Response to TSA proposals - Mr Sinha, CD for Surgical Division

These are my own responses, as Clinical Director for the Surgical Division, a resident of STAFFORD and in the best interests of the population and patients of Stafford.

I will not go into any Financial details or any detailed figures as these can be interpreted in different ways. My responses are solely based on my experience of working in the NHS for over 20 years and at Stafford for over 5 years, in the post 'bad Stafford' days.

There are positives in the TSA proposals with which I agree, but there are a lot of issues where I feel the proposals could be made better to maintain the high standard of care provided at Stafford and for the benefit of the local population in the long term.

I completely agree that we cannot continue as we are. We need to join up with our neighbouring organizations but still be able to provide majority of services locally and only transferring what is essential for better patient outcomes, for ease of recruitment and retention and making the whole thing financially and clinically sustainable in the medium and long term BUT maintaining operational sustainability (ie, PATIENT SAFETY and excellent Quality of Care)

I will take each recommendation of the TSA proposal individually. I will concentrate on my patch, which is the Surgical Division, but will comment on all points.

Draft Recommendation 1. Stafford Hospital should continue to have a consultant-led Accident and Emergency (A&E) department between the hours of 8 am and 10 pm.

I agree with this in principle.

What I do not agree with is the model proposed in support of A&E. If there is an acute medical take, **this should be fully supported** to minimize the risks to the patients of Stafford. This would mean some form of Level 3 Intensive Care Unit support. The present unit will be part of a larger merged / networked ITU, but should stay not only to support the hospital but also to support the larger Unit at UHNS. Shutting beds when there is constant shortage of ITU beds in the region and nationally makes no sense. Spending lots of money to build more capacity at UHNS when the existing excellent facilities can be utilized, again does not add up.

Along with this, the A&E ought to be supported by some form of surgical presence. What this should look like, could be left to the merged Surgical Units of UHNS and Stafford to decide, depending on capacity, local expertise, better utilization of existing facilities, reduction in transferring ill patients as norm etc.

Draft Recommendation 2. An inpatient service for adults with medical problems will continue to be provided at Stafford Hospital for those who need to be in hospital.

I fully agree with the recommendation, again in principle. It is essential for the population of Stafford, which has its own share of medical problems, both for the elderly and the not so elderly.

As this is not in my remit, I will not go into details but I disagree with the details of the recommendation. The current Acute Medical Unit works extremely well. It is run by Acute Physicians who specialize in this and help provide a Consultant led and delivered service. This in turn has made this unit extremely efficient, discharging more than half of all acute medical admissions. This has been one of the reasons for the Hospital Mortality Rate (HSMR) to come down and stay down for the last 3 to 4 years.

The unit (AMU) already provides a very high standard of care for the Elderly. The suggestion that it be changed into a Medical Assessment Unit, will be a huge retrograde step and lead to deterioration in standard of care. Again, it should be left to the combined UNHS and Stafford Medical Consultants to agree to a workable plan.

Draft Recommendation 3. As well as retaining the present inpatient service, a 14/7 Frail Elderly Assessment service is created to provide a one-stop assessment for older people and to take referrals from a wide range of sources. The unit should be staffed by geriatricians to ensure greater links with the community. The Frail Elderly Assessment service should have clear referral systems in place so older people get the most appropriate care.

Again, this is not in my patch, but I strongly disagree. The current model of an Acute Medical Unit provides the above service, but to a much higher standard. To replace it with the TSA proposed model will not be an enhancement, but a retrograde step. The suggestion that this is staffed by Consultant Geriatricians during the day and Advanced Nurse Practitioners at night goes to prove that. It is currently manned by the Medical Team 24 hours a day. As this unit will be admitting the acutely medical ill, the proposals will put patients' life at risk, as staff may recognize the acute illness, but will be incapable of dealing with it.

Draft Recommendation 4. Beds should be available at Stafford Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.

In principle, I agree with this proposal of the TSA.

Draft Recommendation 5. No babies should be born at Stafford Hospital's consultant-led delivery unit as soon as other local hospitals have the capacity to deliver a service for more pregnant women. The TSA's plan is designed to ensure there is sufficient capacity at neighbouring hospitals so that mothers-to-be have a choice of where they have their baby.
Consultant led pre- and post-natal service should be delivered in partnership with UHNS so that local patients can still attend routine appointments at Stafford. Women will have the choice to go elsewhere if they prefer.

