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*Dear John*

## **West Sussex PCT “Fit for the Future” Consultation Proposals**

### **Introduction**

1. Further to my initial response dated 5 October 2007 concerning the consultation process, this letter is my response to the questions posed in the PCT’s “Fit for the Future” consultation paper concerning the three Options for the re-organisation of acute hospital services in W Sussex. In particular, it highlights my views as to whether or not the Options meet the key criteria of clinical and financial sustainability, and deliverability and accessibility, as well focussing on a number of perceived weaknesses which need to be taken into account by the PCT and the SHA before decisions are made.
2. I accept that the current arrangements are not sustainable, that changes may be justified on clinical and financial grounds, and that the closer that you can bring healthcare to people’s homes the better. There are nevertheless a number of ways in which healthcare could be organised, and the three Options proposed may not necessarily be the only ways forward. Also, I am not persuaded that the various discarded Options are as unsuitable as has been stated. This is especially because the consultation paper’s proposals are full of promise, but short on evidence, and hence do not inspire confidence.

## **Clinical Sustainability**

3. Whilst the consultation paper sets out a clinical case for change in respect of the acute hospitals, this view is not universally accepted by local clinicians, nor are all the proposals as soundly evidence-based as possible. The model of care seems to be an inflexible version of the financially-driven McKinsey model defined in 2005; a model which has not been adopted by either the E Sussex or the Surrey PCTs, albeit that they are part of the same SHA. The E Sussex and Surrey models are informed by similar clinical opinions and evidence as the W Sussex model yet, whilst the former have found some flexibility, the W Sussex PCT has taken McKinsey as absolute.

4. However, if the professional clinical opinions are fully justified and maintained, I cannot contradict the view that the Options are clinically sustainable. It would nevertheless have been helpful if there was more clear evidence as to just which changes are fully proven and therefore essential, and which changes fall into the desirable category.

5. Thus, if the clinical evidence is comprehensive and robust, I accept the overall model comprising a Critical Care Hospital (CCH) for tertiary care and a single Major General Hospital (MGH) in W Sussex for secondary care, supported by one (preferably two) Local General Hospitals (LGH). Notwithstanding that there is an argument against the PCT's over-reliance on out-of-county hospitals, this model is also supported by four MGHs situated just outside the county border; at Brighton (in its MGH role) in the SE, Redhill in the NE, Guildford in the NW and Portsmouth in the SW.

6. In particular, I strongly support the development of a Sussex in-house CCH at Brighton. At present the small number of W Sussex patients needing such tertiary care are transported to either Southampton or London and, despite the inevitable transport problems, it would be better if in future they were treated at Brighton.

7. It is more difficult to accept that the pattern of 3 District General Hospitals (DGH) in W Sussex must, on clinical grounds alone, be changed to a single MGH and one or two LGHs. Following the principle of "localise where possible and centralise where necessary", there is clearly a justified case for the centralisation of some services at either a CCH or an MGH, but it is less clear that there is an evidence-based case for there to be just a single

MGH, with its associated A&E and consultant-led maternity departments, supported by LGHs - which would lose their current A&E and maternity units. I suspect that these latter changes are driven more by either the McKinsey template or by financial pressures.

8. I am aware that there is ongoing work to review the balance of activity between the MGH and the LGHs, and that there may be a case for the consideration of additional Options; indeed after the apparent recent declaration of UDI by the Chief Executive of the Brighton Hospital Trust it seems as though the future of the Haywards Heath hospital in its current role may be virtually assured. Thus, if possible, the proposed pattern should be varied so that more acute medical activity, especially that related to A&E and maternity activities, should be available more locally than would be the case if the proposed model of care is maintained unchanged.

### **Financial Sustainability**

9. Although it was strongly denied in the early stages of the consultation process, I have no doubt that there is a financial case for change. The past financial management of the PCT and the hospitals has been less than adequate, and current debts and deficits are a millstone as far as forward financial planning is concerned. There is also a need, within the PCT's overall budget, to transfer funds from secondary care to primary and community care. Thus there are real pressures to find secondary-level savings, and it is clear that the proposed change from three DGHs to a single MGH and one or two LGHs would assist with this requirement. Additionally, it would alleviate the financial pressures caused by the European Working Time Directive (EWTD) and the implementation of the new medical career arrangements.

