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Professor Hugo Mascie-Taylor
Mid Staffordshire Foundation Trust Special Administrator

22 July 2013

Dear Hugo,

OPINION OF THE MSFT NATIONAL MEDICAL CLINICAL ADVISORY GROUP

I am writing to give you the views of the medical Clinical Advisory Group (CAG) on the Mid-Staffordshire Trust Special Administrators' (TSAs) recommendations for the future of services currently provided by Mid-Staffordshire NHS Foundation Trust. These are shortly going out for public consultation as part of the Monitor Trust Special Administration process.

Background and Terms of Reference

The TSAs asked the Academy of Medical Royal Colleges to facilitate a national Clinical Advisory Group of senior medical consultants nominated from medical Royal Colleges to provide them with independent advice.

The Academy and Colleges were very willing to accept the invitation to work with the TSAs because we believe it is essential that any changes to the configuration or provision of health services should be informed by clinical expertise and do not reduce clinical standards and safety.

As a group of independent doctors we had to be very clear about our role in relation to this process and what could or could not be expected of the CAG. This was set out in the published terms of reference that were agreed for the CAG.

It was not the role of the group to devise its own proposals for services currently provided by Mid-Staffordshire Foundation Trust. Neither was it our role to make judgements or recommendations on the relative costs and benefits of proposals.

We were asked to provide advice on the basis of available evidence, standards and current practice in the UK for ensuring the safety and quality of clinical services for the benefit of patients.

Specifically the CAG was asked to review three proposals presented by the TSAs and comment on:

- The clinical safety of proposed schemes
- The extent specific proposals would or would not support the recruitment, retention, training and continuing professional development of appropriate medical staff
- Whether or not proposals move services closer to College clinical standards.

In considering the proposals the CAG was clear that, in general, safety is not definable as a simple choice between safe and unsafe. In many, but not all areas,

there is a sliding scale of gradation of safety. If therefore, we state that one set of arrangements is safer than another that does not automatically imply that the second proposals are unsafe.

However, whilst examining individual speciality services in turn, our considerations have also taken due note of the interdependence of many acute services on other disciplines. The important relationships of cross and inter-disciplinary working contribute to safe and high quality services and are an important feature of modern medical practice, thus influencing our assessment.

We know the TSAs have worked very hard to identify a solution that is clinically sustainable and which seeks to retain, where possible, local services for the local population. The TSAs have engaged with the CAG through a series of meetings and discussions. I believe the CAG has advised and challenged the TSAs, in keeping with our remit, as they have developed their recommendations.

Proposed models
We considered three separate proposals put to us by the TSAs. As this was how we referred to them during our discussions I am calling these:

- The Trust Special Administrator (TSA) model which is what is now being recommended
- The "Local Specified Services" (LSS) model which contained the minimum requirement identified by the local CCGs
- The Contingency Planning Team (CPT) model suggested by the CPT following its review of the Mid-Staffs services.

The TSA Model
We have commented on proposals that are broad in nature and we recognise that there is more detail to be developed over the coming weeks. It is important that the CAG is satisfied that the detailed proposals do not bring up any unexpected problems which would raise concerns about safety. We would therefore expect the opportunity to comment on the detailed proposals in due course.

The CAG is, however, satisfied that the proposals the TSAs have recommended are founded upon principles that should deliver a clinically safe and sustainable solution for services at Stafford and Cannock hospitals for patients and staff.

We believe that if medical staff are properly deployed as part of a rotating network between the Mid-Staffordshire and another large secondary care site(s) as appropriate this would provide improved opportunities for the recruitment and retention and continuing development of doctors.

If the proposed arrangements for medical staffing are to include doctors in training it must be ensured that they provide the required learning and experience and that supervision is compliant with the GMC standards.

We believe that, if implemented fully and effectively, the proposals taken as a whole would bring services in the local area more in keeping with College clinical guidelines and standards.

