

REPORT TO : TRUST BOARD

AGENDA ITEM NUMBER:

6.1

DOCUMENT TITLE	Trust's Response to Monitor's Contingency Planning Team Report		
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PAPER APPROVED BY	Executive Committee		
DATE OF MEETING	28 March 2013	DOCUMENT DATE	21 March 2013

PREVIOUSLY CONSIDERED AT

Executive Committee

COMMENTS (IF ANY) FROM THE ABOVE COMMITTEE / BOARD / GROUP

The Committee supported the key themes of the response.

EXECUTIVE SUMMARY (INCLUDING KEY ISSUES, RISKS AND BENEFITS)

Monitor has received the report of the Contingency Planning Team (CPT), summarising their recommendations for the future configuration of clinical services that would ensure clinical sustainability and financial viability.

This was shared with MSFT Trust Board (in private) on 5 March 2013 and made public by Monitor. The Executive team have developed the attached draft response to the CPT's report and the Executive Committee provided their comments which have been incorporated within the attached draft response.

If approved by Board, the Trust will submit its response (which includes questions, comments and suggestions for other options) to Monitor and, if appointed, to the Trust Special Administrator.

For reference, also attached at appendix 1 are the "red lines" previously agreed by the Board and included within the Chief Executive's report to the Board on 31 January 2013, in public.

RECOMMENDATION CATEGORY *(Indicate with X)*

Approve	<input checked="" type="checkbox"/>	Assure	<input type="checkbox"/>	Note	<input type="checkbox"/>
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RECOMMENDATIONS

To approve the Trust's response to Monitor's Contingency Planning Team final report regarding Mid Staffordshire NHS Foundation Trust.

ALIGNMENT TO FIVE KEY PRIORITY THEMES (*Indicate with X*)

Creating a culture of caring	
Seeing zero harm as our target by keeping patients safe	x
Listening, responding and acting on what our patients and community are telling us	x
Supporting our staff to become excellent, giving responsibility but holding to account as well	
Satisfying our regulators	x

ALIGNMENT TO CARE QUALITY COMMISSION CORE OUTCOME STANDARDS

(*Indicate with X*)

1	Respecting/involving people who use services	x	10	Safety and suitability of premises	x
2	Consent to care and treatment		11	Safety, availability and suitability of equipment	
4	Care and welfare of people who use services	x	12	Requirement relating to workers	
5	Meeting nutritional needs		13	Staffing	
6	Co-operating with other providers	x	14	Supporting staff	
7	Safeguard people using services from abuse		16	Accessing/monitoring quality of service provision	x
8	Cleanliness and infection control		17	Complaints	
9	Management of medicines		21	Records	

Mid Staffordshire NHS Foundation Trust

Draft Response to Monitor's Contingency Planning Team (CPT) Report (March 2013)

1. Purpose of this report

This report has been prepared on behalf of the MSFT Trust Board in response to the Contingency Planning Team's (CPT's) report (dated March 2013) presented to Monitor. The CPT report makes recommendations about the future configuration of MSFT services so that they are clinically sustainable and financially viable in the future. Once approved by the Trust's Board, this response will be submitted to Monitor and the Trust Special Administrator (TSA) (if appointed) to provide further information to influence the final recommendations made by the TSA to the Monitor and then to the Secretary of State for Health.

2. Structure of this report

The main body of this report comprises five components:

- A series of recommendations the Trust Board would expect the CPT and the TSA (once appointed) to take into consideration before finalising any proposals
- The Trust's interpretation of the recommendations contained in the CPT's report relating to the future configuration of services currently provided by MSFT
- The Board's overall comments on the CPT report as presented
- A comparison of the CPT report to the report (dated 26 February 2013) of the Working Group led by Mr Jeremy Lefroy, MP for Stafford and, the "Improving Services for Patients Across Staffordshire" paper (also known as the Board's "red lines" paper, attached as Appendix 1) which was approved by the Trust Board on 1st November 2012
- Specific questions and comments on individual elements of the CPT's report

