

Stakeholder submission to the North East Review Panel

Phase II: Secondary Care

A North East Review Panel has been established to consider evidence on health status and health services in the north-east area of West Sussex. The Panel will make recommendations to the Board of West Sussex Primary Care Trust by the end of 2008.

This submission will form part of the evidence considered by the Panel as part of the Review. You may be called on to discuss the contents of your submission in more detail at a panel meeting in public. Please note that this submission will be published on the PCT's website where it will be in the public domain.

Please complete your contact details below.

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If you are making this submission on behalf of an organisation or individuals, please provide brief details:	
This submission is made on behalf of the Support the Princess Royal Hospital campaign.	

Please use the pages overleaf to outline your concerns about and proposals for the delivery of secondary care in the north-east area of West Sussex.

Please email your completed submission by **no later than 12 September 2008** to claire.hollis@westsussexpct.nhs.uk. You can also post your submission to: Claire Hollis, Stakeholder Submission, North East Review Support Team, 1 The Causeway, Goring by Sea, Worthing, West Sussex, BN12 6BT.

Further information about the North East Review can be found at:

<http://www.westsussexpct.nhs.uk/about-us/north-east-review/>

Outline of gaps/inequities in provision of and access to secondary care services in the north-east area of West Sussex. This includes Mid Sussex, Horsham and Crawley.

The campaign is concerned primarily with the impact of the PCT's *Fit for the Future* determination on the functioning of the Princess Royal Hospital ('PRH') in Mid Sussex and, in particular, the proposal to remove maternity services (both consultant obstetric and midwife-delivered) from that hospital.

As a result of that determination (which is presently the subject of review by the Secretary of State's IRP) the campaign is seriously concerned about the consequences which will flow for mothers and babies in northern and central Sussex. It strongly believes that - were obstetrics to be focussed in the future only on Redhill and Brighton - some form of intermediate care must be provided for women in the North-Eastern part of the county. At least one, and almost certainly two, midwife-led units would need to be provided: one to cater for the needs of women in Horsham and Crawley, and one to cater for the needs of women in East Grinstead and the greater part of Mid Sussex (including the rural communities).

Without such provision there will be a significant gap in service provision, and that gap will lead to the uneven (and inappropriate) treatment of women in different communities.

The detailed arguments underpinning the campaign's concerns, and which support the recommended approach, are set out in the following sheets.

Outline how you believe the gaps/inequities in secondary care outlined above can best be addressed.

The gaps and inequities identified by the campaign in this submission can only be rectified (assuming the total removal of obstetric services from the PRH, which the campaign would wholly deprecate) by the preservation of midwife-led services at the PRH (as a stand-alone midwife-led unit) and the creation of a further midwife-led unit to serve greater Horsham and Crawley.

The campaign would far prefer to see a full obstetric service remain in place at the PRH, supplemented by a co-located midwife-led unit. This, it believes, is the only and proper solution for central Sussex.

The following sheets amplify this approach.

Submission to the PCT North-East County review by the Support the Princess Royal Hospital campaign

Introduction

Although the *Fit for the Future* project sought to determine the future shape for delivery of acute hospital care across West Sussex, the PCT has recognised that the exercise focussed in large measure on the needs of the population located in the west of the county and on the south coast. The project included the acute services delivered by the Brighton and Sussex University Hospitals trust from the Princess Royal Hospital ('PRH') in Haywards Heath, and thus had regard to the services delivered to patients in central Sussex, but it failed to have adequate regard to the needs of patients living or working in the north-east of the county. That failure was compounded by the omission from the review process of the range of acute and community services delivered by the Queen Victoria Hospital in East Grinstead, and of the role played by community hospitals in the North-east of the county.

The Support the Princess Royal Hospital campaign is aware that the Review Panel now established is tasked with reviewing the evidence and data it assembles from an objective and a technical viewpoint. The campaign is also aware that some of the issues it addresses in this submission have been canvassed previously in the context of the *Fit for the Future* exercise, but it is anxious that panel members who may not have seen - or are not sufficiently conversant with - the detail underpinning the arguments are now afforded the opportunity to gain a comprehensive picture.

