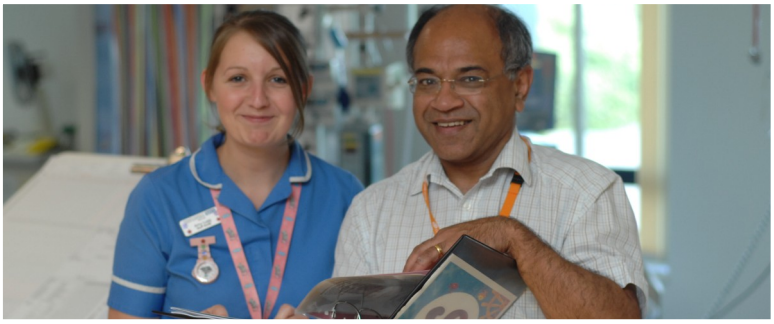

University Hospital of North Staffordshire
NHS Trust

Response to consultation on the draft recommendations of the Trust Special Administrators for Mid Staffordshire NHS Foundation Trust on the future of services for local people using Stafford and Cannock Chase Hospitals

Response of the Trust Board
Discussed in Public

30th September 2013

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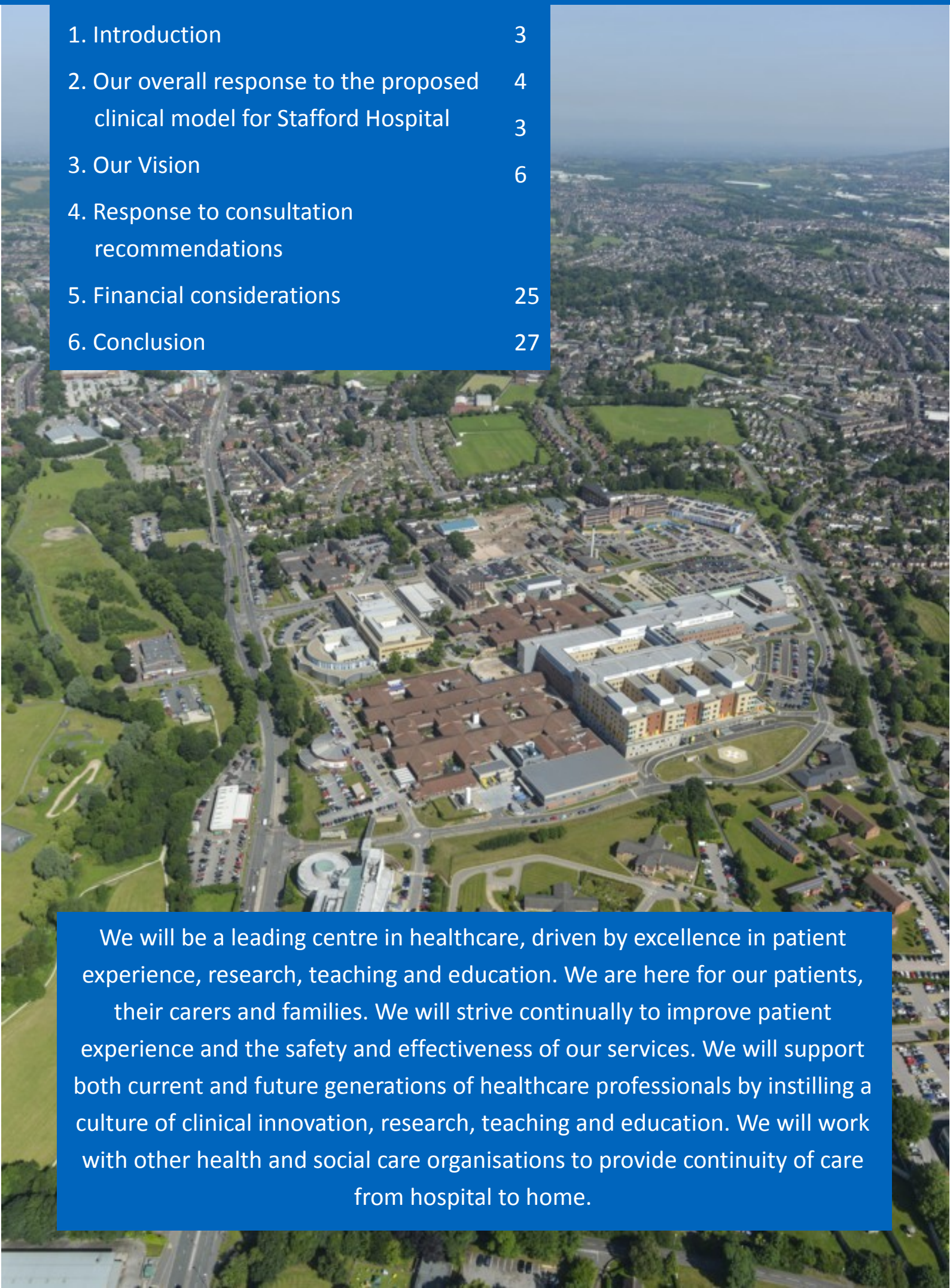

We will be a leading centre in healthcare, driven by excellence in patient experience, research, teaching and education. We are here for our patients, their carers and families. We will strive continually to improve patient experience and the safety and effectiveness of our services. We will support both current and future generations of healthcare professionals by instilling a culture of clinical innovation, research, teaching and education. We will work with other health and social care organisations to provide continuity of care from hospital to home.

In April 2013, the Trust Special Administrators (TSAs) for Mid Staffordshire NHS Foundation Trust (MSFT) undertook a 'Market Engagement Exercise' to assess the extent to which neighbouring NHS Trusts and others would be interested in providing services currently delivered by MSFT. University Hospital of North Staffordshire NHS Trust (UHNS) responded with an expression of interest and has worked closely in recent months with the TSAs to develop a model of care that supported the retention of a local hospital in Stafford and placed patients at the heart of the proposals to build a healthier future for the people of Staffordshire.

Our expression of interest was based on extensive engagement with our clinicians on ways in which we could make services more sustainable and improve the quality of care at Stafford and Stoke-on-Trent through greater integration across both sites. As the service models have been developed, we have also engaged throughout the public consultation period with our staff, Shadow Council of Governors, clinical commissioning groups and local stakeholders including our staff whose families rely on local health services and the public whom we serve to seek their views on these proposals.

The Trust Board has been fully involved in the development of our response to the TSA, through setting clear objectives at the beginning of the process, ensuring appropriate governance arrangements for the scrutiny of proposals as they were developed, and by subjecting the final proposals to a set of 'assurance tests'.

