 to explain the TSA process and to clarify how the Trust would be run going forward, recognising that this is a time of uncertainty for staff. The TSAs continued to run weekly staff drop-in sessions and ward and department visits to engage with staff throughout the pre-consultation period.

200. Further, the TSAs held initial meetings with union representatives and staff groups. The TSAs sought to obtain the views of staff as to how best to engage with them during the consultation period.

201. Throughout the process, the TSAs also communicated with staff through a dedicated staff email address and internal extension number, as well as sending key announcements through staff emails which included staff FAQs reflecting staff queries raised in briefings and questions received through correspondence.

7.5 Clinical guidance to the TSAs

202. On the appointment of the TSAs for MSFT, Monitor made it clear that it was their expectation that the development of proposals for changes to services should routinely draw upon relevant clinical expertise. The TSAs have been working closely with clinical experts to:

- Support commissioners to identify the Location Specific Services and broader commissioning intentions in line with the needs of the local population;
- Identify where suitable alternative provision exists, and where it does not, to identify options for developing suitable provision;
- Develop a solution that is set up to improve clinical standards and outcomes;
- Assess the clinical sustainability of proposed solutions; and
- Determine the conditions required to make the implementation of the TSAs' draft recommendations successful.

203. The TSAs fully recognise the importance of day to day clinical guidance in the work required in developing the draft recommendations. This is a key reason behind the decision to propose that one of the TSAs is a credible and highly experienced clinical leader. Professor Hugo Mascie-Taylor is a Fellow of the Royal College of Physicians of London and Ireland. Hugo has held key roles in the NHS including Chief Executive, Medical Director, Commissioning Director and Director of Strategic Development in NHS trusts in West Yorkshire. He has also recently served as the Medical Director for the NHS Confederation.

204. In addition to Hugo's day to day leadership of the work to develop a proposed solution, the TSAs have drawn upon a wide range of clinical advice, as follows:

- Regular engagement with the Chairs of Stafford and Surrounds CCG and Cannock Chase CCG – both of whom are long established GPs within the local area; and
- Specific engagement with the previous and present MSFT Medical Directors to understand the current challenges faced at the Trust.

- The formation of a National Clinical Advisory Group (CAG) to provide the TSAs with their clinical advice. The CAG was jointly chaired by Professor Hugo Mascie-Taylor (joint TSA) and Professor Terence Stephenson (Chairman of the Academy of Medical Royal Colleges) and comprised representatives from each of the Medical Royal Colleges. The CAG provided the TSAs with their advice with regards to the extent to which the potential clinical models:
    - can be delivered safely;
    - can move services to be more closely aligned with Royal College guidelines;
    - could potentially impact the local health economy; and
    - can support the recruitment and retention of key clinical staff.
- The formation of a National Nursing and Midwifery Advisory Group (NCAG) to provide the TSAs with their professiional advice. The NCAG comprised senior Nurse and Midwifery Representatives from the professional bodies and Trusts nationally. The NCAG had a similar remit to the CAG in providing advice in the four areas identified above.
- The formation of a local Clinical Reference Group (CRG). This group was formed from the Medical Directors of the LHE provider Trusts and the Chair's/Clinical leads from the LHE CCGs and provided the TSAs with a local clinical viewpoint on the proposed clinical model.

7.6 Engaging with stakeholders to developing the draft recommendations

205. In developing the draft recommendations, the TSAs have: worked closely with local commissioners and providers within the local health economy; undertaken a market engagement exercise; and, developed a series of draft recommendations for the clinical model. These activities are outlined in the remainder of this sub-section.

An ongoing dialogue with local commissioners

206. The leads of the TSAs' solution development team met with the leads of Stafford and Surrounds CCG and Cannock Chase CCG - as the lead commissioners for the services currently provided by MSFT – immediately on appointment of the TSAs. The objective of this initial engagement was to confirm and finalise the Location Specific Services (LSS) and to understand the CCGs' latest commissioning intentions. Annex 3 presents the commissioning strategies (2013/14) for both CCGs.

207. The TSAs have established continuing and regular engagement with the CCGs. In line with Monitor's guidance, this engagement serves two purposes: (i) to confirm the LSS; and (ii) to confirm their specific commissioning intentions for any of the non-LSS.

208. The Office of the TSAs has worked with the commissioners on a number of areas to ensure that the clinical models underpinning any proposed service delivery models are sufficiently well described that the public consultation can be meaningful. Given the timescales, the TSAs have had to develop much of this information in parallel with engagement with potential providers of services.

Working closely with the providers in the local health economy

209. Given the potential scale of any proposed change, the TSAs met with providers in the local health economy to discuss the local provision of services that may no longer be provided by the Trust. It is essential that the TSAs understand and establish an action plan to mitigate the potential impact of these changes.

210. The TSAs were also aware that the market engagement exercise (see below) may not identify a viable solution. Therefore, the TSAs engaged with local providers to explore other alternate solutions. This exercise ran in parallel with the market engagement exercise.

Engaging with potential providers of services in Stafford and Cannock

211. The TSAs have conducted a market engagement exercise. The purpose of this exercise was to give any provider of healthcare services – NHS, independent sector and voluntary sector – the opportunity to put forward a proposal on their capability and willingness to provide services to the population of Stafford, Cannock and the surrounding areas.

212. It must be emphasised that this was not a procurement exercise and the results of the assessment of expressions of interest will not lead to any award of a contract, nor will any provider be prejudiced who wishes to apply for the future procurement opportunity. The purpose of the exercise was solely to help the TSAs to identify potential options for consideration.

Developing the preferred solution

213. The TSAs have used the information gathered to develop, analyse and evaluate a series of draft recommendations. Section 9 of this reports sets out the process undertaken to draft these recommendations and in Section 10 we present the detail of the draft recommendations.

7.7 The 'four tests' of health system reconfigurations

214. In 2010, the then Secretary of State for Health introduced 'four tests' that should be satisfied in any reconfiguration of health services. In a recent Parliamentary debate on Stafford Hospital[44] it was stated by The Parliamentary Under-Secretary of State for Health that: "...I would expect that any proposals meet the four tests for any service change and reconfiguration, which were set by the former Secretary of State for Health...".

215. In their final report, The TSAs will demonstrate that their final recommendations meet these tests and the rest of this sub-section summarises how the work of the TSAs, to date, and the draft recommendations align with the tests.

Test 1: The recommendations are underpinned by clear clinical evidence

216. Developing the clinical model has been the central building block of the approach taken by the TSAs. The draft recommendations have been tested with the CAG, NCAG and CRG, and are based upon a range of established clinical standards. The feedback from the clinical advisory groups is summarised in Section 9.9 with full details in Annex 6.

Test 2: The changes have the support from CCGs

217. The local commissioners have been actively involved in the CPT/TSA process from the outset. Indeed, Monitor's guidance for their application of the Unsustainable Provider Regime (UPR) is that CCGs must have a formal role in both the CPT and TSA. This is primarily through the need for the CCG to be the responsible body for developing and signing off the LSS.

[44] http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130704/debtext/130704-0004.htm

218. The CCGs meet with the TSAs' solution development team once a week, were represented on the Local Clinical Reference Group and have been integral in developing and finalising the draft recommendations.

219. The letters sent to the TSAs by the CCGs (Appendices G & H) indicate the provisional support to the TSAs' draft recommendations.

Test 3: The public and local authorities have been genuinely engaged in the process

220. The TSAs have been open and transparent with the public throughout their appointment and will continue to be so during the course of the consultation and beyond. Whilst the public may not agree with all of the statements made by the TSAs, the TSAs have not and will not mislead the public or hide information from the public. Where the TSAs have not answered questions immediately or directly, it is because the TSAs would not want to give misleading or speculative answers to those questions.

221. The main mechanism for gathering public and patient feedback will be the formal consultation, but the TSAs have already engaged with the public during the first 75 working days, as follows:

- Holding three public meetings at venues with sufficient capacity to hold every person attending (c1,100 members of the public attended these meetings). These meetings were independently chaired by Engaging Communities Staffordshire – a local public/patient advocacy group;
- Posting unedited videos of each public meeting on the TSAs website;
- At the request of the independent chair of the group, inviting five members of the public to sit on the Independent Health and Equalities Impact Assessment Group (see Section 8) – including a prominent member of the 'Support Stafford Hospital' campaign group;
- Monitoring traditional and social media coverage of the TSAs, which in some instances has directly led to immediate changes in the way the TSAs have engaged with the public;
- Held regular meetings with members of staff; and
- Issuing regular bulletins and press releases on the progress of the TSA.

Test 4: The changes will give patients a choice of good quality providers

222. The proposed changes would see the choice of providers for some services reduced, but not to the point where there is only a single provider available within the local health economy. The key to this test is access to good quality provision. The TSAs have worked on the basis that any move of services away from Stafford and Cannock is on the basis that this will improve the clinical quality of the service over the medium to long term, given the available resources (human resources, medical technology and funding).

8 Independent Health and Equalities Impact Assessment

223. Monitor's guidance for TSAs states:

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

224. To ensure that the TSAs' draft recommendations meet this requirement, the TSAs have established an Independent Health and Equality Impact Assessment Steering Group (HEIA SG).

225. The HEIA SG was established to provide independent advice to the TSAs. The HEIA SG has been convened with an **independent chair** and a membership that is independent to the TSAs and the Office of the TSAs. The Office of the TSAs will provide information and analysis to support the work of the HEIA SG.

226. This section summarises the terms of reference of this group.

8.1 Role of the group

227. The purpose of the group is to provide expert advice and to design and oversee the production of health and equality impact assessments on the option(s) for health service reconfiguration as developed by the TSAs.

228. More specifically, the TSAs asked the members of the HEIA SG to undertake the production of two reports:

- Proposing and agreeing an initial scope for the health and equality impact assessment (a scoping report, to be published at the same time as the draft recommendations from the TSAs);
- Producing a Health and Equality Impact Assessment of the final recommendations of the TSAs, taking into account any changes to the draft recommendations from the public consultation. This assessment will recommend actions to minimise the negative impacts and maximise the positive impacts of the final recommendations of the TSAs.

229. The HEIA SG will provide independent and expert advice to the TSAs and will submit its report(s) to the TSAs as advice available to shape the final recommendations.

8.2 Responsibilities of the group

230. The responsibilities of the HEIA SG include:

- Fulfilling its independent role as set out above;
- Outlining the necessary scope for an IA and advise the TSAs on this;
- Representing the views and perspective of patients and members of the public in the HEIA process, paying particular attention to protected groups as outlined in the Equality Act 2010;
- Providing relevant impact analysis, whether public or internal data, to inform the health and equality impact assessment;
- Presenting a LHE view and not an organisation-specific view of the HEIA;
- Adhering to the communications strategy set out by the Office of the TSAs; and
- Quality assuring the HEIA output and ensuring the production of an HEIA to the agreed scope.

231. In analysing the relevant impacts of proposed options for service configurations, the HEIA SG has been supported by the Office of the TSA.

8.3 Chair of the HEIA SG

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

Sophia Christie

(Chair HEIA SG)

Sophia is a former NHS Chief Executive, who spent nine years as the Chief Executive of a complex commissioning organisation. She has a proven track record of the design and delivery of health innovation and health improvement.

She spent 18 months at the Deprtment of Health as Director of Alignment and Co-ordination and has held many roles on national advisory boards looking at the safe and sustainable reform of healthcare services. She was an expert witness to the Parliamentary Select Committee on Public Participation in Local Government and Health Services

8.4 Membership of the HEIA SG

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

234. The other members of the HEIA SG are:

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

8.5 What the HEIA SG will be doing

235. The Steering Group held its first meeting on the 22nd May, during which they agreed their Terms of Reference and the approach to scoping the nine protected characteristics (set out in the Equality Act (2010)) and prioritising the impact areas.

236. The scoping report describes the overall health status of the local population and sets out the prioritisation for the nine protected characteristics as set out in the Equality Act (2010). The protected characteristics are:

- Age
- Disability
- Gender reassignment
- Marriage and civil partnership
- Pregnancy and maternity
- Race (this includes ethnic or national origins, colour or nationality)
- Religion or belief (this includes lack of belief)
- Sex
- Sexual orientation.

237. The SG has also decided to add socio-economic deprivation to this list. The scoping report also describes the approach to looking at the discrete service areas (A&E, maternity, etc.) for the impact assessment.

238. The scoping report of the HEIA SG has been submitted to the TSAs and is presented in full in Volume Three of this draft report.

239. During the period of public consultation the group will assess the health and equality impacts on the local population, the nine protected characteristics and socio-economic deprivation for each service type (e.g. A&E, Maternity). The evidence used to assess the impacts will include quantitative and qualitative data, including: literature reviews to understand quantified impacts on health outcomes; bespoke analysis to understand the impact on access – including the impact of patient travel times; and interviews with selected stakeholders to identify potential impacts on users.

240. Based on the evidence gathered during consultation, the Steering Group will make recommendations to the TSAs on how to minimise the negative impacts and maximise the positive impacts. The evidence, analysis and recommendations to the TSAs will be presented in a Health and Equality Impact Assessment report.

241. The TSAs will consider the preliminary outputs from the HEIA SG in order to inform their final recommendations.

242. The Health and Equality Impact Assessment will be included in the final report of the TSAs.

9 Developing the draft recommendations

243. In March 2013, the CPT published its recommendations for the future of clinical services in Stafford and Cannock[45]. These recommendations were focussed on the changes that could be made by MSFT to the current services they deliver in order to assure clinical and financial sustainability.

244. The remit of the TSAs is wider than that of the CPT. It places a greater focus on the influence of (and the impact upon) the local health economy to changes in the services delivered in Stafford and Cannock. Therefore the TSAs have undertaken a separate process to develop a draft clinical model in line with this broader remit and with no pre-determined solution in mind.

245. Having developed a draft clinical model the TSAs have then conducted an evaluation of this model in comparison to the recommended model of the CPT. The TSAs have also evaluated a clinical model in which just the Location Specific Services (LSS) were retained locally in Stafford and Cannock.

246. This section summarises the approach the TSAs have taken to develop a draft clinical model (hereby referred to as the 'Draft TSA model') and the evaluation of this model, the CPT model and the LSS model.

9.1 The TSAs' guiding principles for the clinical model

247. In developing the Draft TSA model and evaluating the model alongside the CPT and LSS models, the TSAs have adopted the following of guiding principles:

- **Principle 1:** First and foremost, each service must be assessed on its own merit and the TSAs must be assured that each service (retained in the current locality or otherwise) will be clinically safe and affordable.
- **Principle 2:** Where possible, services should be retained locally. Moving any single service away from the current locality must be discretely justified.
- **Principle 3:** If the TSAs identify an opportunity to enhance a service or introduce a new service (whether that service is retained locally or moved to another provider) they will work with commissioners to identify the feasibility of doing so.
- **Principle 4:** The TSAs must be conscious that there are pressures on the NHS and the local health economy which cannot be fully addressed locally. However, the TSAs must identify and assess the impact on the whole local health economy of

[45] Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust – Recommendations of the CPT, March 2013.

their recommendations, and where that impact is detrimental, must identify how this impact can be mitigated.

- **Principle 5:** The TSAs should not discount short term investment if they believe it will deliver longer term benefits for the local population.

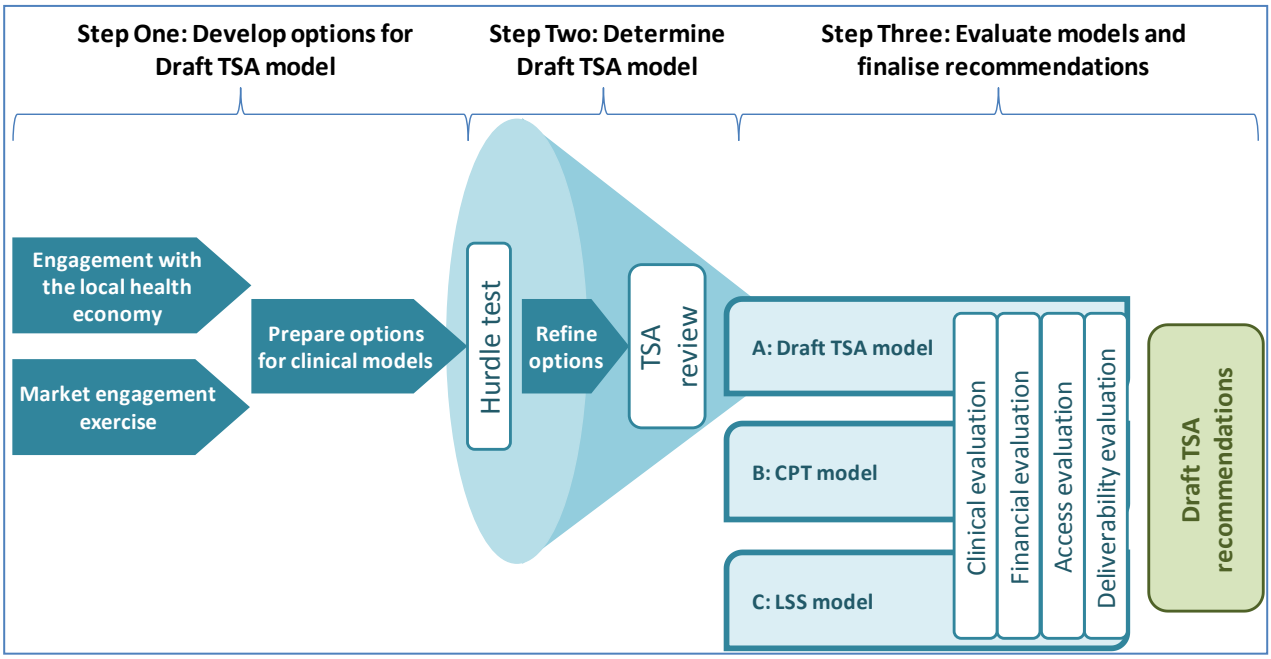
9.2 The high level approach undertaken to develop the TSA's draft recommendations

248. To prepare the series of draft recommendations set out in Section 10, the TSAs have followed a three step process:

- **Step One:** Develop options for a clinical model predicated on the use of clinical networks to deliver services in Stafford and Cannock (summarised in Sections 9.3 to 9.5).
- **Step Two:** Assess these options to determine the 'Draft TSA model' (summarised in Sections 9.6 to 9.7).
- **Step Three:** Evaluate the 'Draft TSA model', the 'CPT model' and the 'LSS model' and finalise the draft recommendations of the TSAs (summarised in Sections 9.8 to 9.12).

249. The process that the TSAs have followed is illustrated in Figure 9.

Figure 9: The approach taken by the TSAs to develop its draft recommendations



250. To develop options for the Draft TSA model the TSAs undertook two processes in parallel that did not focus on theoretical models of care. Rather the TSAs sought to

generate options for clinical models that other healthcare providers would be willing to deliver.

251. This approach does not mean that the TSAs have concluded which organisations should be the providers of the proposed service model, but it has assured the TSAs that there are providers willing to deliver the Draft TSA model.

252. In developing the Draft TSA model, the TSAs have worked with commissioners to understand the extent to which the model is supported by and addresses the key commissioning intentions set out by the CCGs.

253. The remainder of this section details each of these activities and the evaluations that the TSAs have undertaken to arrive at the series of draft recommendations that will be explained in Section 10.

9.3 The market engagement exercise

254. In February 2013, the CPT conducted a survey with all providers of acute healthcare services[46] in England and Wales to indicate whether they may be interested in providing services to the population of Stafford, Cannock and the surrounding areas. Eighteen organisations expressed an interest – sixteen NHS organisations and two independent sector organisations.

255. The TSAs used this feedback to launch, on 22 April 2013, a market engagement exercise. The purpose of this exercise was to give any provider of healthcare services – NHS, independent sector and voluntary sector – the opportunity to put forward a proposal as to how they would provide services to the population of Stafford, Cannock and the surrounding areas.

256. This exercise was not a procurement exercise and has only been used to help the TSAs identify potential options for the clinical service model. If it is necessary to formally procure elements of the clinical service model which is decided upon, then that process will be implemented separately.

257. The TSAs directly invited the 18 organisations who expressed an interest during the original market survey to respond. The TSAs also announced the exercise on their website, through the Health Services Journal and through the NHS 'Supply2Health' portal, inviting any interested party to request information on the market engagement.

258. Those organisations interested in putting forward a proposal were issued with a memorandum that contained background information on MSFT, the services

[46] Defined as those providers who have a registration with the CQC to deliver general hospital services.

operated by MSFT and access to activity, financial, performance and estates information for the Trust. The organisations were also given the list of LSS, on the basis that these services – at a minimum – must be retained within the locality.

259. All organisations were asked to submit proposals outlining:

- Proposals which delivered as a minimum the LSS at Stafford or Cannock or both;
- Their proposed clinical model, including the list of services that they would provide and how they would provide them;
- The staffing models and clinical support services that would enable this clinical model;
- How they would govern and assure the delivery of the services they were proposing;
- What benefits their proposals would deliver for patients;
- How these proposals would enable integration of care across providers;
- The financial implications of their proposals and how they would be financially sustainable;
- Likely implementation timescales for the proposal; and
- How the estate and back office would be managed.

260. The providers were given until Day 20 of the TSAs timeline (14 May 2013) to respond.

9.4 Engagement with the local health economy

261. It was assumed that the draft recommendations of the TSAs would impact other providers in the local health economy and that the solutions to the issues faced would require changes at a range of those providers.

262. Therefore, in parallel to the market engagement exercise, the TSAs engaged with providers in the local health economy to fully understand how each could:

- be impacted if changes are made to healthcare service in Mid Staffordshire;
- be part of a solution for the services currently provided by MSFT; and
- support the TSAs in the implementation of their final recommendations.

263. Due to the timescales that the TSAs have been working to, it was not feasible to wait until the end of the market engagement exercise before starting to work with these providers. As such, the discussions between the TSAs and these providers have been conducted in parallel with the market engagement exercise.

264. The providers in the local health economy were encouraged to submit proposals on the same basis as any other organisations that responded to the exercise.

9.5 Preparing potential options for the Draft TSA model

265. During the market engagement exercise the TSAs received requests for non disclosure agreements from a total of 45 organisations. From these requests an NDA was sent to 40 organisations. Five organisations were not issued with an NDA as they were not providers of healthcare services and therefore not eligible for this exercise. The TSAs received signed NDAs from 32 of the 45 organisations.

266. The TSAs held a provider event on the 29th April 2013 so that the TSAs could brief organisations further on the process and the purpose of the market engagement exercise.

267. The TSAs received responses from 12 different organisations who between them submitted 14 different proposals (organisations could submit more than one proposal).

268. The TSAs tested these proposals with the local commissioners to ensure that the evaluation process would effectively align with the commissioners' broader intentions and sought clarifications from the providers as and when necessary.

269. The TSAs used the responses to the market survey and their engagement with local providers and commissioners to finalise a range of high level options that were evaluated in order to finalise the 'Draft TSA model'.

9.6 Initial evaluation of the responses to the market engagement exercise

270. To ensure the TSAs considered the proposals in a fair, standardised and non-discriminatory manner, a series of initial 'hurdle tests' were established[47].

271. The hurdle tests were the minimum requirements that an organisation's proposal had to demonstrate in order for it to be evaluated in detail; the hurdle tests therefore acted as a filtering mechanism. The hurdle tests used are outlined in Table 29.

272. The hurdle tests were developed for use in filtering proposals to the market engagement exercise. They do not preclude or prejudice any organisation if it is necessary to formally procure elements of the clinical service model which is decided upon.

[47] NB: adoption of these principles should not be taken to imply that this was a procurement exercise or that it is subject in any way to procurement rules or principles.

Table 29: The hurdle test used to filter the proposals submitted during the market engagement exercise

Test order	Description
1	The clinical model can be delivered by a provider/providers who meet the statutory requirements to deliver NHS services and can demonstrate an appropriate level of governance. The TSAs wished to consider clinical models which would satisfy the requirements of both regulators, Monitor and CQC. Therefore the TSAs would only consider proposals from organisations which could: a) confirm their CQC registration, and b) demonstrate appropriate governance arrangements for managing the delivery of services in Stafford and Cannock.
2	The model meets the minimum commissioner requirements for services to be provided locally – in this instance, the delivery of Location Specific Services. One of the core obligations of the TSAs is to ensure the sustainable delivery of the Location Specific Services. The TSAs therefore, would give primary consideration to proposals which had a clear plan to deliver all of the LSS in either Cannock or Stafford. The TSAs would not have been ready to consult on a credible clinical service model if it had needed to construct and then evaluate a solution comprising proposals from multiple providers in order to ensure all of the LSS could be delivered in a sustainable manner.

273. All proposals passed the first hurdle test and six proposals passed the second hurdle test. These six proposals were submitted by five different providers – including NHS and independent sector providers. Eight proposals failed the second hurdle test as they did not clearly identify how the LSS would be delivered for either Stafford or Cannock. Most of these proposals were offers to provide a single service currently provided by MSFT.

274. The six proposals which did pass the hurdle test all varied in one way or another, although there were common themes for each one. Some of the proposals were for a greater range of services than proposed by the CPT, others for a similar range and others for a lesser range. The TSAs met all five providers to clarify specific aspects of their proposals and gather more information to enable the TSAs to define the range of potential clinical models.