10. It has nevertheless been difficult to discern either the financial sustainability of the three Options or to evaluate the financial case for deciding between the Options. This is because the consultation paper contains so little financial information. The PCT's budget for 2007/2008 is £1025m and the projected budget for 2012/2013 will be £1251m (an increase of 22%), but beyond that it is difficult to work out either the revenue or capital implications of the Options. The PCT's response is that its website contains all the relevant data. However, the latter is so detailed as to be thoroughly confusing.

11. It seems, from the “simple” financial summary created by the PCT in response to considerable pressure from consultees, that if no re-organisation takes place, the revenue budget as a whole will produce a surplus of between £30m and £52m by 2012/13. However, whilst Worthing hospital (WaSH) will remain in surplus throughout the period, both Chichester hospital (RWSH) and Brighton and Haywards Heath hospitals (RSCH and PRH) could remain in recurring deficit throughout the period and this would be contrary to the NHS’s break-even rule. As far as the acute hospitals alone are concerned (RWSH, WaSH, RSCH and PRH), the baseline varies between a surplus of £18m and a deficit of £4m. Also, in respect of the accumulated deficit (currently approx £100m), whilst overall it is expected to be eliminated by 2011/12, the hospitals (particularly RWSH and RSCH/PRH) will have a continuing deficit throughout the period (as will WaSH until 2012/13). This situation is not sustainable and change is therefore necessary.

12. As far as the projected position in 2012/13 is concerned, Option A shows a revenue surplus of between £6m and £21m, Option B a surplus of between £19m and £34, and Option C a surplus of between £40m and £55m. Thus, the worst option is Option A, and the best option is Option C.

13. With respect to capital costs, the estimated implications are:

Option A - RSCH - £151m, WaSH - £16m and RWST - nil.

Option B - RSCH - £215m, WaSH - nil and RWST - nil.

Option C - RSCH - £205m, WaSH - nil and RWST - nil.

From this it appears that Option A is the most cost-effective, and that Option B the least cost-effective; albeit that the RWST could be expanded into an MGH without the need for additional capital investment. However, these figures fail to include out-of-area (ie non-W Sussex and B&H) costs, particularly those associated with Option A’s transfer of secondary care and maternity activity from RWST to Portsmouth. There will also be additional capital investment required at Redhill and possibly even at Guildford. Thus, any comparison of the capital costs of each Option is invalid, and it is possible that when the capital costs of expanding Portsmouth, Redhill and Guildford hospitals are added-in (plus the capital investment required by the ambulance service), Option B could be best.

14. Each of the Options will cause activity flows which will make a contribution to the financial sustainability of hospitals outside W Sussex (in Surrey, Kent and Hampshire), as follows:

Option A - Redhill - £15m, Guildford - £7m, Portsmouth - £37m, Kent - £1. Total - £60m.

Option B - Redhill - £10m, Kent - £1m. Total - £11m

Option C - Redhill - £15m, Kent £1m. Total - £16m.

Option A would involve the greatest export of activity and income out-of-area, and Option B would involve the least. Such “exports” would damage the W Sussex health economy, and it is difficult to understand why a reduction of activity in W Sussex should be used to bolster the financial sustainability of hospitals in Surrey, Hampshire and Kent. This is especially as the Surrey PCT has adopted a key objective of sustaining ‘critical mass’ by treating as many Surrey patients as possible within the Surrey health economy. A similar principle would be in the best interests of the W Sussex health economy, and should be adopted here. This would give the W Sussex PCT more direct influence over the care received by the county’s residents, and ensure that it would not be dependent on other PCTs (and other SHAs) for the timely delivery of facilities, capacity and high quality healthcare.