Profile of our Trust

UHNS is a large acute university teaching hospital on the border of Stoke-on-Trent and Newcastle-under-Lyme in Staffordshire. We are one of the largest hospitals in the West Midlands and have one of the busiest emergency departments in the country. Our clinical services are based at the City General Hospital site. Our new, state-of-the-art hospital building is now fully operational and has 1,150 inpatient beds.

We provide a full range of general acute hospital services for approximately half a million people living in and around North Staffordshire. We also provide a range of specialised services for three million people in a wider area, including neighbouring counties and North Wales. These services include cancer diagnosis and treatment, cardiothoracic surgery, neurosurgery, renal and dialysis services, neonatal intensive care and paediatric intensive care.

We are recognised for our particular expertise in trauma, respiratory conditions, spinal surgery, upper gastrointestinal surgery, complex orthopaedic surgery, laparoscopic surgery and the management of liver conditions. We have achieved Level 2 in the Clinical Negligence Scheme for Trusts (CNST), which is a measure of the utmost importance we place on safe, high quality care for our patients.

We continue to develop the City General site with continued building works and alterations to our estate following our move from three sites into our new purpose built hospital at City General Hospital. Recent PLACE1 surveys in our facilities give the Trust high scores for cleanliness and for patient experience of privacy and dignity.

Current works on the site will be completed in August 2014 and will include the demolition of old clinical buildings to make way for 300 extra car parking places, 200 of which would be earmarked to accommodate additional patients from Stafford, should the TSAs' proposals for the provision of services at Stafford Hospital be taken forward.

We are committed to playing our part in the creation of a sustainable model of acute hospital services for the population served by Stafford Hospital. We see our future as being inextricably linked to that of Stafford Hospital in that any significant changes in services in Stafford inevitably impact our Trust.

In recent years, we have seen at first hand the way in which planned changes in services between UHNS and Stafford Hospital can achieve benefits for the populations served by both hospitals. For example, the creation of a vascular surgery network has given us a service which covers a population sufficient to support safe rotas and to maintain expertise. In all, 15 services are currently provided in an integrated model between our two trusts. Any proposal which caused these services to be divided or separated would be difficult to implement.

Currently integrated services are as follows:

1. Major Trauma - UHNS is the Major Trauma Centre for the North Midlands Network within which Stafford sits.

2. Vascular Surgery - UHNS is the vascular hub for Stafford and Leighton Hospitals and also the provider of vascular screening services for the Network.

3. Stroke Services - UHNS is the sub-regional hyper-acute stroke centre and supports local units via advanced telemedicine.

4. Specialist Surgery - ENT, oral surgery, maxillofacial and plastic surgery services at MSFT are all provided by UHNS.

5. All UHNS tertiary services support MSFT. Cardiac surgeons and neurosurgeons carry out clinics at Stafford.

6. Cardiology - an MSFT consultant carries out elective work in UHNS facilities.

7. Emergency Surgery and Urology - plans are at an advanced stage to reconfigure all emergency activity, and elective activity requiring overnight stays, onto the UHNS site.

8. Upper and Lower GI Surgery - UHNS consultants operate at Stafford and support consultant rotas.

9. Obstetrics - high risk births from Stafford are transferred to UHNS.

10. Paediatrics - patients from Stafford are referred for specialist care including paediatric intensive care (PICU) and a UHNS neonatologist supports Stafford Special Care Baby Unit (SCBU).

11. Nuclear Medicine - UHNS provides consultant staff to deliver the Stafford service.

12. Cancer Services - a number of UHNS clinicians attend Stafford multi-disciplinary team (MDT) meetings.

13. A Pathology Alliance is currently strengthening links between the departments.

14. Renal Dialysis – UHNS manages a satellite unit in Stafford.

15. Supplies and Procurement services.

However, where change has been unplanned the impact has been felt in both the north and south of the county. The drift of Accident and Emergency (A&E) attendances and emergency admissions from the Stafford area to UHNS over the past few years has contributed to a 10% increase in A&E attendances and a 7% increase in emergency admissions over the past year when there was little scope to extend capacity without recourse to expensive short-term measures.

Based on this experience, our Trust Board supports the case for change made by the TSAs to MSFT. Planned change is required in the services currently delivered by MSFT in order to maintain the quality and safety of services in the future, achieve financial balance, improve recruitment and retention of high-quality clinicians and meet the changing needs of an ageing population.

The status quo is not an option and our view is that the risks to services at Stafford, Cannock and, through the knock-on effect, neighbouring Trusts such as UHNS will increase unless change is planned and properly managed. For far too long patients and health professionals have been subject to uncertainty, which has prevented service change to improve services and attract the best people to Staffordshire.

Furthermore, our Board believes that there is a compelling public interest in UHNS providing services at Stafford Hospital in order to improve patient care through greater integration of service provision between the two hospitals. This would allow us to centralise services where necessary for safety and quality and to support more local access to services at Stafford Hospital than could be achieved by a standalone provider of services at Stafford.

Greater integration of services would benefit the residents of both North Staffordshire and South Staffordshire who receive our services. A single trust operating across two sites would help us to attract the best people to come and work, learn and research at an integrated university hospital providing services that:

- are sufficiently large in scale to deliver high quality outcomes for patients.
- centred around patients' recovery, locally where necessary and at a distance when required, with staff who are skilled, available and competent to deliver care - 'right place, right care, right staff and right time for care' being our goals.
- supported by excellent facilities that meet the expectations required by the public and policy makers of a modern 21st century healthcare provider.
- focused around the delivery of seven day consultant-delivered emergency care and a flexible, responsive elective care service that is fully digitalised, local and of sufficient capacity to meet the demands placed on it.
- provide, in collaboration with our university partners, Keele Medical School and Staffordshire University:
    - world-class training and education for healthcare professionals, which benefits staff and attracts talented professionals from a national pool.
    - services on a scale that will enable us to develop new and existing partnerships to attract academic medicine, nursing and other allied professionals to Staffordshire.

Our vision is to develop one organisation across two equally important hospital sites with the City General Hospital becoming more focused on emergency and tertiary services while the Stafford Hospital site would provide excellent local emergency and elective services to local people in the borough of Stafford and beyond. These services would be integrated between the two hospitals, working seamlessly and in tandem with community services to ensure that patients receive co-ordinated care for their condition on discharge from hospital, supported by hospital and community services organised by the trust. By working closely with our commissioners and public we would be able to deliver on the expectations of our patients and taxpayers.