275. In some cases, the provider presented optional elements to their proposal. The TSAs used these meetings to explore the opportunities associated with these optional elements. Some of these optional elements were then included within the core models being evaluated.

276. On the basis of these refinements, the TSAs established a series of clinical models for review. These are summarised at a high level in Table 30 for Stafford and Table 31 for Cannock.

Table 30: The potential service models for Stafford

Stafford										
Model	A&E	UCC/ MIU	Acute medicine	Emergency surgery	Critical care	Maternity	Inpatient paeds	Elective surgery	Intermediate care	LSS
1	✓		✓		✓	Pre/post natal		Inpatient & Day case	✓	✓
2		✓				Pre/post natal		Day case	✓	✓
3		✓			✓ (limited)	Pre/post natal + MLU		Inpatient & Day case	✓	✓
4		✓				Pre/post natal + MLU		Day case		✓

Table 31: The potential service models for Cannock

Cannock										
Model	A&E	UCC/ MIU	Acute medicine	Emergency surgery	Critical care	Maternity	Inpatient paeds	Elective surgery	Intermediate care	LSS
5		✓	✓		HDU	Pre/post natal		Inpatient & Day case	✓	✓
6		✓				Pre/post natal		Day case	✓	✓

277. It should be noted that only one provider proposed to provide A&E services and acute medicine at Stafford. In addition, no providers proposed emergency surgery, inpatient paediatrics or consultant led deliveries at Stafford.

9.7 Finalising the Draft TSA model

278. At this stage, the TSAs were satisfied that they had six proposals (four for Stafford and two for Cannock) where there were one or more providers willing to deliver the proposed model of care. In order to evaluate a 'Draft TSA model' against the CPT model and the LSS model, the TSAs needed to finalise which of these proposals would be taken forward.

279. The TSAs consulted with the local CCGs and the three clinical advisory groups (CAG, NCAG and CRG) in order to arrive at the conclusions that the Draft TSA model would comprise:

- **For Stafford:** Option One, on the basis that it offers the widest range of local services. This is the model proposed by University Hospital of North Staffordshire (UHNS).

- **For Cannock:** Option Five - with some reservations about the viability of the HDU, on the basis that it offers the widest range of local services. This is the model proposed by The Royal Wolverhampton NHS Trust (RWT).

280. The proposals from UHNS and RWT have been used as the basis for the Draft TSA model. This does not mean that the TSAs have decided that UHNS and RWT should be the organisations to deliver services in Stafford and Cannock. There are a number of organisations interested in providing services in Stafford and, especially, Cannock.

281. The TSAs have spoken to, and are continuing to speak to, a range of providers, including UHNS, RWT and Walsall Healthcare NHS Trust (WHT) in their work to determine their recommendations for the future of services in Stafford and Cannock.

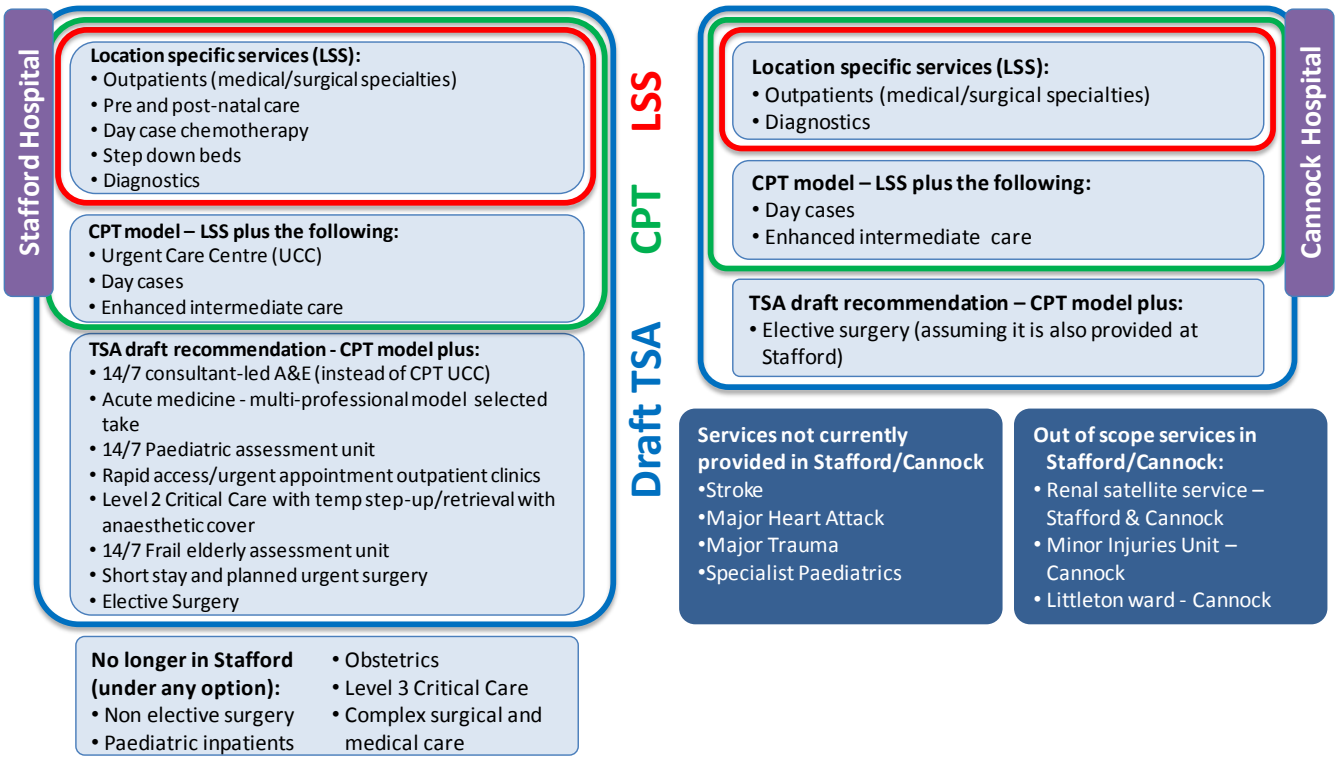
282. Step three of the process undertaken by the TSAs was a comparison of: (a) the Draft TSA model; (b) the CPT model; and, (c) a model based upon the LSS alone.

283. Bearing this in mind, options Two and Six were not considered further at this stage as they are essentially the same as the CPT model. Option Three was no longer considered due to concerns about the viability of a small critical care service when there was no A&E on site. Option Four was not considered further, as, although it met the LSS, it fell short of commissioner intentions to move towards a more integrated care model.

284. It should also be noted, that given the recent challenges in A&E services across the region, the commissioners were very interested to understand whether the TSAs could establish a viable model which retained an A&E in some form.

285. The Draft TSA Model retains a wider range of services in Stafford and Cannock than that of the CPT model. Indeed, the CPT model is a subset of the Draft TSA model and the LSS model is a subset of the CPT model. Figure 10 outlines the range of services included in each of the models that were subsequently evaluated.

Figure 10: An outline of the range of service included in each model evaluated



9.8 Evaluating the models

286. Four criteria were identified by the TSAs to assess the relative strengths and weaknesses of the clinical models. These criteria are outlined in Table 32. The TSAs evaluated each proposal using a balance of quantitative evidence and the assessments of external advisory groups.

Table 32: A summary of the evaluation criteria

Evaluation order	Description
1	**Is the model clinically sustainable (see Section 9.9)?** In the opinion of the CAG and NCAG, is the model clinically safe? Does the model move clinical services nearer to Royal College guidelines than they are now? Are the services sufficiently close to these guidelines to satisfy the CAG that they would be sustainable? Is it likely, in the opinion of the CAG and NCAG, to improve recruitment and retention of staff?

Evaluation order	Description
2	**Is the model reasonable with regards to access to services for patients, and their friends/family (see Section 9.10)?** Is access for patients and visitors of patients reasonable (i.e. retaining as many services locally as possible)? Do patients have reasonable access to short duration visits (e.g. outpatients)?
3	**Is the model financially sustainable (see Section 9.11)?** Within three years of implementation starting, does the income associated with delivering the activity currently associated with patients from Mid Staffs exceed the cost of delivery? Do the proposed changes ensure there is not a detrimental impact on the finances of another NHS organisation?
4	**Is the model deliverable (see Section 9.12)?** Is there broad stakeholder buy-in to the model? Is the degree of change likely to implemented successfully?

9.9 The clinical evaluation of the models

287. To support the clinical assessment the TSAs formed a National Clinical Advisory Group (CAG) and a Nursing and Midwifery Advisory Group (NCAG).

288. Further details on the composition and terms of reference of the CAG and NCAG are in Annex 6.

289. The CAG met six times during the development of the draft recommendations and the NCAG met four times. A summary of each meeting is outlined in Table 33, with the detailed notes of these meetings included in Annex 6.

Table 33: A summary of the clinical advisory group meetings

Date	Objectives and achievements
National Clinical Advisory Group (CAG)	
9 May 2013	• The CAG was briefed on the TSA process and agreed its role in providing an opinion on the clinical models.
23 May 2013	• The CAG was presented with the proposed clinical models and they provided their expert opinion and opinions from their respective royal colleges on the safety of the proposed models. • The CAG also provided a view on to what extent the proposed models would contribute to the recruitment and retention of key clinical staff to ensure services would remain sustainable going forward. They were of the opinion that the proposed clinical networks would have a positive impact on the recruitment and retention of staff.
3 June 2013	• The CAG reviewed the Draft TSA model and was of the opinion that it was safe as long as it is appropriately staffed. They emphasised the need for well implemented staff rotations.
11 June 2013	• The CAG were briefed on the further work undertaken and some further areas of clarity were agreed on the clinical models. The Terms of Reference were re-confirmed by the CAG, following the extension of the TSA process.
25 June 2013	• The CAG reviewed both the LSS and CPT models to provide their expert opinion on each one. • For the LSS model they concluded that there would be some concerns over a standalone Consultant delivered step down unit in Stafford without the support of other services, particularly overnight. It was noted that the impact on other providers by the withdrawal of emergency and acute services would be significant. • For the CPT model the CAG concluded that there would be significant safety concerns over a Step Up unit in Stafford without strict patient selection criteria and without the support of other services. Concerns were also raised regarding the patient selection for the provision of elective surgery in Cannock and the level of cover needed at night to provide this safely. • The reliance on middle grade cover would be an issue for recruitment and retention for the CPT model. • The CAG viewed that out of the three models the TSA draft recommendation would be their preferred model.
16 July 2013	• This was a joint meeting with the Nursing and Midwifery Advisory Group. • The CAG and NCAG gave its final support for the TSAs' draft recommendations. It identified some further questions to be answered specifically for the provision of Elective surgery at Cannock which the TSA would need to address.

Date	Objectives and achievements
Nursing and Midwifery Advisory Group (NCAG)	
4 June 2013	• The NCAG was briefed on the TSA process and agreed its role in providing an opinion on the clinical models. • The Draft TSA model for Stafford and Cannock was presented. The NCAG reviewed the model and agreed that there were no significant safety concerns on the recommendations.
13 June 2013	• The NCAG further reviewed the Draft TSA model and concluded that it was safe based on the level of information available to them. The NCAG identified some particular areas to be clarified for the Cannock models
28 June 2013	• The NCAG reviewed the CPT and LSS models. • They viewed the LSS model to be safe but would have some concerns about night cover for the step down beds. • The NCAG had concerns over the provision of Step up care under the CPT Model, particularly regarding which patients would be suitable for the service based on the lack of support services available. • The NCAG had concerns on the ability to recruit key nursing staff into the LSS and CPT models due to the potential lack of career progression and work experience in each one.
16 July 2013	• This was a joint meeting with the Clinical Advisory Group (CAG). • The CAG and NCAG gave its final support for the TSAs' draft recommendations. It identified some further questions to be answered specifically for the provision of Elective surgery at Cannock which the TSA would need to address.

290. A Local Clinical Reference Group comprising the clinical leads across the local health economy was briefed on the TSA process and reviewed the clinical models. They were presented with the CAG's view on the models and they concurred with the position taken by the CAG.

291. The conclusions of the CAG and NCAG with regards to the three models are summarised in Table 34.

Table 34: A summary of the conclusions from the CAG and NCAG with regards to the three models

	Is the model clinically safe?	Impact on LHE	Is it likely to improve recruitment and retention of staff?
LSS	• No issues from safety perspective. • Consultant led step down beds in Stafford are the only overnight service, so it is likely there will be challenges associated with maintaining appropriate night time cover.	Not providing any emergency care services in Stafford would have a significant impact on the LHE Concern regarding the LHE's ability to maintain safe services if demand increased significantly	CAG: A truly integrated clinical network would be required to improve recruitment of consultants; i.e. one team. Rotation of junior/middle-grade staff may be beneficial. NCAG: Recruitment of nursing staff to an integrated team would improve recruitment but rotation of staff would probably be confined to senior posts only.
CPT	• With no critical care on site, only very low risk elective surgery (inpatient and day cases) should be conducted. This is likely to be significantly lower volumes than currently treated. • With appropriate patient selection, step down care safe but substantial concerns with step up care (unless supported by a range of acute specialities and diagnostics). • Although there will be a few more beds in Stafford there are likely to be similar issues to LSS around overnight cover. The number of beds in Cannock (for intermediate care) will lead to similar issues as the LSS model for Stafford.	• The provision of a UCC in Stafford would reduce the volume of minor attendances at other units • Large volumes of Ambulance attendances remain with the same number of admissions as LSS, therefore the concerns raised for the LSS model were still relevant	• NCAG: Similar nursing issues as LSS. • CAG: Clinical network would be required to provide attractive employment opportunities for consultants. • CAG: Significant challenge to recruit Stafford/Cannock based middle grade doctors as services would be seen as low complexity and unlikely to maintain core skills. Networking is unlikely to address this as networking typically intended for consultant grade doctors.
Draft TSA	• No issues from a safety perspective, but would prefer not to have a separate critical care unit, preferring a capability nearer the recovery area. • Would expect length of stay to increase if step down beds were part of the model.	• No specific issues were raised on the impact on the LHE of the Draft TSA model	• CAG: The two site networked model for consultants would have a positive impact on recruitment with the opportunities to rotate through a specialist site. • NCAG: Nursing recruitment to a standalone PAU without inpatient Paediatrics may be difficult.

292. On the basis of the feedback from the CAG and NCAG, the TSAs concluded that:

- It was possible to put in place safeguards to ensure that all three models could be delivered in a clinically safe manner. The exception was the use of 'step up' beds within the CPT model. There was concern that this would lead to admissions into intermediate care beds without a diagnosis – something that is addressed in the Draft TSA model through the use of the MAU.
- The loss of the A&E in Stafford – as seen under the CPT and LSS models - could have a detrimental impact on other providers within the local health economy. The LSS would have the greatest associated risk as all patients with minor injuries/illnesses would have to travel to an alternative location.
- The implementation of a clinical network would improve the recruitment and retention of consultants. However, the CPT model could cause an issue for recruitment and retention of middle grade doctors (who would most likely not rotate across a clinical network) due to the absence of a critical care and A&E service.
- Nursing recruitment and retention could be difficult under the CPT and LSS model due to limited opportunities for career progression within the organisation. This would be mitigated in the Draft TSA model, although recruitment of paediatric nurses into the PAU may be difficult in this model.

293. The TSAs have concluded that, from a clinical perspective, the Draft TSA model is preferable to the CPT and LSS models. The CPT and LSS models have different issues that mean they are less desirable from a clinical perspective.

9.10 Evaluating access to services

294. The access evaluation was based upon an analysis of how many services over and above the LSS would be provided locally and the proportion of patients that would still be able access services locally.

295. Intrinsic to patient access is the travel time to alternative providers if the service is no longer available in Stafford or Cannock Chase Hospitals. Travel times were used to inform the CCGs' decisions with regards to the definition of LSS and will be an integral part of the Independent Health Equality Impact Assessment (HEIA) – especially with regards to the impact on those who rely on public transport. Annex 9 is a brief paper that sets out the methodology and validation process used by the TSAs to assess travel times. Volume Three of the draft report is the scoping report for the work of the HEIA and sets out how travel times will be used by that independent group.

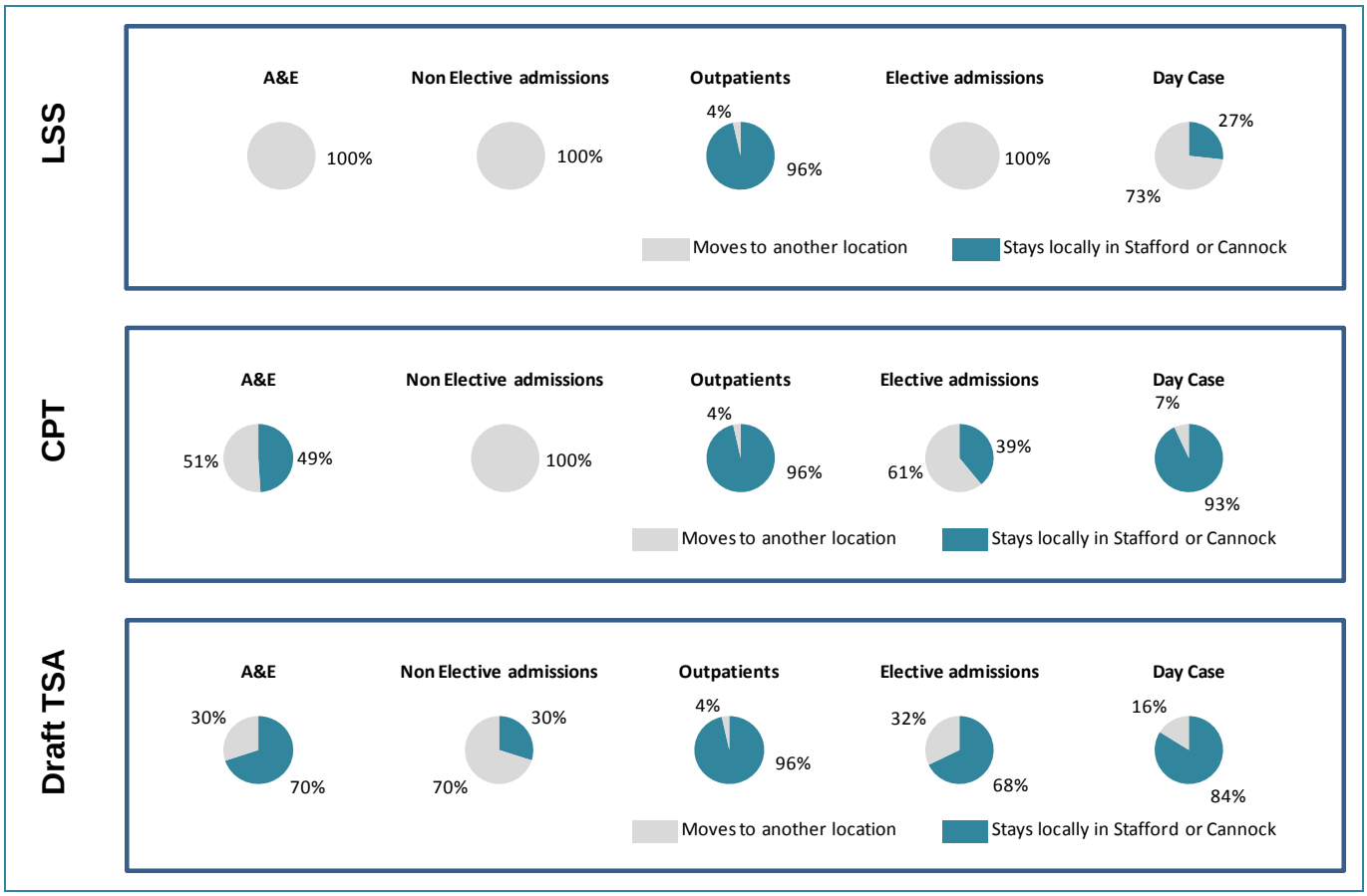
296. The TSAs have assessed what proportion of activity would continue to be provided locally under each of the models. Taking the current activity levels of MSFT as a baseline, the proposed clinical models were compared against this baseline to show the impact this would have on patients having to access services outside of the current locality. The analysis is based on the current working assumptions with providers and the overall percentages may change once the final range of elective and day case procedures is agreed.

297. Table 35 summarises the outcome of this analysis and Figure 10 break this down into the points of delivery for these services.

Table 35: A summary of the activity that will remain in Stafford or Cannock for each of the models

LSS model	CPT model	Draft TSA model
75%	84%	91%

Figure 10: A breakdown of the access for each point of delivery in each model



298. Based on this analysis, the TSAs concluded that the Draft TSA model was clearly preferable to the CPT and LSS models in terms of access to services.

9.11 The financial evaluation of the models

299. The TSAs have evaluated all three models from a financial perspective. In simple terms, the question that the TSAs have sought to assess is: *'From April 2017, can the cost of delivering the activity associated with patients from Mid Staffs be less than the income associated with that activity?'*

300. In assessing this question, the TSAs have worked with some core assumptions, as follows:

- For the purposes of the analysis, Stafford and Cannock Chase Hospitals are assumed to be run by separate organisations and will primarily serve their local population – this is especially important in determining the levels of activity and associated income in each hospital.
- The implementation of the TSAs' draft recommendations will start in April 2014 and will take no longer than three years to achieve financial balance.

301. The TSAs have worked closely with local providers (notably UHNS, RWT and WHT) and the NHS Trust Development Agency to develop, analyse and validate the information presented in this evaluation. This work has also sought to understand the financial impact the proposed models would have to these other providers. There is still more work to do and this will continue alongside the public consultation.

302. Annex 7 is a detailed summary of the financial evaluation undertaken by the TSAs. The remainder of this sub-section is a high-level summary of the evaluation and sets out the following:

- The TSA's forecast for the financial position of MSFT as of April 2014 – this is effectively the starting point for the analysis;
- The anticipated impact on the financial position of cost inflation and income deflation over the period 2014-2017;
- For each of the three models, the estimated future distribution of activity/income associated with the services currently provided by MSFT;
- The estimated level of investment that will be required to deliver each model, and the impact this will have on the financial position due to associated depreciation;
- The range of savings that the TSAs have estimated could be delivered in each of the models during the implementation period and the impact on the financial position;
- A forecast position for each of the three models as of March 2017;
- Opportunities to reduce the forecast deficit;

- The funding that will be required to manage the transition to each of the proposed models; and
- A comparison of each of the three models to determine which of the models is most effective from a financial perspective.

The forecast future financial position of MSFT in April 2014

303. The timescales associated with the TSA process mean that the Secretary of State for Health will have until 31st December 2013 to make a decision upon the final recommendations of the TSAs. As stated in Section 4.7, it is essential that implementation of the approved recommendations commences as soon as possible. On this basis, the TSAs have used a start date of April 2014 to be the start of a three year transition/implementation period. This is the start of the new financial year for NHS organisations (FY15).

304. At the end of FY13 (March 2013), MSFT reported a closing deficit position of £14.7m. This included non-recurrent funding of £4.5m, so the underlying deficit of the trust was £19.2m. The TSAs have forecast that at the end of FY14 (March 2014), the underlying deficit for MSFT will be £20.2m[48].

305. This is the start point for the financial evaluation conducted by the TSAs, with the aim being to assess to what extent each of the proposed models would address this deficit over the following three years to March 2017 (FY15, FY16 and FY17).

Additional cost pressures during the period FY15-FY17

306. All NHS Trusts are expected to deliver year on year cost improvements. This is because funding in the NHS is not increasing in real terms, but costs are increasing, often well above annual inflation/RPI rates. This means there are additional cost pressures every year for all NHS Trusts, regardless of any historic savings that may be made.

307. These pressures take two forms, as follows:

- Anticipated cost inflation: For planning purposes, every trust in the country should plan for cost inflation of c4% of the previous year's expenditure[49].

[48] The detail of this forecast is set out in Annex 7.