3. MSFT Board Recommendations for Future Reconfiguration of Services

3.1 All of the following recommendations are made on the provisos that:

- the safety and quality of care and patient outcomes and experience are equal to or better than that already provided at Stafford Hospital and Cannock Chase Hospital (CCH)
- other providers have the commitment to deliver the recommendations within the agreed timescale

3.2 CCH and Stafford Hospital sites should be utilised in preference to building new estate elsewhere.

3.3 Stafford Hospital should be merged with another specialist acute hospital and clinical services networked between the two sites. Wherever possible, clinicians should travel between sites – not patients. A clinical service strategy should then be developed which helps alleviate capacity shortfalls elsewhere and utilises estate at Stafford Hospital.

3.4 CCH should be offered to a best practice NHS provider, if possible a local one, to own/operate and clinical services integrated with the new provider.

- 3.5 Cannock Clinical Commissioning Group (CCG) should commit to using CCH site both for hospital activity and, if needed, relocate community and social care activity. The term “services in the locality” which has been used by the CCG and the CPT is confusing to the public. CCH is a good facility and should be retained and utilised for both acute and community activities.
- 3.6 It is absolutely essential that acute medicine (including care of the frail elderly) is retained on the Stafford site, given the current population and future demographics in South Staffordshire.
- 3.7 The definition of an Emergency and Urgent Care Service (EUCS) needs to be defined, by the Commissioners. The clinical services which then are needed to support an EUCS can then be defined. However, the EUCS is defined and commissioned it will need to be networked/merged with another acute hospital or with a community service if the EUCS is defined as a Minor Injuries Unit (MIU)).
- 3.8 If an EUCS (which was more than a GP led MIU) and acute medicine were retained on Stafford site, this would need suitable clinical infrastructure, including Intensive Therapy Unit (ITU) Level 1/2 beds. The Board does not consider acute medicine, emergency and urgent care or ITU could remain as standalone services and recognises that these would need to be networked (as a minimum) with another acute Trust.
- 3.9 The CPT scope did not include a review of organisational form. However, if organisational form were considered then this would open up other possibilities for the configuration of clinical services that could be financially viable and clinically sustainable. No decisions about clinical services should be taken unless organisational form has been considered.
- 3.10 The Paediatric service should become more community focused and there are several options which should be explored which include retaining a local Paediatric Assessment Unit that should be networked to another Trust.
- 3.11 Obstetric services should be maintained at Stafford. It would not be viable to continue to provide midwifery led services only on Stafford site as there would be insufficient mass to maintain (circa 400 births per annum) a sustainable service. Any obstetric service should be networked with another Trust.
- 3.12 Whilst the national policy is to increase care in the community, which would lead to a reduction in acute beds, it is our view that the current community, primary and social care services are not sufficiently robust at this time to facilitate major changes in acute services. Therefore, before any changes are planned it is essential that existing and future capacity and capability for change in these services is tested.

4. Summary of Recommendations of the CPT report

- 4.1 Table 1 below outlines the Trust’s interpretation of the future proposals for services at Stafford and Cannock Chase Hospitals (CCH) based on the information provided in the CPT report. The table compares the current composition of services in CCH and Stafford Hospital to the future configuration proposed in the CPT report.