Greater integration of services would also benefit the residents of both North Staffordshire and South Staffordshire who receive our services in other ways:

- enabling more services to be supported at Stafford Hospital than would be possible for a standalone provider at Stafford. A networked model of service with rotation of key clinical staff between Stoke-on-Trent and Stafford is the best solution to the difficulty Stafford Hospital faces in recruiting and retaining key clinical staff.
- providing services at Stafford Hospital reduces the drift of activity to UHNS and lessens pressure on capacity at UHNS.
- a planned transition process is the best means of securing benefits for patients and managing risks. A planned transition with support for transitional costs would underpin the development of the changes to capacity (buildings and people) that will be needed at UHNS and Stafford to provide the new service

models, should the Secretary of State approve the TSAs' recommendations. Our close clinical links with Stafford Hospital and experience in working on service change with MSFT put us in a good position to be a key partner in this transition.

- greater efficiencies can be achieved from the merger of support services, e.g. pathology.
- a bigger catchment population enables us to secure specialist services such as cardiac surgery in north Staffordshire for the benefit of patients throughout the county.
- Creating opportunities to develop our teaching, education and research base, thereby ensuring a vibrant and innovative Staffordshire provider of acute services for the future.
- developing our reputation and making this area an attractive place to work for the best clinicians. For example, we know that Keele Medical School and UHNS are well-regarded by medical students as providing a good medical education, but we currently retain too few of the doctors who train here as they progress through their careers. This point is endorsed by the Dean of the Medical School, who has raised concerns with us on the attractiveness of medical rotation placements at Stafford.

Our Board is also concerned to ensure that any changes made to services at Stafford are clinically and financially sustainable beyond the transitional period not only for the benefit of current Stafford services, but also for UHNS as the 'receiving' Trust.

Perhaps most importantly, our vision for these services is not just about ensuring clinical and financial sustainability but is grounded in a commitment to improve the quality of services we provide. We will do this in a number of ways, including:

- Increasing the scale of some services will support improved quality standards to the benefit of all patients. For example, increasing the population covered by emergency surgical rotas supports greater specialisation on those rotas. Increasing the number of births at UHNS allows us to support a greater level of consultant cover of labour wards and improve the ratio of midwives to patients.
- Increasing the scale of some services allows us to move further towards a model of consultant -delivered services and higher levels of consultant cover out-of-hours and at weekends.
- Rotating staff between the specialist centre at UHNS and Stafford improves staff training and the robustness of staff cover arrangements.
- Planning capacity across two hospitals and commissioning community ‘step down’ care we can better ensure patients are in the right place for their needs and reduce occupancy levels at the City General site.
- Planning the required development of the facilities at Stafford Hospital site to improve patient experience, privacy and dignity to meet modern standards, regulatory requirements and the lessons of the recent Keogh and CQC reviews of hospitals.

In summary

Our Board supports the overall draft clinical model set out by the TSAs for Stafford Hospital. However, we demonstrate later in this response that the current proposals will not be affordable to the Trust on national tariff payments. Our support for the final plan will depend on the outcome of due diligence and the agreement of the financial, operational and governance arrangements both for the transition programme and in the longer term.

Proud to care

We consulted closely with our doctors, nurses and other healthcare professionals to ensure that patients' best interests were at the heart of our proposals to reprovide services at Stafford Hospital. We include here a snapshot of some of the main benefits that we believe our proposals would bring for patients and the population of Staffordshire.

Ability to keep and develop specialist services such as neurosurgery, cardiac surgery, specialist stroke care and specialist paediatric services in Staffordshire, reducing need for patients to travel to Manchester or Birmingham for care.

High quality, safe and sustainable clinical services, operating within latest recommended clinical standards.

Sharing best practice and learning between staff from UHNS and Stafford.

£50m

would be invested at City General to provide four new wards, develop new critical care facilities to treat specialty patients and provide parking.

Aiming to develop world class services that would attract best doctors, nurses and other healthcare professionals to work, learn and research in NHS in Staffordshire.

Increased range of outpatient and day case services would be provided at Stafford. No patient from Stoke would need to have treatment in Stafford and all patients would still be able to choose where to have their treatment.

Fuller range of services would be provided at Stafford than previously recommended by earlier reviews.

Greater support for patients with long-term conditions.

17 - 20

extra patients from Stafford each day admitted as an emergency at UHNS. (6,400 a year). 4 - 5 extra A&E attendances each day from Stafford (1,600 per year).

Less need for admission to hospital as result of development of care in alternative settings, including patients' homes.

3 - 5

extra patients from Stafford each day at UHNS for planned procedures (1,200 a year).

Services delivered within agreed target, cancer patients have the right to be seen by specialist within a maximum of two weeks from urgent GP referral if cancer is suspected and 18 week targets for patients for non-emergency treatment.

No changes would happen overnight.
We would work closely with staff both at University Hospital and Stafford Hospital to enable all the appropriate facilities to be put in place during a transitional period of two to three years.

2 - 3

additional babies from Stafford delivered each day at UHNS (800 – 1,000 per year).

More seamless care
when UHNS is working together with different organisations such as community services and social care on behalf of patients. Cost savings resulting from greater integration of non-clinical services.

Extra car parking
places available from 1st November 2013 at City General Hospital with another 200 spaces proposed in response to consultation recommendations..

£70m

(approx.) would be invested in Stafford Hospital to bring facilities there up to national standards.

Emergency and urgent care

Recommendation 1:

Stafford Hospital should continue to have a consultant-led Accident and Emergency department between the hours of 8am and 10pm daily.

Clinical rationale and sustainability

We believe that the continued operation of a consultant-led Accident and Emergency (A&E) department at Stafford Hospital, operating between the hours of 8am and 10pm, represents an appropriate clinical model. Our support for this model is contingent on the service at Stafford being provided by UHNS as part of a network with the A&E department and Major Trauma Centre at City General Hospital in Stoke-on-Trent.

We would not support the continuation of the current arrangements for a standalone A&E department at Stafford as the department is not of a size that would enable it to recruit and retain senior clinical staff in the longer term. Any interim arrangements to support the department with staff from outside the Trust would be unlikely to be sustainable in the longer term.

We support the clinical argument for providing a full A&E department at Stafford rather than a GP-led Urgent Care Centre or some other form of urgent care service. Without a full A&E department, many of the patients currently seen in Stafford would have to go elsewhere and we estimate that only approximately half of the current A&E attendances would remain at Stafford.

In addition, A&E has strong interconnections with services in the rest of the hospital and our view is that a consultant-led A&E department is necessary in order to maintain acute medicine and critical care services in the hospital for the benefit of local people.