This submission is premised on the following:

- that the Princess Royal Hospital will retain a full range of acute hospital functions (excepting emergency surgery) which are consonant with its status as a district general hospital (for modelling purposes referred to as local general hospital-plus)
- that the PRH is an integral part of the Brighton and Sussex University Hospitals Trust, which trust provides acute secondary care as a single hospital delivering services across two sites
- that the PRH delivers acute hospital care for patients across central Sussex, reaching down to the south coast and up to the north of the county, and stretching laterally into parts of East Sussex
- that at present the PRH provides comprehensive consultant-led obstetric service for pregnant women and their unborn babies, and that that service delivers in the order of 2,400 births each year (which figure is likely to increase for a range of reasons), and
- more particularly, in the light of the recent determination by the PCT of the *FFF* review, the PRH is destined to lose its entire maternity service - that is to say, both its consultant-led obstetric service and any form of maternity service provided by midwives, either in conjunction with obstetricians or as a stand-alone unit.¹

¹ The PCT determination is now subject to review by the Secretary of State's IRP (referral made by Joint HOSC on 25.7.08).

This submission does two things. It addresses the on-going concern of the central Sussex community about the provision of maternity services; and it highlights the need for better access by the community to specialty medical services in general, by bringing consultants to more locally-based clinics.

First, this submission argues that the downgrading, or the entire removal, of maternity services from the PRH will have a significant deleterious impact on the safety and well-being of mothers and babies in central Sussex. The campaign believes that, notwithstanding the arguments advanced by the PCT and some of its clinical advisers, removal of a consultant-led service is a move which fails to have sufficient regard to the benefits which will be lost by the downgrade and to the consequences which may flow (including the loss of ground-breaking neo-natal support arrangements); and that removal of an entire maternity service is perverse and runs counter to the weight of evidence which shows that there is a minimum threshold of service below which patient safety will be jeopardised.

The campaign believes that at the commencement of the *FFF* exercise (and more particularly at the commencement of the public consultation phase) the PCT had failed to provide a coherent needs-analysis and delivery strategy for obstetric and maternity services, and for neo-natal care.² That omission is still evident in the context of the north-east of the county.

Against this backdrop this submission argues that the issue of maternity services is now a crucial matter for those who live in the north-east of the county. Families and potential family units in north Horsham district, Crawley and north Mid Sussex (especially Pease Pottage, Cophorne, Crawley Down and East Grinstead) are reliant upon a disparate range of service providers, straddling the borders of Surrey, West Sussex, West Kent, and East Sussex. Since the downgrade of Horsham and Crawley hospitals to community hospital status, this segment of the population has to look to Redhill, Tunbridge Wells and Haywards Heath for the provision of consultant-led maternity services. The loss of maternity services from the PRH means that patients will shortly have to travel even further south (to Brighton or Worthing), expending precious time and suffering inconvenience or worse.

In the context of making consultant clinical services more easily accessible to patients, the submission argues that the concordat between the BSUH Trust and the QVH Trust should be implemented in such a way that the trusts exchange and share specialties with each other (such as dermatology and oncology), and provide clinics for a wider range of functions at all three key hospitals, exploiting in particular the geographic

² This is a serious omission in the PCT's current and previous approach to reorganisation of services. In the Horton Hospital (Banbury) advice to the Secretary of State, the Independent Reconfiguration Panel (IRP, February 2008) highlighted the following concerns:

- that the changes to paediatric, maternity, special care and gynaecology services at that hospital were being "driven by future medical staffing constraints, not by providing a better service for local people";
- that access to local services was a significant factor to which inadequate weight had been given;
- that alternative options were "too easily dismissed";
- that the outcome failed to deliver "an accessible or improved service" to the people of north Oxfordshire; and
- that the PCT had failed to produce a coherent and comprehensive overall strategy for the delivery of, inter alia, children's and maternity services across the county as a whole (see report at paras 5.2.7 to 5.4.1, and related recommendations, in particular).