It will be essential to develop and follow very clear protocols across specialties in terms of when it will be safe to provide care at Stafford or Cannock and when the safe solution would be to transfer or refer patients to larger centres.

The LSS and CPT models
We had a number of comments that applied to both these models.

Safety and capacity of services in the health economy
Both models propose to considerably reduce services in Mid-Staffordshire particularly with the closure of A&E. The CAG has considerable concern about the implications on other providers who would have to pick up this work. From what we have heard we have serious doubts that there is the capacity in the system for other local providers simply to absorb this emergency and acute medicine activity. We would therefore have concerns about the safety of care in other local areas if these models were adopted without significant support for those providers expected to take on activity no longer occurring in Mid-Staffordshire.

The CAG felt that services would be further from rather than closer to College clinical guidelines and standards with these two models, albeit recognising that such standards are mainly aspirational rather than absolute.

Recruitment and retention of medical staff
The CAG felt that the LSS and CPT models in overall terms would make it harder to recruit and retain consultants at Mid-Staffordshire because the range of the posts and services would be less attractive. There were also concerns as to whether the required middle grade (i.e. non trainee) doctors would be readily available. The CAG did, however, recognise that the removal of A&E services would also remove the recruitment/retention issue for those staff in Stafford. It might therefore make recruitment and retention easier at surrounding hospitals.

Our comments on the specific models were:

LSS Model
We had concerns at the proposal for a stand-alone geriatric unit at Stafford without acute care back-up. With a “Step-Down” facility the selection of appropriate patients becomes crucial – and potentially subject to dispute. To be safe senior medical staffing would have to be provided on a networked basis.

With the proposals for Cannock there was considerable concern about how night-time cover and support would be provided. The Group was clear that no ASA (American Society of Anaesthesiologists) Level 3 cases should be handled. The Group was also clear that the services should not be dependent on trainees.

The management of transition to this model would be crucial.

CPT Model
In respect of services at Stafford, there was greater concern about the “enhanced intermediate care” (“Step-Up”) for elderly patients without availability of 24 hours acute back-up. The selection of patients would be complex and subject to disagreement.

There should be a limited rather than a full range of day cases offered otherwise it is impossible to guarantee that there will not be a requirement for admission when the

level of back-up available would not be adequate. In addition there should be clinical staff available with details of the individual patient's specific case to advise if discharged patients have complications and ring for advice. Advice should not be provided by a different centre without knowledge of the individual case.

The CAG had real doubts about the operational viability of the 5 day ward model. There would be a clear need for consultant availability to handle surgical complications.

In essence, increasing the level of activity beyond the routine and straightforward requires there to be a level of interdependent back-up services that are not proposed in this model.

The concerns over the CPT proposals for services at Cannock were the same as those with the LSS model proposed for Cannock

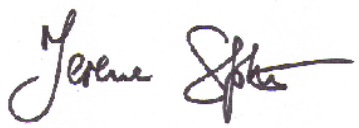
Conclusion

In conclusion the CAG was clear that both in respect of the services that would be provided at Stafford and Cannock and also because of their implications for other organisations the CPT and LSS models were intrinsically less safe than the TSA model. As stated earlier we believe, on the evidence that we have seen, that if implemented properly the TSA model should deliver a clinically safe and sustainable solution for services at Stafford and Cannock hospitals for patients and staff.

Finally, the CAG felt that whilst the proposal we supported appears clinically safe these are not the only options that could provide clinically safe services. The Group was also clear that in expressing its views it is not formally endorsing any specific individual provider or organisation.

The local population of Mid-Staffordshire rightly expects to have access to high quality, clinically sustainable healthcare services. That is why I, and my colleagues on the CAG, are fully committed to continuing to work with the TSAs over the coming weeks as they consult the residents of Mid-Staffordshire and develop their final recommendations.

Yours sincerely



Professor Terence Stephenson
Co-Chairman National Clinical Advisory Group
Chairman Academy of Medical Royal Colleges