We agree with the TSAs' view that if the A&E department were to be reduced at Stafford, there would be a major impact on those A&E services provided at surrounding hospitals which are already under strain from recent increases in demand. We have examined the option to extend the opening hours for A&E at Stafford and concluded that it would be financially unsustainable. It would also be very difficult to staff the department overnight with trained A&E clinicians.

However, we would wish to examine with commissioners the option of providing a primary care-led urgent care service from A&E between the hours of 10pm and 8am, to be run by a GP Out-of-Hours (OOH) provider. With ambulances diverted elsewhere, this service would meet the needs of approximately half the patients arriving out of hours and would arrange urgent transport to a neighbouring hospital for those patients who needed it. In this way local people could benefit from the provision of high quality out-of-hours primary care with access to diagnostic facilities at the hospital, enabling better patient care.

We agree that existing arrangements should continue for patients with major trauma, stroke and certain cardiac problems who are transferred to City General Hospital by the West Midlands Ambulance Service. Ambulances transporting these patients currently bypass Stafford Hospital and proceed to a larger neighbouring hospital, ensuring that patients receive the right care at the right time and in the right place. We would propose that these arrangements should be extended under a networked model for A&E.

In a networked model, most medically-ill patients who arrive at Stafford A&E would continue to be admitted to Stafford Hospital. If Stafford were no longer able to provide the service needed by these patients, ambulances would bypass the hospital and proceed to the nearest hospital providing emergency surgical services. These changes should be planned with neighbouring providers

and West Midlands Ambulance Service.

We believe that an A&E department working to this model could be staffed sustainably. Our proposed staffing model would involve a rota combining consultant leadership and a supervised middle tier of doctors with junior doctors and enhanced nurse practitioners. The service would manage both major and minor emergencies and would provide dedicated services to assess the needs of frail elderly patients and children.

The service would work closely with the Acute Medical Unit, which would open between 8am and 10pm, and would be staffed until midnight. This would enable elderly people, children and adults of working age to be seen, assessed, treated and admitted to the right place at Stafford Hospital or where the complexity of their condition demands it, to be transferred to City General Hospital.

Our A&E clinical leaders believe that a networked arrangement would enable UHNS to provide a consultant presence at Stafford Hospital on a rota system that would ensure a safe and effective A&E service. We would increase the size of the consultant workforce (from 15 to 20) and some of these consultants would work at Stafford on a rotational basis. As a Major Trauma Centre, UHNS has been able both to attract and retain consultant staff in A&E.

Although Stafford Hospital currently has a relatively stable rota of middle grade doctors, there is nonetheless a national shortage of middle grade A&E doctors, which is likely to continue into the foreseeable future. As a result, all trusts will eventually need to change their A&E workforce model to ensure sustainable services in the longer term. We believe that being part of a larger, networked service would place both City General Hospital and Stafford Hospital in a stronger position to face those challenges as they arise.

Our view on the A&E infrastructure at Stafford is that the service requires a significant degree of refurbishment and reconfiguration in order to support modern A&E care and provide a dedicated area for children's assessment and treatment. We would expect these developments to be funded as part of a future transition programme.

In summary, we believe there is a strong clinical rationale for providing a consultant-led A&E department at Stafford Hospital as part of a network with the A&E department at the City General Hospital in Stoke-on-Trent. This change would make the service more clinically sustainable.

Financial consequences

The Contingency Planning Team report that preceded the appointment of the TSAs highlighted the fact that the cost of the A&E department at Stafford Hospital was in excess of the income received under tariff arrangements. Indeed, the service made the largest deficit, at approximately £4m, of any of the Trust's services in the year to March 2012 although it should be noted that the service operated 24 hours per day during that period.

There is some scope to mitigate this loss by recruiting to posts that have been covered by expensive locum and temporary staff. However, the proposed operating model would see UHNS operating a full A&E department with rotas staffed to recommended standards for levels of activity that would be approximately 30% lower than current volumes (Stafford A&E is already among the smallest Type 1 A&E services in the country). Overall, we believe that the service will continue to make a deficit if funded on the basis of current national tariffs.

In summary, it is our view that this service is clinically sustainable but not financially sustainable.

Inpatient services for adults

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.

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.

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.

Clinical rationale and sustainability

On Recommendation 2, we support the view that Stafford Hospital should continue to provide an inpatient service for adults with medical problems who need to be in hospital. Our support for this model is contingent on the service being provided by UHNS as part of a network with the acute medical service at the City General Hospital in Stoke-on-Trent.

Under this model, most of the patients with medical problems who arrive at Stafford Hospital could be seen and treated there. The care of some patients may be undertaken on an ambulatory basis (i.e. no overnight stay needed) in what is termed 'hot clinic' settings. Other patients may require medical assessment and a relatively short stay in hospital.

Acute medicine is predominantly a service for older people. Older patients who are seen in hospitals are frequently frail, have a complex pattern of illness (including dementia) and a wide range of associated conditions and care needs. The acute medical service specialises in the holistic assessment of a patient's clinical, care and support needs and ensures that these patients receive the right services either inside or outside hospital. For these reasons, the acute medical service cannot be seen in isolation from the A&E department, critical care, 'step up' hospital services and the services available in the community.

On Recommendation 3, we support the view that a Frail Elderly Assessment service, supported by geriatricians who specialise in the care of elderly people, would be essential in Stafford for patients with complex needs, particularly as the age profile of our population increases in line with national trends. We operate a similar service successfully in Stoke-on-Trent, enabling GPs and others to refer patients directly to the service. In doing so, they are able to prevent most elderly medical patients from needing to be seen in A&E, which can be a source of anxiety at any age. However, we do not see this as a unit which is separate and distinct from the acute medicine but is instead an integral part of the acute medical assessment process.

On Recommendation 4, we agree with this proposal with the requirement that rehabilitation or 'step down' beds are managed by UHNS in order to ensure a seamless transition from a hospital stay to rehabilitation. In this way we would be better able to organise care around patient needs and work with GPs, mental health and community services to deliver the best services. In addition to providing an appropriate setting that supports rehabilitation and reablement for these patients, this proposal would also reduce pressure on beds at City General Hospital from the Stafford area.

