

31st October 2007

Mr John Wilderspin
CEO West Sussex PCT
The Causeway
Goring-by-Sea
Worthing
BN12 6BT

Dear Mr Wilderspin,

Response to 'Fit for the Future'

In September 2006 the consultants of St Richard's Hospital wrote to you with our thoughts on the reconfiguration process¹. Now, a year later, we are almost at the end of the formal period of consultation on three proposed options for change. We are now aware that subsequent developments are such that other options are under consideration. We will therefore confine our comments to general aspects of the reconfiguration and to making the case for St Richard's to be a Major General Hospital (MGH) in the future.

On this last point, we draw your attention again to our previous statement that "we are a cohesive clinical group who have a good track record of working constructively with our managers". To this we would add "and clinical colleagues elsewhere" and reiterate that we feel we can help facilitate the process of change to the benefit of the public. In saying this, we recognise the need to grow in order to sustain our top quality clinical services in the context of future financial developments and risks.

In supporting the reconfiguration proposals we recognise two specific significant financial drivers: the European Working Time Directive and expensive emerging technologies. The latter have always been an issue in healthcare and, in the past, smaller hospitals such as those in West Sussex have been at the end of the queue for central funding, or have acquired large items through local fundraising initiatives. Increasing public education via the internet, improved clinical governance and associated litigation makes it less acceptable than ever to allow our population to wait several years for such access to modern healthcare.

Both these drivers mean that small hospitals such as our local DGHs will be increasingly non-viable in the future, none of them having the critical mass to ensure the efficient deployment of the increased staffing requirements and expensive equipment.

As individuals, we have different and varying levels of concern around major restructuring proposals, but we all recognise that change in the form of some acute reconfiguration is inevitable. We therefore support planned and sensible change as a result of rational decision making rather than ignoring the inevitable and thereby risking a haphazard result as a consequence of indecision. To that end, we will make the case for St Richard's Hospital.

Quality of Care – Case for St Richard's

That St Richard's is a "top hospital" is irrefutable in the fact of so many current and past awards for high quality clinical care. This is especially impressive given the significant financial challenges of recent years. In business terms it makes sense to build on this, particularly as there is sufficient room to expand within the existing St Richard's estate.

Our Accident and Emergency (A&E) department has a prominent 7-day consultant presence and has not had to close in recent memory. It is well placed to receive casualties from our own area and further afield. It has two readily useable helipads and is able to take small and large helicopters. One helipad is immediately adjacent to A&E and does not require further ambulance transfer to the department.

We are a Beacon site for our acute medical admissions service, consistently achieving the shortest lengths of stay for emergency patients. We have a modern highly equipped cardiac catheterisation and angiography suite which is up to the standards required for interventional procedures and has the capacity to expand on current throughput. The radiology department performs an extensive and evolving range of interventional procedures and has many years of experience.

Our surgical and critical care services have the capacity to cope with the increased workload required of a MGH with an increased catchment population. We have a long and distinguished reputation for our vascular surgery service.

In obstetric services, bigger units offer greater breadth and depth of facilities and training opportunities. There is clear objective evidence that St Richard's has significant medical, neonatal nursing and midwifery experience in dealing with maternal and fetal medicine problems and high risk obstetrics. This includes experience with neonates born between 28 and 32 weeks gestation. It is important to recognise that there is a national shortage of staff with these skills. If the PCT decide to place the MGH elsewhere, they would need to ensure that these staff would be able and willing to follow, whereas placing the MGH at St Richard's should ensure the continuation and enhancement of this experience and maximise safety for the mothers and babies of West Sussex.

In conjunction with this, we have a well-staffed paediatric service, including two consultants with recent tertiary level experience, and an established nursing rotation to Portsmouth for tertiary experience.

The Trust experiences few difficulties in recruiting staff at all levels (we have a full A&E, Obstetric and Paediatric consultant establishment) and good relationships are maintained throughout the hospital while embracing multidisciplinary working. We train undergraduate medical and dental students from London, Brighton and Southampton and receive consistently good feedback from students and medical school training supervisors. As a result, the hospital is a top choice for junior doctors of all grades. The professional colleges and deanery have given us very favourable reports on the quality of junior doctors' training across a range of specialties and a 2005 survey of junior staff placed us joint 1st for training across the region.

Quality of Care – Risks of proposals under consultation

We have an established reputation for working together with our colleagues in Primary care. We support the proposals to move some (traditionally secondary care) services out into the community, but repeat our previously mentioned recommendations that you do not cancel existing arrangements before any new form of service delivery has been developed and fully assessed for safety and outcomes. Please don't be tempted to do otherwise and please recognise that past successes are at least in part due to the existing close working relationship between primary and secondary care. This has been built over many years and its continuation cannot be guaranteed following major disruption of service provision.