Table 1 – Comparison of current versus future services for MSFT

CPT RECOMMENDATIONS

Stafford

Cannock

<ul style="list-style-type: none"> • Now <ul style="list-style-type: none"> • 14/7 365 Day A&E • Maternity • Critical Care • Paediatrics Assessment/Inpatient and Daycases • Elective and Non Elective Inpatients • Elective and Non Elective Surgery • Acute Medical Inpatient – Elective and Non Elective • Daycases • Outpatients • Care of Elderly • Diagnostics • Therapies • Clinical Support Services (Pharmacy etc) 	<ul style="list-style-type: none"> • Now <ul style="list-style-type: none"> • Minor Injuries Unit • Rheumatology • T&O Day Case / Short Stay • Outpatients • MRI • Rehab and Elderly Care Inpatients • Step Down • Community Ward • Therapies • Clinical Support Services
<ul style="list-style-type: none"> • After – Core element <ul style="list-style-type: none"> • 24/7 Emergency and Urgent Care Centre (Incorporating GP Out of Hours) with 50% reduction in current activity • Outpatients • Clinically Appropriate Day Cases • Intermediate Care Beds (50-100 but recommending 50) • Therapies for Intermediate Care and GP Direct Access • Diagnostics • Clinical Support Services 	<ul style="list-style-type: none"> • After – Core element <ul style="list-style-type: none"> • Nurse Led Minor Injuries Unit • Outpatients • Clinically appropriate Day Cases • Clinical Support Services
<ul style="list-style-type: none"> • After – Potential Add On <ul style="list-style-type: none"> • Hub for primary and Community Services • Elective IP Activity (current or other providers work) 	<ul style="list-style-type: none"> • After – Potential Add On <ul style="list-style-type: none"> • Hub for primary and community care services • GP led intermediate care beds • Elective IP Activity (current or from other providers) • Assumption that these add ons will require therapy support

4.2 The CPT report makes a clear distinction between Core and Add on Services. In no part of the report are these brought together into one model and the report uses differing definitions of services, particularly around Emergency and Urgent Care. The above model interprets the information on Figure 7 (page 50) and in subsequent paragraphs of the CPT report.

5. Overall Board Comments regarding the CPT Report

5.1 The Board disagrees with the downgrading of services at Stafford Hospital as dramatically as has been proposed. It should not be all or nothing and indeed finding innovative solutions is important as other small/medium District General Hospitals (DGHs) face the same difficulties.

5.2 The Board agrees with the widely held view that acute hospital services need to change and, as a small DGH, this change applies to MSFT which cannot safely sustain clinical services without change and without networking with other hospitals. The Trust's clinical sustainability and financial viability has also been affected by its historically poor reputation and the lower levels of income caused by a general reduction in GP referrals and activity over recent years.

- 5.3 The potential solutions required to address the risks identified are not within the gift of MSFT alone. The necessary changes will require clear commissioning decisions by CCGs and cooperation from neighbouring hospitals, community healthcare providers and ambulance providers and social care.
- 5.4 Monitor and the TSA have no power over non NHS Foundation Trusts or the Clinical Commissioning Groups (these are accountable to the National NHS Trust Development Agency and the National Commissioning Board). Therefore the Board is concerned that the TSA does not have the necessary powers to ensure the required changes (once agreed) are delivered to the timescales agreed. Having said this, the Board believes implementation of the final recommendations, need to be done quickly to minimise the risks of destabilisation. An advantage of a TSA could be that this could be done more quickly under their powers and with their available resources.
- 5.5 The Board is concerned about the risks to governance, safety and quality of clinical services whilst the service changes are being discussed, consulted upon and implemented. This continued uncertainty, in addition to the recent media attention, affects staff morale and places continued pressure and stress on our staff who, despite these unprecedented pressures, continue to work hard to improve and maintain the quality of care and service to our patients. Since the publication of the report we have had a number of reference requests for key clinical staff in emergency and critical care areas.
- 5.6 We are delighted that through the efforts of the staff the Trust has no conditions from the Care Quality Commission. However, clinical services could become fragile as staff leave to seek job security elsewhere. This may result in unplanned service change and/or a deterioration in service quality. Unplanned changes would put further pressure on other local hospitals and services.
- 5.7 The ability to negotiate effective contracts with suppliers and maintain supplier relationships has been made more difficult and will continue.
- 5.8 Given the well documented four national tests required for service reconfiguration [1], it is disappointing to see no specific mention of these within the report and how these are to be met.
- 5.9 The context in which the report has been prepared is lacking. Disappointingly, Robert Francis recommendations are not referred to, quality outcomes and patient experience are not mentioned within the report.