In our view, the success of the proposed model of care for adult inpatients at Stafford Hospital

would depend on two further building blocks being in place:

- The Stafford site requires significant refurbishment and reorganisation to support an adult acute medical inpatient service that meets modern standards on infection control, single-sex accommodation, basic privacy and dignity and enables inter-dependent clinical services to be located close together in the best interest of patients. The current positioning of the acute medical unit and wards at Stafford Hospital would not support the proposed model. We would expect these developments to be funded as part of a future transition programme, alongside funding of the necessary development at City General Hospital to accommodate the additional patients who would be admitted in Stoke-on-Trent. Expert assessments have shown more than £40m of capital investment in the current structure at Stafford Hospital would be needed to meet these standards, which are becoming ever more urgent and must be provided in the next three to five years.
- The effectiveness of the adult inpatient service would depend on the availability of effective community and mental health services for frail elderly patients with complex needs. Such services prevent unnecessary hospital admissions for patients who do not need care in an acute setting, sparing them the trauma often associated with being in hospital. Good community and mental health services would also enable patients to leave hospital when their condition meant they no longer needed a hospital bed and would benefit from being cared for in the community or at home. Without these community 'step down' services, operating seven days a week, Stafford Hospital would struggle to discharge patients, resulting

in a reduced capacity for new patients.

It is outside of the scope of the TSAs' terms of reference to make specific recommendations about the models of community service needed in South Staffordshire. However, we would expect a clear commitment from commissioners to develop existing community services as a part of the transition programme for changes at Stafford Hospital.

We are currently discussing a proposal with healthcare commissioners in Stafford to implement arrangements for 'prime providers' of 'step down' community services in order to facilitate discharge from hospital should UHNS take over responsibility for acute medical services at Stafford Hospital.

Under these arrangements, UHNS would be given the budget for 'step down' community services and would buy 'packages of care' from providers who were best able to meet the needs of patients and facilitate prompt discharge. This innovative approach, which has received considerable support from the public, patients, and local stakeholders, would enable us to deliver a better service to both to patients and taxpayers.

We believe that the acute medical service could be staffed on a sustainable basis by appropriately qualified and experienced medical and nursing staff who would enable rapid diagnosis and treatment of patients. In our view, the service should operate on a 24/7 basis and be open to GP and A&E referrals from 8am to 10pm. It should be staffed by three tiers of doctors (consultants, middle and junior grade doctors) in addition to an advanced nurse practitioner who would provide cover at night to support general medicine, 'step down' and rehabilitation services, supported by the three tier acute medicine rota.

The acute medical service would be supported by critical care and retrieval of patients would be undertaken in hours by the Major Trauma team. A trust grade doctor would provide out of hours cover at Stafford Hospital with an on call consultant providing support at Stafford Hospital.

In summary, there is a strong clinical rationale for providing an acute medical service at Stafford Hospital, which delivers a rapid assessment and treatment service to a mainly frail and elderly group of patients. The service should have access to beds in Stafford Hospital to support 'step up' and 'step down' care and be supported by effective community services to prevent unnecessary admission to hospital and support prompt discharge. We propose that innovative 'prime provider' arrangements are introduced as part of the implementation of the new service model to support UHNS in commissioning the discharge support services needed to make the systems work.

Financial consequences

The proposed operating model would see UHNS operating a full acute medical rota to recommended standards with supporting hospital-at-night cover in addition to cover for the 'retrieval' of sick patients to a specialist centre. However, the level of admission would be approximately 30% lower than current volumes. Overall, we believe that the service would continue to make a deficit if funded on a current national tariff basis. In summary, we believe that this service is clinically sustainable but not financially sustainable.

Maternity services

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 TSAs' 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 care 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.

Clinical rationale and sustainability

The Trust Board recognises the sensitivity of this recommendation and the understandable view of many people in Stafford and the surrounding area that they should be able to choose to have their children at their local hospital.

Depending on the responses received during consultation from commissioners and, there may be a requirement for further detailed discussion on the plans for maternity services both in the short term and longer term. UHNS would welcome the opportunity to remain part of these discussions and our stance would be dictated by three guiding principles:

- Is the service model safe?
- Is the service model affordable on the income we receive from commissioners?
- Can the service model be delivered operationally?

Our current view is based on a detailed examination of the issue, informed by discussions with our local clinicians, national advisers and commissioners. We agree with the clinical advice given to the TSAs that the small number of births at Stafford would make a consultant-led maternity unit unsustainable on both clinical and financial grounds. We also agree with advice on the feasibility of a midwife-led unit at Stafford. The number of women who choose to give birth at a midwife-led unit is likely to be much lower than the current numbers at Stafford, and some of those who choose Stafford would be transferred if they needed the services of a consultant-led unit. We believe that this would make the model financially unsustainable and make it difficult to maintain standards at such a small unit.

Under the TSAs' proposals, mothers-to-be would no longer have their babies at Stafford Hospital but the hospital would provide a full range of antenatal clinics, scanning facilities, and an early pregnancy assessment unit. We believe that we would be able to provide these services in a clinically sustainable way at Stafford.

We estimate that these proposals would result in approximately 800 additional deliveries a year (two to three per day) in our Maternity Centre on the City General Hospital site. All these births would be to mothers-to-be from the Stafford area who had been assessed as being at low risk. All mothers-to-be assessed as potentially high risk deliveries are already transferred to the City General Maternity Centre and other neighbouring units.

No capital expenditure would be needed to accommodate additional deliveries in the Maternity Centre. The public will understandably want to be assured that the City General will be able to cope with the additional deliveries. We would like to state here that there have been no closures in our Maternity Centre or Midwife-Led Unit at the City General Site for more than two years. Past closures were caused by staff shortages, not lack of physical space.

We believe the clinical model can be staffed sustainably and would improve consultant and midwife cover. We would require consultants and midwives to cover daily planned caesarean lists and also an increased consultant presence on the labour ward. By early 2014 we would plan to have 84.5 hours of consultant presence on our labour ward, which would rise to 112 hours per week with the larger consultant workforce. This will ensure a consultant presence for mothers and their babies from 8am to 12 midnight, seven days per week. We have set out some examples of how the new model would work:

Example 1: Stafford mother-to-be screened in local antenatal clinic as being low risk

What happens now?

All antenatal care, scans and screening tests carried out at Stafford Hospital in a midwifery-led or consultant-led clinic. Delivers baby at Stafford Hospital.

What would happen under these proposals?

All antenatal care, scans and screening tests carried out at Stafford Hospital in a midwifery-led or consultant-led clinic. At the start of labour mother-to-be travels to MLU at City General Hospital. Delivers normally in MLU and returns home.

Example 2: Stafford mother-to-be assessed in local antenatal clinic as being low risk develops unexpected complications during first or second stages of labour.

What happens now?

All antenatal care, scans and screening tests carried out at Stafford Hospital in a midwifery-led or consultant-led clinic. Mother-to-be delivers baby at Stafford Hospital. (Mothers-to-be with severe complications are transferred to CLU at City General Hospital).

What would happen under these proposals?