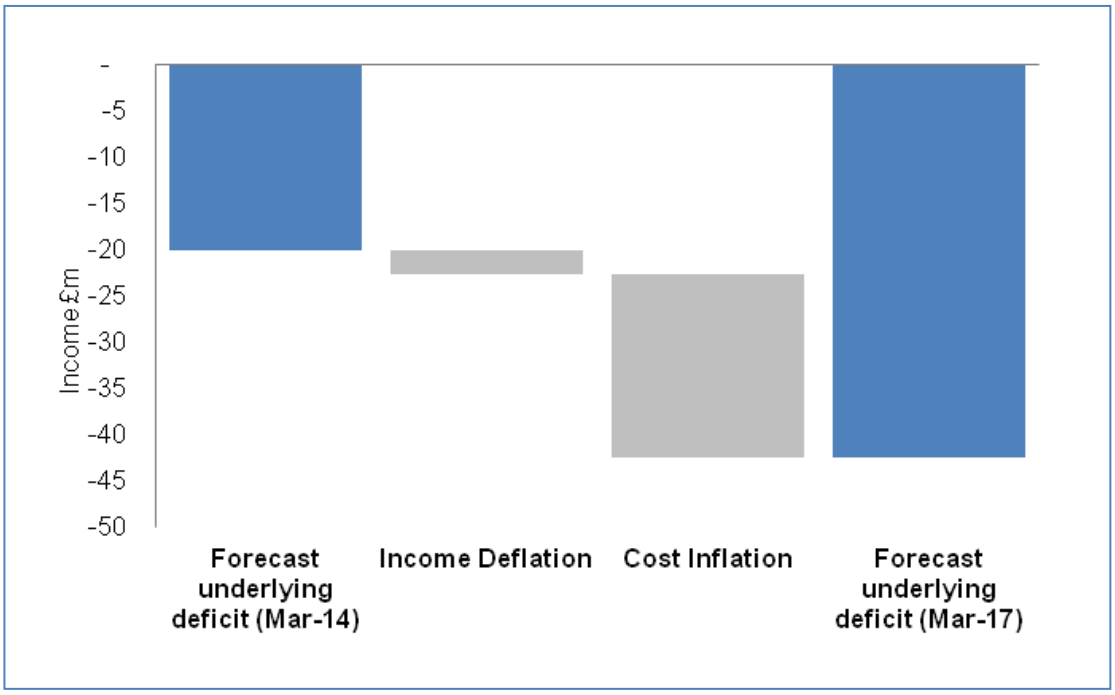
[49] Everyone counts: planning for 2013/14. NHS England

- Tariff deflation: For planning purposes, every trust in the country should plan for tariffs (essentially the primary driver for trust income) to reduce by 1.3% in FY15 and 0.2% every year thereafter[50].

308. What this means in practical terms is that if nothing changed at MSFT over the period FY15-FY17, the deficit would increase year on year due to the impact of these pressures. With regards to MSFT, this means that the Trust needs to reduce the annual running cost of the Trust by £22.3m over FY15-FY17 in order to just address the impact of these additional pressures.

309. When these pressures are added to the forecast deficit for the start of that period (April 2014) of £20.2m, this means that the forecasted underlying deficit in March 2017, would be £42.5m. This is illustrated in Figure 11.

Figure 11: The forecast deficit for March 2017



310. This is effectively the level of savings that the TSAs need to identify in order for the services currently delivered by MSFT to break even in March 2017.

The expected distribution of activity for the three clinical models

311. Each of the three models retains differing volumes of activity in Stafford and Cannock, with the remaining activity being distributed across other providers. The

[50] Everyone counts: planning for 2013/14. NHS England

TSAs have made a series of assumptions about the distribution of activity. These assumptions are set out in detail in Annex 7, but in broad terms:

- Activity retained in Stafford and Cannock: The TSAs have primarily assumed (with some minor exceptions) that Stafford residents will attend Stafford Hospital for those services that are offered in Stafford and Cannock residents will attend Cannock Chase Hospital for those services that are offered in Cannock.
- Elective activity moving away from Stafford/Cannock: For the majority of services, the TSAs have assumed that activity will be split across other providers in the local health economy based upon historic referral patterns in the two CCG areas and in alignment with where elective services are likely to be delivered. This is because elective care is driven by GP referrals and patient choice.
- Non-elective activity moving away from Stafford/Cannock: For the majority of services, the TSAs have assumed that activity will be split across other providers in the local health economy based upon the geographic location of patients on the two CCGs and which acute hospital is nearest to their location which offers the required service.

312. On the basis of the assumptions made by the TSAs, it is assumed that activity and income will be distributed across providers in the local health economy as set out in Table 36.

Table 36: The distribution of income for each of models

	Stafford	Cannock	UHNS	RWT	WHT	Others	Total
LSS model	£38.3m	£31.6m	£34.2m	£28.8m	£10.3m	£12.8m	£156m
CPT model	£48.8m	£43.8m	£24.9m	£16.6m	£9.8m	£12.1m	£156m
Draft TSA model	£67.3m	£48.1m	£15.1m	£13.8m	£5.2m	£6.5m	£156m

Notes:
1: The providers included in 'Others' is BHFT, SaTH and Good Hope
2: The income associated with Stafford and Cannock is based upon the proposed services retained in Stafford and Cannock and is not related to any specific provider of services in Stafford or Cannock.

313. It should be noted that a significant amount of income is retained in Stafford and Cannock under the Draft TSA model – this is because the TSAs have assessed that 91% of activity currently delivered at MSFT will be retained in Stafford and Cannock.

Estimated investment required to deliver the models

314. Implementing each of the models will require investment in order to ensure the proposed service models can be delivered without a detrimental impact on any

organisation and consequently the quality of services that can be provided. This investment can be categorised into three elements:

- Capital expenditure in Stafford or Cannock to ensure the healthcare facility is fit for purpose. This is required because: a) there is a large backlog of maintenance at Stafford and Cannock Chase Hospitals (see Section 2.6); b) Stafford Hospital is a relatively old site and the configuration of wards and theatres is inconsistent with latest standards on healthcare facilities (for example, size of theatres, spaces between beds on wards);
- Capital expenditure at other healthcare providers to ensure there is sufficient capacity at that provider to manage activity that would no longer be delivered in Stafford and Cannock;
- Investment in the ambulance service to manage the changing requirements on that service due to the changes in provision.

315. The TSAs have been working with the local providers with regards to estimating the levels of capital investment they believe will be required to deliver the three models. The TSAs have also sought independent advice on these estimates. This work is ongoing with regards to developing more detailed plans associated with the TSAs' draft recommendations and will continue in parallel with the period of consultation.

316. Table 37 sets out the position with regards to capital investment for each proposed model.

Table 37: Capital investment for each of the models

	LSS model	CPT model	Draft TSA model
Investment in Stafford and Cannock	£20.2m - £68.1m	£27.4m - £86.9m	£32.1m – £97.6m
Investment in other providers	£172.0m	£157.4m	£99.8m

Notes:
1: Under the LSS and CPT models, it is likely that less than 50% of Cannock Chase Hospital would be occupied. In this instance, it would be appropriate to consider building a new purpose built facility.
2: The wide range in the investment numbers for Stafford and Cannock is due to ongoing considerations around the levels of reconfiguration investment required in Stafford to bring it in line with the latest healthcare facility standards.
3: The estimated investment required at other provider sites is based upon the estimates of those providers.

317. The TSAs are continuing to work with local providers to validate the assumptions and proposed investment requirements. The objective of this work is to reduce, where possible, the levels of investment required. Initial estimates of these reduced levels of investment are included in Annexes 7 and 10, but the higher amounts have been presented in this report.

318. Capital investment places additional financial pressures on any organisation that receives the investment, in the form of:

- Additional depreciation costs associated with the investment;
- Additional Public Dividend Capital (PDC), which is effectively the finance charge to the organisation associated with capital expenditure.

319. Table 38 sets out the cost of depreciation and PDC for each of models, based upon the estimated upper levels of capital investment.

Table 38: The estimated additional depreciation and PDC for each model

	LSS model	CPT model	Draft TSA model
Additional cost (per annum) of depreciation and PDC	£10m	£10.3m	£10.5m

Notes:
1: The period used to calculate depreciation is based upon the remaining life of the building. In the case of investment in Stafford and Cannock this period is less than investment at other providers – due to the comparative age of the buildings.
2: The values quoted are based upon the higher values in the range of investment required for Stafford and Cannock.

320. The TSA has engaged with West Midlands Ambulance Service (WMAS) to understand what the expected impact on them will be from the draft recommendations. Table 39 summarises the additional costs that they have estimated.

321. The LSS and CPT model have the largest additional costs due to the removal of the current A&E service. In this scenario all of the current emergency ambulance transfers will go direct to alternative A&E departments. In addition, WMAS predict the volume of calls will increase due to the local service being removed.

322. The Draft TSA model has the least amount of additional costs due to the A&E department being retained in Stafford. There will be additional costs from the increase in transfers from Stafford to other Hospitals and also from some patients being transported directly to other hospitals where clinically appropriate.

Table 39: The estimated additional investment required for the ambulance service

	LSS model	CPT model	Draft TSA model
Anticipated additional Ambulance servic costs	£2.7m	£2.7m	£1.2 m

Opportunities to deliver savings

323. As stated above, the TSAs have estimated that the underlying deficit of MSFT would equal £42.5m in March 2017 if no changes were made. The TSAs have also estimated that additional costs of ca. £10m, associated with depreciation and PDC, will be need to be addressed under any of the proposed models.

324. This means that the proposed changes will need to deliver ca. £52.5m of savings from the current cost base of MSFT (which is forecast to be ca. £175m).

325. MSFT has a reference cost of 118. This means that MSFT's average cost of treating a patient is 18% above the NHS average. If the delivery of activity associated with MSFT were delivered at the national average level (a reference cost of 100) the expenditure would be £27m less than it is at present. There are evident inefficiencies in the delivery of services at MSFT and the TSAs have sought to identify realistic opportunities to reduce the cost of delivery.

326. In addition, there are a range of additional savings opportunities that could be delivered through the merger of Stafford and Cannock Chase Hospitals with larger hospitals as part of a clinical network.

327. The TSAs have assessed a range of savings opportunities which have addressed the majority of this forecasted gap in income and expenditure. Work is ongoing to assess further savings so that the gap is fully addressed. Given the starting position for MSFT – and indeed in any provider which will take on a significant percentage of the activity – it should be noted that the savings have been set at realistic (usually national average) levels. Other service reconfigurations elsewhere in the country have been predicated on higher performance levels that have not subsequently been achieved. Table 40 summarises the savings identified. The detail behind these savings is set out in Annex 7.

Table 40: A summary of the savings opportunities identified by t he TSAs

Category	Short description	LSS model	CPT model	Draft TSA model
Corporate/back office savings	The reduction of management and back office functions to NHS averages and taking into account collaboration savings in these areas.	£10.8m	£11.1m	£11.6m
Clinical synergies	The reduction in clinical costs associated with collaborating with another provider (e.g. reduction of on-site diagnostic support services).	£2.5m	£2.5m	£2.5m

Category	Short description	LSS model	CPT model	Draft TSA model
Productivity savings	Reduction in ward costs due to reducing average length of stay for inpatients to the national average.	£4.5m	£4.5m	£6.2m
Workforce synergies	The reduction in temporary staff costs, the removal of some duplicate positions and the alignment of staff structures to NHS standards that would be possible through the closer networking and collaboration with other providers.	£7m	£7.4m	£4.4m
Non pay synergies	The reduction in non-pay costs that would be possible through the closer networking and collaboration with other providers.	£1.8m	£1.5m	£1.8m
Estate savings	Reduction of estate costs to nearer the average for the NHS.	£2.7m	£2.7m	£4m
Tactical cost improvements	All NHS providers are expected to deliver 4-5% tactical cost improvements every year – to counter the rising cost of service delivery. The TSAs have assumed MSFT would deliver 2% of tactical cost improvements each year.	£10.4m	£10.4m	£10.4m
Total		£39.7m	£40.1m	£40.8m

Notes:

1: Workforce synergies are lower for the Draft TSA model due to the greater retention of services in Stafford and Cannock, notably the 14/7 A&E, the anaesthetic cover and the acute medical inpatient beds. The synergies are higher for the CPT model due to economies of scale in the delivery of day case procedures.

2: Productivity savings are primarily around improvements in length of stay and the impact on costs of inpatient beds. The TSAs have not assumed substantial productivity savings where the inpatient activity is displaced to another provider as this will be outside the scope of any implementation programme. As more inpatients beds are retained in Stafford and Cannock in the Draft TSA model, it is assumed this will deliver the greatest opportunity for productivity savings.

3: Estate savings are less for CPT and LSS because there will be a loss of rental income associated with Cannock due to calculations being based upon there being a new build facility.

4: The values are rounded to the nearest £0.1m.

The forecast financial position of each model in March 2017

328. This evaluation has set out that there are various factors that will add cost pressures to the delivery of the activity currently delivered by MSFT between now and March 2017. It has also set out a range of opportunities to reduce costs during that period. The quantum of these pressures and opportunities differs for each of the potential models. Figures 12 to 14 summarise these pressures and opportunities for each model and set out what the financial gap will be in March 2017 once these are taken into account.

Figure 12: The financial summary for the LSS model

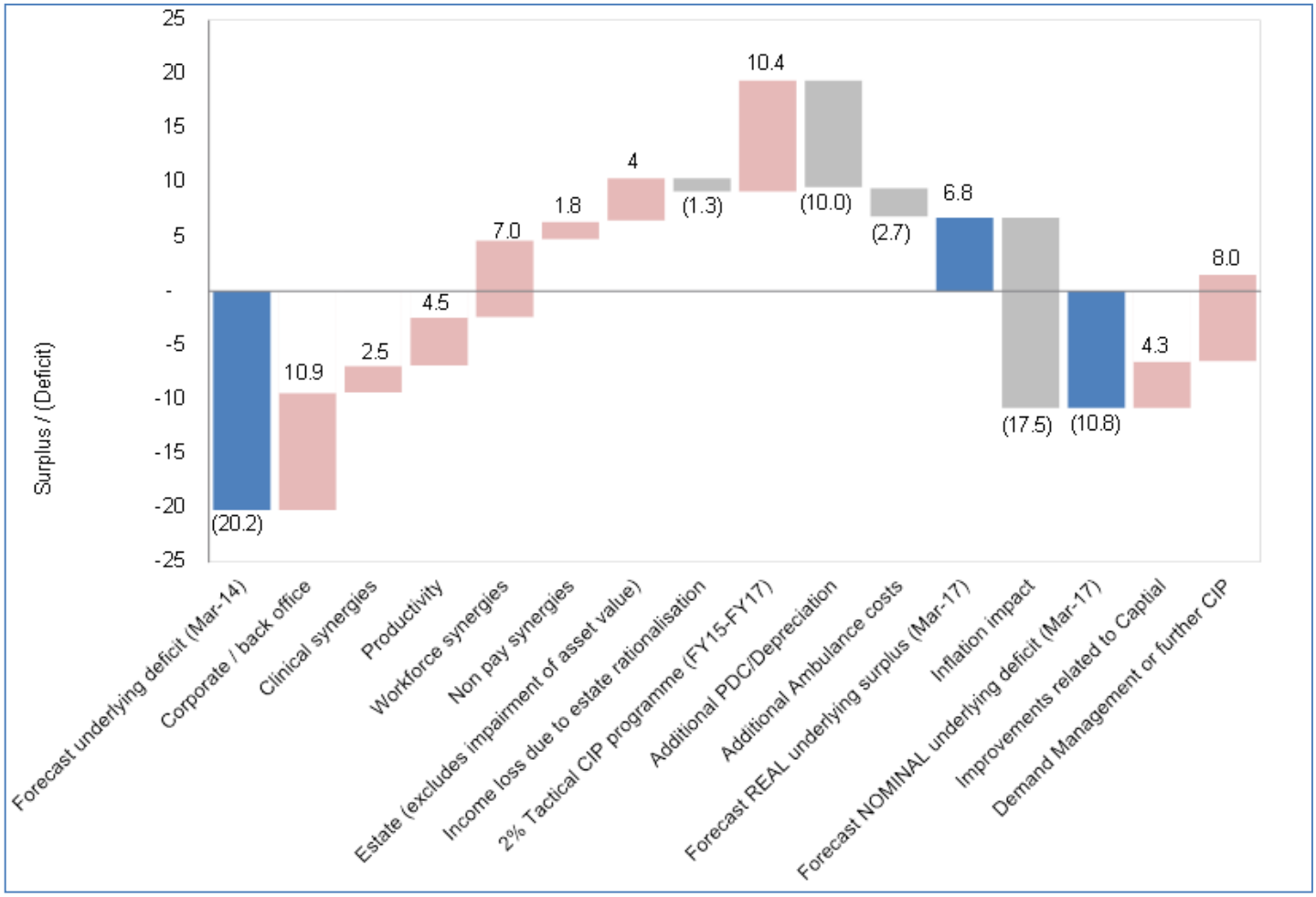


Figure 13: The financial summary for the CPT model

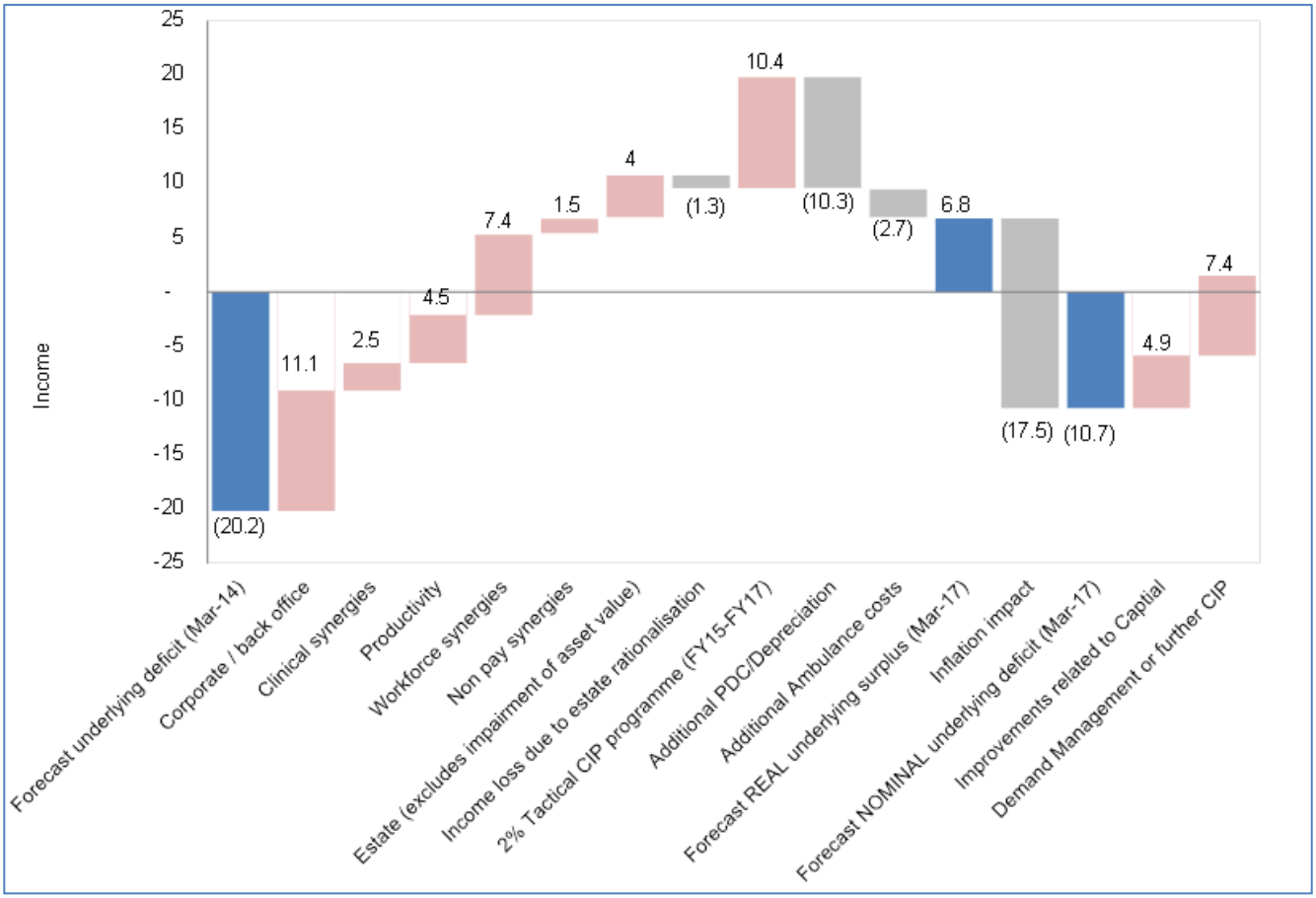
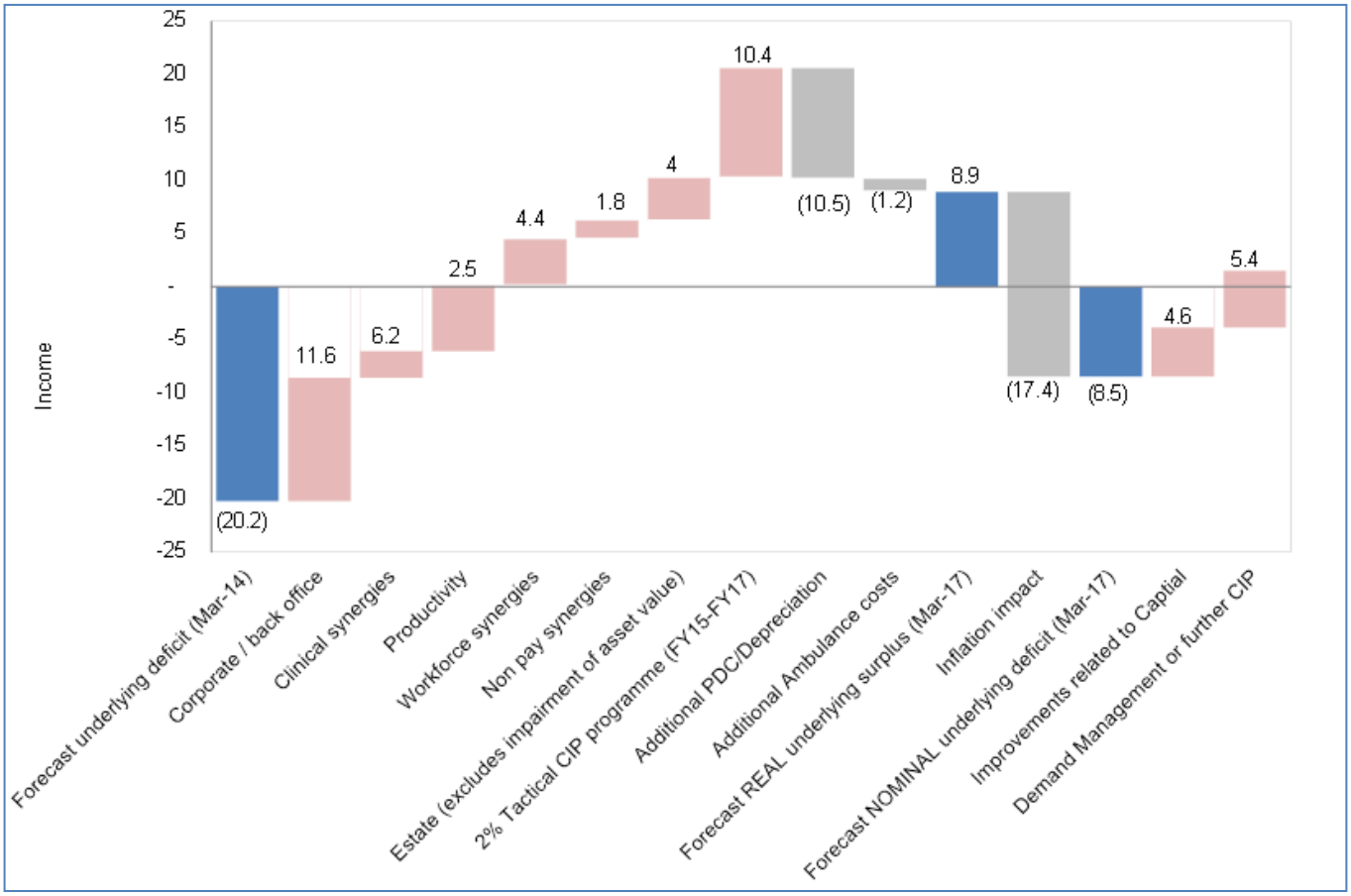


Figure 14: The financial summary for the Draft TSA model



Notes:

1: The levels of inflation that are presented in these figures are lower than the amount indicated at the start of this evaluation. This is because these reflect the impact of inflation after cost improvements have been taken into account. The values presented at the start of this evaluation related to the impact of inflation on total expenditure without any cost improvements.

2: The category 'Improvements related to capital' relates to the expectation that the additional costs associated with depreciation/PDC will reduce as more work is conducted with regards to capital investment requirements.

3: The category 'Demand management or further CIP' is the estimated financial gap having taken all cost improvements into account. This assumes the delivery of a 1% surplus in March 2017 (the requirement of all FTs), rather than a break even position. This 1% surplus is ca. £1.56m.

329. As stated in the notes, the TSAs believe the cost of depreciation/PDC will reduce as further work is undertaken to finalise the required capital investment. However, the conclusions of this analysis are that:

- All three models will deliver a surplus in real terms (i.e. the level of estimated savings offsets the forecast deficit for April 2014 plus the cost of additional depreciation/PDC;
- In all models, the estimated pressure of additional cost inflation and tariff deflation during the three year transition period means that more cost

improvements will need to be delivered in order for each of the models to deliver the expected 1% surplus on the activity currently provided by MSFT.

330. Table 41 summarises the assessed gap for each of the models.

Table 41: A summary of estimated financial gap for each model

	LSS model	CPT model	Draft TSA model
Deficit prior to estimated reduction in depreciation/PDC	£10.8m	£10.7m	£8.5m
Gap after reduction in depreciation to achieve a 1% surplus	£8.0m	£7.4m	£5.4m

Reducing the forecasted deficit

331. The TSAs are continuing to work with local CCGs, local providers, the NHS TDA and other organisations to identify additional cost improvement opportunities. The TSAs expect to set out the outcomes of this work in their final report. The type of opportunities currently being explored include:

- Evaluating further ways to reduce the length of time patients have to stay in hospital;
- Developing plans to reduce the number of patients that are referred to and admitted into hospital (also known as demand management);
- Working across the local health economy to identify cost improvements that could be delivered through organisations working together in more effective ways;
- Assessing ways in which any surplus estate in Stafford and Cannock could be used to generate additional income.