[1] DH Gateway Reference 14543: The Secretary of State has identified four key tests for service change which include support from GP Commissioners, strengthened public and patient and local authority engagement, clarity on the clinical evidence base and consistency with current and prospective patient choice.

- 5.10 Information about the quality of services of other providers is not included in the report, in particular any current Care Quality Commission conditions. Quality should be assessed service by service.
- 5.11 The capacity and capability of other providers is not fully explored, neither is the timing of increase additional capacity elsewhere.
- 5.12 The report is unclear about the final vision and detail for clinical services. This makes it difficult to assess both the financial impact (which is lacking in the report) and the impact on quality, safety and patient experience. Expectations and measures of success for the change are currently missing and would need to be included in the final recommendations.
- 5.13 At the start of the process the Board submitted, to the CPT, its recommendations for which services it thought should be networked, and which services it considered should continue to be provided at CCH and Stafford Hospital (MSFT Board paper dated November 2012). Disappointingly, this is not referenced in the CPT report and does not appear to have been considered.
- 5.14 None of the initial proposals appear to have considered either the potential for networking or repatriation of activity into Stafford or CCH. This would still require a change of organisational form (to address reputational issues and GP support) but could make better use of the estate and retain some acute services locally.
- 5.15 For completeness and transparency the report should reference the current CCG commissioning budget and spend.
- 5.16 There is a lack of detail and robust plans/guaranteed support from other hospitals and the community should acute inpatient and maternity services no longer be provided at Stafford Hospital or CCH.
- 5.17 Travel times and the impact on the Ambulance Service and Social Services do not appear to have been properly considered. Neither does the impact on access to services on those who do not have access to a private car or ambulance transport.
- 5.18 It is deeply disappointing that despite working with the Clinical Commissioning Groups (CCG) over the past 12 months the CCG have not yet defined their vision for Emergency and Urgent Care Services (page 70).
- 5.19 Changes, as suggested by the CPT report, do not consider the impact on pre and post registration nurse or doctor training, the availability of key staff, potential workforce redesign and on the Educational Providers. Reconfiguration of services would impact on the availability of training places for Junior Doctors. DGHs are considered to be good training grounds for doctors.
- 5.20 NHS Commissioners' two challenges for 2013/14 are:
- Challenge 1 - guaranteeing no community is left behind or disadvantaged

- Challenge 2 - treating patients respectfully as customers and putting their interests first

How does this report and the Clinical Commissioning Groups' list of protected services address these challenges?

5.21 Whilst the report references engagement with the Trust Board it is important to note the scope, scale and outcomes from that engagement. For both the Clinical Advisory Group (CAG) and the Operational and Finance Groups (OFG) (the fora at which the majority of the board level engagement took place) these meetings were limited in number (3-4 sessions), time (1 ½ - 2 hours each), attendance and interaction. The meetings lacked detail and were constructed in a way that did not allow for alternative solutions or challenges to be discussed.

6 Comparison of CPT Report, Working Group Report and Improving Services paper approved by MSFT

6.1 The CPT report makes reference to consultation with a number of stakeholders including the Trust Board and the Working Group led by Mr Jeremy Lefroy MP. Both have produced reports stating what they believe are the services that should be retained. For the Trust Board this report covers both Stafford and Cannock (attached as Appendix 1). For the Working Group this report covers Stafford Hospital services only.

6.2 All parties start from the premise that Mid Staffs NHS Foundation Trust is no longer clinically or financially viable, as stated in the first report from the CPT. The table below demonstrates the views of the various parties regarding future service provision.