This last-mentioned point seems particularly apposite in the West Sussex context.

location of the PRH to enhance the range of services delivered to the community within Mid Sussex.

The key issues on maternity

The campaign believes that for nine reasons - each linked to clinical safety - some form of maternity provision should be reinstated at the PRH. Each reason has validity in its own right but, taken cumulatively, they provide an overwhelming case for revisiting the maternity provision. The reasons are these:

1. Capacity: wasting it at the PRH, overloading it at the RSCH

Today at the PRH some 2,400 births are handled each year, and the number of referrals by GPs to that hospital is well in excess of that number.³ If the obstetric unit were to be replaced by a midwife-led unit only, the potential number of non-complex births suitable for that unit is estimated to be in the order of 700.⁴

Given that the optimum size of a stand-alone midwife-led unit is a 350 throughput, the net result is that a PRH unit would be at least 100% oversubscribed.

The consequence of that oversubscription would be that over 2,000 births - not all requiring full obstetric cover - would have to be transferred to other centres. The first port of call would be the unit at the RSCH in Brighton. However, that unit is today oversubscribed and frequently is unable to cater for the peaks of demand.⁵ The birthing rate at the RSCH is presently in the order of 3,400 per year.⁶ There have been several instances where women have had to be turned away through lack of bed capacity.⁷

2. Undermining of achievement at the BSUH Trust

In January 2008 the Healthcare Commission published its national review of maternity services. The BSUHT's services were rated by the Commission in the category of 'best performing', and the trust achieved the third highest overall

³ In the calendar year 2007 the total number of referrals was 3046; for 2008 the predicted figure (based on Jan - April) is in the order of 3,500.

⁴ According to the senior consultant obstetrician at the PRH, the estimated split between cases requiring medical intervention and those requiring only midwife-care is about 70:30. 30% of the present birthing throughput produces a figure of 720. [Letter from Dr T. Bashir to PRH campaign 18.4.08]. The high risk cases that would not be suitable for midwife handling are those involving twin births, augmented birth, vaginal breech, ventouse, forceps, shoulder dystocia, caesarean sections, manual removal and 3rd/4th degree tears.

⁵ In this, of course, the RSCH is not alone. According to the national press (based on Fol-obtained information) 42% of all hospital trusts over England and Wales could not get through 2007 "without turning women away at least once". Larger maternity units closed more often. (See *The Guardian*, 21 March 2008).

⁶ In the calendar year 2007 there were 3,401 recorded births at the RSCH. In the first 7 months of 2008 the total was 2,093 births (which figure, when projected forwards, becomes 3,588 for a full year). Data based on response (dated 1.9.08) to Fol request by Campaign.

⁷ For instance, Emma Johnson was turned away from two maternity units, and gave birth to her baby on the floor of the PRH (reports in *The Argus* 19 & 23.6.08); and Linda Corbett was turned away from one unit, and had her baby in the car park at the PRH (report in *The Argus* 27.6.08). But for the existence of the PRH maternity unit, these mothers would have had to have given birth in unsafe and (more) uncomfortable circumstances without medical care.

score in England. This outstanding recognition covered the maternity units at both the RSCH and the PRH.⁸

By contrast, the Surrey and Sussex Healthcare NHS Trust scored as 'least well performing' for its maternity services. Although the trust achieved an acceptable level of performance rating for its training of obstetrician and midwife staff, its overall staffing levels were deemed poor.⁹

In other words, in terms of quality of service and care, the acute hospital at Redhill is already significantly challenged in the way in which it can deliver its existing level of services. The consequences of loading more responsibility on to the hospital are discussed below. By contrast, the Royal Sussex County and the PRH are delivering services of a high quality, and that level of achievement should be built upon for the benefit of the community, not undermined by retrenching the maternity function at the PRH.