332. Some of these initiatives are outlined in Section 10.7.

Transition funding

333. There will be costs associated with the implementation of any of the proposed models. The TSAs have made some initial estimates as to what these might be and they are summarised in Table 42. These costs are a conservative estimate and there may be additional costs which need to be factored. The TSAs will continue to work with the appropriate stakeholders over the coming weeks to refine these estimates and will present further detail in the final report.

Table 42: A summary of the estimated transition costs

Category	Short description	LSS model	CPT model	Draft TSA model
Deficit funding	The ongoing subsidy from the DH in order to underwrite the continuing deficit of MSFT.	£83.4m	£80.4m	£77.1m
Implementation costs	The costs associated with the management of the implementation programme and specialist support/advice during the period.	←---------- -------£18m----------→		
Redundancy costs	The costs associated with reducing the workforce in line with the proposed new clinical model (taking into account that some staff may move to other organisations based on alternate locations).	←---------- -------£5.3m----------→		
Double running costs	The costs associated with continuing to run services in Stafford/Cannock that are being introduced at other providers (on the basis that the service won't be decommissioned in Stafford/Cannock until it is fully operational at the other provider).	←---------- --------£8m----------→		
Total		£114.7m	£111.7m	£108.4m

Funding requirements

334. Delivering the final recommendations will require additional funding, regardless of the final clinical model that is approved by the Secretary of State for Health. This funding will need to cover the transition costs, the capital expenditure and the subsidisation of any deficit.

335. Table 43 summarises the level of funding that would be required for each of the models.

Table 43: A summary of funding requirements for each model

		LSS model	CPT model	Draft TSA model
Transition costs	Deficit funding	£83.4m	£80.4m	£77.1m
	Implementation costs	£18m	£18m	£18m
	Redundancy costs	£5.3m	£5.3m	£5.3m
	Double running costs	£8m	£8m	£8m
	Sub-total	*£114.7m*	*£111.7m*	*£108.4m*
Capital expenditure		£240.1m	£244.3m	£197.4m
I&E support post transition		Nil- assuming deficit bridged		
Total		£354.8m	£356.0m	£305.8m

Notes:
1: The capital expenditure numbers presented in this table are the top of the range numbers. The TSAs are continuing to work with various stakeholders and organisations to identify how these numbers can be reduced.
2: There are potentially additional costs at Cannock to do with the estate. These are currently being explored further.

Comparing the models from a financial perspective

336. The levels of funding required are significant. In order to make an effective comparison, the TSAs have calculated the Net Present Value (NPV) of the three models over a ten year period post implementation. In simple terms, this NPV is the estimated cost to government (expressed in terms of present value) to deliver each model.

337. To enable a broader comparison, the TSAs have also assessed the NPV of a 'do nothing' scenario. In Section 4.6, the TSAs presented a summary of the potential outcomes of not implementing a planned programme of change to secure sustainable service in Mid Staffordshire. The precise range of outcomes cannot be fully predicted, but the TSAs have an obligation to secure the future delivery of LSS. Therefore, the TSAs have based their 'do nothing' scenario on the basis of no changes for three years – during which time the ongoing deficit at MSFT will need to be subsidised – followed by the implementation of the LSS model.

338. Table 44 summarises the calculated NPV for the three models and the 'do nothing' comparison.

Table 44: A summary of estimated NPV for each model

	LSS model	CPT model	Draft TSA model	'Do nothing'
3 year transition + 10 year breakeven	(£255m)	(£248m)	(£206m)	(£427m)

Notes:
1: The NPVs for the three models are based upon a three year transition period followed by ten years of break even for the delivery of services.
2: The 'do nothing' value is based upon three years of deficit funding + three years of transition + seven years of break even for the delivery of services.

340. The TSAs have therefore concluded that from a financial perspective the Draft TSA model is preferable. The estimated capital expenditure and transition funding is the lowest with the Draft TSA model and the savings opportunities are the greatest. It will cost the least amount to deliver in the short and long term.

341. There is more work to be done to finalise the financial position and to give greater certainty that the Draft TSA model will break even after the period of the transition.

There are further opportunities to develop and the TSAs will continue to do this in parallel with the consultation period.

9.12 The deliverability evaluation of the models

342. The final evaluation conducted by the TSAs was to assess the deliverability of the three models. The deliverability evaluation is based on five key areas:

- Scale of change – how much change will be needed to deliver the clinical model?
- Acceptability – which model will have the greatest acceptability from key stakeholders?
- Ease of implementation – to what level will there need to be infrastructure changes i.e. capital developments to support the changes?
- Timescale – how quickly can the changes be made to ensure that the current services can be maintained through transition?
- Impact on other providers – how easily will providers be able to either deliver the new services in or accommodate the activity which will transfer to their host site?

343. Table 45 summarises the TSAs views on the deliverability of each model.

Table 45: A summary of the deliverability evaluation

Criterion	LSS model	CPT model	Draft TSA model
Scale of change	• Retains 75% of activity • Large changes will need to be made to transfer complete service areas i.e. A&E, inpatients • The size and complexity of these services will result in a the largest programme of change	• Retains 84% of activity • Re-design of services being retained i.e. urgent care centre will require a large programme of work • Some transfer of complete service areas i.e. medical inpatient services will require a large programme of work	• Retains 91% of activity • A smaller range of services will be transferred than the LSS and CPT models • The least amount of change is undertaken compared to others
Timescale	• Creating capacity for activity to transfer will increase the implementation period	• New protocols will need to be developed for the retained new services i.e. urgent care before they can be safely delivered	• Less need on capacity elsewhere which means some services can moved more easily and stabilisation of services retained at Stafford and Cannock can happen in a shorter timeframe

Criterion	LSS model	CPT model	Draft TSA model
Acceptability	• The downgrading of both hospitals will cause the greatest amount of concern from all stakeholders – including those outside the area of Mid Staffordshire as there will be the greatest perceived risk to other providers • The plan to redevelop Cannock into an outpatient centre will also cause concern	• Local hospitals will be retained with more services than the LSS • Evidence from the reaction to the CPT proposals show that there will be wide spread concern with any model which doesn't retain: A&E, maternity and paediatrics •	• Increase in services in Cannock will be welcomed from the Cannock population • Whilst the Stafford model retains most services there will be concern about the plans to move maternity and paediatrics to other providers and not to revert back to a 24/7 A&E
Ease of implement-ation	• The biggest capital programme at other providers will be required to provide the transferred activity • Less integration of systems needed at Stafford and Cannock due to the limited services being provided	• There will be capital requirements both at other providers and at Stafford and Cannock • Less integration of systems needed at Stafford and Cannock due to the limited services being provided	• There will be capital requirements both at other providers and at Stafford and Cannock • A large programme of systems integration will be needed to be able to manage the services on both sites
Impact on providers	• Providers may not be able to maintain services with the volumes of emergency and non elective activity they will receive • It will support some providers in developing a critical mass from increased centralisation	• Less volume will move than the LSS model. Will not reduce the volumes of non elective being transferred which will create pressure on the system • Without organisational integration, this will be less acceptable to other providers as it primarily moves non-elective services to other providers (which are higher risk and put most pressure on finances)	• Less impact on providers from activity transferring due to A&E and some non elective activity being retained

344. There are deliverability challenges with each model. On balance the Draft TSA model has fewer deliverability challenges to overcome and therefore would be the preferred model from a deliverability point of view.

9.13 The TSAs' preferred clinical model

345. On the basis of the analysis undertaken, the TSAs have ranked the three models against each of the criteria. Table 46 summarises these rankings.

Table 46: A summary of the evaluations and final ranking of the models

Criteria	LSS	CPT	Draft TSA
Clinical	2nd =	2nd =	1st
Access	3rd	2nd	1st
Financial	3rd	2nd	1st
Deliverability	3rd	2nd	1st
Conclusion	**3rd**	**2nd**	**1st**

346. The draft recommendations of the TSAs are set out in the following section. **These recommendations are based upon the adoption of the Draft TSA model.**

10 The TSAs' draft recommendations

347. The TSAs have identified and evaluated a range of clinical models for both Stafford and Cannock and have concluded that the 'Draft TSA model' is the best model to use as the basis for their draft recommendations. The majority of this section summarises the draft recommendations associated with the Draft TSA model and how this model can be delivered in a clinically sustainable manner in Stafford and Cannock. The draft recommendations about the clinical models for Stafford and Cannock are to be put forward to the public for consultation. These draft recommendations are presented in Sections 10.3 and 10.4.

348. The TSAs are confident that there are providers willing and capable of delivering these clinical models. However, the TSAs will not be making draft recommendations in the report about who should provide services in Stafford and Cannock. Although no final decision has been made about who will provide services in Stafford and Cannock, the Draft TSA model is based upon the proposals put forward by UHNS (Stoke) and RWT (Wolverhampton). The TSAs have been working with these organisations – and WHT (Walsall) – to refine the information upon which the draft recommendations are based. If the draft recommendations are approved, consideration will be given as to whether there needs to be any form of formal procurement to determine which organisations will deliver the services in Stafford and Cannock. The implications for the organisational form of MSFT and potential future providers of services in Stafford and Cannock are outlined in Section 10.5.

349. Delivering the draft recommendations will require an investment of funds. Section 10.6 briefly outlines the TSAs estimates of the funding that will be required. These funds will cover:

- the capital investment required in Stafford, Cannock and other NHS hospitals;
- the management of the safe transition of services from the current state to the recommended future clinical model; and
- the subsidisation of the MSFT financial deficit during the period of transition.

350. The TSAs have been working closely with the local CCGs during the last few months and have identified a range of commissioner led enabling actions that will be required to ensure the full and successful implementation of the draft recommendations. These actions are summarised in Section 10.7.

351. The draft recommendations are complex but the TSAs believe they present the opportunity to deliver high quality, clinically and financially sustainable services for the local population of Stafford, Cannock and the surrounding areas.

10.1 The nature of the TSAs draft recommendations

352. The remit of the TSAs is to present a series of draft recommendations to ensure the safe and sustainable delivery of the services currently provided by MSFT. In doing so, the TSAs must be mindful of the impact on the wider health economy, but have not made any recommendations about changes to services currently delivered by other providers.

353. However, the TSAs have observed that there are a number of actions across the local health economy that are essential to enable the successful implementation of the draft recommendations. The TSAs do not have the power to recommend these actions. Instead, the TSAs have presented these actions in this draft report as 'enabling actions' for consideration by local and national commissioning organisations.

354. The primary focus of the TSAs to date has been on the clinical models for Stafford and Cannock. There are many services which, in the TSAs' view, should and can be kept local. Where the TSAs are recommending that any discrete service is not to be retained locally, this section will present the reasons behind this.

355. When discussing the potential clinical models with other providers in the local health economy the TSAs have identified some services which are currently provided for the local population of Stafford and Cannock outside of the locality. Some of these services could be provided in Stafford or Cannock in the future. This will enhance the current service provision and has been noted alongside the TSAs' draft recommendations.

10.2 Delivering clinical sustainability through the establishment of clinical networks

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

357. Clinical networks can take various forms and there is no single definition. Examples of clinical networks could include out-reach services, multi-site working, formal/informal collaborations (e.g. shared services) and integrated care teams.

358. Although there is no single definition, there are three clear characteristics of a clinical network that are essential when considering the benefits for Stafford and Cannock, namely:

- The network enables resilience in the delivery of services;
- The network places the burden of travel on those delivering the service, rather than those receiving the service; and
- The network enables closer coordination of service delivery across the organisations in the network.

One example of a clinical network

Calderdale and Huddersfield NHS Foundation Trust provides Acute services across two sites in Yorkshire. In 2006 work began at the Trust to re-design its portfolio of services across both sites as part of the local health economy plan "looking to the future". The Trust retained some services across two sites but also centralised some services onto one site and delivered them within a clinical network.

In 2007 one of the first changes that the Trust made was to centralise planned surgery such as orthopaedics and general surgery on to the Calderdale Royal site whilst centralising emergency and complex surgery on the Huddersfield Royal Infirmary site. This improved patient outcomes by reducing length of stay.

To support the network the Trust worked with the ambulance service to ensure that patients who needed to be moved to another site could be transferred quickly and safely. The Trust also provided a free bus service between the two sites for patients to use.

http://www.future.cht.nhs.uk/

359. One of the central arguments around whether MSFT is clinically sustainable is that many of its services are sub-scale. This means that deploying sufficient numbers of appropriately skilled resources is a challenge and those resources may not be exercising those skills on enough occasions to maintain them to an appropriate standard.

360. The TSAs believe that the establishment of a clinical network for Stafford will address this issue for some of the services that are currently unsustainable. This will enable a greater number of services to be retained locally – one of the guiding principles for the TSAs when developing their draft recommendations.

361. Although the clinical sustainability challenges are more associated with services currently based in Stafford (A&E, Emergency Surgery and Paediatric care), it is likely that a clinical network will be necessary for the services in Cannock and the Draft TSA model has been developed on this basis.

362. Clinical networks will not address all of the problems of clinical sustainability. There are some services where the patient volumes are not sufficient to ensure a viable service can be maintained.

363. The use of clinical networks should also address some of the causes of the recruitment and retention issues faced by MSFT, notably the preference for clinical staff to work at larger more specialised hospitals due to the diversity in patient conditions to treat and the prestige of the organisation. This was the clear view of the CAG when they considered the impact of clinical networks (see Section 9.9).

364. When considering which organisations may currently be in a position to manage a clinical network in Stafford and in Cannock, there are limitations on the range of providers that could do this in an effective manner. The most notable limitation is the distance between the provider's site(s) and the sites in Stafford and Cannock. This is a factor, because:

- Some of the clinical staff will need to operate across multiple sites. A clinical network can introduce potential inefficiencies in the staff deployment model associated with the cost and time incurred due to the staff member travelling between sites.
- The network will enable all outpatient services to be delivered locally (which is necessary as outpatient appointments are part of the list of LSS for Stafford and Cannock), but there will be some associated inpatient procedures that are not conducted in Stafford and Cannock. The further away the provider's inpatient service is from Stafford and Cannock, the greater burden (time and cost) that will be placed upon the patient to travel for their inpatient treatment.

365. The ability to operate an effective clinical network with Stafford and possibly Cannock will be one factor taken into consideration when developing final recommendations about the future organisational form and the providers delivering services from Stafford and Cannock. The TSAs have started to consider these matters and have summarised their current consideration with regards to organisational

form in Section 10.5. The final recommendations on organisational form and providers delivering services in Stafford and Cannock will be dependent on the final recommendations for the clinical model.

366. In Section 4.4, it was proposed that the integration of care delivered by multiple care providers (e.g. primary, secondary, community and social care) across care pathways can deliver improved patient outcomes. Integration can take on several forms, including organisational mergers, formal joint ventures and the deployment of multi-disciplinary teams. Although the TSAs are not making any formal recommendations around integration of care, they do believe that any opportunities for multi-disciplinary team working across multiple health and social care providers should be explored and where possible implemented.

10.3 The draft recommendations for the clinical service model in Stafford

367. The TSAs' minimum obligation is to secure the sustainable delivery of the Location Specific Services in Stafford over the next ten years. The detail around developing the LSS for Stafford was set out in Section 5.5 and the 'Core LSS' are summarised in Table 47[51].

Table 47: The LSS for Stafford

Stafford & Surrounds CCG Location Specific Services
At Stafford: Services identified as a LSS on the basis that not doing so would impact Health Inequalities: • Outpatients • Patient-facing diagnostics • Day case chemotherapy • Pre-natal and post-natal care • Step down beds ***These are the 'Core LSS'.***

368. These services will be retained for delivery in Stafford for the population of Stafford and Surrounds.

369. At present, patients from Cannock Chase access some of these services in Stafford as they are not provided in Cannock. In the draft recommendations for Cannock, the TSAs are proposing that some services currently provided only in Stafford should in the future also be provided in Cannock for the population of Cannock Chase (see Section 10.4).

[51] The TSAs are not obliged to define a service model that retains the 'non-core LSS' (as summarised in Section 5.5) in current locality. The TSAs are obliged to identify a plan for how they can be delivered in a sustainable manner over the next ten years and where there is currently insufficient capacity, how that capacity is to be established.

370. It is clear, through discussions with the CAG and other organisations, a clinical network offers opportunities to retain a broad range of acute services in Stafford, over and above the LSS, and deliver them in a clinically sustainable manner. There is also the opportunity to enhance some of these services retained.

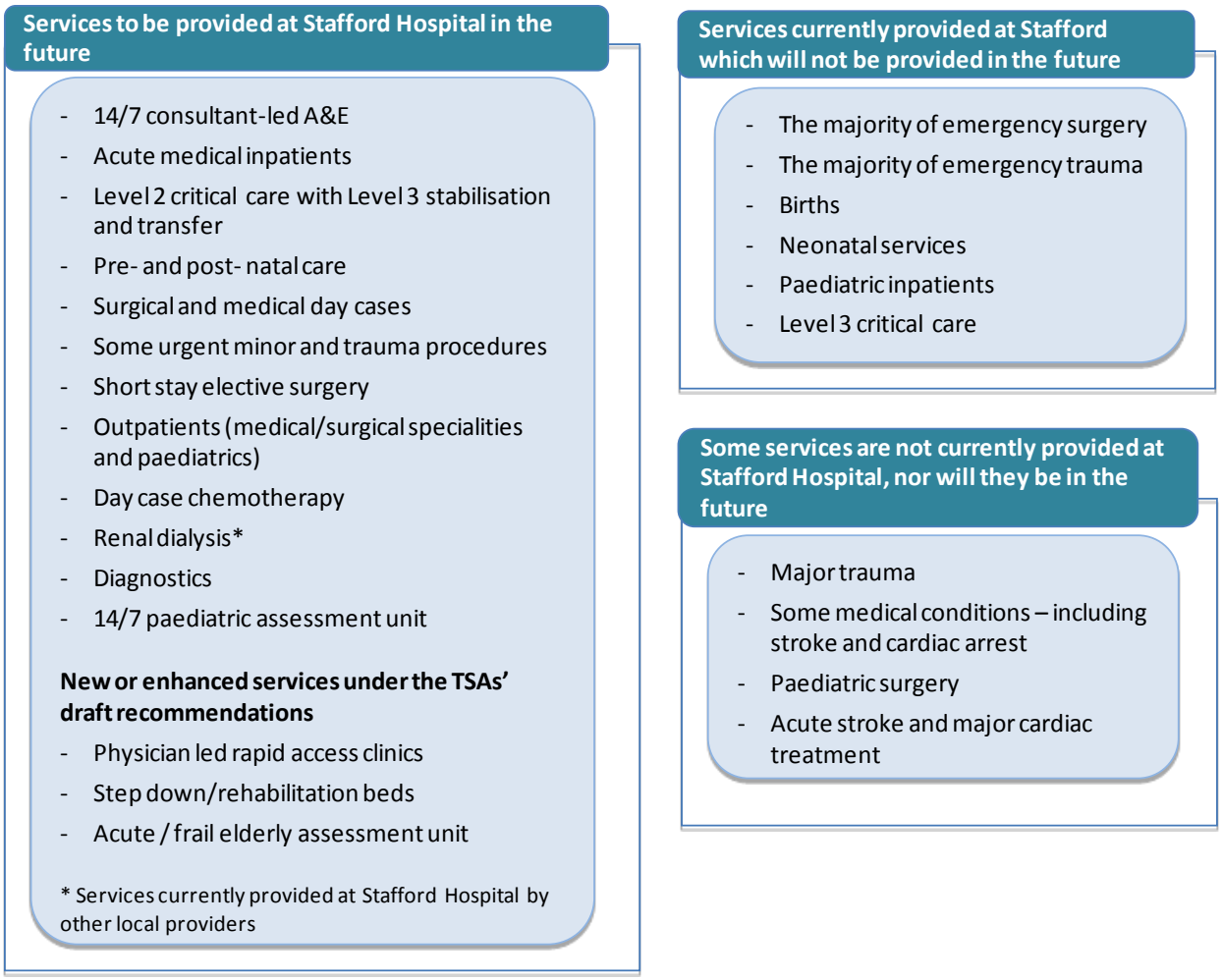
371. However, there are some services currently delivered in Stafford which, in the opinion of the TSAs and the CAG, would be more appropriate for delivery at a larger more specialised hospital, for example UHNS.

372. The Draft TSA model - which the TSAs draft recommendations are based upon – retains a number of services in Stafford over and above the LSS and CPT models, but not the full range of services currently provided in Stafford. Figure 15 summarises the service model proposed for Stafford.

373. The remainder of this sub-section presents the draft recommendations for Stafford grouped into seven broad service areas:

- Emergency and urgent care;
- Inpatient medical care for adults;
- Maternity services;
- Paediatric services;
- Emergency surgery;
- Critical care; and
- Elective surgery and day case work (surgical and medical).

Figure 15: A summary of the proposed clinical model for Stafford



Emergency and Urgent Care in Stafford

TSA DRAFT RECOMMENDATION 1

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

374. The Trust has made concerted efforts over the last two years to ensure the A&E service in Stafford is sustainable, and the number of consultants on the rota has increased by one post since the CPT analysis. Nevertheless, the number of consultants operating in the department is significantly lower than the Royal College guidance on staffing levels to operate a safe 24/7 A&E service.

375. Indeed, the TSAs are concerned that MSFT are operating a 14/7 rota within a fine margin of what would be clinically safe, especially if the situation with two staff acting up is maintained as the status quo. The TSAs do not believe the current staffing model is sustainable on a stand-alone basis.

376. However, the TSAs believe that reducing the current 14/7 A&E service provision in Stafford would present a significant risk to the other providers in the LHE in terms of increasing the pressure on already challenged A&E departments. These pressures have amplified since the CPT prepared its recommendations in February 2013 and the CAG/NCAG concur that substantial changes to the A&E in Stafford could jeopardise the ability of other providers to effectively manage their emergency care provision (see CAG letter in Appendix E).

377. Establishing a clinical network, for example with UHNS, to deliver the current A&E provision will ensure there is significantly improved resilience in the consultant rota being operated in Stafford and will address the current clinical sustainability issues. It will provide opportunities for consultants operating across multiple sites to maintain their skills. It should also provide a more attractive opportunity to recruit workforce in the future as it creates opportunities for medical training and clinical experience across diverse sites (major acute hospital and smaller local hospital) and different catchment populations. This position has also been agreed by the CAG (see CAG letter).

378. The TSAs did consider whether it was possible to operate a 24/7 A&E, but have concluded that this would not be feasible. The introduction of a clinical network will address the resilience issues currently faced at Stafford A&E, but it will not create additional resources. It would be necessary to introduce 4 additional A&E consultant grade doctors onto the rota operating across the network in order for a 24/7 service in Stafford to be clinically viable. Stafford A&E is one of the smallest in the country

(132nd out of 150, based upon attendances). On an average day, there are c120 attendances[52], which is an average of 8-9 new attendances every hour. Data from the West Midlands Ambulance Service has shown that on average they attend c16 patients between the hours of 22:00 and 08:00 (i.e. less than 2 per hour) that would be taken to Stafford if the A&E were open 24/7. This level of demand would make the networked rota uneconomic to operate and unattractive for consultants to work within.

379. The delivery of out-of-hours primary care is not within the scope of the work that the TSAs have the authority to review. However, the TSAs would welcome and encourage the CCGs and providers of primary care services to consider co-locating an out-of-hours (i.e. overnight and weekends) primary care service at Stafford Hospital.

380. The current pathways for taking acutely ill emergency patients to larger more specialised hospitals, such as UHNS and RWT, should remain in place (e.g. those with the signs/symptoms of major cardiac problems and stroke). There are established protocols where the ambulance service takes patients directly to these specialist centres and not to or via Stafford.

381. In addition, the Draft TSA model includes other patient cohorts who should be taken directly to larger more specialised hospitals. This is on the basis that certain acute services would no longer be provided in Stafford and it would not be appropriate to take patients that obviously need access to these services to Stafford in the first instance.

382. These patient cohorts equate to ca. 10% of the current patient attendances at Stafford A&E and include:

- cases where it is evident that emergency surgery is required;
- very sick children who may have a life threatening illness; and/or
- very sick adults/older people.

383. Based upon these draft recommendations, the A&E should remain shut overnight with the department closing for new arrivals between the hours of 10pm and 8am. Patients who require emergency or urgent services overnight will continue to access the services at other Trusts as per the current protocols.

384. It is highly likely that in the medium and long term there will be further advances in specialist and emergency medicine which will mean that a wider range of patients will have better chances of survival and recovery if they are taken directly to larger

[52] 2012/13 Trust data

more specialised hospitals. This means that, over time, some patients who will be treated in Stafford will be better served if they are treated in a larger more specialised hospital.

385. The following examples summarise what would happen to a small range of patients under the TSAs' draft recommendation for emergency and urgent care.

Emergency and urgent care patient examples

Example One

A 27 year old woman has bad asthma. She has an asthmatic episode during the day and her partner calls an ambulance. The paramedics assess the women and she is taken by ambulance to Stafford hospital for further tests and treatment.