15. On the assumption that the financial forecasts provided by the PCT are robust, the best overall solution for W Sussex would be achieved by the selection of Option B. As far as revenue is concerned, it is better than Option A but, though not as good as Option C, it would provide the maximum amount of medical support of all three Options. In respect of capital expenditure, the Chichester site in Option B would require no additional investment, and Option B would probably require the least total investment when the requirements of Portsmouth, Redhill and Guildford are added-in. Also, Option B would involve the least export of activity and income out-of-area, and thus provide the greatest benefit to the W Sussex health economy.

### **Deliverability**

16. There are a number of factors which impact unfavourably on all the Options. These include the prospects for delivering improved primary care before any changes are made to secondary care, the risks involved in the

timely availability of capital to finance the changes, the ability of the PCT to manage the changes successfully, and the quality of service provided by the out-of-county MGHs and CCHs.

17. Primary Care One of the major deficiencies of the consultation proposals is that the PCT is seeking to determine the future organisation of the acute hospitals before the new arrangements for primary and community care are fully defined. The proposals about the future organisation of primary care are not clear, and this is particularly so in relation to the future of community hospitals which should be defined before any irrevocable decisions are taken concerning the future of the acute hospitals. Also, there is a great deal of uncertainty as to whether or not the PCT's aspirations for the revision of primary care can be delivered. There is evidence that a large number of GPs have not been fully consulted, and costs will rise if the central services currently provided in the DGHs are dispersed throughout the community. The PCT has stated that no changes will take place to secondary care before alternatives are in place, and this important commitment may compromise the delivery of any reorganisation; not least as there has to be an overlap.

18. Capital Finance Risks The proposed changes to the arrangements to secondary and tertiary care depend upon a large amount of additional capital, some of which will need to be provided by PCTs other than W Sussex and by an SHA other than South East Coast. However, no risk assessment has been provided. No relevant business cases have been prepared and, even in the case of the proposed £150m to £215m expansion of Brighton hospital, there is no firm evidence that the DoH is formally committed to providing the whole amount as or when it is required. As far as Redhill, Guildford and Portsmouth hospitals and the South East Coast and South Central Ambulance Services are concerned, only cursory financial planning has been completed thus far, and the availability of the necessary capital is a major risk to the PCT's proposals. Additionally, any necessary expansion of Portsmouth hospital could not be achieved before 2012.

19. Management of Change A combination of poor past (and some present) financial management by both the PCT and the hospital Trusts, the evidence that some of the Trusts continue to have difficulty in producing satisfactory clinical performance, and the evidence of a great deal of particularly poor staff work throughout this consultation process, instils very little confidence that the PCT is competent to deliver the changes that are proposed to the

organisation of health care across the county. Past reorganisations have promised much, but have been light on delivery, and the potential enormity of the proposed changes poses a challenge which the PCT may not be able to manage. This is an aspect which should be given close attention before any change decisions are made.

20. Quality of Service Whilst the three DGHs in W Sussex are generally well managed and are providing high quality medical services, there are serious concerns about the quality of the services being provided by the neighbouring hospitals upon which the delivery of the PCT's proposals also depend. Brighton, Redhill and Portsmouth hospitals all have serious shortcomings, and it is possible that the quality to which the residents of W Sussex have become used is about to be sacrificed in the interests of centralisation without any guarantee that the neighbouring MGHs will actually improve their performance in time to absorb additional activity from W Sussex. At present, a considerable number of patients from E Sussex, Surrey and Hampshire prefer to use the W Sussex DGHs because of the poor quality of their own local hospitals. Promises of improvements are not sufficient; evidence of improvement must be the baseline, and no changes should be made to the W Sussex DGHs until Brighton, Redhill and Portsmouth hospitals are seen to be fully competent, high quality establishments; which may take several years to achieve.

### **Accessibility and Transport**

21. From the beginning of this consultation process, access (as related to travel) has been a topic mired in confusion and obfuscation. Accessibility is one of the three key criteria to be considered before any significant changes are made but, by sleight of hand, the PCT Board decided in March 2007 that for consultation purposes it would be changed to deliverability. Since then, the PCT has admitted that accessibility remains an important factor, and that both the PCT and the SHA will give it proper consideration before decisions are made. On the other hand, there have been moves to widen the definition of accessibility to include waiting times; an action which confuses rather than clarifies the position.