This is a tricky one. There is a lot of passion regarding this both in the community and in the Obstetric department. The delivery rate has fallen over the last few years to around 1800 deliveries. This makes the unit small. The unit is fully staffed and provides a high quality of care that is recognized nationally by the Royal College of Obstetrics and Gynaecology. But this comes at a price – it is an expensive service to run.

The **obstetric service is on the list of short-term LSS (Location Specific Services).** This means that the CCGs know there is no capacity to move this service in the region in the short term. This can only be decommissioned if there is capacity created elsewhere for the service to be transferred. This could take a lot of time.

My big concern is that once it is formally announced that this service is to be decommissioned, a lot of the Consultants who provide a high quality of a 40 hour a week service will either leave or retire. Also, there is already, (after a long time), increasing vacancies in the Midwifery department. This has not been the case in the past, but with the uncertainly of the Unit, it has been almost impossible to recruit. This combination will lead to the collapse of this service with nowhere else for patients to go – as there is no capacity at either UHNS or RWH or Walsall, to take on the extra work at this stage.

As the hospitals are going to be merged, especially in the north with UHNS, the two departments will become one. The correct thing to do will be to have one department with 2 sites, both providing full Obstetric services. **The two departments can discuss what expertise can concentrate of either site and locate these accordingly. This will help with capacity and help UHNS pull more deliveries from the North**. This will come at a price but that has to be negotiated with the Department of Health. The risk of this service folding up in the Transition period will be disastrous for the population of Stafford.

Also, the TSA proposal cannot go against the requirements of LSS.

Draft Recommendation 6. Children should no longer be admitted as inpatients to Stafford Hospital and the service should stop as soon as other local hospitals have the capacity to accept them safely. Patients should be transferred to larger specialist hospitals for appropriate inpatient care.

Again, this does not come on to my patch – but does directly affects us.

My fundamental problem with this proposal is that the Paediatric Department does provide a good service. There is no infrastructure in the community for children to be managed outside of the hospital setting. All that will happen by closing this unit is that all the referrals and admissions will be transferred to a much larger unit. A lot of these are of minor to moderate severity needing about a 2 day stay. These do not need to go to a Tertiary Centre Unit, where the more sick children are looked after. It will negatively impact on the running of that unit as a lot of their resources will be taken up in looking after the relatively minor illnesses which will end up there.
The service should continue till one has more information and guidance from the Colleges as to how the National drive to close a lot of the smaller units in Paediatrics is produced. Stafford should not be made an example or an experiment for this.

Also, there is no model of a Nurse-led Paediatric Assessment Unit in the UK. Why experiment in Stafford? **The Unit should join up with UHNS and /or RWH and the infrastructure in the community improved**. Only when that has happened and evidenced, should this even be considered.

The model also affects all Surgery for children, even if they may be considered minor. One will not be able to do any ENT elective paediatric operations, eg Tonsils or grommets as there will be no ward and no Paediatric doctor on site. Also, any children attending with fractures that need an anaesthetic cannot be done here, again for the same reasons. It will not be safe to anaesthetise any children with no back up of a ward or Paediatric team. This will put undue strain on a Tertiary centre and will be extremely detrimental for the local population.

Draft Recommendation 7. Children will continue to be assessed at Stafford Hospital's existing Paediatric Assessment Unit (PAU). This will be between the hours of 8 am to 10 pk. The PAU will be led by specially trained nurses who will consult with paediatricians from UHNS. Referrals will either be through A&E, GPs or other health care professionals as they are now.

Again, this is not in my patch. But I fail to see how this will work. There is no model of this kind in the UK (as far as I am informed). Why experiment with something in Stafford, that has not been tried elsewhere?

Draft Recommendation 8. Major Surgery should no longer be carried out at Stafford Hospital with the exception of minor surgical procedures which can be dealt with by A&E or where the patient can be stabilized by A&E and scheduled to return to Stafford Hospital for minor surgery. Most major emergency surgery would instead be provided by a local larger hospital such as UHNS or RWH. The TSAs have already had initial positive discussions with UHNS about this.
This means there will no longer be a surgical assessment unit on-site. A&E Consultants at Stafford Hospital will be able to consult surgeons remotely at larger hospitals about patients' surgical needs. Patients would then be transferred to another hospital for surgery where required.