Moreover, in emphasising that the PRH is "very much 'open for business'", the BSUH Trust has announced steps to strengthen the maternity services there by –

- investing in ten more midwives for the PRH
- recruiting a fifth permanent consultant for the hospital
- creating a single consultants' rota across the PRH and RSCH, so that maternity services will deliver as a cohesive hospital operation over both acute sites.

The hospitals trust believes firmly that the "minimum need" is for a "strong and vibrant midwife-led service at PRH".¹⁰

3. Loss of SCBU facility at the PRH

Loss of maternity services at the PRH means the loss of a pioneering scheme designed to provide safe and sustainable neonatal provision. This scheme - which today is an intrinsic part of the maternity service delivered from the PRH

⁸ See *Chief Executive's Friday message* to staff and stakeholders (BSUHT), 25 January 2008. The review covered 2007, and the overall assessment was based on 25 performance indicators. One of the highest scores (rated 5) related to the extent to which staff were trained in core maternity skills: see *Review of Maternity Services 2007: Scored Assessment* for Brighton and Sussex University Hospitals NHS Trust (Healthcare Commission, publ. 23.1.08), clinical focus: indicator 7. This score reflects the ability of the hospital to provide a 'safe service'. That level of safety was previously reflected in an assessment by the NHS Litigation Authority (November 2007) which awarded a rating of CNST level 2 to the BSUHT, affirming the standards the trust was already then achieving. That trust-wide rating included maternity, which was assessed separately. See *Chief Executive's Friday message* 23 November 2007.

⁹ See *Review of Maternity Services: Scored Assessment* for Surrey and Sussex Healthcare NHS Trust (Healthcare Commission), clinical focus: indicator 7, and efficiency and capability: indicator 17.

¹⁰ See *Chief Executive's Friday message* (BSUH Trust, 6 June 2008). This approach is in line with that adopted elsewhere in England. For example, in the NHS East of England review, the health authority has decided to "co-locate midwife led birthing units with flexible staffing alongside existing obstetric units" and to create "robust [clinical] networks for maternity and neonatal services". This will ensure the delivery of "equality of care across the region". The method of delivery is to pair each of the four smaller obstetric units (West Suffolk, Hinchingbrooke, James Paget and the QE at King's Lynn) with a larger unit, thus avoiding the need to create two very large obstetric units. See *Towards the best, together* (East of England NHS, May 2008), pp 62, 64. In other words, as with the PRH/RSCH, two units will work as a single enterprise. The intended outcome is to provide more - and not less - choice for women.

site - has received national recognition and continues to offer a first class service to mothers and their babies.

The service is led by a team of up to 10 Advanced Neonatal Nurse Practitioners (ANNPs), supplemented by 2 staff-grade doctors. Working within-hours a consultant is dedicated to the PRH, attending daily ward rounds on the special care baby unit (SCBU), and offering a weekly on-site outpatient clinic.

This resource has proved extremely valuable to mothers and babies who otherwise would have to transfer to Brighton or Redhill or beyond. It has proved its worth, and it would be a retrograde step to undermine the continuing role it has to play for the community of central Sussex (of which the north-east of the county is an integral component).

4. Enhanced risk to mothers in transfer

The maternity service at the PRH is so placed geographically that it can (and does) cater for a large hinterland of population, stretching northwards to Crawley, East Grinstead and beyond, and eastwards into East Sussex. The hospital is within reasonable reach of the north-east of the county by road, whether by car or by ambulance.