Service/Option	Trust Board Paper	Working Group Paper	CPT Report
A&E	✓ Current model or EUCS model agreed with commissioners and appropriately networked	✓ current model or hybrid model	X although model of Emergency and Urgent Care Service needs TBC
Urgent Care	✓	✓	✓
Maternity Care	✓ with future networking	✓	X
Paediatrics	✓ community focused and clinically networked	✓	X
Outpatients	✓	✓	✓
Elective Day Case	✓	✓	TBC
Obstetrics	✓	✓	X
Elective Surgery	✓ with appropriate clinical networks	✓ subject to partnership working	TBC
Non Elective Surgery	X	X	X
Repatriation of Activity to MSFT as an option	✓	✓	X

6.3 The CPT report has not provided clarity on the future of Emergency and Urgent Care Services (EUCS), Day Case or Inpatient provision therefore a comparison cannot be made.

6.4 The Commissioners have said that the needs of the population are ambulatory care, 24/7 minor injuries, immediate services for elderly care. The Trust would want to develop a service model which satisfies the needs of the Commissioners and retains appropriate services on site which would remove the need to take all acute services elsewhere.

7. Queries and Comments regarding the CPT report

The report requires further detailed analysis for some of its assumptions. On reviewing the report the Trust have the following questions and queries that require further clarification.

Paragraph/ Page Reference	CPT report comment	Comment/Question
Para 1.1 Page 2/3	Patients would benefit from the establishment of local hospitals in both Stafford and Cannock. This would offer local access to regularly used services. CPT recommends the consolidation of emergency and specialist services into larger more specialist hospitals in the area and closer integration of acute, community and social care.	Detail is needed about what are “regularly used services” and closer integration. The Cannock CCG has said that they wish to have services in Cannock, although not necessarily using CCH. How do these statements fit together? What scale/scope of integration is required to allow the proposals to be successfully implemented? Is this realistic given the timeframes proposed and the evidence base for such strategies?
Para 1.2 Page 3	Catchment population is 210,000	The Trust current uses a catchment population figure of 276,500. Demographic growth should be based on long term projections longer than the 10 years quoted – in particular the proposed growth from the extension of the military garrison. This is particularly relevant to maternity services.
Para 1.4 Page 5	Both CCGs have stated their intention to shift care away from acute hospitals into community and home based services through their commissioning.	The Trust supports the aim to care and treat patient’s closer to home/in their own home, although the cost benefit of this policy is still to be proven. Whilst this is a laudable intention there is little evidence of this being done successfully, either nationally or locally and robust plans must be in place before this could happen. What are the inter dependencies to facilitate the proposed changes occurring. How is the risk of this strategy not being implemented successfully been considered/mitigated?

<p>Para 1.5.1 Page 6 Para 1.5.2 Page 7 Para 1.6 Page 8</p>	<p>Centralise where necessary</p>	<p>Whilst medicine and surgery becomes more specialised there are alternatives to centralising services onto one site and making patients travel for less complex treatment. Through clinical networking (and possible merger of services across hospitals or organisations) it would be possible to maintain services on non specialist hospital sites and for clinicians to travel to see patients, provided the right infrastructure was in place.</p>
<p>Para 1.5.2 Page 7 Para 3.3.1 Page 26 Table 10 Page 34</p>	<p>Stafford would include a clinically appropriate 24/7 Emergency and Urgent care services. Although the report uses various definitions of Emergency and Urgent Care. CPT conclusion 3: Commissioners wish to commission 24/7 emergency and urgent care service in Stafford</p>	<p>This is not defined clearly within the report. It is also deeply disappointing that the report now awaits the review (led by Bruce Keogh) when the CCG has been developing its service specification for an Emergency and Urgent Care service for over a year, the development and concept of which the Trust has supported. How can decisions be made about which clinical services should remain on Stafford site without that clear definition?</p>
<p>Para 1.5.2 Page 7</p>	<p>The description of Stafford and Cannock services.....</p>	<p>Some of these are ill defined. For example intermediate care beds are referenced here and later in the report (the figure of between 50 to 100 intermediate care beds are mentioned). On what planning basis have these numbers been made? Would these beds be based across both CCH and Stafford Hospitals or on one site? It is difficult to understand how these figures have been arrived at and how the number and location(s) impact on financial and clinical sustainability. There is also a risk that in reducing the size and type of services on both sites would impact on the recruitment and retention of quality staff. The medical staffing model for the intermediate care beds (eg GPs, Geriatricians or Acute Physicians) for is not described. Once described, it is important to ensure that there is appetite by GPs to manage these beds (if to be GP led).</p>
<p>Para 1.6 Page 9 Para 1.7.1 Page 9</p>	<p>The CPT has assessed that over 80% of the current patient attendances to either Stafford Cannock</p>	<p>The report does not define on which classification of patient activity this is based, although it is assumed it is outpatient and day cases. This needs</p>