All antenatal care, scans and screening tests carried out at Stafford Hospital in a midwifery-led or consultant-led clinic. At the start of labour patient travels to MLU at City General Hospital. Mother-to-be develops unexpected complication and has immediate access to medical care if necessary, including:

- consultant present for her care 112 hours per week (and on call for the other 56 hours)
- highly skilled neonatal resuscitation for her baby
- immediate access to subsequent, highly skilled neonatal care
- interventional radiology- if needed, this could save her womb or even her life

Mother-to-be has an assisted or operative delivery and returns home. Access to skilled care in High Dependency Unit, if required.

Example 3: Stafford mother-to-be assessed as being high risk owing to medical problems or previous complicated childbirth history

What happens now?

Mother-to-be may choose to have her antenatal care at Stafford or City General Hospital or may require transfer of care to City General Hospital antenatal clinic . Many mothers-to-be deliver their baby in CLU at City General Hospital.

What would happen under these proposals?

Mother-to-be may choose to have her antenatal care at Stafford or City General Hospital or may require transfer of care to City General Hospital antenatal clinic. Baby delivered in CLU at City General Hospital, which gives immediate access to medical care if necessary, including:

- consultant present for her care 112 hours per week (and on call for the other 56 hours)
- highly skilled neonatal resuscitation for her baby
- immediate access to subsequent highly skilled subsequent neonatal care not requiring transfer
- interventional radiology, which, if needed, could save mother's womb or even her life

Mother-to-be has an assisted delivery and returns home.

Services for children

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.

Recommendation 7:

Children will continue to be assessed at Stafford Hospital's existing Paediatric Assessment Unit (PAU) during its present opening hours of 8am to 10pm every day. 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.

Clinical rationale and sustainability

We agree with the view that children should no longer be admitted to Stafford Hospital once other local hospitals have the capacity to take them. When children are so unwell that they need to be admitted, they should receive the standards of care that their families expect and deserve. Two key standards recommended by the Royal College of Paediatricians for these children are:

- they are seen by a paediatrician on middle or consultant grade rotas within four hours of admission
- they are seen by a consultant paediatrician (or equivalent) within the first 24 hours.

The delivery of these standards, both in and out of hours, requires a paediatric rota that Stafford Hospital would be unable to maintain. Even if the rotas could be filled, the volume of work would not be sufficient to maintain and develop the skills of doctors and nurses. It will be increasingly difficult for all small paediatric departments like that at Stafford Hospital to recruit to sustainable paediatric rotas in the future. Bigger trusts such as UHNS are able to operate a rota that is large enough to achieve the required standards.

We would propose to offer paediatric assessment and Hospital@Home services from Stafford Hospital. In this way, we believe we would be able to reduce the number of hospital admissions of children and ensure that they were only admitted to UHNS when absolutely necessary.

We would not propose the provision of a distinct Paediatric Assessment Unit as the predicted number of children (approximately 8-10 per day) would be too low to make this feasible. Instead, we would propose a paediatric assessment process in A&E in a dedicated children's area. Paediatric trained medical and nursing staff would be available on every shift for A&E. In addition, children's outpatient clinics would operate on a daily basis and urgent 'next day' appointment slots would be available to GPs requiring urgent advice or assessment.

Our view is that the A&E department at Stafford Hospital would require a significant degree of refurbishment and reconfiguration in order to support care for children. We would expect these developments to be funded as part of a future transition programme alongside the development of the Children's Centre at the City General, which would be required to accommodate an increase in child admissions. We also recognise that we would need to review the availability of accommodation for parents who would want to stay overnight at the hospital to be close to their child.

UHNS does not provide paediatric outreach services. In North Staffordshire, these are operated by the Staffordshire and Stoke-on-Trent Partnership NHS Trust (SSOTP) for babies and children from 0 to 19 years old. The service is highly integrated with the hospital service and team members work seamlessly with our matrons and the on-call consultant paediatrician. They also work closely with the GP Out-of-Hours (OOH)

service and there is a plan for the service to be located in the same place as the GP OOH service. The current Hospital@Home service in Stafford is provided by the Shropshire and Staffordshire Healthcare NHS Foundation Trust.

It is not clear to us how this service differs from the SSOTP service in terms of the operating model and the capacity that is commissioned by Staffordshire and Surrounds CCG for the Stafford population. We would wish to seek clarification from the CCG on these specific points and we would naturally be keen to understand and learn from current best practice in Stafford.

The proposed model is underpinned by a full integration of clinical services between Stoke and Stafford. We would suggest that, over time, there should be a single integrated provider of Hospital@Home services operating in Stoke, North Staffordshire and Stafford. There is also a need to examine the case for further integration of children's services in the County across community and acute services where this can be shown to benefit patients.

There are two key elements to the Hospital@Home service provided to UHNS, which we believe works well and we would seek to ensure that the same level of service was put in place in Stafford:

- admission avoidance - GPs may refer directly into the service for home-based support as an alternative to hospital assessment or admission
- early discharge - a representative of the Hospital@Home service attends the daily bed meetings at UHNS and arranges home support to facilitate early patient discharge, eg by providing IV antibiotics, respiratory or gastro support etc. It is able to support orthopaedic patients for a period of 'home leave'.

To support understanding, we set out a number of different scenarios to show the way children would be cared for under these proposals.

- A seriously injured or seriously unwell patient in Stafford referred by a GP or the ambulance service would be taken directly to UHNS by ambulance, which happens regularly now.
- A patient who is not seriously injured or unwell would be seen in the A&E at Stafford and assessed by a team led by a consultant with experience in assessing and treating children, and paediatric trained nurses:
  - a patient with minor illness or injury would be assessed, treated and discharged
  - some patients may need observation for a period of time and would then be discharged home after completion of their treatment or to the Hospital@Home team to have their treatment completed at home.
- If hospital admission is likely to be needed, the patient would be transferred to the inpatient facility at UHNS.
- Patients admitted to City General Hospital would be discharged home after completion of their course of treatment or to the Hospital@Home team to have their treatment completed at home.
- If an extremely ill or injured patient presented unexpectedly to Stafford ED and required resuscitation, this would be undertaken by the team in Stafford ED. The patient would then be transported to an appropriate intensive care unit by the specialised 'retrieval' service, which is already well established.

In addition, GPs would have access to urgent next day and routine consultant paediatric clinic appointments for patients who did not fit any of the above categories. Patients who may currently be travelling to Birmingham for certain types of specialist treatment such as gastroenterology, respiratory medicine, specialist allergy, epilepsy, echocardiogram or endocrinology would be offered the opportunity to attend specialist clinics at UHNS, which will help services in the county.