She is fully examined by the A&E team and after some treatment she is well enough to go directly home.

Example Two

A 43 year old man trips in the street on his way home after a night out with his wife. He hurts his knee and cannot put any weight on it at all. He is in a lot of pain and discomfort and needs some emergency attention. His wife manages to get him to their car to take him to A&E. It is 10.30pm so goes to UHNS instead of Stafford as it is still closed after 10pm at night.
The man is assessed at the A&E in UHNS and is found to have a dislocated knee. Following his treatment he his sent home on crutches. He receives his follow up care in a few weeks time in Stafford.

Example Three

A 35 year old woman has an accident at work and cuts her hand quite badly. Her work colleagues take her to Stafford A&E as the cut looks quite deep and is bleeding a lot.

She is reviewed in the A&E department and whilst the cut is quite deep it has not hit any nerves or tendons. The nurse in A&E cleans the cut thoroughly and gives the woman a number of stitches before bandaging and sending home.

Inpatient medical care for adults in Stafford

TSA DRAFT RECOMMENDATION 2

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

386. A full acute medicine/care of the elderly inpatient service is currently provided by MSFT in Stafford. This service receives admissions directly from A&E and directly from primary care (GPs) and other healthcare professionals. These admissions are for diagnosis and treatment.

387. The demand for acute medicine and care of the elderly services in Stafford is expected to increase in the future due to the forecast demographic changes in the local population. Whilst this increase is a national challenge, the projected rate of growth in the catchment area for the age group 65+ is higher than the national average (see Table 48).

Table 48: The projected rate of growth for the age group 65+

Area	2011 population for age group 65+	Predicted 2021 population for age group 65+	% change
Stafford and Surrounds CCG	23,700	28.900	+21.9%
Cannock Chase CCG	30,000	36,600	+22.2%
All Staffordshire CCGs	160,600	197,400	+22.9%
England	9,055,900	10,787,100	+19.1%

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

388. Furthermore, with the proposed retention of a 14/7 A&E in Stafford, it is sensible and appropriate to ensure there is the ability for non-elective patients to be admitted into an inpatient bed at the same location for ongoing treatment.

389. Therefore, the TSAs believe that an acute medicine/care of the elderly inpatient service should remain in Stafford, however this service needs to change in order to better meet the changing needs of the local population and the intentions of local commissioners.

390. There should be closer working between the providers of acute, primary, community and social care. This will ensure patients are treated in the right place and that an admission to hospital is only made when it is the best place for the patient to be treated. This is particularly crucial as the current emergency admission rates of MSFT

are higher than average (see Table 49). Closer working across organisations can be achieved in a number of ways, especially through some of the commissioner led 'enabling actions' outlined in Section 10.7.

Table 49: Admission rates for the local CCGs

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

Source: National General Practice profiles, Public Health England

391. With regards to the acute medical service in Stafford, it is proposed that:

- There shall be an enhancement of the current Medical Assessment Unit (MAU) to include specialist support for the frail and elderly (see Draft recommendation 3);
- The existing 'step down' facility is extended (see Draft recommendation 4) to ensure Stafford residents are transferred back to their local hospital as soon as possible when they are treated at a more specialised hospital;
- There is a managed reduction in the number of acute medical beds. This will be enabled by a range of factors including:
    - the enhancements of the MAU will reduce the number of admissions to an acute bed;
    - closer integration of care with other care providers – which the FEAU and multi-disciplinary teams will support;
    - the very sick older patients having their initial period of treatment at a larger more specialised hospital; and
    - delivering the range of demand management schemes proposed by the CCGs enabling more care to be delivered out of an acute setting. Section 10.7 outlines a range of enabling actions that will support the TSAs' draft recommendations. All of these actions will support the reduction of acute medical beds.

  The TSAs have made initial estimates on the number of beds this service will require as part of their financial evaluation. The TSAs will continue to work with CCGs and local providers to further test these estimates and in the final report will set out more detail about the number of beds required and how the reduction will be managed.

TSA DRAFT RECOMMENDATION 3

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

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

392. The needs of older people are often complex and the acute hospital is not always the best care setting. There are circumstances when rapid referral to a community care, social care or mental healthcare provider would avoid the need to inappropriately admit the older person into an acute inpatient bed (this would include getting the older person back home with support from community/social care providers). The TSAs believe that, in order to meet the increasing needs of older people, it is essential that acute care, community care, primary care, social care and mental healthcare providers work more closely together to ensure the most appropriate handling of every patient.

393. It is proposed that the current MAU at Stafford Hospital should be enhanced to include a specialist focus on assessing the frail and elderly. The MAU should ensure that only acutely unwell patients end up in an acute bed, and less acutely ill patients are referred for treatment in a more appropriate setting.

394. Admissions into the MAU will be between 08:00 and 22:00, seven days a week (in line with the recommended A&E opening times), but the beds in the unit will be operated 24 hours a day. Patients can be admitted into the MAU by the A&E at Stafford and directly referred to the MAU by community care and primary care providers.

395. The MAU will assess the patients and determine how their care needs will be best managed going forward. The multi-disciplinary team managing the MAU will have the ability to:

- admit patients into an adult inpatient bed in Stafford Hospital;
- refer patients to a larger more specialised hospital if their treatment needs are more complex than can be provided in Stafford; and
- discharge patients to local community/social care providers for treatment in a community hospital or a home-based care package.

396. The precise staffing model for the MAU is still being developed, but should include a combination of consultant geriatricians during the day and Advanced Nurse Practitioners at night.

TSA DRAFT RECOMMENDATION 4

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

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

397. As previously noted, there are a range of Stafford patients who are currently treated at larger more specialised hospitals. These include patients who have suffered a cardiac incident, stroke or major trauma. There are also a small number of patients who will have been treated at a larger hospital having been taken to the hospital's A&E at night time. It is important that these patients can be 'repatriated' back to Stafford Hospital as quickly as possible so that their rehabilitation and ongoing treatment can take place as close to home as possible.

398. MSFT already operate a small number of 'step down' beds which are used to repatriate some of these patients back into Stafford hospital (e.g. those patients that have suffered a stroke and are being treated at a larger more specialised hospital). These beds were identified by the local CCGs as being part of the core set of Location Specific Services. The TSAs' proposed clinical model includes an increase in the number of 'step down' beds in order to repatriate more patients back to Stafford in the future.

399. This proposal is aligned with the stated commissioning intention to provide 'care closer to home'. As a large number of patients who would be suitable for repatriation back to Stafford will be older patients, it is recommended that the staffing model for the step down beds includes geriatricians whose primary focus will be on the safe, effective and timely discharge of older patients from the step down facility. The TSA believes that the effectiveness of the service would be enhanced if there is some form of collaboration/integration with local community/social care services and are continuing to explore the opportunity for this.

400. The following examples summarise what would happen to a small range of patients under the TSAs' draft recommendations for acute medical inpatient care.

Acute medical and care of the elderly patient examples

Example One

An 87 year old man has a fall at home one afternoon and is found by his next door neighbour who rings an ambulance. The paramedic assesses the man and decides to take him to Stafford hospital as he is confused and he may have broken some ribs.

The man is assessed by the A&E doctors and is admitted to the Assessment Unit. He has some tests and fortunately his ribs are not broken. The consultant team suspect he has an infection and prescribe a course of antibiotics. They decide to keep him in for a few days and he is admitted onto one of the wards for monitoring.

After a few days his condition gets better and he is well enough to be discharged home.

Example Two

An 83 old lady is found unconscious at home. Her daughter thinks that her mother might have had a stroke and calls 999 for an Ambulance.

The paramedics arrive at the home and assess the elderly lady. The paramedics agree it is possibly a stroke and so take her directly to Stroke Unit in Stoke as Stafford has not provided emergency stroke services for a period of time.

When she arrives in Stoke, she is taken to the Stroke Unit and is assessed by the specialist team who undertake a series of tests to confirm whether she has had a stroke or not.

She receives some emergency treatment and over the next few days she began to recover and is well enough to transfer to Stafford Hospital for rehabilitation.

Example Three

A 52 year old man with chronic bronchitis has developed a chest infection. He visits his GP who examines him and prescribes antibiotics. After a few days of the course of treatment he is not improving and feels worse. The GP goes to see the man at home and after some further examinations decides the man needs to be admitted to hospital for further tests.

The man is admitted directly to the assessment unit at Stafford Hospital where he is received by the Consultant Physician who orders a number of tests. He is admitted to the wards at Stafford. After a few days of monitoring and intensive treatment he is well enough to be discharged back home.

Example Four

A 72 year old woman is unwell and has been for a few days. Her husband calls the out of hours doctor during the night as her condition worsens. He rings 999 and the paramedics come and assess her. The paramedics decide she needs to be assessed by a consultant and they take her to A&E. As it is during the night she is taken straight to UHNS as Stafford Hospital A&E remains closed overnight. She is seen by the A&E doctors who decide she needs to be admitted for further tests and monitoring.

She is admitted to the assessment unit she has a number of tests and is diagnosed with acute pneumonia. As she is struggling to breathe she is admitted onto the respiratory ward who start her treatment and monitor her for a few days.

The woman starts to make an improvement after a few days and the consultant team decide she can be transferred to Stafford hospital where we will continue to receive care under the consultant team.

She remains in Stafford hospital until she is well enough to be discharged home.

Maternity services in Stafford

TSA DRAFT RECOMMENDATION 5

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

This plan should create the additional capacity across multiple providers in the local health economy to ensure there is continuing patient choice across multiple providers.

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

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

401. Stafford currently has an obstetric (consultant) led delivery suite in Stafford which sees c1800 births a year[53]. The maternity service also provides ante and post natal care for women at Stafford. This service is one of the smallest in the country. As stated in Section 4.2 it ranks 135th out of 148 maternity services in England, based upon number of births.

402. National standards[54] require at least 40 hours consultant presence per week on the delivery suite. The view from the CAG is that a unit managing less than 2,500 births per annum is unlikely to be able to support training and keep the skills of the staff up to date as a stand-alone unit.

403. It is possible that this issue could be addressed by a clinically networked solution. However, alongside this level of consultant cover, a consultant-led obstetric unit requires the presence of Paediatrics, Special Care Baby Unit (SCBU), Intensive Treatment Unit (ITU)/Critical Care Unit (CCU), General Surgery and Anaesthetics as well as other support services. It is likely that managing less than 2,500 births per annum will be very challenging financially. This is supported by the fact that during

[53] As previously stated, it is possible that this level could increase to c1,900 with the development of the barracks at MOD Stafford.

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

the market engagement exercise and engagement with the local health economy there was no organisation willing to manage a networked obstetric service in Stafford – on the basis that the volume of patients was too low for the service to be financially viable.

404. Therefore, the TSAs have concluded that the current obstetric led service should be decommissioned with just pre and post natal care being retained in Stafford.

405. However, the obstetric service is on the list of short-term LSS. This is because the local commissioners do not believe there is, at present, sufficient capacity at other local providers to manage the c1800 births that currently take place in Stafford. Therefore, the obstetric service is Stafford cannot be decommissioned until such capacity is established in the local health economy. This will require some investment in the facilities located at other providers (see Section 10.6). The TSAs do not believe that this capacity should be concentrated on a single site, as a wide range of choices should be available for mothers-to-be.

406. Once the obstetric service is decommissioned, mothers-to-be will have a choice about which provider is responsible for their care. In many circumstances, geography is a key factor in the choice of provider. For planning purposes, the TSAs have assumed that travel to the nearest alternate provider will be the determinant in where there should be additional capacity established across the local health economy and this has informed the assessment of capital requirements to support the delivery of the draft recommendations. The TSAs have estimated the number of births that would move to other providers (UHNS, BHFT, WHT, RWT and SaTH) and will continue to work with local CCGs and these providers to plan how, when and where this additional capacity should be established. This information will be presented in the final report.

407. Ante and post natal care are on the core list of LSS and will continue to be provided in Stafford once the obstetric service is decommissioned. These services will need to be provided as part of a clinical network with an obstetric led service based at another site. This will ensure that patients will be able to access most of their routine ante and post natal appointments locally but will have the delivery at another site.

408. Where there are complications post-23 weeks, patients will need to be seen at the most appropriate obstetric unit and not in Stafford. In 2012/13 this would have been c150 cases (i.e. 8%).

409. Patients who have complications pre-23 weeks will be seen in an Early Pregnancy Assessment Unit (EPAU) in Stafford. This EPAU will operate during the day Monday – Friday. Any high risk patients at the point of referral will be directed to UHNS.

410. There are examples of standalone midwifery led maternity units (MLU) in England. Indeed, there is an MLU already established in Staffordshire with the MLU at the Samuel Johnson Hospital in Lichfield - which is provided by Burton Hospital, and there is also an MLU in Walsall. These units are typically networked to a nearby obstetrician led service at another site to ensure there is the ability to safely transfer patients that experience complications.

411. Approximately 50-60% (900-1,000) of the births in Stafford could be suitable for a MLU[55]. However analysis demonstrates that where an obstetric led unit is replaced by an MLU only 10-12% of mothers-to-be choose to use the MLU[56]. This means that the expected number of annual births would be approximately 200.

412. The cost of operating an MLU with a very low number of births will be significantly more than the income received for the unit (see Table 50), meaning that a stand-alone MLU in Stafford would also not be financially viable.

Table 50: A summary of the estimated staff costs and income for an MLU in Stafford

	£
Staffing costs[57]	520,000
Income[58]	295,000
Contribution (before non pay costs, unit overheads, insurance and other running costs)	(225,000)

413. The following examples summarise what would happen to a small range of patients under the TSAs' draft recommendation for maternity services.

[55] 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

[56] Hospital Episode Statistics maternity data 2011/12.

[57] Based upon: 1) a nine bedded MLU; 2) 1.56 nurses per bed; 3) a60/40 qualified(Band 6)/unqualified (Band 2) ratio; 4) Band 7 unit manager.

[58] Based upon a tariff of £1,477 and 200 births

Maternity patient examples

Example One

A 23 year old woman has become pregnant and has chosen to receive her antenatal care at Stafford.

At 14 weeks she develops some difficulties and rings up her Midwife for some advice. The Midwife doesn't suspect there is anything seriously wrong but tells her to go to the early pregnancy assessment unit in Stafford so she can be checked out to make sure everything is fine. The pregnant woman goes straight to the unit where she is assessed and does not need any further treatment. She is sent home and continues receiving her routine care through the midwife and visits at Stafford.

Example Two

A 23 year old woman become pregnant and goes to her GP. Her GP gives her a choice of where to receive her maternity care and she chooses to receive her regular ante and post natal care in Stafford with the birth at UHNS.

Unfortunately, at 34 weeks she develops significant complications and is sent by her midwife directly to UHNS to be assessed. After an initial assessment she is admitted to the obstetric unit for some monitoring.

The obstetric team decide that the baby should be delivered as soon as possible to safeguard its health. The woman is taken into theatre where she receives a caesarean section.

After the birth the baby requires a few days in the neonatal care unit where it has some specialist care and monitoring. Fortunately the baby responds well and both the woman and baby are sent home after a few days.

The woman takes the baby for her routine post natal checks in Stafford.

Paediatric services in Stafford

TSA DRAFT RECOMMENDATION 6

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

414. The guidelines from the Royal College of Paediatrics are that the minimum number of paediatricians required to support a clinically safe inpatient paediatric unit is ten consultants[59]. Currently Stafford has five which is significantly below the recommended levels. The TSAs believe that continuing to deliver a paediatric inpatient unit would not be clinically sustainable with the current staffing.

415. The TSAs considered the use of a clinical network to address the levels of staffing, but have concluded that there are insufficient volumes of paediatric inpatient cases treated at Stafford to support a dedicated unit. In 2012/13 there were 2,362 paediatric admissions and on average each child was admitted for 2.5 days which equates to a need for 13 beds. Even though there is an inadequate level of consultant grade staff working within the unit, the unit requires 24 medical staff to operate safely. This is almost a ratio of two medical staff per bed, which is not financially sustainable. The use of a clinical network will not address this.

416. It should also be noted that the level of paediatric admissions into Stafford Hospital is higher than the national average (12.9% of MSFT admissions were for the age group 0-14, compared with 11.4% nationally[60]). If the admission rate were to reduce in line with the national average, then the number of beds required would reduce, but it would be unlikely that the level of medical staffing could be safely reduced.

417. Furthermore, the view of the CAG is that a paediatric inpatient unit of this size is unsustainable and this was substantiated by a recent statement from the 'Royal College of Paediatrics and Child Health'[61].

> *"There are too few paediatric consultants across the UK and too many general units to deliver the best possible healthcare for children, according to the latest workforce census conducted by the Royal College of Paediatrics and Child Health (RCPCH)."*
>
> Dr Hilary Cass, President of the Royal College of Paediatrics and Child Health, said:

[59] Facing the Future: Standards of paediatric services (2011) – Royal College of Paediatrics and Child Health
[60] A&E Provider Level Analysis, 2011/12 Hospital Episode Statistics
[61] http://www.rcpch.ac.uk/news/shortage-consultants-and-too-many-units-reveals-latest-census-children%E2%80%99s-doctors

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

418. The TSAs propose that children should continue to be taken to the Stafford A&E for initial assessment. However, very sick children will be taken directly by the ambulance service to a larger more specialised hospital and very sick children who arrive at Stafford A&E by other means will be immediately transferred to a larger more specialised hospital.

419. Where a child seen at Stafford A&E cannot be discharged immediately, they will be further assessed in the Paediatric Assessment Unit (PAU) in Stafford – see Draft Recommendation 7.

420. The CPT conducted an assessment of paediatric inpatient capacity across the local health economy to inform the development of the LSS. The CCGs were satisfied at the time that there exists enough capacity across the local health economy to manage the volume of paediatric inpatients currently treated in Stafford.

421. This assessment should be repeated by the CCGs prior to the decommissioning of the service at Stafford and the service only decommissioned once the CCGs are satisfied that the capacity is sufficient. It is not envisaged that there will need to be investment in other providers to establish additional capacity.

422. It should be noted that paediatric surgery, including non-elective paediatric cases and specialist paediatric services, such as paediatric oncology, is not currently delivered at Stafford.

TSA DRAFT RECOMMENDATION 7

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

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

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

423. Stafford Hospital currently has a Paediatric Assessment Unit (PAU) and the TSAs propose that this should be retained in Stafford, working alongside the A&E, and networked with a larger more specialised hospital, for example UHNS.

424. The PAU will deploy paediatric nurses with access to the rapid input from paediatricians based at the larger more specialised hospital**.** The PAU may also have access to the A&E medical team at Stafford should there be any need for urgent medical attention.

425. The primary objective of the PAU will be to assess the ongoing treatment needs of the patient and to coordinate the delivery of this treatment, including admission to a paediatric inpatient bed at a larger more specialised hospital, or referral to community/primary care for ongoing treatment.

426. Enhancements and investment will be required with the local ambulance service in order to support this draft recommendation (see Section 10.7).

427. Increasingly, more paediatric patients can be treated at home if there are suitable services available for children who have a known care plan. If this service were introduced for GP referrals, this would reduce the number of patients that are being admitted for inpatient treatment.

428. In 2012/13, 313 out of the 2,362 admissions into the paediatric inpatient service in Stafford were direct from a GP. Many of these admissions could be kept out of hospital in the first place if a home based service were available.

429. As well as keeping children out of hospital, home based care can also support earlier discharges for children who do require inpatient treatment. In 2012/13, 328 children had an admission which was greater than three days long. Many of these may have been discharged sooner had an appropriate home based service been available.

430. UHNS currently operate a 'Paediatric Hospital @ Home' service which is primarily used to care for children at home after discharge from hospital. In 2012/13 this service had 874 referrals from the hospital and 1,830 referrals direct from GPs.

431. The TSAs are working with the CCGs to determine the potential for a similar service in Mid/South Staffordshire. The progress of this work will be included in the TSAs' final report and should complement any existing community paediatric services.

432. The following examples summarise what would happen to a small range of patients under the TSAs' draft recommendation for paediatric services.

Paediatric patient examples

Example One

A seven year old girl is stung by a bee whilst playing outside over the weekend. She has a nasty reaction to the sting and after speaking to the out of hours doctor her parents are advised to take her to A&E to be reviewed.

The parents take her to Stafford Hospital on Saturday afternoon where the girl is seen by the A&E consultant who gives her the appropriate treatment before being sent home well.

Example Two

A young child is seen at home by the on-call GP at 3:00 am one morning. The doctor suspects meningitis and calls an ambulance which takes the child directly to the Specialist Unit at UHNS.

The diagnosis confirms meningitis. Following the relevant investigation, a very intensive treatment is given. The child requires a short period of stay in paediatric care unit. But fortunately she makes a full recovery and is transferred back home in Stafford.

The child has a follow-up by the paediatric home service from Stafford and also seen at the outpatient clinic in Stafford to make a full recovery.

Example Three

A seven year old develops a severe chest infection and is taken to the A&E department at Stafford Hospital. Following the assessment in the A&E department the child is transferred to the Paediatric Assessment Unit for some further monitoring and treatment.

Following assessment the view was taken that the child is too sick to return home and therefore taken to Stoke to be admitted in the Specialist Unit.

After a few days the child makes a full recovery and is discharged home. The child has a follow-up by the paediatric home service from Stafford.

Non-elective / Emergency surgery in Stafford

TSA DRAFT RECOMMENDATION 8

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

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

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

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

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

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

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

433. Emergency surgery is currently provided in Stafford by a range of clinical specialties which can be categorised as trauma and non-elective general surgery.

434. The current arrangements for trauma patients are:

- No major trauma patients are treated in Stafford. These patients are taken to larger more specialised hospitals, for example UHNS or RWT. There are protocols for the ambulance service to take these patients directly to the larger more specialise hospital. In the case of an A&E walk-in case at Stafford, the patient would be triaged and then stabilised whilst a transfer to the Trauma centre was arranged.
- The trauma service at Stafford currently provides urgent delivery of moderately complex trauma procedures, i.e. fractures which require some treatment under

a general anaesthetic, and also minor trauma procedures which are typically treated under a local anaesthetic.

- All of these moderate and minor cases will have initially been triaged and diagnosed in the A&E department.

435. The non-elective general surgery provision is provided by a number of clinical specialties: colorectal, GI surgery and general surgery. Patients who may need emergency surgery are currently assessed in A&E, admitted to the Surgical Assessment Unit under the care of a surgeon prior to the procedure being carried out when a suitable theatre slot is available.

436. The provision of non-elective general surgery has been one area where MSFT has already transferred some of the more specialist procedures to larger more specialised hospitals - notably vascular surgery is now undertaken at UHNS.

437. In 2009, the Royal College of Surgeons conducted a review into surgical practices at MSFT[62]. This review highlighted serious concerns about the sustainability of the emergency surgery service.

438. Furthermore, the review conducted into MSFT by Professor Sir George Alberti noted that with regards to emergency surgery:

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

439. This was a driver for the consolidation of major trauma surgery and vascular surgery into UHNS and RWT. It is expected that increasing sub-specialisation of surgery will push more activity to larger units in the future, indeed there are ongoing plans (outside of the TSAs process) to centralise urology from MSFT into a larger more specialised hospital.

440. An emergency surgery service should provide 24 hour access per day which is staffed at all times and a dedicated emergency theatre. The rota for this service should be staffed by a minimum of eight general surgeons. Currently MSFT employ five general

[62] This review was not published, but was reported to the public inquiry chaired by Robert Francis QC. http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf

surgeons on the emergency surgery rota, and whilst the rota is staffed 24/7 there are insufficient surgeons to operate a dedicated emergency theatre.

441. Between April 2011 and March 2013 there were 2,426 emergency surgery / trauma cases which is an average of 4 per day (2 emergency surgery and 2 trauma). Each of these cases on average took 70 minutes giving a total theatre time of approximately 4 ½ hours per day.

442. The view from the CAG was that an emergency surgery service with these low volumes is not sustainable in the long term. The low volume of cases does not provide an environment for training both medical and nursing staff and has the potential to de-skill the theatre team in the long term.

443. Therefore, the TSAs have concluded that non-elective/emergency surgery should be decommissioned from Stafford as soon as possible.

444. All major trauma cases will continue to be treated at the dedicated trauma centres across the region as per the current protocols. At present, patients are taken directly to these hospitals by the ambulance service.

445. In the future, where any patient attended to by the ambulance service who is identified as requiring a surgical procedure will be taken directly to a larger more specialised hospital, for example UHNS, RWT or WHT.

446. Patients taken to, or self presenting at, Stafford A&E who are identified as requiring a surgical procedure will be taken to a larger more specialised hospital, for example UHNS, RWT or WHT for that procedure.

447. Enhancements and investment will be required with the local ambulance service in order to support this draft recommendation (see Section 10.7).

448. The only exceptions to this are:

- any minor surgical cases which can be managed by emergency physicians at Stafford A&E (during the hours of 08:00 to 22:00). These procedures can often be treated under local anaesthetic and will not require admission to a bed.
- any surgical case that is not urgent and where the patient can be brought back the next day for an elective/planned procedure.

449. Examples of minor surgical cases that could be exceptions would be excision of abscesses or treatment of simple fractures.