Closure of the maternity unit would mean the need for a greater number of transfers of women in labour over greater distances (with inbuilt delays). As the King's Fund report on *Safe Births: Everybody's business* makes clear, sudden transitions in patient stability have to be catered for: "Although pregnancy and birth are normal physiological processes, unexpected emergencies can develop rapidly".¹¹ An RCM survey of heads of midwifery conducted in May 2007 revealed that 53% of respondents indicated that births were becoming more complex.¹²

What is clear is that speedy access to competently staffed birthing units is essential to ensure the safety of both mother and child.¹³ In the context of home births, for example, it is known that women who booked a home birth but required transfer, whether during pregnancy or at labour onset, "had relatively high IPPM rates".¹⁴ As Professor Philip Steer said, where unpredictable events occur during labour, "recourse to quick action makes a difference".¹⁵ In a similar way, mothers who go into labour at home, but are booked into a birthing unit, need to be able to

¹¹ Report (published 29 February 2008), Conclusions in section 2 'Maternity services in context'.

¹² See Joanna Gray *Failing to deliver?* W I Life, April 2008, pp25-28 at p27. Complicating factors are obesity, age and ethnicity of mothers, aggravated by such issues as family incomes, housing conditions, and language and cultural barriers (the last of which also impact on the degree to which women are prepared to access antenatal services).

¹³ Complications need to be treated quickly, and call for "immediate, safe transfer", sometimes to a consultant-based unit. In the interim, community-based facilities need to be equipped to handle the "initial management and referral of obstetric and neonatal emergencies": see *National Service Framework: Maternity Services* (DfES, DoH, Sept. 2004) at para 8.5.

¹⁴ IPPM (rates) means intrapartum perinatal mortality (rates). See R. Mori, M. Dougherty, M. Whittle *An estimation of intrapartum-related perinatal mortality rates for booked home births in England and Wales between 1994 and 2003* BJOG: An International Journal of Obstetrics and Gynaecology, April 2008, vol 115 pp554-559 at p559.

¹⁵ See BJOG press release *Are booked home births safe?* (2.4.08).

access that unit with the minimum of delay. Proximity of that unit is a key factor in achieving stability and a healthy outcome.¹⁶

5. Risk of negative impact on ITU sustainability

The campaign has previously drawn attention to the close inter-relationship between ITU provision (at level 3) and the availability of anaesthetists, whose numbers increase when there is an obstetric function on-site.

Clearly the campaign welcomes the decision of the PCT to retain level 3 ITU at the PRH as an integral part of the acute medicine offering, but remains concerned that the ITU should be maintained at this level and should be resourced in a sustainable manner. Even if the PRH operated with only a midwife-led birthing unit, access to ITU when a mother develops an unforeseen critical medical condition remains important.

6. Capacity and capability at Redhill

Faced with no maternity provision in Mid Sussex (bar home-birthing, which is a safe option for only around 5 to 6% of births in non-complex situations) expectant mothers living within the district will be forced to go further afield to give birth. At present the birth rate for Mid Sussex is in the order of 1,460 births per annum.¹⁷ Redhill hospital (based on 2006/07 figures) caters for some 4,062 births p.a.¹⁸, of which only around 90 come from Mid Sussex.

Even if 50% of the Mid Sussex births were to go to Brighton (mainly from the south of the district), some 700 would have to go elsewhere. Today some 90 or so births go to the birthing centre at Crowborough (which figure would probably remain unaltered),¹⁹ leaving some 600 (or thereabouts) who would need to go to Redhill.²⁰ Redhill would be the obvious destination for north-east county patients once the PRH obstetric unit closed. These 600 cases would impact on the capability of Redhill to deal within its present capacity envelope. Redhill (across the year 2007) was operating at 98.7% capacity.

¹⁶ Again, in the context of home births, over the previous 12 months' period, transfers occurred as follows: 35 to the RSCH (213 booked less 178 actuals), 18 to the PRH (67 less 49) and 87 to Redhill (155 less 68): see survey of maternity units compiled for The Daily Telegraph by Dr Foster Research *Midwife shortage hits home births* at <http://www.telegraph.co.uk/core/Content/displayPrintable.ihtml:isessionid=PBNDPUIIS> (26.4.08).

Transfers to Redhill hospital were relatively high.