Major emergency surgery

Recommendation 8:

Major emergency 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 stabilised 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 The Royal Wolverhampton Hospitals NHS Trust. 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.

Clinical rationale and sustainability

The volume of major emergency surgery currently being performed at Stafford Hospital is relatively small as vascular surgery and major trauma have already been centralised at City General Hospital and plans to centralise urology are underway.

We agree that the levels of major emergency surgery remaining at Stafford Hospital are not clinically or financially sustainable and that, where possible, these procedures should be undertaken at hospitals that can support a robust emergency surgical rota. A greater concentration of gastrointestinal surgery will make surgical rotas at City General Hospital more specialised and more sustainable for the benefit of patient outcomes.

We support the proposal that some minor trauma and other minor surgical procedures can continue to be provided at Stafford.

Critical care

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. UHNS 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 centres.

Clinical rationale and sustainability

The TSAs' recommendations envisage the need for critical care to reduce at Stafford Hospital as a result of the removal of major emergency surgery. However, as a hospital providing acute medical services Stafford will require a smaller scale critical care capability to support medical patients whose condition deteriorated. As noted in the TSAs' recommendations, this would cover the stabilisation of patients prior to the transfer to more appropriate settings.

We support the recommendation to provide a small critical care area at Stafford Hospital if this is provided as part of a networked approach with UHNS in which key staff rotate between Stafford Hospital and the large critical care unit at City General Hospital in order to maintain their skills and ensure consistency of standards.

We would propose that the unit is equipped and staffed to treat Level 2 (high dependency) patients, but that patients requiring Level 3 care

are stabilised and transferred to the Critical Care Unit at the City General Hospital. This will include patients requiring advanced respiratory support, or basic respiratory support together with support of other organ systems, and patients requiring support for multi-organ failure.

We believe that this unit could be staffed sustainably. Medical care would be provided by trust grade doctors covering the unit and providing support to the rest of hospital, i.e. A&E, recovery, theatre lists, and intubation and stabilisation. Consultant cover would be provided by critical care consultants at City General Hospital and Stafford Hospital's on call consultant anaesthetic rota. The additional staff would enable the provision of two 1-in-6 rotas at City General Hospital, as recommended by the professional bodies.

The 'retrieval' process would be operated by the Major Trauma team from 8am to 8pm and out-of-hours by the trust grade doctor at Stafford Hospital, backed by the consultant on call supporting at Stafford Hospital or vice versa. Our views are conditional on understanding more fully the TSAs' proposals, agreed with West Midlands Ambulance Service, on the retrieval specification for such a service.

Our view is that the Critical Care Unit at Stafford Hospital would require a significant degree of refurbishment and reconfiguration in order to support modern critical care. We would expect these developments to be funded as part of a future transition programme alongside the funding of the expansion of critical care capacity on the City General Hospital site, which would be required to accommodate an increase in patients. Our initial views on the capacity and configuration of critical care will be further refined when we are able to undertake more detailed clinical analysis on the critical care data for Stafford patients.

Financial consequences

Providing safe rota arrangements in a very small unit, combined with the requirements for anaesthetic cover for intubation and stabilisation of deteriorating patients, is not a typical model of critical care on which national pricing assumptions are based. In our view it would not be possible to provide this service within existing national tariff arrangements.

Elective care and day cases

Recommendation 10:

Elective care and day cases should remain in Stafford. This would include orthopaedic surgery.

Clinical rationale and sustainability

We support the recommendation to continue to provide elective (planned) care at Stafford Hospital if this is provided as part of a networked approach with UHNS.

In our view, the focus should be on providing non-complex, short stay elective cases from Stafford Hospital and more complex procedures should carried out at City General Hospital. We believe that it would be possible to increase the number of elective cases undertaken at Stafford but this would depend on patients choosing to have their surgery there. In recent years many local residents have chosen to have their surgery at other hospitals including City General Hospital, but as confidence in Stafford Hospital is re-established, we believe this trend can be reversed.

We note that the TSAs propose a major expansion of surgical capacity at Cannock Chase Hospital linked to the service at New Cross Hospital in Wolverhampton. This could result in many patients from South Staffordshire choosing to go to Cannock whereas previously they would have elected to have their surgery at Stafford Hospital.

The expansion of elective capacity at Cannock Hospital would reduce the catchment population for Stafford Hospital and would mean that we would not be able to make the most effective use of the elective capacity at Stafford. Given their close proximity and the availability of other providers, it is unlikely that both Stafford and Cannock Hospitals should provide elective surgery sustainably.

Our view is that there needs to be a careful consideration of the options for elective surgical, out-patient and diagnostic services to the population served by the Cannock CCG, given the choices available at Walsall, Wolverhampton, Stafford and Telford.

Our view is that the theatres, day case and outpatient areas at Stafford Hospital would require a significant degree of redevelopment and reconfiguration in order to support modern elective care. We would expect these developments to be funded as part of a future transition programme.

In our view elective surgery at City General Hospital can be staffed sustainably. Surgeons would rotate from City General Hospital to Stafford Hospital for theatre sessions and outpatient clinics for those patients having their operations at Stafford. Surgery for children would be undertaken in line with guidelines from the Royal College of Surgeons, which stipulate that children must be cared for by a paediatric nurse in a designated area. Robust plans for the transfer of children to the neighbouring inpatient Paediatric Unit at City General Hospital would need to be in place in the rare event that this was needed.

Cannock Hospital

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.

Recommendation 12:

Elective surgery is retained at Cannock Chase Hospital. There should be new surgical specialties 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.

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.

Clinical rationale and sustainability

On Recommendation 11, we would support the provision of rehabilitation services at Cannock Hospital alongside a range of other community services, which would provide care close to home for the population of Cannock. We believe that the services operated at Cannock should be closely integrated with primary care provision and other community services provided in the area.

On Recommendation 12, we would support the retention of the current levels of elective surgery at Stafford Hospital but could not support elective surgery at Cannock Hospital as this would have a direct impact on the viability of elective surgery at Stafford Hospital. In addition, it is likely that the creation of new capacity in the local health economy would drive an increase in access rates for elective surgery and would impact on the affordability of acute services for commissioners. Further, the catchment population for the elective surgical service at Cannock is not set out in the consultation document.

If the catchment population is just Cannock and surrounding areas of South Staffordshire, then this would fall well below the Royal College of Surgeons recommended catchment population of 450,000 to 500,000 for an elective surgical service. If the catchment population is wider than this, then the potential impact of surrounding units should be made clear.