450. The majority of patients in the Stafford and Surrounds area are likely to be taken to UHNS for treatment. Plans to move this activity to UHNS will be developed for the final report.

451. The majority of patients in the Cannock Chase CCG area are likely to be taken to RWT or WHT for treatment. Plans to move this activity to RWT/WHT will be developed for the final report.

452. The following examples summarise what would happen to a small range of patients under the TSAs' draft recommendation for emergency surgery.

Emergency surgery patient examples

Example One

A 27 year old man falls from a ladder during the day and suspects he has broken his wrist. His wife takes him to the A&E department at Stafford where he is seen and an X-ray is taken.

As suspected he is found to have fractured his wrist. His fracture is fixed and plastered at Stafford and he is discharged home the same day.

After a few weeks in plaster he returns to Stafford to have the plaster removed and the fracture checked. It has healed well and the man is discharged home with no further treatment needed.

Example Two

A 69 year old woman develops severe abdominal pain and her concerned husband calls an ambulance. The paramedics see that she is very ill, and has low blood pressure. She is taken directly to the major unit at UHNS.

When she arrives at UHNS, she is rapidly assessed and investigation shows an aortic aneurysm. She is seen by a specialist vascular surgeon and is taken as quickly as possible to the theatre for the aneurysm repair.

Following her operation she spends a couple of days on the critical care unit where she can be closely monitored.

She is soon transferred to the ward where she spends a week under the care of the Vascular Surgeon before being well enough to be discharged home.

Example Three

There is a major road accident at the outskirts of Stafford, the driver sustains multiple serious injuries including broken limbs and a head injury. The paramedics at the scene stabilise the man and he is taken to the Major Trauma centre at UHNS as per the current protocols for major trauma.

On reaching the hospital the patient is assessed in the A&E department by the emergency doctors and some specialist teams. Following the assessment the man is taken straight to the theatre for his injuries to be treated.

Following his major operation he is admitted to the critical care unit at UHNS where he spends a few days with intensive support.

The man soon becomes well enough to move out of critical care and is transferred onto one of the main wards at UHNS to continue his recovery.

After a while on the ward recovering from the operation he is ready to start his rehabilitation which he does so at UHNS. He is soon after transferred back to Stafford Hospital where he is able to continue his recovery closer to his home.

After he is discharged home he is seen later on in the outpatient clinics at Stafford hospital.

Emergency surgery patient examples

Example Four

A 24 year old man develops pain on the right side of his abdomen and goes to see his GP. Following an examination by his GP he is sent to the Stafford A&E department where he is seen by the A&E consultant.

After investigation, a diagnosis of acute appendicitis is made. The A&E consultant discusses the man's condition with a Surgeon at UHNS where they decide he should be operated on as soon as possible. The patient is transferred by ambulance to Stoke for the further treatment.

The surgery is successful and the man makes full recovery and is discharged home.

He has a follow up appointment as an outpatient at Stafford a few months later.

Example Five

A 30 year old Woman develops a nasty looking abscess at the bottom of her back. She decides to visit the A&E department at Stafford to get it checked out. She is seen in the department by the A&E consultant who speaks to the surgical team at UHNS for some advice. They decide that she needs a minor operation on the abscess, but as it is a simple operation and her condition is stable she is sent home with some pain relief and advised to come back to Stafford the next day for her procedure.

The next day she returns to Stafford early in the morning and she is admitted as a daycase patient where she has the small operation. Following a short recovery period on the daycase unit she is discharged home in the evening.

Critical care in Stafford

TSA DRAFTRECOMMENDATION 9

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

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

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

453. Stafford hospital has a small critical care unit that has the capability to ventilate patients and manage patients who require multiple organ support. This capability is typically described as 'level 3'/intensive care provision.

454. A range of services within Stafford Hospital need to be co-located with a critical care unit in order to operate a safe service. The CPT report noted that 39% of patients that are admitted to the critical care unit are surgical patients, specifically non-elective/emergency surgical patients. Patients who have a major surgical procedure or whose age/disease profile will mean they require an intensive level of support post surgery will be admitted to the critical care unit once the procedure is complete. Within the unit they will receive the intensive support appropriate for their needs. These patients will often need ventilation or multiple organ ('level 3') support.

455. The TSAs have recommended that 'non-elective/emergency general surgery and trauma surgery will no longer be undertaken at Stafford hospital' – Draft recommendation 8. This reduction in the volume of surgical activity of an emergency nature will reduce the demand at Stafford for a critical care unit, especially 'level 3'/intensive care.

456. The staffing levels required for a 'level 3' unit means that the current small unit is already financially challenging for MSFT, and this reduction in demand for 'level 3' care will make this even more challenging.

457. Furthermore, under the TSAs' draft recommendations, patients who require ventilation and multiple organ assistance will not be admitted to Stafford hospital. Therefore, there will be less demand for 'level 3' beds and the TSAs have concluded that a 'level 3' critical care facility will not be viable in Stafford.

458. Although there will be less demand for critical care from post-surgery patients, the TSAs are recommending the retention of an acute medicine/care of the elderly inpatient service (see Draft recommendation 2). This means that Stafford will need to retain a dedicated critical care presence. This service should comprise of a small number of 'level 2' / high dependency beds and the 24/7 presence of anaesthetists at Stafford.

459. The latter will ensure there is a constant presence of staff with the capabilities to ventilate patients. This is critical as there will be situations where there are patients who will develop the need for services offered by a 'level 3' critical care facility during their treatment in Stafford. In this scenario, the patient will be immediately ventilated and stabilised prior to their rapid transfer to an appropriate specialist centre which operates a 'level 3' critical care facility (for example, UHNS).

460. The consultant anaesthetist presence in Stafford would need to be operated as part of a clinical network that rotates anaesthetists across the two sites. This would ensure the anaesthetists maintain their clinical skills. A network with UHNS, for example, would give all anaesthetists the opportunity to work with ventilated patients in a 'level 3' ITU at a larger tertiary hospital.

461. Enhancements and investment will be required with the local ambulance service in order to support this draft recommendation (see Section 10.7).

462. The following examples summarise what would happen to a small range of patients under the TSAs' draft recommendation for critical care.

Critical Care patient examples

Example One

22 year old man has taken an overdose of tablets. His parents ring an ambulance and the paramedics, after reviewing the man, bring him in to Stafford A&E. Shortly after arriving his breathing deteriorates to the point where he needs to have some form of assisted ventilation.
The Anaesthetist at the Hospital is called who chooses to intubate the man and put him on to a ventilator. He is stabilised on the ventilator and within a few hours begins to recover. After a short while he is taken off the ventilator and is monitored closely in the HDU area. He soon becomes well enough to be moved to one of the inpatient wards in Stafford where he makes a quick recovery before being discharged home.

Critical Care patient examples

Example Two

A 78 year old woman has had some elective surgery at Stafford. Although she was carefully screened prior to her operation she develops complications and deteriorates very rapidly and develops both respiratory and renal failure. She is transferred to the critical care unit for close observation but continues to deteriorate. During the night the decision is taken to stabilise her and transfer her to UHNS where she can receive longer term specialist input. The overnight resident Anaesthetist intubates the patient and places her on a ventilator.

Having been stabilised she is transferred by Ambulance to UHNS where she will cared for initially in the critical care unit.

Following her transfer she develops further complications which frequently occur with patients of this type. Fortunately she is in a regional centre where the expertise is available to deal with the complications.

After a lengthy period on the critical care unit she is transferred to general ward in Stoke and makes a gradual recovery.

When she is well enough she is transferred back to Stafford for step down care. Her continuing medical problems are dealt with in Stafford before being discharged home when she is well enough.

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

TSA DRAFT RECOMMENDATION 10

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

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

Any procedures that do not continue to be delivered in Stafford will be consolidated with services at other sites in the local health economy.

NB:

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

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

463. Elective inpatient surgery is currently conducted in Stafford across a range of surgical and medical specialties. The primary specialities are: urology, gynaecology, colorectal, gastroenterology, general surgery, ear nose and throat (ENT), gastro-intestinal (GI) surgery, and breast surgery.

464. Elective day case procedures (surgical and medical) are also currently conducted in Stafford across a wider range of specialities than elective inpatient surgery. Specialties include those named for elective inpatient surgery, some specialist surgery areas such as oral surgery and day case medical procedures, such as day case chemotherapy.

465. MSFT splits elective surgery across the Stafford and Cannock sites, with a range of orthopaedic surgical procedures being carried out in Cannock.

466. Elective work is typically high in volume and low in cost. This means that such work is attractive for healthcare providers as they typically deliver a positive financial contribution. Regardless of this, any provider of elective surgery needs to manage a critical mass of patient volumes through their elective service. This is essential due to the broad range of specialities covered by elective surgery and the need to maintain the skills of the professionals delivering the service. The need for a critical

mass of procedure volumes is rising due to the increasing specialisation of surgeons and advances in medical technology. Surgery is becoming increasingly specialised at a sub-specialism level (for example, where GI surgery was a single specialism a number of years ago, surgeons are now increasingly specialising in 'Upper GI' or 'Lower GI' procedures).

467. This need for a critical mass at specialism and sub-specialism level is leading to a need to consolidate some specialities into a smaller number of sites. However, this doesn't mean consolidation of all specialities into a single site is the right answer, rather that some hospitals within a local health economy should deliver some specialities whilst other hospitals in the same local health economy should deliver other specialities.

468. A range of elective procedures should be delivered at Stafford Hospital providing local access for elective care to Stafford-based residents. The exact range of elective procedures that would be delivered in Stafford would be dependent on discussions with CCGs and the provider that operates the elective service.

469. For example, in the discussions that the TSAs have had with UHNS, they have indicated they would deliver a range of elective inpatient specialities, including orthopaedics (currently provided at Cannock Chase Hospital), ENT, oral and maxillofacial and plastic surgery. UHNS have also indicated they would offer a range of day case specialities including general surgery, orthopaedics, urology, gynaecology and oral surgery.

470. However, no decision has been taken at this stage as to which provider would ultimately operate services out of Stafford, and so the precise range of elective services may differ from the indicative example given here.

471. The CCGs included some day case medical treatment as part of their LSS. On this basis, all will be retained in Stafford, including day case chemotherapy and endoscopy.

472. The following examples summarise what would happen to a small range of patients under the TSAs' draft recommendation for elective care.

Elective care patient examples

Example One

An 83 year old woman has difficulty walking because of a painful hip. She visits her GP who decides she needs to see a specialist and refers her to Stafford Orthopaedic Outpatient unit.
Upon investigation she needs to have a hip operation, which can be done in Stafford now instead of Cannock, under the care of the Orthopaedic Surgeon.
She is listed for surgery and returns to Stafford in a few months time and has a successful operation.
She recovers on the ward for a few days and is seen by the Consultant and his team as well as receiving some physiotherapy.
After the short period of rehabilitation she is discharged home and has a follow up appointment at a later date with the Consultant at Stafford Hospital.

Example Two

A 52 year old man has been referred to see a consultant surgeon at Stafford Hospital with some stomach complaints. He is referred for a number of tests and goes back to see the surgeon in a few weeks time. He is diagnosed with a bowel disease. He needs surgery and is listed for a bowel procedure at a later date.
This procedure is no longer undertaken at Stafford due to its complexity and risks and therefore the man goes to UHNS for the operation.
Following the operation the man stays on the ward at UHNS for a few days before being well enough to be discharged home.
After his discharge he returns to Stafford at a later date for a review by his surgeon in his outpatient clinic.

Example Three

A 32 year old woman goes to see her GP with a stomach complaint. She is referred for some tests and following an ultrasound she is diagnosed with a hernia. She is referred to a consultant surgeon at Stafford.
The woman sees the consultant in an outpatient clinic at Stafford and is listed for surgery as a daycase procedure in Stafford.
The woman has the procedure at Stafford and is discharged the same day. She returns at a later date to see the surgeon in his outpatient clinic in Stafford.

10.4 The recommended service model for Cannock

473. The TSAs' minimum obligation is to secure the sustainable delivery of the Location Specific Services in Cannock over the next ten years. The detail around developing the LSS for Cannock was set out in Section 5.5 and the 'Core LSS' are summarised in Table 51[63].

Table 51: The range of LSS for Cannock Chase

Cannock Chase CCG Location Specific Services
At Cannock: Services identified as a LSS on the basis that not doing so would impact Health Inequalities: • Outpatients (including pre-natal and post-natal care) • Patient facing diagnostics ***These are the 'Core LSS'.***

474. These services will be retained for delivery in Cannock for the population of Cannock Chase.

475. At present, patients from Stafford and Surrounds access some of these services in Cannock as they are not provided in Stafford (e.g. Orthopaedic surgery). However, the draft recommendations are that these services are also provided in Stafford for the population of Stafford and Surrounds (see Section 10.3).

476. MSFT currently delivers a range of services in Cannock Chase Hospital, as follows: outpatient services; elective orthopaedic surgery; elective day case surgery across a range of specialties; inpatient elderly care; inpatient rheumatology and rehabilitation services.

477. In addition, there are other services provided by different organisations including a 16/7 Minor Injuries Unit, a number of GP-led intermediate care beds, the renal unit and the MRI scanner.

478. Currently, Cannock Chase Hospital costs more to operate than the income it receives for the treatment of patients. This is largely due to the inefficiency of operating a facility with unused space and low utilisation in those areas that are used. Continuing in this manner is not feasible. Therefore, the Draft TSA model is predicated on the basis that a broader range of services is offered in Cannock than at present and that these services should primarily be provided for the residents of Cannock Chase.

[63] The TSAs are not obliged to define a service model that retains the 'non-core LSS' (as summarised in Section 5.5) in current locality. The TSAs are obliged to identify a plan for how they can be delivered in a sustainable manner over the next ten years and where there is currently insufficient capacity, how that capacity is to be established.

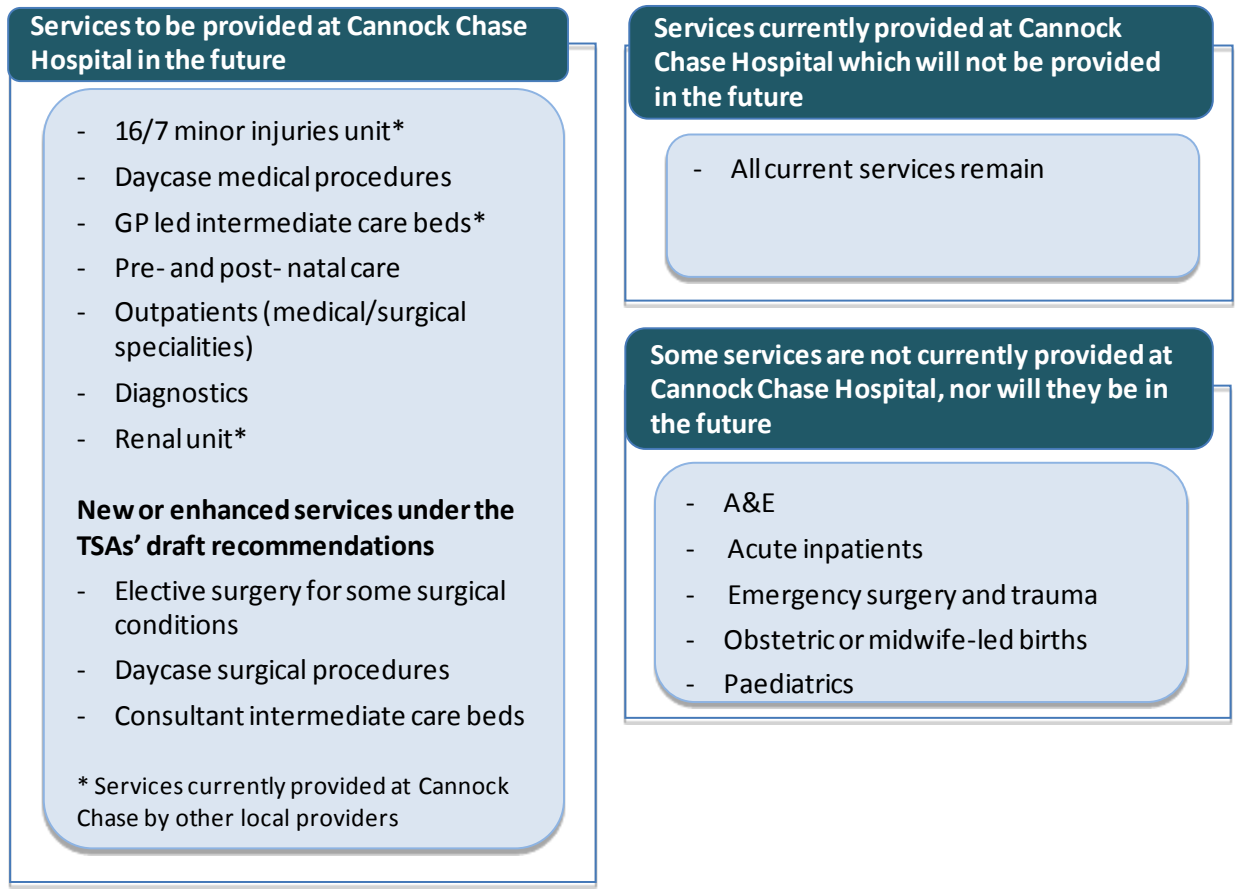
479. It is the TSAs view that this can only happen if Cannock Chase Hospital is operated as a satellite hospital to a larger hospital than Stafford. The recommendations with regards to the services in Cannock are made on this basis.

480. It is clear, through discussions with the CCGs, CAG and other organisations, that there are opportunities to provide a broader range of sustainable services in Cannock than currently exist. The TSAs have identified and recommended some of these services, whilst other opportunities will be dependent upon the nature of the organisation that manages the hospital, and following agreement with local commissioners.

481. It is also possible that multiple providers may provide complementary services in Cannock. The proposals from WHT and RWT contain complementary elements that the TSAs are continuing to explore.

482. Figure 16 summarises the services model that the TSAs' draft recommendations is proposing for Cannock.

Figure 16: The proposed service model for Cannock



483. Beyond the delivery of outpatient services and diagnostics (the LSS for Cannock), the TSAs have developed their draft recommendations for Cannock around four broad service areas:

- Emergency and urgent care;
- Intermediate care;
- Elective inpatient surgery; and
- Day case (surgical and medical).

484. NOTE: As no services are being recommended for removal from Cannock Chase Hospital, the following sections do not include the brief patient examples that were used in the section on recommendations for Stafford Hospital.

Emergency and Urgent Care in Cannock

485. A nurse led Minor Injuries Unit (MIU) is currently provided in Cannock by SSOTP. The service operates 16 hours a day, seven days a week (08:00 – 24:00).

486. As the MIU is not provided by MSFT, it cannot be included in the development of LSS for Cannock. However, it is a stated commissioning intention of Cannock Chase CCG that there remains an MIU in Cannock.

487. It may be appropriate for the provider who is delivering the majority of services in Cannock to take on the running of the MIU, but this would be subject to decisions made by the CCGs.

488. The MIU currently treats patients with the following conditions[64]: Lacerations capable of closure by stripping, gluing etc.; soft tissue injuries; minor fractures; non-penetrating superficial foreign bodies in the eye; bites, stings and allergy related issues; GP referrals; injuries of a severity not amenable to domestic first aid; blows to the head without loss of consciousness; eye injury; partial thickness thermal burns/scalds with broken skin; minor trauma to hands, limbs or feet; 999 call for the treatment of minor injuries; emergency contraception.

489. For Cannock Chase patients with urgent care needs that cannot be treated by their local GP or the MIU, there will be a retained A&E department in Stafford (see Draft recommendation 1). This A&E will treat the majority of patients that are currently seen, but not all. For example, patients requiring emergency surgery will not be treated in Stafford. Therefore some Cannock residents who would previously have been taken to Stafford A&E will instead be taken to an alternative A&E (e.g.

[64] Source: SSOTP website

Wolverhampton or Walsall) by the local ambulance service. This will be dependent on the location of the patients and the clinical protocols established with the ambulance service.

Intermediate care in Cannock

490. At present there is one ward in Cannock which provides 27 GP-run intermediate care beds (Littleton ward) which predominantly provides rehabilitation services. As with the MIU, this service was not considered for inclusion in the list of LSS as they are not provided by MSFT. Cannock Chase CCG wish to retain this service in Cannock as it is aligned with their commissioning intentions to reduce patient admissions to acute hospital beds.

TSA DRAFT RECOMMENDATION 11

A consultant led 'step down' facility should be introduced in Cannock to work alongside the existing GP-led intermediate care service.

Clear clinical protocols will need to be established to ensure appropriate use of the facility and to ensure equitable access to primary care and secondary care providers.

491. Currently, there are not substantial acute medical or surgical services in Cannock. Therefore, in order to support the commissioning intentions of delivering care closer to home, it is recommended that consultant led 'step down' beds are introduced into Cannock. This will enable the repatriation of Cannock patients from other hospitals (notably New Cross in Wolverhampton and the Manor in Walsall) to complete the rehabilitation and continuing care associated with their inpatient procedures. This in turn will release some capacity at those other providers.

492. The TSAs want to see closer working between health and social care providers to make sure patients are being treated in the most appropriate care setting and to avoid unnecessary and inappropriate hospital admissions. Therefore the TSAs proposed that the new 'step down' facility should be staffed by a multi-disciplinary team. The exact nature of the staffing model would be dependent on discussions between the CCGs and the organisation managing services at Cannock Chase Hospital.

493. The TSAs are continuing to work with the local CCGs and providers to determine how many step down beds should be established in Cannock and will include further information on this in the final report.

Elective inpatient surgery in Cannock

TSA DRAFT RECOMMENDATION 12

Elective surgery could be retained in Cannock. There will be a reduction in inpatient elective orthopaedic surgical activity as patients from Stafford and Surrounds will now be treated in Stafford, but this could be counteracted by the introduction of new surgical specialities into Cannock.

Whether it is possible to retain a viable elective inpatient surgery service will be dependent upon the other services being delivered in Cannock and the capability and willingness of an alternative provider to deliver this service safely and within the local commissioning budget.

This CAG have emphasised that this draft recommendation is dependent on the level of overnight medical cover on site.

494. The current provision of elective inpatient surgery is predominantly limited to orthopaedics. Cannock has a suite of laminar flow theatres – which are necessary to minimise deep wound infections. MSFT currently provide orthopaedic surgery in Cannock for both Cannock and Stafford patients.

495. In assessing how elective surgery can be delivered in Stafford on a sustainable basis, and following discussions with potential providers, the TSAs have recommended that elective orthopaedic surgery for Stafford patients should form part of the clinical model for Stafford (Draft recommendation 10). This means that ca. 50% of the elective orthopaedic surgery which is currently delivered in Cannock will move to Stafford.

496. This will leave some elective surgical capacity in Cannock which could be used for other services. As noted in Draft recommendation 10, elective surgery typically delivers financial benefits for healthcare providers. On this basis, a reduction in the elective surgical capacity in Cannock would cause a detrimental impact on the financial sustainability of Cannock services. This is not a desirable outcome.

497. Therefore, and in order to replace the portion of orthopaedic activity that would no longer be provided in Cannock, there is an opportunity to extend the range of elective surgical procedures provided in Cannock. This would significantly improve local access for Cannock residents to a range of elective surgical procedures.

498. However, as previously noted in Section 2.6, the theatres in Cannock are under-utilised. This means that the financial viability of retaining elective inpatient surgery in Cannock will be dependent upon: a) the willingness and capability of an alternate provider to do so; b) the willingness and ability of local commissioners to

commission this activity within tariff/budget; and, c) the ability to safely care for patients overnight – which may limit the range of procedures that can be delivered in Cannock.

499. The willingness of alternate providers to deliver elective inpatient surgery in Cannock could be influenced by their ability to use the capacity in Cannock to relocate activity that is currently being delivered at another site. This could free up additional capacity at that alternate site – something which may be desirable for that provider.

500. Therefore, the TSAs are recommending that an increased range of elective inpatient surgical procedures are established at Cannock. Examples of the types of procedures that could form part of an enhanced service in Cannock include: general surgery, breast surgery, urology and gynaecology. This would be possible by using a clinical network to rotate consultants and nurse specialists into Cannock from the provider's primary site.

501. A key consideration, and one that the CAG has emphasised, is that the range of surgical procedures that can be provided in Cannock will be dependent on the level of overnight medical cover on site.

502. Ongoing discussions with local providers have demonstrated that there is a willingness to achieve this recommendation, although the exact range of procedures that would be provided would be dependent on: future discussions with CCGs and the provider running services in Cannock; and, assurance by the CAG that they are satisfied with the proposed range of services offered.

Day cases (surgical and medical) in Cannock

TSA DRAFT RECOMMENDATION 13

The current range of day case procedures (surgical and medical), including the Rheumatology service, should be maintained and, where possible enhanced to provide a broader range of services.

503. A range of day case procedures (surgical and medical) is currently provided in Cannock, including Rheumatology which is used by local patients and patients from outside of the catchment area. These services are clinically sustainable and are not detrimental to the financial sustainability of services in Cannock. Therefore, there is no rationale as to why they should no longer be provided in Cannock.