	hospitals will remain within the same locality	clarification and should make clear the impact of travel and attendances on transferring inpatient services. The Board would want to see more of a focus on the 20% who would be required to travel. For what? How often? How is the impact on these individuals been factored into these proposals? The reference that the majority of patients remain unaffected is misleading
Para 1.7 Page 10	Private car travel times would increase, but remain comparatively low. Enhancement to mitigate the impact of changes for patients using public transport	Impact on private car travel times needs to be defined. Impact on public transport travel times need to be defined and described and the mitigation needs to be described and implemented before changes are made.
Para 1.7.2 Page 10	The operation of local hospitals can be financially sustainable. However, this can only be achieved with significant reduction of the current cost base and in line with the proposed clinical models.	Have the current clinical proposals for both sites been modelled into the current estate and costs that could be released by reducing the footprints of the estates be estimated? If so, what is the net gain? It is difficult to see how this can be delivered from the information presented in the report.
Para 1.7.3 Page 10	The proposed reconfiguration could make a positive financial contribution to other providers in the local health economy – that is the revenue associated with the increase in activity will cover the cost of delivery.	The financial modelling to support this statement is not included in the report and therefore it is not possible to understand the basis for this statement. It was never an objective of the review to improve the financial position of other local providers.
Para 1.7.3 Page 10	There are currently some capacity constraints across the local health economy	This is a gross understatement of the pressures that hospitals and the ambulance service are under. The Board would ask for a more detailed review of these current pressures and that future projections need to be taken into consideration.
Para 1.7.3 Page 10	The additional capacity would need to be developed over time and services moved when the required capacity is available.	This assumes that other Trusts would need to build in some additional capacity. This would require capital and revenue. Has the costs of these been modelled and compared to existing costs? The Board is greatly concerned about timing of change and sustainability of services in the meantime.
Para 1.7.3 Page 11	Ideally, much of the	There is little evidence, nationally and

	required capacity could be created through redesigning services across acute, community and primary and social care, leading to both lower demand and improved length of stay in hospitals.	locally that care has been transferred from hospital into the community and the cost benefits of doing so are not proven. To achieve this on the scale required would require health economy leadership which is not evident in Staffordshire and would require sustained and long term efforts (far beyond the appointment of a TSA)
Para 1.9 Page 12	The CPT believes implementing its recommendations in full could take up to 3 years, at an estimated cost that could exceed £60m	The costs associated within the changes are not fully recognised - £60m as an estimate feels some way short of what the true figure will be and needs to be addressed as a matter of urgency. What does this cost include? Is it capital and/or recurrent costs and does this include necessary investment elsewhere? Change over a 3 year period would bring significant instability to services at CCH and Stafford Hospitals, could undermine quality and safety and income as patients and GPs decide that hospital services will be closing and refer elsewhere.
Para 2.3.4 Page 17	CPT Conclusion One: A major acute hospital in Stafford will not be clinically sustainable	This presumably assumes a standalone hospital. However, maintaining Stafford hospital should be considered as part of a merger with another acute, specialist hospital.
Para 3.2.1 Page 24 Para 3.4.1 Page 29	Tables 2-8 present an overview of the other providers There is a general unease/lack of confidence about the other providers in the local health economy, especially in light of recent news of mortality rates and the financial position in some of the local providers	Disappointingly this information does not include data about the quality of services. The report does not seek to define what these confidence concerns are or the mortality rates No services should transfer unless patients could be assured it would be at the same or better level of quality. The review of quality should not just be at a provider level but should be assessed at service/specialty level. Detailed modelling of current service provision (both finance and quality) alongside future forecasts based on the proposed service changes should be conducted for each of the local providers. This should include a number of reasonable downside scenarios with appropriate mitigations identified.
Para 3.4.1 Page 29	Many stakeholders are clear that they do not want these changes to be used	The Board expressed this view in its "red lines paper", explaining that the local health economy was electively