Any changes which impact on surgical flows for populations beyond the Stafford and Cannock catchments should be subject to public consultation in their own right. We would suggest that the CCGs examine potential alternatives and innovative options for these services which maintain the ethos of Cannock Hospital as a local hospital serving the community of Cannock.

On Recommendation 13, we are unable to support the retention or expansion of surgical and medical day case procedures at Cannock Hospital as it would have a detrimental impact on the viability of elective surgery at Stafford Hospital. In addition, introducing new capacity into the local health economy would be likely to drive an increase in access rates for elective surgery and would have a negative impact on the affordability of acute services for commissioners. We would want rheumatology services for Stafford CCG patients to be delivered in Stafford by UHNS.

Recommendation 14: To allow for the TSAs' draft recommendations 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 organisation be dissolved.

Clinical rationale and sustainability

We agree with the view that the future clinical sustainability of the hospitals in Stafford and Cannock would be improved by greater integration with larger hospitals. In implementing these changes, organisational change would be needed to bring services together across hospitals.

Under the TSAs' recommendations, all of the services currently provided by MSFT would move to new trusts, so it would appear inevitable that MSFT as an organisation will be dissolved at some point in the future. The timing of this change would need to be planned as part of the overall transition programme, which would be agreed once plans for the future of MSFT are agreed.

The move to new organisational arrangements should be handled with care to ensure that quality and safety is maintained during the transition period. Should the financial affordability issues be resolved, and following an appropriate period for due diligence work to be undertaken, we believe that Stafford Hospital should be brought under the management control of UHNS. We would support similar arrangements for Cannock Hospital when there is an agreed and viable plan for the future of that hospital.

However, as explained in below in the section on financial considerations, as they stand the TSAs' proposals would still have a detrimental impact on the viability of UHNS, even if MSFT is dissolved.

In considering the financial implications of the TSAs' recommendations, we have taken the proposed clinical model and worked through the detail of the way in which we would run these services, what it would cost to deliver them and the income we would receive from commissioners. We have considered how we would staff the services to safe levels, the cost of drugs, consumables, and other non-pay costs. We have made assumptions about delivering more efficient services and the productivity improvements we could make by looking at 'best practice' benchmark data from other hospitals.

This analysis demonstrates that there would be significant financial disincentives to running an A&E department and acute medical services on the scale of those at Stafford Hospital for the relatively small number of patients who would use the hospital under the TSAs' proposals. These services have fixed costs associated, for example, with the requirements of running a medical rota. Compensation for these costs would be inadequate in the light of the low levels of activity, and therefore low levels of income, that these services would attract.

Furthermore, the TSAs make clear in their public consultation document that they have been unable to 'balance the books'. They identify a residual overspend in 2017/8 for all MSFT's current services of £8.5m per annum after assuming a year-on-year savings programme of 8.5%. Our cost estimates currently show a deficit against assumed tariff income that is greater than the TSAs' estimates. Our cost model builds in challenging productivity improvements, but we consider the TSAs' identified savings target of 8.5% each year for three years to be unachievable.

Our cost estimates build in quality improvements and include investing an estimated £67m in improving buildings and equipment at Stafford Hospital to bring the facilities up to current standards. This figure should be seen in the context of an estimated current 'backlog maintenance' cost for Stafford of c.£40m. In addition, we estimate that we would need to invest a further £58m in expanding capacity on the City General Hospital site to accommodate the more acutely-ill patients who would in future come north. In summary, our costs include bringing the physical environment and medical and other clinical staffing levels at Stafford Hospital up to current standards and fulfilling our vision for the integrated trust.

We remain committed to finding a way to deliver sustainable acute services for the populations of North and South Staffordshire, but clearly cannot put our current plans to achieve financial sustainability at UHNS at risk. We are therefore working on measures that can be taken to make the TSAs' clinical proposals financially sustainable. These include the following:

- mitigating the financial disincentives described above by maximising the amount of elective inpatient and day case work that would be carried out in new facilities at Stafford Hospital. We are concerned that the TSAs' proposals to expand elective facilities at Cannock will create more disincentives than exist in the present system and therefore cannot support the proposals.
- strengthening community health services in order to benefit patients who, evidence shows, recover more quickly at home, and reduce admissions to hospital and the time people need to be in hospital.
- undertaking a 'due diligence' process, which would give us a more detailed picture of the current services at Stafford Hospital and provide more opportunities to make the most of synergies and productivity improvements across the two sites. However, we are also conscious that it may equally bring to light more risks that would need to be addressed.
- in order to minimise transitional costs, it is

essential that decisions are taken quickly and the period of change is minimised. We have not as yet developed a detailed view of transitional costs but we recognise that this will need to be done as a matter of urgency once the outcome of the public consultation is known. We do not have the resources to meet transitional costs and would be seeking reimbursement for these.

Despite measures to improve financial sustainability at Stafford Hospital, many of the major services that the TSAs envisage being provided there do not relate directly to volume of activity. These include:

- the A&E department, which is open for a number of hours regardless of the number of attendances
- the Acute Medical Unit, which supports medical assessment and is essential to support A&E
- the Critical Care Unit, which is necessary to support the sickest patients.

If local CCGs support this model of care and commission these services, we will be seeking local pricing agreements that reflect the full cost of providing these and other services.

In conclusion, the TSAs' proposals for Stafford are clinically but not financially sustainable at present. The view of the UHNS Trust Board is that unless the Trust receives the level of funding required we will be unable to run safe, high-quality services at Stafford.

We will continue to work with the TSAs' and others to bridge the financial gap in the proposals.

SECTION 6 - CONCLUSIONS

Patients and local people have endured many years of uncertainty about the future of Stafford Hospital during which many staff have moved on and a number of key services have been adversely affected by the impact of unplanned change. For those staff who have remained, it has been a challenging period in which the ever-present spectre of adverse media coverage casts a shadow over their very real achievements and improvements achieved in recent years. During that time staff at UNHS have worked ever more closely with colleagues at Stafford Hospital to create more seamless care for patients.

Our networking arrangements have brought common standards and processes across our two hospitals and delivered better services to patients in areas such as Vascular Surgery and Urology. We at UHNS are keen to build on these and other achievements, working together with our colleagues at Stafford Hospital to integrate key services and create one hospital across two sites.

The longer that a decision is delayed on the future plan for Stafford Hospital, and the longer the delay in implementing that plan, the greater the risk that services at Stafford Hospital become destabilised and the greater the risk that quality and safety will suffer. An early decision on the future of Stafford Hospital is crucial in order finally to put an end to the uncertainty and mark a new chapter not only in the history of Stafford Hospital but also that of UHNS.

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