22. The same level of confusion and obfuscation has been applied to the topic of travel, and particularly to the question as to whether or not patients, carers and visitors will have to travel further and longer to access secondary care in the future. From the very start of the consultation, it was implied that

travel would not be a problem, and thus that the key criterion of accessibility would not be a barrier to change. However, the consultation paper provided no travel or patient activity-flow data.

23. The PCT's website is populated with a plethora of activity-flow, access and travel data from which people are supposed to work out for themselves the access and travel implications of the various Options. However, despite NHS guidance which stresses the need for clarity, this data is so detailed as to be thoroughly confusing, and originally contained many anomalies and flaws. In particular, the PCT's 125 page summary (sic!) document alleged that there were really no significant travel problems. Moreover, the statistics were deliberately skewed by the inclusion of non-acute care activity, and the shortcomings of the transport model were generally ignored or concealed. As a result, there was a huge ground-swell of mistrust and suspicion, and it was very difficult to discern the implications of the PCT's proposals.

24. After repeated requests, the travel time data base has recently been updated. However, most of the deductions arising from it continue to be invalid. For example, the new information says that "For the entire population, the average time to reach [all] services has increased by on average 6 minutes during peak times". But what it fails to say is that, though the consultation exercise is about changes to acute services, this deduction (as well as many others throughout the document, is derived from data which includes local visits to people's GPs and other sub-MGH medical activity); thus presenting an optimistic but totally false picture about the time to reach acute services. This is a quite deliberate error, which must be corrected before any decisions are taken about the impact of accessibility and travel on the proposed Options in relation to acute medical services.

25. If W Sussex is provided with a single MGH, travel distances and times will increase for between 64% (Options B and C) and 68% (Option A) of the patients (as well as their carers and visitors) who will need secondary care at an MGH. Under Option A, 39k major A&E patients pa will be treated at different hospitals from those they currently use, and under Options B and C the figure is expected to be 46k pa. A similar situation will apply in the case of maternity activity where, under Option A, 5.5k mothers pa will give birth at different hospitals from those they currently use, Under Options B and C the figure is expected to be 4.6k pa. There are also a large number of other secondary medical activities which will need to be treated at an MGH. Under Option A, 61k such patients pa will be treated at different hospitals

from those they currently use. Under Option B, the figure will be 50k pa and under Option C, it will be 80K. These are not small numbers and they will have a major impact on the travel and access-related problems of the people concerned.

26. An important factor affecting access and travel, which will have an impact on all of the Options, is the road network in W Sussex, especially that along the south coast where the A27 trunk road is one of the most congested stretches of road in the whole of the south east, and forecast to worsen over time. Also, none of the PCT's documents mention W Sussex's urban/rural balance, whereby 90% of the people live in urban areas which comprise just 10% of the geographic area. Thus the impact of the proposed changes on those who live in the rural areas is masked in the overall results, especially because of the very high proportion of the total population who live in the urban southern coastal fringe of W Sussex where the chosen MGH will be located. The needs of those who live in the rural hinterland, many of whom are old and frail, must be considered.

27. Turning to car travel, the fact that distances and times will be longer is a serious matter, especially when both inter-urban and intra-urban congestion, as well as parking arrangements, are taken into account. At present only 28% of patients presenting themselves at A&E are brought in by ambulance, and most women who are about to give birth travel by car, as do most of those patients attending for other secondary medical activities. A considerable number of patients, carers and visitors in W Sussex will therefore continue to travel to hospital by car in the future, with many of their journeys to an MGH involving travel on the congested A27.

28. In respect of public transport, the key here is the geography of W Sussex. Other than within the main towns and cities, public transport availability is generally poor, particularly in the rural areas, the frequency of services is poor, and the hospitals are not located at transport interchanges. This is a problem now, but for those patients, their carers and visitors who will have to travel further in future to access MGH facilities the problem will be exacerbated; by distance, time and cost. Thus, it is important that any public transport-related predictions in support of the proposed Options are realistic. Also, there is a possibility that voluntary assisted-travel arrangements may be at risk as a result of the need for patients to travel further and for longer.