	as an excuse to introduce private sector providers, although when challenged very few stakeholders can explain why they hold this view	over provided for and new market entries (ie private sector) would further increase the financial instability of trusts in the locality because it would take market share in elective care where most trusts made a “profit” and this supported emergency and urgent care costs. It is disappointing that the CPT appear not to have listened to the rationale of the MSFT paper
Para 3.4.1 (1) Page 29	If there is spare capacity/empty wards with CCH why can't MSFT bring in more activity and consequently revenue	MSFT have asked but have not seen the CCG/PCT spend on elective activity (although had recommended this to the CPT) so is unable to comment what, if any income and activity the CCG/PCT could redirect from outside the area to support this aim.
Para 3.4.2(1) Page 29	Were MSFT to operate more services at either site, assuming commissioners were able and willing to pay for those services – then it would need to bear the cost of providing those services. It is quite conceivable that, especially in light of the higher than average cost base, these services would cost more money to operate than the revenue the Trust would receive	This is a flawed assumption. Has there been any financial analysis of this against the capital and revenue costs of moving services and having to build additional capacity at other sites? If not, there should be before final decisions are made. Many of the issues underpinning the poor financial performance stem from poor utilisation of the estate. Growth, if commissioned, would make a positive contribution to the financial position of the Trust.
Para 6.1.1 Page 45	The CAG deemed that the “warm site” option in Stafford was clinically undesirable	This assumed that the surgical services and/or organisations were not networked or merged. Once a decision is made about surgery then the report adopted a thought process that then said (Critical Care Unit (CCU) becomes unviable and without CCU unselected medical take and a consultant led obstetrics service becomes unsustainable.
Para 6.1.1 Page 46	Report Comments – “In January 2013 the NHS Commissioning Board commenced a review (being led by Sir Bruce Keogh, MD of the NHS) into the model of urgent and emergency services in England	Having checked, although high level principles will be set out in Summer 2013, the final outcome of this review is not expected until Summer 2014. Advice from Sir Keogh is to continue to find local solutions not wait for the national report.
Para 6.1.2 Page 46	The conclusion of CAG was that it [a standalone midwife led unit] was not viable	The Board agrees that a standalone midwife led unit is not viable. However, it does believe that

		networked to another unit Obstetrics could be viable, in their current form at Stafford.
Page 50, Figure 7	The table suggests that Therapy provision will only be available for Inpatient and intermediate care provision.	The table and remaining document makes no reference to Outpatient Therapy support at CCH or Stafford Hospital. Would outpatient therapy be provided at either of these sites?
Page 55 Para 7.2.3	It is not clear how the travel times are derived – is this based on actual patient demographics or notional population numbers	If this is based on notional population numbers – has the travel time calculation taken into account the impact on the most frail and vulnerable ?
Page 58	The report does not make any reference to a PAU (although the slide pack presented to Trust Board on the 5/313 did)	Under these proposals are Paediatric Inpatients and/or a Paediatric Assessment Unit (PAU) retained on the Stafford site?
Page 58 Para 7.2.4	The case studies make no reference to maintaining quality through these proposed changes	Under the proposals how will the quality of services be measured to ensure there is no deterioration?
Page 71 Bullet Point 4	The report makes reference to Clinically appropriate Day Cases but there is no clear definition of the process and this could significantly impact on the “80%” assumption re patient travelling time	How does the CPT define “clinically appropriate” day cases? Whose decision is this, the Administrator or any potential Trust taking on CCH and/or Stafford or the CCGs? If it is the potential Trust who takes on CCH and/or Stafford how will the CPT ensure equity of access for patients? (i.e. if separate Trusts run Stafford and CCH there could be the potential for no provision of certain specialties on either site. This would further increase the 80% assumption around services remaining, and increase patient travelling time.