¹⁷ This figure (obtained by the campaign) is derived from statistics held by the General Registrar of Births, and involves an aggregation of the live birth figures for each local government ward in Mid Sussex district during 2006.

¹⁸ See NHS figures for deliveries categorised by provider trust: Written answer by Ann Keen, MP to Andrew Lansley, MP for *NHS hospitals, England 2006-07*, Hansard 1 April 2008. This figure (4,062) may be an under-record. For a similar period (albeit the *calendar* year 2007) the Surrey and Sussex NHS Hospitals Trust (with responsibility for East Surrey Hospital) produced a figure of 4,245 births, of which 41% were classified as 'low risk' (ie capable of being delivered in a midwife-led unit), and of which less than 1% (35 births) were from mothers living within Mid Sussex postcode areas: response to FoI request made by campaign (June 2008).

¹⁹ Probably a further 70 to 80 would be home births.

²⁰ In 2007 Crowborough handled 312 births. For 94 of those births the closest hospital to home for mothers-in-labour would have been the PRH. Base figures for birthing numbers (but not sources) obtained from East Sussex Hospitals NHS Trust, via FoI request (NHS letter 5.3.08).

It is not unusual today - without significant increase - for expectant mothers to be turned away from Redhill on arrival, and to be sent to other destinations.²¹ The hospital itself acknowledges that across its various acute services it could extend capacity (to accommodate the original *FFF* proposals and their out-of-county impact), but that would be dependant upon capital receipts to effect building extension works.²²

7. Eradicating patient choice

Patient choice is a cornerstone of the government's commitment to mothers and mothers-to-be. The Department of Health has committed itself to providing "high quality, safe and accessible services that are both women-focussed and family-centred". Amongst other things, the government has committed, by the end of 2009, to giving "all women choice in where and how they have their baby and what pain relief to use, depending on their individual circumstances. This will be a national choice guarantee".²³ The obligation placed on local health providers is, amongst other things, to deliver "appropriate services and capacity to respond to the full range of choice options". That in turn requires the injection of sufficient resources to provide high quality maternity care, with trained staff "working flexibly across community and hospital settings".²⁴

The guarantee replicates the government's previous commitment that "women should have easy access to supportive, high quality maternity services, designed around their individual needs and those of their babies".²⁵ What this means in reality is that access should be made as easy as possible for women. Services should be local and should take account of women's physical needs in pregnancy, their family needs, and – where appropriate – any disability needs. The need for lengthy travel and unsettling waits should be minimised so far as possible.

Against this backcloth the removal of maternity services in general – but midwife-led services in particular – from the PRH makes little sense. Instead, the health bodies should be making more (not less) local provision for women. The reality of the situation when looked at in the specific context of the north-east of the county is that there is a need, and demand, for two and not one midwife-led units, and they should be located at the PRH and (probably) in Crawley. The PCT needs to have regard in its planning to a range of factors which point in this direction. They are:

- the requirement for a range of services which are genuinely local and accessible to women with varying personal needs and commitments
- the need to address the differing but essential challenges faced by urban and by rural communities

²¹ During 2007 the maternity unit was closed on 6 occasions, either because that unit or the neo-natal unit was operating at full capacity.

²² In its current business plan provision is made for development of a co-located midwife-led unit which would provide (with the existing obstetric unit) an additional 18 inpatient beds.

²³ See *Maternity Matters: Choice, access and continuity of care in a safe service* (DoH, April 2007) at paras 1.2, 1.8.

²⁴ See *Maternity Matters* at App. A, choice no. 3.

²⁵ See *National Service Framework* (op. cit.) at para 1.3 (Standard).

- the need to take proper account of the changing societal arrangements and demographics, accentuated by the substantial growth in house-building over the coming decade
- the need to have regard to the distribution of deprivation across central Sussex (both in the north in greater Crawley, and in the south in and around Burgess Hill and parts of Haywards Heath)
- the need to have regard to the cultural and ethnic backgrounds of women who may have need of these services.