29. All the proposed Options will have a major impact on the ambulance service which, in the case of SECAMB, is already delivering an inadequate response in the rural areas. As far as ambulance travel is concerned, distances and times will be longer, though this may not be significant medically because “time in ambulance” supported by trained staff may not be a major clinical problem. However, according to the PCT’s UCC CRAG Report, “One A&E would increase ambulance transfer times” and “If ambulances are tied up transporting patients long distances, response times can only be maintained by employing more vehicles and trained staff. Such staff are both expensive and scarce”. Two related problems stem from this. First, whilst SECAMB meets its national response time target as a whole in W Sussex, there are no obvious plans to address the problem of its poor performance in the rural areas. Second, it is apparent that the additional investment allocated to ambulance services in the PCT’s 2012/2013 budget will only cover inflation. No additional funds have been allocated either to make good current deficiencies or to meet the Fit for the Future proposals. Thus, despite the PCT’s transport summary saying that “It is important how fast the ambulance gets to you and can start assessment and treatment”, and the consultation paper’s good words that “Developing the ambulance service is critical to the changes we are proposing”, there is an operational risk that SECAMB’s performance will continue to be less than adequate.

30. In summary, as far as travel and access is concerned, the forecasts of individual transit times will never be completely accurate, and perfection is the enemy of the good. Also, delays happen now. Thus the key as far as the Options are concerned, is for people to be aware of the differences between now and the future. Unfortunately, despite the recent corrections and updates, the PCT’s deductions concerning travel times and distances remain suspect, and there remains a need for more statistically-sound conclusions to be reached. As has been quite obvious from audience reaction at the very many FfF-related public meetings, there is a great deal of scepticism and concern about the PCT’s approach to the whole topic of “Access and Travel”; a situation which needs to be resolved before any decisions are contemplated.

### **Choosing an Option**

31. Despite all the above comments, I remain aware that you are specifically seeking an answer to the question as to whether or not the future pattern of acute hospitals should be Option A, Option B or Option C and, essentially,

this is dependent on the answer to the sub-question as to whether St Richard's hospital in Chichester or Worthing hospital should become the sole MGH in W Sussex.

32. This is a difficult judgement, but if such a stark choice must be made then the best Option for West Sussex as a whole is clearly Option B. This Option would provide a Critical Care Hospital at Brighton, a Major General Hospital at Chichester, two Local General Hospitals (one at Worthing and one at Haywards Heath) and three Urgent Care Centres (one at Chichester, one at Worthing, one at Crawley and one at Haywards Heath).

33. The specific reasons for recommending that St Richard's hospital in Chichester should be chosen as the MGH are as follows:

- a. RWST is a high quality hospital. It is the only hospital in England to have received the CHKS Top Hospitals Award for the last seven years. Also, in the Healthcare Commission's October 2007 "national health check review", RWST - for the 2<sup>nd</sup> year in a row - was given an overall rating of "good" for its quality of services. Over the two year period, and amongst all the acute Trusts in the South East, RWST achieved the second highest score.
- b. After suffering financial control difficulties two years ago, a successful recovery has been achieved; financially RWST was the most improved Trust in England in 2006/07, and it is on track to meet its 2007/08 budget and turnaround target. It is now well managed.
- c. RWST has the capacity to be expanded into an MGH without the need for any additional capital expenditure.
- d. RWST already has two helicopter landing sites; one immediately alongside the A&E Dept and one nearby.
- e. RWST already has adequate car parking capacity, with room for expansion without difficulty.
- f. RWST is well located in relation to the south coast road network.
- g. RWST serves a large rural area which is thinly populated by significant numbers of older non-car owners who already have

difficulties in access to the hospital. Many of the areas in which they live are ill-served by public transport, many already rely on carers, and many rely on voluntary transport arrangements to move them to and from hospital. The need to travel to an MGH in either Portsmouth or Worthing would increase the stress and strain on such people, and may not be a safe solution. Thus demographic and geographic factors favour the selection of RWST.