This is again a difficult one. There has been a lot of instability in the Surgical Department at Stafford. There has been talk of Surgical Alliance with UHNS for a long time. As per National Guidance, major elective and all emergency Vascular Surgery work moved to UHNS in April 2012. Some elective vascular work is still done at Stafford. Lately, Urology Alliance has been moving forward successfully and is due to go live mid October 2013 with all inpatient Urology work and all emergencies being done at UHNS, with the Stafford team TUPEd over. A lot of day case Urology will move to Stafford.

There is general acceptance that things cannot carry on as it is. It is likely that most major emergency General Surgery work will move to UHNS, once there is capacity available.

Debate is whether there is any emergency work done here during the day. This will depend on what model is finally agreed with UHNS. Also it will depend on whether there is appetite to do any elective work at Stafford. The main issue will be capacity, both with regards beds and theatres at UHNS. My feeling is that to maintain a surgical presence at Stafford, there should be some elective General Surgery work done here. This could most likely be colorectal work. This does not have to be the major complex surgery but the more routine colorectal surgery. This would be in addition to a CEPOD list where minor emergency surgery is done. By doing this, there will be Surgical presence to cover the Acute Medical take, gastro-enterology and may also help sustain the activity of the Intensive Care Unit.

Having no Emergency Surgery would put patients' lives at risk. These patients often need surgery urgently and if they have to wait for a bed at UHNS, they may deteriorate and not survive the episode. This would specially affect the elderly. The figures used by the TSA grossly under-estimates the amount of emergency general surgery happening safely at Stafford.

The TSA certainly underestimate the use and need of the Surgical Assessment Unit. This is an invaluable part of the hospital where a big number of patients are assessed, investigated, about 10% ending up having surgery and the rest either being discharged after settling down (about 50%) and the remainder getting admitted to the Surgical wards for further investigations and conservative treatment.

Having no SAU would unnecessarily put extra strain on already stretched resources of UHNS. Even a CDU model of A&E would not do this job as it would only be A&E Consultant led with no or minimal input of the Specialist General Surgeon. Having an SAU would be very beneficial for the local population in rapidly turning around patients.

I would propose that SAU remains along with some emergency surgery at Stafford. Some major elective colorectal surgery should be moved over to Stafford. This would not be independent but be part of a larger unit having a HOT site at UHNS and a COLD site at Stafford. This would greatly help alleviate the bed pressures at UHNS. Once the major elective patients are dealt with at UHNS, they can then be transferred to Stafford for further stabilization and rehab before being discharged home. Consultants would be part of one team and rotate here, maybe for a week at a time (eg 1 in 10 weeks). They could bring the trainee juniors with them and thus help keep some trainees at Stafford.

The other big disagreement I have with the TSA model is to do with Orthopaedics. All agree that No major trauma comes to Stafford. That is not happening anyway even today. Major trauma does not even go to RWH, but to either UHNS or Birmingham as two of the three Major Trauma Units in the Midlands, third being Coventry.

TSA propose that there should be no routine Orthopaedic trauma surgery at Stafford. They do not seem to appreciate the considerable numbers going through the unit. Their figures have completely missed out all trauma done on the planned Trauma Lists and specialist Trauma lists (10 lists per week). We do about 250 fracture neck of femurs and in the latest National Hip Fracture Database results for 2012 have done very well. TSA seem to think that this is major trauma. It is not. This is bread and butter for Orthopaedics. We get almost 80 to 90% of these patients operated within 36 hours, which is Best Practice. **Transferring this large group of elderly patients to UHNS is unnecessary, will be unsafe and impractical**. With a largely elderly population and the Medical Unit to have Geriatricians, it would be common sense to operate on these safely at Stafford. In fact, if UHNS is struggling, there is no reason why some of their fracture neck of femurs cannot be done at Stafford. We could work together to improve the pathway further. Along with this, there is no reason why routine inpatient Orthopaedic trauma should not happen at Stafford. This would include ankle fractures, wrist fractures, shoulder fractures etc. On the other hand, it would help to transfer patients the other way, from UHNS to Stafford for these simple fractures, to utilize the resources of Stafford better and ease the pressure on both theatre space and beds at UHNS.

Draft Recommendation 9. A small critical care area should be retained at Stafford Hospital so that very ill patients who come to A&E or inpatients who become very unwell can be kept stable prior to urgent transfer to a larger specialist hospital.
Current staff on the critical care unit should work as part of a clinical network established with a neighbouring hospital. UNHS has proposed offering these services and the specialist staff to network with Stafford.
An urgent transfer service should be established for very ill adults which is the same as the approach already used successfully across England to transfer sick children to regional services.