Since our last letter, the NHS Service and Delivery Organisation's (NHS SDO)² research paper on primary care delivery of secondary care services has been published. It concluded that "GP minor surgery may reduce quality of care" and "The merits of GP with Special Interests (GPSI) clinics require further investigation".

Proposals around emergency care also need further detailed work if they are to be successful. Not only will there be a need for clear and unambiguous guidance for triage by healthcare professionals in the community (including ambulance and primary care staff) but there will need to be a simple, easily accessed and oft repeated public education campaign to ensure that those who make their own travel arrangements know where to go.

An "Urgent Care Centre" needs full clinical and managerial definition. We are unhappy with the ambiguity in this title and would recommend the use of "Minor Injuries Unit" and/or "GP walk-in centre". Clarity is required as to the staffing and back-up provided for any "urgent care" centre which does not provide full A&E services.

Finance – Case for St Richards

At the start of the reconfiguration process, the PCT was facing a financial crisis. That seems less likely now, but the broader reconfiguration proposals are not likely to be cheap. It is therefore imperative that the PCT ensures that secondary care is provided in the most cost-efficient configuration to release the funds required to move services closer to the patients' homes.

The detailed discussions around finance have been long and protracted, and analysis of the data has been more than adequately done elsewhere³ (ref DW). The one unarguable fact is that the proposals in which St Richard's is a Major General Hospital are the most financially attractive.

Finance – Risks of proposals under consideration

The provision of secondary level care in patients' homes sounds like utopia, but it will not be without cost. We have already drawn your attention to the Birmingham study⁴ which shows that relocating services into primary care does not reduce demands on hospital services or reduce costs. This conclusion is also supported in the aforementioned NHS SDO paper. On top of this, there will be significant double-running costs during the transition period.

In none of the consultation documents have we seen anything resembling a robust business case for these proposals. We recommend that this be progressed without delay and with full involvement with the clinical staff who currently provide the service, and those who it is proposed will do so in the future. Without such involvement, the plans are at best doomed to failure and at worst to significant clinical risk.

Access – Case for St Richard's

St Richard's serves a catchment area of 340 square miles (44% of West Sussex). It is predominantly rural with a significant population base on the Manhood peninsula to the south. Even now, the ambulance service is not meeting its targets for our rural areas with only 23% of category "A" calls in one rural area meeting government guidelines and only 36% in the Witterings to the south.

Our population is predominantly elderly, many of whom no longer drive or have access to transport. These are the people who have the most need of acute services.

On top of our recognised established population we have a significant second home and tourist population (West Wittering beach is the biggest visitor attraction in the south, with more visitors than even Windsor Castle). These visitors often require health services. It is essential that they can access these readily, especially A&E, in an area unfamiliar to them.

Our local population is set to grow by over 10% by 2016. Behind this statistic are two even more significant statistics supporting the need for St Richard's to be the MGH,

retaining full A&E, maternity and paediatric services: in the same time frame, our population under the age of five will expand by 20.4% and over 84 years by 13.4%.

Brighton has a new paediatric hospital which is easily accessible to patients in the east of West Sussex. It therefore makes sense to keep full paediatrics services at St Richard's by upgrading it to a MGH. To do so will ensure that the increasing numbers of children in this western part of West Sussex retain the good access to excellent paediatric care that they receive at present.

Access – Risks of proposals under consideration

The poor road and public transport infrastructure in West Sussex is a recurring theme. This is a worry under both current services and reconfiguration proposals. It is a particular concern to our rural population where public transport is almost non-existent whereas those living in more urban developments are better served. Whatever the outcome of the consultation, the PCT should be making representation to those responsible for roads to add weight to the need to accelerate the road improvements required.

In summary, we urge you to take the decision to build on the already top quality services and teamwork of St Richard's Hospital and make it the Major General Hospital for West Sussex.

Yours sincerely

On behalf of the Consultants, Associate Specialists, Staff Grade doctors (108 signatures attached representing over 98% of the senior medical staff) **After posting, further signatures received equal to 100% support.**

1. Letter to Mr J Wilderspin 28th September 2006 (attached)
2. An assessment of the clinical effectiveness, cost and viability of NHS General Practitioners with Special Interest (GPSI) services
NHS Service and Delivery Organisation DoH September 2006.
3. West Sussex PCT and Brighton & Hove PCT “fit for the future” Re-organisation proposals: The Financial Picture
DM Waller review/Commentary August 2007
4. Making the Shift: Key Success Factors – A rapid review of best practice in shifting hospital care into the community
Debbie Singh University of Birmingham Health Services Management Centre
July 2006