504. During the process for developing the Draft TSA model, a number of providers indicated that it may be possible to introduce a more comprehensive range of day

case procedures into Cannock for the local population, for example in specialities such as general surgery, dermatology, urology, ENT, orthopaedics, plastic surgery, breast surgery and gynaecology.

505. However, no decision has been taken at this stage as to which provider would ultimately operate services out of Stafford, and so the precise range of elective services may differ from the indicative example given here.

506. This would be possible by using a clinical network to rotate consultants and nurse specialists into Cannock from the provider's primary site. Ongoing discussions with local providers have demonstrated that there is a willingness to achieve this recommendation, although the exact range of procedures that would be provided would be dependent on future discussions with CCGs and the provider running services in Cannock.

10.5 Organisational implications

507. The core of the draft recommendations being made in this report are focused on the clinical service model for Stafford and Cannock and the need for clinical networks to be established with both Stafford and Cannock in order to create a sustainable solution.

508. To successfully deliver the proposed clinical model will require changes with the organisations delivering services in Stafford and Cannock. Some draft recommendations have been put forward in this report, whilst other can only be made following the public consultation – and following the finalisation of the recommended clinical model.

TSA DRAFT RECOMMENDATION 14

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

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

509. The clinical service model draft recommendations for Stafford and Cannock are dependent on the use of clinical networks.

- A network with another secondary care provider will enable a shared pool of resources to be deployed over multiple sites for some services (for example, A&E, outpatient obstetrics, and critical care), addressing several of the clinical sustainability issues.

- Networks with community, primary and social care providers will enable multi-disciplinary/integrated teams to be deployed in Stafford (e.g. the Medical Assessment Unit in Stafford, intermediate care beds), reducing the challenges associated with multiple organisations managing patients through a care pathway and reducing unnecessary admissions to secondary care beds.

510. If MSFT continues to operate as a standalone organisation, then a number of the necessary draft recommendations will not be possible. The draft recommendations are based upon the movement of some emergency activity from Stafford/Cannock to another hospital with an amount of elective activity moving in the opposite direction. The financial margins associated with elective and emergency/non-elective activity differ and if the proposed reorganisation of activity were between two separate trusts, then it is inevitable that the financial position of one trust (the one receiving more non-elective activity) would be negatively impacted.

511. Therefore, clinical networks would need to be operated from within a single organisation (through a merger, acquisition or transfer).

512. The TSA believes that it is unlikely a single provider will be able to provide the proposed service models for both Stafford and Cannock. Therefore, the proposed service models have been developed on the assumption that Stafford and Cannock are networked with different hospitals. During the market engagement exercise, organisations did propose to deliver services in both Stafford and Cannock, but none of those proposals offered the full range of services that the TSAs are recommending for each location.

513. On this basis, the TSAs believe that in the future Stafford and Cannock Chase Hospitals should no longer be part of the same organisation. The TSAs have concluded that Mid Staffordshire NHS Foundation Trust should be dissolved at an appropriate point in time to enable the recommended clinical models to be established.

514. At this stage the TSA is not making any recommendations on which organisations will provide the services in Stafford and Cannock in the future. As previously noted, the TSAs have engaged with multiple providers through the market engagement exercise and, more recently, have had further discussions with UHNS, RWT and WHT. The Draft TSA model is based upon the proposals from UHNS for Stafford and RWT for Cannock, but there has been no decision about which providers will ultimately run services in Stafford and Cannock.

515. Any final recommendations approved by the Secretary of State for Health involving UHNS or RWT may require the integration of some parts of MSFT, UHNS or RWT.

Further work and discussions are required with not only UHNS and RWT but also with other local providers, the relevant health organisations, and local commissioners to further progress this solution. The TSA has contacted the Office of Fair Trading (OFT) in accordance with Monitor's guidance. Merger notifications to the OFT are voluntary and the TSAs have not received an enquiry letter from the OFT. Accordingly no further steps are required in relation to the OFT at this point.

516. The TSAs expect to put forward more information in their final report on when MSFT might be dissolved and, potentially, who would provide the services in Stafford and Cannock Chase Hospitals.

10.6 Funding requirements

517. Annex 7 sets out the financial evaluation conducted by the TSAs and this is summarised in Section 9.11. The TSAs are continuing to develop their financial assessment of the draft recommendations and will do so in parallel with the period of consultation.

518. The key element of this work is around the level of capital investment required to deliver the final recommendations. The TSAs have been working with local commissioners, local providers and independent parties to assess and validate what changes in the facilities in Stafford, Cannock and other providers would be appropriate to ensure the safe and sustainable delivery over the short, medium and long term.

519. This TSAs have estimated the level of funding that will be required to:

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

520. Table 51 sets out the range of funding estimated by the TSAs to deliver the draft recommendations.

Table 51: A summary of the estimated funding requirements to deliver the TSAs' draft recommendations

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

10.7 Actions that will support the TSAs' draft recommendations

521. The TSAs have made a series of draft recommendations with regards to the services delivered by MSFT in Stafford/Cannock and to the organisation itself. The TSAs do not have the remit to make recommendations about other organisations within the local health economy.

522. However, the TSAs have identified a range of actions that, if implemented alongside the draft recommendations, will support the delivery of the TSAs draft recommendations.

523. Furthermore, some of these actions would be expected to contribute towards additional financial benefits and will support the delivery of a financial surplus.

524. Most of these actions are within the remit of the CCGs. CCGs have an important role to play in managing any health system as they have some ability to implement incentives and levers to manage the parts of the system. The TSAs have identified four actions that should be considered, which are summarised in this sub-section.

Demand management

525. The demand for healthcare is increasing in Staffordshire (see Annex 3). This rising demand is placing greater pressures on the providers in the local health economy. For example, A&E departments across Staffordshire and the wider West Midlands are currently facing significant issues due to rising demand – issues recently summarised in a letter from the heads of the 18 A&E departments in the West Midlands (see Appendix J).

526. Demand management is not a new or unusual concept within the NHS. Demand management is the process of identifying where, how, why, and by whom demand

for health care is made and then deciding on the best methods of managing this demand to achieve certain goals i.e. a reduction in A&E attendances. However, there are few if any good examples of significant and sustained demand management schemes.

527. As stated in Section 5 both CCGs have set demand management targets for 2013/14, as follows:

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

528. The TSAs have not made assumptions based upon the full delivery of demand management benefits but have noted that this one opportunity to deliver greater financial benefits with the draft recommendations. The TSAs believe that delivering demand management benefits will support the draft recommendations and will deliver benefits for the local population by ensuring some patients are treated in a care setting more appropriate than an acute hospital.

Investment in the ambulance service

529. It is not conceivable that the TSAs' draft recommendations could be implemented successfully without an investment in the ambulance service. This investment will ensure that the ambulance service is able to transport patients safely and appropriately to other A&E departments when it is not appropriate for them to be taken to Stafford, and also to transfer patients from Stafford or Cannock to another hospital when necessary.

530. Annex 8 provides details of how the West Midlands Ambulance Service (WMAS) is responding to the future needs of healthcare and working with organisations to ensure that patients continue to have an appropriate level of access to healthcare services.

531. With the TSAs draft recommendation to centralise some emergency treatments such as surgery and paediatrics it is clear that some patients will be transported directly to an alternative A&E department other than Stafford. This will increase the overall journey distance for the ambulance crews.

532. As well as centralising some services, there will be an increase need for emergency transfers as a result of the draft recommendations. Patients who need level 3 critical care will be stabilised and then transferred by the ambulance service. Similarly some emergencies who present at A&E in Stafford will need to transfer to a specialist centre following assessment.

533. If the current ambulance service levels are not enhanced then it would be difficult for WMAS to ensure that its crews can respond in an appropriately and timely manner to support the changing demands caused by the TSAs' draft recommendations. It is therefore expected that a level of investment will be needed to increase the current crew capacity.

534. The TSAs have engaged with WMAS to understand how it can respond to the draft recommendations. The level of investment required in the ambulance service has been estimated and taken into account in the financial evaluation. The TSAs will continue work with WMAS - and the local commissioners - to finalise their needs. This ongoing work will be summarised in the TSAs' final report.

Prime provider commissioning

535. Care pathways are often delivered by multiple care providers. This typically means that accountability for the efficiency and effectiveness of the care provision is spread across multiple organisations. It is not unusual for one organisation to blame another when there are issues in the delivery of care.

536. Stafford and Surrounds and Cannock Chase CCGs are working to develop a prime provider model for Cancer, End of Life Care and Dementia services.

537. The principle of a prime provider model is that one provider looks after the whole care pathway and sub-contracts elements of the pathway to organisations which have the capability and capacity to deliver those elements. For example, you could give a lead provider of an A&E service the budget for urgent care and they would then have to determine how best to procure the urgent care services which would sit alongside the A&E, such as a minor injuries unit, GP out of hours service etc.

538. The commissioners of that service would manage the performance of the prime provider through service level agreements and incentives/penalties for that organisation alone.

539. The objective and benefits of the model would be to increase integration of services, reduce fragmentation of the clinical pathway and create a more seamless delivery of care for patients.

Case study

Pennine MSK Partnership is a single organisation which provides an integrated service for all musculoskeletal (MSK) patients in Oldham. It has a single contract with the commissioner and takes responsibility for providing the full range of services from within the same organisation. As specified in its service level agreement, it provides non-admitted care in elective care pathways in orthopaedics, rheumatology and MSK pain. In most places in the country these NHS services have been provided from separate primary, community and secondary care organisations.

The provision of an integrated budget for MSK services allows more effective care pathway commissioning and the identification of unwarranted variation that may indicate suboptimal performance. By having a single and clinically led pathway service, with clear accountability and budget for whole pathway quality and productivity, Pennine MSK Partnership is able to use clinical judgment and skills to improve and, where necessary, redesign services to achieve better value. The integrated programme budget can deliver better clinical outcomes from commissioning spend because providers are incentivised to reduce waste and deliver high quality care. The system also encourages investment in primary care, shared decision making and supports self-care as a means of delivering optimal care for specific patients in the right setting to demonstrate best value for money. This prevents unnecessary referral to secondary care pathways and ensures that patients proceed along the most appropriate pathway.

Source: www.rightcare.nhs.uk

Gain share incentives

540. A gain share arrangement is where there is an agreement between two organisations that the benefits associated with delivering specific outcomes will be shared between the organisations. This creates incentives to organisations who are willing to take on a greater level of risk and accountability for the services which they are responsible for delivering.

541. An example of how this could work in the delivery of healthcare services would be where a commissioner sets a provider target for delivering certain outcomes and rewards that provider if those targets are exceeded. For example a provider could be set a target to deliver a reduction in inappropriate hospital admissions will be given a budget by commissioners to achieve this. Where the level of inappropriate admissions exceeds the target, the provider will have to pay a penalty for any failure to meet the agreed targets, but if the provider can keep inappropriate admissions below this target, the commissioners will pay them a 'reward' for doing so.

542. A gain share arrangement for reducing inappropriate admissions is currently being piloted between commissioners in the North of Staffordshire with SSOTP with the objective of reducing admissions to UHNS.

543. These types of agreements can deliver benefits for all parties:

- Patients benefit because there will be a reduction in inappropriate admissions to hospital;
- The community provider benefits as they get a financial incentive if they deliver the reduction which they can then reinvest into patient care;
- The local acute trusts benefit as it reduces the pressure on them, creating capacity that can be used to manage additional appropriate admissions or to save costs through reducing capacity; and
- The commissioners benefit as it reduces the cost to them of paying for inappropriate admissions to secondary care.

10.8 Recommendations to be developed

544. The draft recommendations have been developed to enable a public consultation on the proposed changes to the clinical services in Stafford and Cannock.

545. The TSAs have an obligation to deliver a full implementation plan for their recommendations in the final report to Monitor and the Secretary of State for Health. Therefore, the final report will contain a range of recommendations that are not presented in the draft report.

546. These recommendations will be based upon the ongoing work of the TSAs, which will continue during the public consultation, the feedback from the public consultation and the finalisation of the recommended clinical model – which can only happen once the responses to the consultation have been taken into account. The type of additional recommendations that will be made in the final report will include, but may not be limited to recommendations about:

- The recommended organisations to deliver the clinical networks in Stafford and Cannock;
- The implications for competition and the involvement of the Office of Fair Trading;
- The impact of the recommended clinical model on MSFT estate in Stafford and Cannock, including what would happen to any surplus estate (for example, is there any requirements of NHS Propco);
- The timescales associated with dissolving MSFT;
- The impact on the ambulance service and any investment that might be needed in ambulance/patient transport associated with the safe and effective delivery of the recommended clinical model;
- Finalisation on the capital investment required to deliver the recommended clinical model; and
- Finalisation of the costs associated with implementing the final recommendations.

11 Next steps

11.1 The public consultation

547. This draft report forms the basis for the public consultation. The consultation takes 40 working days, running from Tuesday 6th August 2013 until Tuesday 1st October 2013. The feedback from the consultation will be assessed and used to inform the final report that will be submitted to Monitor on Tuesday 22nd October 2013. The detail of how the consultation plan will be operated is provided in the TSA Consultation Plan that is included as Annex 1.

548. The TSAs are fully aware of the local public interest in the work that is being undertaken and the future of healthcare services in Mid Staffordshire. The TSAs would assure all stakeholders that the feedback from the consultation is critical to the TSA process and will be considered fully and appropriately.

11.2 Finalising the recommendations

549. A significant amount of work has been undertaken over the last 75 working days. This has been possible due to the commitment and considerable efforts of many organisations and individuals to support the work of the TSAs.

550. There is, however, much more work to be completed to: more fully develop the recommendations; assess the impact of the draft recommendations; developing those supporting recommendations that have not been presented in this draft report (e.g. the impact for the estate of MSFT); developing a detailed plan for the delivery of the draft recommendations; and, continuing to work with the broad range of organisations who have supported the TSAs over the previous period, notably the local CCGs and healthcare providers.

551. This work will be undertaken over the coming 40 working days – in parallel with the consultation – so that the focus of the TSAs, once the consultation is concluded, can be on how the feedback from the consultation can be best incorporated into the final report.

Appendices and annexes

A series of appendices and annexes have been presented in support of the TSAs' draft report. The appendices are included alongside the main report in Volume One and the annexes are presented in Volume Two. These appendices and annexes are as follows.

Appendices (included in this volume):

- A: Glossary of terms
- B: References and sources for information/evidence presented in the draft report
- C: The assessment of catchment population – Public Health Staffordshire
- D –H: Letters sent to the TSAs from various stakeholders who have worked with the TSAs to help the development of the draft recommendations
- I: The detailed breakdown of services currently provided by MSFT and what will happen to services in the future
- J: A copy of the letter from A&E leads in the West Midlands to the Trust Chief Executives and lead commissioners across the region

Annexes (Volume 2):

- 1: The consultation plan
- 2: MSFT performance summaries
- 3: Local CCG strategies
- 4: The TSAs' governance review
- 5: TSA stakeholder engagement
- 6: Clinical advisory groups – terms of reference and meeting notes
- 7: TSAs' financial evaluation
- 8: West Midlands Ambulance Service paper
- 9: Travel times methodology
- 10: MSFT Estates review

Volume 3

- The Independent Health and Equality Impact Assessment (HEIA) scoping report

Appendix A: Glossary of terms

Term	Description
2006 NHS Act	Sets out, in Chapter 5a, the NHS failure regime – which is subsequently amended in the Health and Social Care Act 2012
A&E	Accident and Emergency
Acute Care	A pattern of health care in which a patient is treated for a brief but severe episode of illness, an urgent medical condition, or during recovery from surgery
BHFT	Burton Hospitals NHS Foundation Trust
CAG	Clinical Advisory Group
CC	Cannock Chase
CCGs	Clinical Commissioning Groups
CCU	Coronary Care Unit
CHC	Continuing Health Care
CIPs	Cost Improvement Plans
Clinical Networks	Organisations used to deliver locally integrated services across a number of providers, usually where there is benefit in sharing specific expertise or resources to improve outcomes for patients.
CPT	Contingency Planning Team
CQC	Care Quality Commission
CRG	Clinical Reference Group
Critical Care	Encompasses a range of units (including High Dependency Units (HDUs), Intensive Care Units (ICUs)), which concentrate special equipment and specially trained personnel for the care of seriously ill patients requiring immediate and continuous attention.
CSIP	Clinical Service Implementation Programme
DH	Department of Health
Draft TSA model	Draft clinical model
EDs	Emergency Departments
Elective Surgery	A planned, non emergency surgery procedure
ENT	Ear, Nose, and Throat
EPAU	Early Pregnancy Assessment Unit
FAQs	Frequently Asked Questions
FT	Foundation Trust
FTN	Foundation Trust Network
FY13	Financial Year 2013
GI Surgery	Gastrointestinal Surgery
GPs	General Practitioners
GUM	Genito Urinary Medicine
HCC	Healthcare Commission
HEIA	Health and Equality Impact Assessment

HEIA SG	Health and Equality Impact Assessment Steering Group
HSMR	Hospital Standardised Mortality Rates
ITU	Intensive Therapy Unit
KPIs	Key Performance Indicators
LATs	Local Area Teams
Level 2	High Dependency Care
Level 3	Intensive Care
LHE	Local Health Economy
LSS	Location Specific Services
MAU	Medical Assessment Unit
MIU	Minor Injuries Unit
MLU	Midwifery Led Units
MoD	Ministry of Defence
Monitor	The independent regulator of foundation trusts and responsible body for the CPT
MSFT	Mid Staffordshire NHS Foundation Trust
NCAG	National Nursing and Midwifery Advisory Group
NDA	Non-Disclosure Agreements
NHS	National Health Service
NHS TDA	NHS Trust Development Agency
NPV	Net Present Value
OFT	Office of Fair Trading
Outpatient	A patient who attends a hospital for a scheduled appointment but does not require admission.
PAU	Paediatric Assessment Unit
PDC	Public Dividend Capital
PFI	Private Finance Initiative
PHS	Public Health Staffordshire
PMO	Programme Management Office
Primary Care	The collective term for all services which are people's first point of contact with the NHS, e.g. GPs, dentists.
Protected Services	Protected services are defined by local commissioners as those services provided by a healthcare provider that is likely to fail, where there is no alternative acceptable provider of those services.
Providers	A hospital, clinic, health care professional, or group of health care professionals who provide a service to patients.
RCI	Reference Cost Index
RCPCH	Royal College of Paediatrics and Child Health
Royal Colleges	The professional bodies working to improve the quality of healthcare by ensuring the highest standards of care for the population
RWH	Royal Wolverhampton NHS Trust
S&S	Stafford and Surrounds CCG

SaTH	Shrewsbury and Telford Hospitals NHS Trust
SCBU	Special Care Baby Unit
SCR	Strategic Change Reserve
SHMI	Summary Hospital-level Mortality Indicator
SSOTP	Staffordshire and Stoke-on-Trent Partnership NHS Trust
the Trust	Mid Staffordshire NHS Foundation Trust
TSAs	Trust Special Administrators
UCC	Urgent Care Centre
UHNS	University Hospitals of North Staffordshire NHS Trust
UPR	Unsustainable Provider Regime
WHT	Walsall Healthcare NHS Trust
WMAS	West Midlands Ambulance Service
WTE	Whole Time Equivalent

Appendix B: References

The table below provides a summary of the information and documents used to inform the Draft recommendations. This does not include any documents or information which are referenced to for information only in the report.

Information/documents used
Monitor - Contingency Planning Team Mid Staffordshire NHS Foundation Trust – Recommendations of the CPT, March 2013
Laing's Healthcare Market Review 2011/12, Laing and Busson
MSFT Public Inquiry: http://www.midstaffsinquiry.com/assets/docs/Inquiry_Report-Vol1.pdf
Referral rates - provided to the TSA by the Trust
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MSFT WTE information - provided to the TSA by the Trust
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Bagust (1999). Dynamics of bed use in accommodating emergency admissions: stochastic simulation model www.bmj.com/content/319/7203/155
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QIPP national work stream: back office efficiency and management utilisation. Department of Health, November 2010.
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Provider CQC reports, accessed from www.cqc.org.uk
ROSC rates: http://www.bbc.co.uk/news/uk-england-21994421
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Delivering High Quality Surgical Services for the Future, the Royal College of Surgeons, 2006'
Stafford borough planning statistics: http://www.staffordbc.gov.uk/the-plan-for-stafford-borough

Facing the Future: Standards of paediatric services (2011) – Royal College of Paediatrics and Child Health

Emergency Medicine Taskforce - Interim Report (Dec 2012) – The College of Emergency Medicine

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Emergency care and emergency services 2013, view from the frontline.' Foundation Trust Network, June 2013

Quarterly monitoring report, The King's Fund, February 2013

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Economic and Social research Council: http://www.esrc.ac.uk/impacts-and-findings/features-casestudies/features/25376/future-nhs-funding-squeeze-highlighted-by-ifs-research.aspx

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The relationship between distance to hospital and patient mortality in emergencies: an observational study', Nichol et al, 2007

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CCG Commissioning Intentions - Stafford and Surrounds CCG

CCG Commissioning Intentions - Cannock CCG

The CCGs outcomes indicator set 2013/14 – NHS England

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

Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts, 5 April 2013, London: Monitor

The four tests for reconfiguration: http://www.publications.parliament.uk/pa/cm201314/cmhansrd/cm130704/debtext/130704-0004.htm

2012/13 Hospital Episode Statistics (HES) data for Inpatients, Midwifery and A&E.

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

Towards Safer Childbirth' - Royal College of Obstetricians and Gynaecologists, Royal College of Midwives (1999)

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

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

MSFT 6 facet survey – NIFES consulting

Everyone Counts: Planning for 2013/14. NHS England

Appendix C: Public Health Staffordshire – assessment of catchment population

Staffordshire County Council

Catchment population – Mid Staffordshire NHS Foundation Trust

Hospital catchment areas and populations

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

Calculating hospital catchment populations

There are many ways to calculate catchment populations. In the method used here there is a direct relationship between hospital usage and the size of the catchment population.

Factors that affect the catchment population

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

Mid Staffordshire NHS Foundation Trust's catchment population

There is no such thing as a single catchment population for a hospital - it varies by specialty, type of admission and can change over time. The catchment population for MSFT for all admissions was estimated to be 226,300 in 2009. Locally derived information indicates a decline in the catchment population from 2009/10 onwards. Public Health Staffordshire's (PHS) estimate, based on all hospital admissions between 2010/11 and 2012/13, suggest that the catchment population has fallen by around 11% to 204,400 with a likely range between 192,000 and 217,000.

What is an appropriate catchment population?

Guidelines suggest the catchment population size for an acute general hospital providing the full range of facilities for both elective and emergency medical and surgical care would be 450,000 –500,000 and that the minimum should be 300,000. Just over 50% of NHS trusts have catchment populations under 300,000. MSFT has a higher proportion of older people and fewer children than England in their catchment population and this is fairly consistent with the age profile of Cannock Chase and Stafford and Surrounds clinical commissioning groups.

The resident population of Cannock Chase and Stafford combined is 228,300 and the population served by Stafford and Surrounds and Cannock Chase clinical commissioning groups is around 276,500. The Association of Public Health Observatories (APHO) produced hospital catchment population estimates for English trusts and Table 1 shows how the catchment area compares with the catchment population.

Table 1 Mid Staffordshire NHS Foundation Trust catchment area and catchment population

Catchment area			Catchment population	
Resident population of Cannock Chase and Stafford[1] (2011)	Registered[*] population of Stafford and Surrounds CCG and Cannock Chase CCG (2012)	MSFT Website (2012)	Association of Public Health Observatories (APHO) (2006-07 to 2008-09)	Public Health Staffordshire (2010/11 to 2012/13)
228,300	276,500	276,500	226,300	204,400

Source: Population estimates - 2011 mid-year population estimates, Office for National Statistics, Crown copyright, 2012 GP registered populations, South Staffordshire PCT and North Staffordshire PCT, Catchment populations - Association of Public Health Observatories

[1] Resident population: People who live within the geographical boundaries of Cannock Chase Borough and Stafford District

[2] Registered population: People who are registered with GPs who are part of the Stafford and Surrounds or Cannock Chase Clinical Commissioning Groups (CCGs)

1 Factors that affect the catchment population

Many factors affect the catchment population - these include:

- The type and size of hospital: A district general hospital with a full range of services will probably have a larger catchment population than a smaller unit with fewer services;
- Level of specialisation;
- Proximity to other hospitals;
- Accessibility;
- Patient choice;
- Reputation;
- Relationships with referring GPs;
- Population characteristics - levels of deprivation, proportion of elderly people, morbidity.

For the same hospital the catchment population will vary depending on which specialty, disease group or admission type is being investigated and the catchment population could change over time. If, for example, more people chose to have treatment at a neighbouring hospital then the catchment population would reduce.

2 Mid Staffordshire NHS Foundation Trust's catchment population

It is important to note that there is no such thing as a single catchment population for a hospital - there are separate catchment populations for each specialty and for elective and emergency admissions for example. However, effective service planning requires the provision of estimates that aim to quantify the population that is actively served or potentially served by a hospital. The Association of Public Health Observatories (APHO) estimated that for all admissions between 2006-07 and 2008-09 the catchment population for MSFT was 226,300, more recent estimates produced by Public Health Staffordshire estimate the catchment population to be 204,40.