Generic Comments / Concerns from the Report
The assumption that recurrent 4% efficiencies can be delivered year on year through this period is high risk. All available evidence suggests costs increase through large scale change programmes/re-structuring.
The Board would question the view that the services proposed could be profit making if operated out of both the Cannock and Stafford sites. Doing less activity at a lower level of income could potentially exacerbate the current losses.
What are the assumptions around “rightsizing” and required capital investment? The required staffing models and at what salary scales? the impact of changes in tariff income (ongoing deflation, year of life tariffs, unbundling, best practice tariffs etc).
What sits beneath the assumption of a 30% reduction of the cost of capital? Could any

reductions made as a result of “rightsizing” be largely offset from the increased capital charges required for implementation?
MRI as a modality of diagnostic services at Cannock is not mentioned in the report – is this an omission given the new scanner having just been sited there?
What assumptions have been made regarding income? Particularly non SLA income and CQUIN? It is unlikely that the proposed service portfolio could attract much of either.
The assumption that local providers can absorb additional activity without additional investment (over and above tariff) does not reflect local discussions.
Current commissioning intentions for 2013/14 include the request to develop podiatric surgery and the takeover of Dermatology services for the health economy. How is this reflected?
The 24/7 EUCS – What assumptions have been used to assess income and expenditure impact of this service? Currently loses circa £3-4m per annum?
The efficiencies from potentially merging management structures and back office functions appear high at circa £10m? Where is the evidence that changes in organisational form would deliver savings of this level previously?
It is difficult to see who MSFT could potentially merge with or get taken over by? All local, alternative providers have some combination of either financial or operational/clinical difficulties/concerns.
The financial base line for 2015/16 set at £17m deficit is optimistic. We are facing the removal of circa £5m SCR monies and the instability likely to be caused by the notified changes is likely to increase costs. This is well evidenced in case studies of similar change programmes.
How does the CPT recommendation consider the 5 “offers” (as per the Operating Framework) that commissioners should consider in planning future services?
Has the CPT considered the IT infrastructure costs to ensure effective sharing of patient information across all sites?
The margin of circa 30% based on the service portfolio and likely costs associated with the required changes that would need to be funded appears optimistic.

8. Conclusion

The Board of Directors recommend to Monitor and Trust Special Administrator, if appointed, that this report and the recommendations within it are taken into account when considering the future provision of clinical services for patients and service users within our local health economy.

Appendix 1

The Board's view – previously agreed and known as “the red lines”

The Board previously discussed and formed a view about which services were required in Cannock and Stafford and had made these views known to the CPT to inform their review.

The Board's view was that:

- Emergency and urgent care medicine is needed at Stafford
- The emerging plans to develop an Emergency and Urgent Care service is the right direction of travel, particularly in light of the Commissioners decision not to re-commission a 24/7 A&E. Once finalised further consideration is needed about a clinical network for this service.
- Community and primary care services need to develop further so that patients can access emergency and urgent care and avoid emergency admission and receive more care in the community.
- Maternity care – both obstetric and midwife led care should continue at Stafford.
- Paediatrics should become more community focused and clinically networked.
- A number of MSFT clinical services should be networked to other hospitals to ensure sustainability.
- A health care presence is required at Cannock Chase Hospital, albeit the services may need to change to meet the health needs of the local population. The premises do not necessarily need to be owned or operated by MSFT.
- Vertical integration with community services could improve patient care and financial viability.
- Infrastructure – transport, links to community and social services must be considered in the planning of any changes.