I agree that the Critical Care Unit of both Stafford and UHNS become part of one big unit. It makes no sense to me to close the Level 3 facility at Stafford when there is regional and national shortage of Critical Care beds. The unit at Stafford is very efficient with proven excellent outcomes.

The size of the unit remaining at Stafford should be debated, but its presence will support the Acute medical take. There is no existing model in England where there is an Acute Medical take with no Level 3 Critical Care facility. Why do the TSA want to experiment at Stafford of all places? Have the population here not suffered enough? By doing this, will inevitably mean patients dying either during transfer or deteriorate so much waiting for a bed and transfer, that they will succumb here at Stafford.

The proposal of patients being stabilized here before being transferred within 4 to 6 hours is just not workable. This does not happen in real life. Patients are not often stable for transfer for much longer; sometimes even a couple of days. Also, the principle should be for transfer only as a last resort and not the NORM. Transfer of sick patients routinely is WORST practice and will certainly lead to increased morbidity and even mortality in this vulnerable group.

Also, the proposed TSA model of urgent transfer model of the very ill adult based on transfer of sick children model is a dangerous proposal and should not even be considered.

I would propose to join up the unit with UHNS and keep a critical number of Level 1,2,3 beds at Stafford in dialogue between the two units. Also, it would be logical to co-locate other areas like NIV, Acute Cardiac Unit and monitored beds within or next to Critical Care so that the nursing and medical establishments can work together, flexibly and help save costs and prevent unnecessary transfers.

Draft Recommendation 10. Elective care and day cases should remain in Stafford. This would include Orthopaedic surgery.

I completely endorse this proposal of the TSA. I also agree that the exact range of elective procedures that would be delivered at Stafford would be dependant on discussions with CCGs and the provider that operates the elective services.

I would add that in addition to Orthopaedics, ENT, some oral and maxillofacial and plastic surgery, there should also be some Colorectal surgery and Gynaecology as Elective surgery done at Stafford. This would only be done as part of a bigger unit for all the specialities, better utilizing the bed and theatre facilities at Stafford to turn around big numbers safely and efficiently.

In addition, UHNS have already indicated that they would offer a range of day case specialities. I completely agree with this.

Draft Recommendation 11. Beds should be available at Cannock Chase Hospital for recovering patients, following a spell of inpatient treatment at a specialist hospital, to rehabilitate nearer to home.

I completely agree with this proposal.

Draft Recommendation 12. Elective surgery is retained at Cannock Chase Hospital. There should be new surgical specialities introduced, enhancing the current range of elective inpatient services for Cannock patients. This recommendation assumes that the ongoing discussions with the National CAGs regarding safe overnight staff cover can be successfully resolved.

I completely agree with this proposal.

Draft Recommendation 13. The current range of day case procedures (surgical and medical), including rheumatology services, should continue at Cannock Chase Hospital and the range be increased where possible.

I agree with this proposal as well.

Draft Recommendation 14. To allow for the TSAs' draft recommendation to work in a way that does not negatively impact the safety at other hospitals or their financial position, it is recommended that MSFT as an organization be dissolved.

I accept that this is inevitable. This will be in the form of a merger, acquisition or transfer with more than one neighboring organization.

I would think that the most likely partners would be UHNS in the north and RWH in the south.

My BIG WORRY is the TRANSITIONAL period or the Implementation phase, as the TSA call it. If this is anything more than a few months, it is very likely that a number of specialties may collapse. If that happens, the whole model will fall flat and put large numbers of patients at risk of delayed treatment, poor care, and seriously affect patient SAFETY. This will be because the neighboring hospitals do not have the capacity now to transfer all that is proposed, and staff at Stafford may not have the patience to wait any longer for that to happen. There has already been uncertainty for too long. They will leave.

At the moment, the proposed implementation phase would be over 2 to 3 years. This needs to be cut down to around the 1st April 2014. That should be the latest when Stafford should cease to exist and the name changes to UHNS or similar for the north and to RWH for the south. Until the Staff knows that Stafford is part of UHNS and Cannock is part of RWH within a few months of January 2014, the uncertainty will be detrimental and will result in the population of Stafford and Cannock suffering unnecessarily.

I hope this commentary will be heeded to by the TSAs and help them to come up with a Final Recommendation that is effective, practical, workable, SAFE, financially attractive with not having to spend over £200 million in Capital expenditure and over £100 million in Transition costs to overcome a shortfall of around £20 million per year!!!

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