This list is not for one moment exhaustive, but it underscores the need to have regard to a diversity of issues which are not simply catered for by a one-size-fits-all or a one-location-suits-everyone model. Using 'Birthrate Plus' or similar evidence-based tools, it should be possible for the PCT to model accurately the "make-up of the midwifery workforce required to provide care for a defined population of women in a specific care setting".²⁶

Put simply, the removal of all forms of maternity service from the PRH undermines the ability of women to exercise patient choice, and runs counter to the government's philosophy and undertakings. It is inconsistent and irrational.²⁷

8. Equity of approach

The *FFF* exercise recognised the strengths of the three acute hospitals in West Sussex: at Worthing, Chichester and Haywards Heath. For some reason the leading-edge Queen Victoria Hospital at East Grinstead was omitted. The outcome of the exercise was that Worthing was designated the MGH, leaving Chichester and the PRH with LGH-plus status.

However, although obstetric services were to be transferred from Chichester to Worthing (thus enhancing Worthing's existing consultant provision), Chichester is to retain a free-standing midwife-led unit. The PRH also lost in this stage of the reorganisation process the obstetric services it had successfully delivered for decades but, inexplicably, failed to retain a midwife-led unit in line with the Chichester model, notwithstanding the hospital acquiring exactly the same status as Chichester's.²⁸

This approach is inequitable and biased towards the south and the west of the county. It demonstrates three things:

- that the PCT has thus far given inadequate attention to provision in the north-east of the county
- that, by determining in advance of the review that provision should be limited to a single midwife-led unit, the PCT has failed to grasp the separate but complementary needs of central Sussex and those within the north-east

²⁶ See *Safer Childbirth* (RCOG et al., London, October 2007) at para 4.1.6.

²⁷ It is also unnecessary, as is demonstrated by the NHS East of England experience, referred to above in section 2.

²⁸ In the East Sussex PCTs' reconfiguration exercise (which affected only maternity services), as a direct result of call-in and review by the Secretary of State's IRP, both Eastbourne and Hastings hospitals (within a single acute hospitals' trust) are to retain full maternity services.

- that the PCT has recognised that there are advantages in locating a midwife-led unit within an existing general hospital complex (in Chichester), but has failed to consider why and how those advantages should not be replicated at the PRH.

There is also the issue of deprivation. The research group Action in rural Sussex has highlighted the disparities which can (and do) arise when funding and investment is targeted specifically on the urban poor, basing that approach on the use of standard indicator measures. The group says that, by targeting health resources to areas and wards with the highest concentration of health need, the rural poor “miss out”, “particularly given that they are scattered across diverse communities which often contain significant proportions of better off socio-economic groups.”²⁹ This has already been a determining factor in the location of the MGH in the *FFF* exercise, and its impact on the rural community is liable to be compounded if the PRH were to lose its maternity facility in its entirety. Deprivation and need is less visible in a rural context than in an urban one.

9. The Joint HOSC recommendation

The Joint HOSC gave careful attention to a range of evidence relating, amongst other things, to the provision of obstetric and maternity services in West Sussex (and the impact of the proposed changes beyond the county boundaries).

In the Joint HOSC’s formal Response to the PCT’s *FFF* proposals (May 2008) the joint committee, in accepting the principle of a consultant-led unit on the south coast, added a significant caveat:

“However, the Committee is not convinced, on the evidence provided, that the closure of the CLU at the PRH will meet the needs of the population in central and north West Sussex and the western part of East Sussex, in the light of:

- the potential changes to maternity services in East Sussex,
- potential population growth,
- the potential pressures on the CLU in Brighton,
- opportunities for innovative staffing arrangements given the PRH’s links with the RSCH,
- the existing and innovative service provided by the Advanced Neonatal Nurse Practitioners, which should be retained.”

The joint committee could have added that the birth rate within Mid Sussex was also forecast to increase at a rate far higher than elsewhere within the county.