h. RWST serves the people of the Manhood Peninsula to the south of Chichester, and it is often almost cut off from the rest of the south coast in the summer by the congestion on the A27. Also, it contains large numbers of older people, whose journey times to Portsmouth or Worthing, as opposed to Chichester, would increase dramatically.

i. RWST serves not only the indigenous population of western W Sussex, as well as some of those who live in south east Hampshire, but also a very large tourist population, especially in the summer. This is already reflected in the pattern of attendances at the A&E Dept, and should be included in the population statistics.

j. Selection of RWST would preclude the need for additional capital investment at Guildford and Portsmouth hospitals, and thereby reduce the risk of such facilities being unavailable. In any case additional A&E facilities at Portsmouth could not be provided before 2012.

k. Selection of RWST would preclude the need for additional capital investment and revenue expenditure in support of the South Central Ambulance Service.

l. Selection of RWST would retain significant expenditure (up to £40m pa) and activity in-county to the benefit of the W Sussex health economy.

m. Selection of RWST would significantly reduce the operational pressure on SECamb, which is already having great difficulty in achieving its Cat A performance target in most of the rural areas of Chichester District.

- n. Whilst selection of RWST, as part of Option B, would not deliver the biggest savings for the PCT, it would deliver greater savings than Option A.
- o. Selection of RWST would minimise travel and access problems from both the south and north of the area, especially from the Manhood Peninsula, and particularly for women who generally travel to hospital by car to have their babies.
- p. Whilst the Chichester and areas to its north do not contain as much deprivation as the Littlehampton and Worthing areas, the former is well spread out over the whole of RWST's large rural catchment area, rather than being concentrated in the smaller urban areas. In any case, the key to reducing deprivation is to provide improved primary care rather than to re-engineer the pattern of acute secondary care.

## **Conclusion**

34. In my view, Option B is the best way forward for the re-organisation of the acute medical services in W Sussex. This Option would provide the best clinical solution, with a CCH at Brighton, an MGH at Chichester, two LGHs (one at Worthing and one at Haywards Heath) and four UCCs (one at Chichester, one at Worthing, one at Crawley and one at Haywards Heath). It would also provide the best overall financial solution. As far as revenue is concerned, it is better than Option A but, though not as good as Option C, it would provide the maximum amount of medical support of all three Options. In respect of capital expenditure, the Chichester site would require no additional investment, and Option B would probably require the least total investment. Additionally, Option B would involve the least export of activity and income out-of-area, and thus provide the greatest benefit to the W Sussex health economy.

35. As far as deliverability is concerned, there are a number of problems which impact unfavourably on all the PCT's proposals. These include the prospects for delivering improved primary care before changes are made to secondary care, the risks involved in the timely availability of capital to finance the changes, the ability of the PCT to manage the changes successfully, and the quality of service provided by the out-of-county MGHs and CCHs. All these problems need to be satisfactorily resolved before any final decisions are taken.

36. Similarly, in relation to accessibility and transport, there is considerable uncertainty; not the least of which is the confusion created by the deliberate, but quite wrong, inclusion of data relating to non-acute medical activities in the statistical baseline for making deductions about the impact of the proposed changes to acute facilities. Also, the change from three DGHs to one MGH and two LGHs will have a major impact on the travel and access-related problems of the people concerned; many of whom are old and frail, do not own cars, and who live in rural areas ill-served by public transport.

37. Of the two candidates for consideration as the MGH - Chichester and Worthing - the former is best placed to take on the new and additional responsibilities; albeit that both are good quality DGHs which currently provide an excellent service to those patients (and their carers and visitors) who use them today.

38. Finally, if there is still flexibility surrounding the final decision, I urge that serious consideration be given to my formal "Modified Option B" proposal which recommends that the two LGHs should be provided with at least some acute medical facilities (including A&E), thus defining them as Local Acute Hospitals (LAH) and that, if their current consultant-led maternity departments have to be closed, they should both be provided with midwife-led birthing units. This recommendation would seem to be clinically and financially sustainable, it would be deliverable, and it would improve accessibility. It would also improve the choice available to patients, and would take better account of the geography and demography of W Sussex than is the case with the present Options.

Yours sincerely

*Derek Waller*