Appendix D: Letter to TSAs from the Regional Director of NHS England, Midlands and East

NHS England

NHS England, Midlands & East
2 – 4 Victoria House
Capital Park
Fulbourn
Cambridge
CB21 5XB

Tel: 01223 597 561

Our Ref: PW/jd

By e-mail:

Alan Bloom, Joint Trust Special Administrator
Hugo Mascie-Taylor, Joint Trust Special Administrator
Mid Staffordshire NHS Foundation Trust

23 July 2013

Dear Alan and Hugo

I am writing on behalf of NHS England in response to your letter dated 19 July to David Bennett where you request an NHS England perspective on the TSA proposal for Mid-Staffordshire

The TSA has carried out extensive work to identify a service proposal that is designed to meet the twin requirements of clinical and financial sustainability. In doing so, the current service proposal moves well beyond the LSS defined by local CCGs and envisages a much wider range of services being maintained on both the Stafford and Cannock sites. This has been proposed in order to mitigate the impact on other hospitals of implementing the original LSS and because a networked service model has been developed to overcome the clinical staffing challenges of maintaining A&E and acute medicine on the Stafford site.

We would support the clinical model and the intent to maintain a wider range of services in the Stafford and Cannock sites, subject to further assurance that financial sustainability can be secured without a tariff premium for commissioners. The high level financial assumptions that have led to the conclusions that this would be the more financially attractive option have been shared with us, but not at a level of detail that would allow us to provide independent assurance. We would like to discuss these assumptions with you in more detail in parallel with the consultation process.

We note that the TSA has evaluated the residual gap to be £5.4m and a number of options are presented to resolve this including further CIP, downward pressure on Capex and demand management. Whilst we would accept that there has been insufficient time for a full solution to this gap to be described, we would note that it has yet to be demonstrated exactly how this remaining gap will be bridged. We would encourage the TSA to carry out further work on this during the consultation. We are assuming that the detailed solution will not include a tariff premium for commissioners.

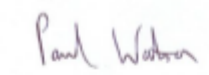
High quality care for all, now and for future generations

The implementation costs of the proposal are significant. Again, the high level financial assumptions have been shared with us but not at a level of detail that would allow us to give independent assurance. We understand from Monitor that these transitional costs would need to be funded directly from the Department of Health and would not be a call on NHS England or CCG funds. Our support for the TSA proposal is based on the assumption that transitional costs will be treated in this way.

The TSA proposal envisages the removal of emergency surgery, in-patient paediatrics and obstetrics from the Stafford site. Whilst we can see the clinical arguments for doing this, we would encourage you to ensure that the consultation document sets out very clearly why the networked assumption being proposed for A&E and general medicine cannot be applied to these services. Likewise, it would also be helpful if the rationale for excluding a midwife-led delivery unit is clearly set out.

In summary, the TSA has tackled a very difficult service issue and has worked constructively with partners on developing these proposals. With the provisos set out above, we would support the current proposals being put forward for public consultation.

Yours sincerely



Dr. Paul Watson
Regional Director (Midlands and East)

High quality care for all, now and for future generations

Appendix E: Letter to TSAs from the National Clinical Advisory Group (CAG)

ACADEMY OF
MEDICAL ROYAL
COLLEGES

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academy@aomrc.org.uk

Professor Hugo Mascie-Taylor
Mid Staffordshire Foundation Trust Special Administrator

22 July 2013

Dear Hugo,

OPINION OF THE MSFT NATIONAL MEDICAL CLINICAL ADVISORY GROUP

I am writing to give you the views of the medical Clinical Advisory Group (CAG) on the Mid-Staffordshire Trust Special Administrators' (TSAs) recommendations for the future of services currently provided by Mid-Staffordshire NHS Foundation Trust. These are shortly going out for public consultation as part of the Monitor Trust Special Administration process.

Background and Terms of Reference

The TSAs asked the Academy of Medical Royal Colleges to facilitate a national Clinical Advisory Group of senior medical consultants nominated from medical Royal Colleges to provide them with independent advice.

The Academy and Colleges were very willing to accept the invitation to work with the TSAs because we believe it is essential that any changes to the configuration or provision of health services should be informed by clinical expertise and do not reduce clinical standards and safety.

As a group of independent doctors we had to be very clear about our role in relation to this process and what could or could not be expected of the CAG. This was set out in the published terms of reference that were agreed for the CAG.

It was not the role of the group to devise its own proposals for services currently provided by Mid-Staffordshire Foundation Trust. Neither was it our role to make judgements or recommendations on the relative costs and benefits of proposals.

We were asked to provide advice on the basis of available evidence, standards and current practice in the UK for ensuring the safety and quality of clinical services for the benefit of patients.

Specifically the CAG was asked to review three proposals presented by the TSAs and comment on:

- The clinical safety of proposed schemes
- The extent specific proposals would or would not support the recruitment, retention, training and continuing professional development of appropriate medical staff
- Whether or not proposals move services closer to College clinical standards.

In considering the proposals the CAG was clear that, in general, safety is not definable as a simple choice between safe and unsafe. In many, but not all areas,

1

there is a sliding scale of gradation of safety. If therefore, we state that one set of arrangements is safer than another that does not automatically imply that the second proposals are unsafe.

However, whilst examining individual speciality services in turn, our considerations have also taken due note of the interdependence of many acute services on other disciplines. The important relationships of cross and inter-disciplinary working contribute to safe and high quality services and are an important feature of modern medical practice, thus influencing our assessment.

We know the TSAs have worked very hard to identify a solution that is clinically sustainable and which seeks to retain, where possible, local services for the local population. The TSAs have engaged with the CAG through a series of meetings and discussions. I believe the CAG has advised and challenged the TSAs, in keeping with our remit, as they have developed their recommendations.

Proposed models

We considered three separate proposals put to us by the TSAs. As this was how we referred to them during our discussions I am calling these:

- The Trust Special Administrator (TSA) model which is what is now being recommended
- The "Local Specified Services" (LSS) model which contained the minimum requirement identified by the local CCGs
- The Contingency Planning Team (CPT) model suggested by the CPT following its review of the Mid-Staffs services.

The TSA Model

We have commented on proposals that are broad in nature and we recognise that there is more detail to be developed over the coming weeks. It is important that the CAG is satisfied that the detailed proposals do not bring up any unexpected problems which would raise concerns about safety. We would therefore expect the opportunity to comment on the detailed proposals in due course.

The CAG is, however, satisfied that the proposals the TSAs have recommended are founded upon principles that should deliver a clinically safe and sustainable solution for services at Stafford and Cannock hospitals for patients and staff.

We believe that if medical staff are properly deployed as part of a rotating network between the Mid-Staffordshire and another large secondary care site(s) as appropriate this would provide improved opportunities for the recruitment and retention and continuing development of doctors.

If the proposed arrangements for medical staffing are to include doctors in training it must be ensured that they provide the required learning and experience and that supervision is compliant with the GMC standards.

We believe that, if implemented fully and effectively, the proposals taken as a whole would bring services in the local area more in keeping with College clinical guidelines and standards.

It will be essential to develop and follow very clear protocols across specialties in terms of when it will be safe to provide care at Stafford or Cannock and when the safe solution would be to transfer or refer patients to larger centres.

The LSS and CPT models
We had a number of comments that applied to both these models.

Safety and capacity of services in the health economy
Both models propose to considerably reduce services in Mid-Staffordshire particularly with the closure of A&E. The CAG has considerable concern about the implications on other providers who would have to pick up this work. From what we have heard we have serious doubts that there is the capacity in the system for other local providers simply to absorb this emergency and acute medicine activity. We would therefore have concerns about the safety of care in other local areas if these models were adopted without significant support for those providers expected to take on activity no longer occurring in Mid-Staffordshire.

The CAG felt that services would be further from rather than closer to College clinical guidelines and standards with these two models, albeit recognising that such standards are mainly aspirational rather than absolute.

Recruitment and retention of medical staff
The CAG felt that the LSS and CPT models in overall terms would make it harder to recruit and retain consultants at Mid-Staffordshire because the range of the posts and services would be less attractive. There were also concerns as to whether the required middle grade (i.e. non trainee) doctors would be readily available. The CAG did, however, recognise that the removal of A&E services would also remove the recruitment/retention issue for those staff in Stafford. It might therefore make recruitment and retention easier at surrounding hospitals.

Our comments on the specific models were:

LSS Model
We had concerns at the proposal for a stand-alone geriatric unit at Stafford without acute care back-up. With a "Step-Down" facility the selection of appropriate patients becomes crucial – and potentially subject to dispute. To be safe senior medical staffing would have to be provided on a networked basis.

With the proposals for Cannock there was considerable concern about how night-time cover and support would be provided. The Group was clear that no ASA (American Society of Anaesthesiologists) Level 3 cases should be handled. The Group was also clear that the services should not be dependent on trainees.

The management of transition to this model would be crucial.

CPT Model
In respect of services at Stafford, there was greater concern about the "enhanced intermediate care" ("Step-Up") for elderly patients without availability of 24 hours acute back-up. The selection of patients would be complex and subject to disagreement.

There should be a limited rather than a full range of day cases offered otherwise it is impossible to guarantee that there will not be a requirement for admission when the

level of back-up available would not be adequate. In addition there should be clinical staff available with details of the individual patient's specific case to advise if discharged patients have complications and ring for advice. Advice should not be provided by a different centre without knowledge of the individual case.

The CAG had real doubts about the operational viability of the 5 day ward model. There would be a clear need for consultant availability to handle surgical complications.

In essence, increasing the level of activity beyond the routine and straightforward requires there to be a level of interdependent back-up services that are not proposed in this model.

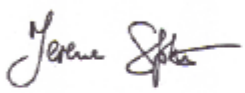
The concerns over the CPT proposals for services at Cannock were the same as those with the LSS model proposed for Cannock

Conclusion
In conclusion the CAG was clear that both in respect of the services that would be provided at Stafford and Cannock and also because of their implications for other organisations the CPT and LSS models were intrinsically less safe than the TSA model. As stated earlier we believe, on the evidence that we have seen, that if implemented properly the TSA model should deliver a clinically safe and sustainable solution for services at Stafford and Cannock hospitals for patients and staff.

Finally, the CAG felt that whilst the proposal we supported appears clinically safe these are not the only options that could provide clinically safe services. The Group was also clear that in expressing its views it is not formally endorsing any specific individual provider or organisation.

The local population of Mid-Staffordshire rightly expects to have access to high quality, clinically sustainable healthcare services. That is why I, and my colleagues on the CAG, are fully committed to continuing to work with the TSAs over the coming weeks as they consult the residents of Mid-Staffordshire and develop their final recommendations.

Yours sincerely



Professor Terence Stephenson
Co-Chairman National Clinical Advisory Group
Chairman Academy of Medical Royal Colleges

Appendix F: Letter to TSAs from the National Nursing and Midwifery Group (NCAG)

26 July 2013

Professor Hugo Mascie-Taylor
Trust Special Administrator
Office of the TSA
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Dear Hugo,

Re: MSFT Nurse Clinical Advisory Group (NCAG)

On behalf of the members of the NCAG I am writing to you to confirm the views expressed by the group from the process we have undertaken with the TSA. The remit of the group was established with the following terms of reference:

- Comment, on the basis of the information available, on the clinical safety of proposals presented to the Nurse CAG by the TSA rather than recommend ideal services which no organisation has offered to provide
- Comment on any aspect of the clinical safety of proposals for example
  - Whether a proposal appears clinically safe or unsafe exactly as it is
  - What adjustments or amendments would be required to make a proposal clinically safe
  - the circumstances in which a proposal would or would not be clinically safe
  - the evaluation required on an on-going basis to judge whether the proposals remain clinical safe
  - Whether they move services closer to designated College clinical standards
- Comment on the extent it believes specific proposals would or would not support the recruitment, retention, training and continuing professional development of appropriate staff

As a group of senior nurses representing a cross section of the profession we have provided you, in good faith, our views on the proposals presented to us and on the information available. Detailed below is a summary of our views of each model presented to us to review. First of all is the TSA model which has the groups support as the preferred option for the TSAs draft recommendations and in our opinion will deliver the most amount of sustainable services for both Cannock and Stafford. Our views on the LSS and CPT models are also summarised:

TSA Model

Safety

- There are no significant safety concerns made about this model
- There needs to be appropriate protocols in place to ensure the safe transfer of patients when needed

Recruitment and retention

- A networked model will not have a significant impact on recruitment and retention as a lot of the nursing roles will not be suitable for rotation
- There may be issues of recruiting paediatric nurses to the PAU

LSS model

Safety

- There are no significant safety concerns made about this model
- The provision of step down beds at Stafford need to be supported by clear protocols which ensure that the appropriate patients end up there. Appropriate medical cover would also be required overnight. A nurse led service may be more appropriate for this model

Recruitment and retention

- Recruitment for the standalone service would be difficult under the current model unless it was made more dynamic. One way to do this would be do just have a nurse and therapy led unit
- Career progression is an important fact for recruiting quality staff. This may be limited at Stafford and Cannock with the limited range of services provided
- It is important in this model that there is strong nurse leadership for it to function properly as there is a limited amount of other support on site

CPT model

Safety

- We have concerns about step up provision particularly if it is to be located on site without other services co-located as it needs specific specialist input
- This could also increase the volume of transfers to other sites which would not be desirable for the elderly population
- The provision of elective surgery in a standalone unit either at Stafford or Cannock would need appropriate cover as well as patient selection. Without this it would pose some clinical sustainability issues.

Recruitment and retention

- The same issues noted for the LSS model apply for the CPT model as well
- Career progression is an important fact for recruiting quality staff. This may be limited at Stafford and Cannock with the limited range of services provided
- It is important in this model that there is strong nurse leadership for it to function properly as there is a limited amount of other support on site

Whilst we would support the TSA model as the draft recommendations of the TSA this is only based on the information provided to us at the time. Any refinements to this model would need further clinical scrutiny and review to ensure safety is maintained. We would all welcome the opportunity to support the TSA on the further development of its recommendations.

Yours sincerely,

Elizabeth McManus

On behalf of the Nurse Clinical Advisory Group

Appendix G: Letter to TSAs from the Chair of the Stafford and Surrounds CCG

NHS
Stafford and Surrounds
Clinical Commissioning Group

Greyfriars Therapy Centre
Unit 12 Greyfriars Business Park
Greyfriars
Stafford
ST16 2ST

Telephone: 01785 221043

24 July 2013

Mr Alan Bloom
The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Dear Mr Bloom,

I am writing an initial letter in conditional support of the work undertaken by the TSA, on behalf of Monitor, to explore the options for reconfiguration of services at MSFT.

Early in the process the two CCGs were asked to work with the CPT to define the Protected Services which absolutely had to remain within Stafford and Cannock communities. The definition of Protected Services, now renamed as Location Specific Services (LSS) is tightly defined by Monitor and this definition constrained the considerations of the CCG.

Nonetheless, Stafford and Surrounds CCG were able to identify a core of LSS which we agreed with the Contingency Planning Team. These LSS were to be supplemented by further services as defined in the CCG commissioning intentions.

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

We have had initial sight of the financial calculations which back this proposal, and whilst on superficial inspection, they appear to be more favourable than the financial implications of the LSS as a standalone service, we must emphasise that our CFO has not yet had opportunity to consider the TSA proposals in depth.

The CCG has been unable to undertake a detailed due diligence of the underpinning financial implications and we will be working with the TSA over the next few weeks to fully understand the financial breakdown and consequences. The financial bridge appears to demonstrate how the LHE position (for the services currently provided by MSFT) can be brought back into surplus. The CCG recognises that additional capital is very likely to be needed to provide the extra capacity for the service changes required to implement the TSA preferred option but this would be even higher for LSS and CPT models.

It is also important to emphasise that owing to the extremely tight timescale, the Membership Board and the Governing Body of the CCG have not had opportunity to consider these proposals. Further discussion is needed at several levels within the CCG and the organisation will feed its comments into the wider consultation process.

Page continued 1 of 2

We recognise that this draft report is only one step in the wider TSA process and that the recommendations may change as a result of the consultation feedback. However we feel that the TSA draft report now contains sufficient detail to allow the TSA to go to consultation on its initial recommendations.

Yours sincerely

Dr Margaret Jones
Chair, Stafford & Surrounds CCG

Cc Graham Urwin
Director, Area Team

Appendix H: Letter to TSAs from the Chair of the Cannock Chase CCG

NHS
Cannock Chase
Clinical Commissioning Group

Greyfriars Therapy Centre
Unit 12 Greyfriars Business Park
Greyfriars
Stafford
ST16 2ST

Telephone: 01785 221043

22 July 2013

Mr Alan Boom & Professor Mascie Taylor
The Trust Special Administrators
Mid Staffordshire NHS Foundation Trust
Stafford Hospital
Weston Road
Stafford
ST16 3SA

Dear Mr Bloom and Prof Mascie - Taylor

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

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

From the figures we have to date, it would appear that the TSA is offering a financially sustainable model to the local and neighbouring health economies. However, due to the short time frame we have been unable to carry out detailed due diligence. The CCG would expect only to pay for services at tariff, and not a premium, and would not expect any provider deficit to be at extra cost to the commissioner. Whatever the proposed organisational form, the CCG would expect to have lead commissioner, and not associate commissioner, status with any new major provider.

Thus, the CCG supports the TSA recommendations subject to the above conditions and provided agreement is secured from our members during the consultation process

You have the full support of the CCG to go out to public consultation

Yours sincerely

Dr Johnny McMahon
Chair, Cannock Chase CCG

Cc Graham Urwin
Director, Area Team

Cannock Chase CCG Chair: Dr Johnny McMahon Accountable Officer: Andrew Donald

Appendix I: Detailed service model

The following table shows the detailed breakdown of services currently provided at Stafford and Cannock. This breakdown is based on 2012/13 data provided by the Trust and gives an overview of where services are available according to how the Trust currently records its activity.

	Stafford Hospital				Cannock Chase Hospital			
Service	Day Cases	Elective	Non-Elective	OP	Day Cases	Elective	Non-Elective	OP
Accident & Emergency	Y		Y					
Anaesthetics				Y				Y
Breast Surgery	Y	Y	Y	Y				
Cardiology	Y	Y	Y	Y			Y	Y
Cardiothoracic Surgery				Y				
Chemical Pathology				Y	Y			Y
Clinical Haematology	Y	Y	Y	Y			Y	
Clinical Oncology	Y	Y	Y	Y				
Colorectal Surgery	Y	Y	Y	Y	Y	Y		Y
Community Obstetrics				Y				
Critical Care	Y	Y	Y					
Dermatology			Y	Y	Y	Y	Y	Y
Diagnostic Imaging				Y				Y
Dietetics - adult & child				Y				Y
Endocrinology	Y	Y		Y				Y
ENT	Y	Y	Y	Y				Y
Gastroenterology	Y	Y	Y	Y	Y	Y		Y
General Medicine	Y	Y	Y	Y	Y	Y	Y	Y
General Surgery	Y	Y	Y	Y	Y		Y	Y
Geriatric Medicine	Y	Y	Y	Y	Y	Y	Y	Y
GUM				Y				
Gynaecology	Y	Y	Y	Y	Y	Y		Y
Interventional Radiology	Y							
Nephrology				Y				Y
Neuro Rehab								Y
Neurology	Y			Y	Y			Y
Neurosurgery				Y				
Nursing Advice				Y				Y
Obstetrics		Y	Y	Y				Y
Occupational Therapy adult & child				Y				Y
Ophthalmology	Y			Y				Y
Oral Surgery	Y	Y		Y				
Orthodontics				Y				
Paediatric Assessment Unit			Y					
Paediatric Dermatology				Y				Y

Paediatric Diabetic Medicine				Y				Y
Paediatric Endocrinology				Y				Y
Paediatric Gastroenterology				Y				
Paediatric Ophthalmology				Y				Y
Paediatric Respiratory Medicine				Y				Y
Paediatric Surgery	Y	Y	Y	Y				
Paediatric Urology				Y				
Paediatrics	Y	Y	Y	Y				Y
Pain Management	Y		Y		Y			
Physiotherapy adult & child				Y				Y
Plastic Surgery				Y	Y	Y		Y
Pre-Assessment				Y				Y
Rehabilitation								Y
Rehabilitation Plan Only								Y
Respiratory Medicine	Y	Y	Y	Y	Y	Y		Y
Rheumatology	Y		Y	Y	Y	Y	Y	Y
SCBU	Y	Y	Y					
Speech And Language Therapy								Y
Trauma & Orthopaedics	Y	Y	Y	Y	Y	Y	Y	Y
Upper Gastrointestinal Surgery	Y	Y	Y	Y	Y			
Urology	Y	Y	Y	Y				Y
Vascular Surgery	Y	Y	Y	Y				
Well Babies			Y					

Appendix J: Letter sent from A&E clinical leads in West Midlands

In May 2013, the following letter was sent from the clinical leads of the A&E departments across the West Midlands to acute hospital chief executives and CCGs in the West Midlands.

FAO: CEOs of Acute Trusts and heads of Clinical Commissioning Groups in West Midlands region

Dear Colleague,

We write as a group of Service Leads for Emergency Medicine in the West Midlands, representing Emergency Medicine consultants in the region, with responsibility for eighteen of the region's twenty one Emergency Departments (EDs). The EDs of the region manage in excess of 1.5 million patient attendances annually, in a region with a population of 5.36 million. This represents 8.5% of all ED attendances in England.

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

All of our EDs have been under immense pressure for the last few months. This pressure has been unprecedented and relentless, and felt by every ED in the region. All have shown inexorable rises in attendance rates, year on year, coupled with increasing intensity in workload, as we care for a rapidly aging population with complex needs. There is toxic ED overcrowding, the likes of which we have never seen before. Nurses and doctors are forced to deliver care in corridors and inappropriate areas within the ED, routinely sacrificing patient privacy and dignity and frequently operating at the absolute margins of clinical safety.

We regularly see our EDs overwhelmed with patients, with all cubicles occupied, and no egress into the hospital forthcoming, while patients continue to pour through the doors. Our departments are simply not equipped to safely care for such numbers of patients, an increasing proportion of whom are elderly and frail with complex medical, nursing and social needs. All of the available evidence demonstrates that in-hospital mortality is increased when the ED is overcrowded and patients have to wait excessively for beds. Such overcrowding is now the norm in our EDs. In addition, we are seeing an inevitable and unsurprising increase in serious clinical incidents and complaints, as well as delays and deficiencies in care. And for every incident reported, we know there are multiple examples of substandard care that go under the radar. We and our staff are carrying a huge burden of clinical risk which no other agency seems willing or able to share.

While matters have recently come to a head, this situation has been in the making for a number of years, as evidenced by the fact that the recruitment of doctors to Emergency Medicine is in a state of national crisis, and our region has not escaped the problem. The Herculean burden of work, responsibility and clinical risk is so obvious to junior doctors that they are unwilling to join us in the practice of what we once considered the most rewarding areas of clinical medicine, and instead opt for more attractive and sustainable careers. There is institutional exhaustion amongst ED staff, at all levels, across nursing, medical and clerical. We appear to be the only healthcare workers in our organisations who are expected to work under these conditions, and it is not sustainable. Recruitment is almost impossible, and retention is becoming hugely challenging. The relentless volume of work, coupled with a perceived lack of clinical support from outside the EDs is demoralising and destructive.

Recent developments such as the introduction of 111 and financial penalties for holding ambulance crews in ED are touted as solutions to the crisis: however we as ED physicians recognise that these measures will actually make the problem worse instead of better, and evidence is already emerging to support our opinions. Furthermore the unilateral and dictatorial manner in which these and other policies have recently been introduced have only served to compound the problems in our departments.

The position is such that we can no longer guarantee the provision of safe and high quality medical and nursing care in our EDs. It is not a case of standards slipping, but the inevitable consequence of being forced to work in sub-standard conditions. The aforementioned issues have led to us routinely substituting quality care with merely safe care; while this is not acceptable to us, what is entirely unacceptable is the delivery of unsafe care; but this is now the prospect we find ourselves facing on too frequent a basis.

As a group of committed clinicians, we have worked hard to improve safety, quality, efficiency and timeliness of care in our departments, but have now exhausted all of our own resources. The pressures in ED and the ambulance service reflect an overall emergency system failing to cope –a coordinated system -wide response is now urgently needed. We know there is no simple answer to this conundrum; however as things have continued to escalate in this unrelenting fashion with detrimental effects on patients and staff alike, it would be unethical of us not to highlight this to our Executive teams and Clinical Commissioning Groups. Furthermore, we firmly believe and strongly recommend that ED leads should be intimately involved with and consulted on the commissioning of Emergency services in the region, as well as other related emergency care changes-such as 111. He that wears the shoe knows where it pinches; it is imperative that the experts in delivering Emergency Care- i.e. ourselves and our colleagues, are an integral part of its development and reconfiguration.

We reiterate our profound distress with the state of EDs in the region; and, while not wishing to apportion blame or devolve ourselves of responsibility, we call urgently on behalf of our patients and our staff for a radical Health Economy-wide response to the urgent care needs of the population of the Midlands. We furthermore call for our EDs to be suitably staffed and supported whilst under such pressure and while longer term solutions are put in place.

Yours sincerely