In the light of these concerns, the joint committee specifically recommended “that the PCTs undertake further work with BSUH to examine alternative ways to sustain the CLU at PRH”. This view was

²⁹ See Dr Simon Kiley *Determining Health Need in Rural Areas: Working Towards Equitable Health Provision* (April 2008, Action in rural Sussex), p11. The difficulty is that, whilst “there may be relatively significant proportions of the population in need within the whole rural population, once this is fragmented into ward averages the impact [for rural communities] is lost”: *ibid.*, at p25.

without prejudice to the committee's separate view that one midwife-led unit be "located in the north of the county".³⁰

The Joint HOSC was clearly of the opinion (and remains of that opinion) that proper maternity cover should continue to be provided at the PRH.³¹ The campaign believes that that aspiration is still worthy of serious consideration but, failing its long-term viability, that - at absolute minimum - a midwife-led unit should operate in place of the consultant-led unit. On the reasoning of the JHOSC, that midwife-led unit should probably be additional to, and not an alternative to, another unit serving the north of the county. As the JHOSC itself put the point (in a slightly broader context) "offering stand-alone MLU(s) increases patient choice and helps to maintain a geographical spread of places to give birth even with fewer CLUs".³²

Finally, it is right to mention finance. The Joint HOSC recorded the view of the CRAG that "in general MLUs 'can be an expensive financial option' – there needs to be proof added value eg through the provision of antenatal services and education".³³ Two things need to be said about this. First, the campaign is aware that GPs in the north-east of the county (for example, in Horsham) are anxious that enhanced ante-natal services are provided by the hospital trusts more locally to their (the GPs') patients eg. scanning services. In other words, there is already a demand for value-added services in such units. Secondly, the PCT has itself acknowledged that finance is no longer a driving factor in the service reconfiguration review.³⁴

The linkage with the QVH

The campaign has said previously to the PCT that there exists an important window of opportunity to build on the complementary skills available in the BSUH Trust and the Queen Victoria Hospital in East Grinstead and, in so doing, to bring closer to a larger audience across central Sussex (and beyond) the specialist services which each presently delivers.³⁵ The advantage of the location of the PRH is that it lies at the median point between Brighton and East Grinstead, and it can conveniently accommodate a variety of specialist clinics which would then be more easily accessible to a significant catchment of population. The aim should be to link-up the three hospitals' sites, and to ensure a regular exchange of consultant knowledge and expertise.

³⁰ See Joint HOSC's *Response to the proposals from [the PCTs]* (May 2008) at para 1.16 (Conclusions and recommendations), sub-paras 28, 29. Since that recommendation was made, the PCT has approached the BSUHT and obtained a response from the trust's chief executive (which simply re-states the trust's earlier stance, viz. that should birthing demand "materially increase", the trust would reconsider its position). However, the PCT failed to seek to engage on the issue in the manner envisaged by the JHOSC and simply asked "whether there was any material difference between PRH and the rest of the county as regards maternity services" (see West Sussex PCT board agenda for 4.6.08 at item 4, response to para 28). That issue remains unaddressed, and no attempt has been made to examine alternative ways to sustain a consultant-led unit at the PRH. Instead, the PCT is focussing only on the location of the remaining midwife-led unit.

³¹ See Joint HOSC's call-in letters to the Secretary of State dated 25.7.08 and 1.9.08.

³² Joint HOSC's *Response* at para 7.8.7.

³³ Joint HOSC's *Response* at para 7.7.3.

³⁴ *Per* Brian Hughes, at the public presentation at East Grinstead on the North-east county review (23.5.08).

³⁵ See the campaign's *Formal response to the 'Fit for the Future' consultation*, November 2007, at Part 6, paras 115, 116.

Since the campaign first raised the possibility of creating a service-base larger than the sum of its parts, the two acute hospital trusts have entered into a formal Memorandum of Understanding. This concordat was agreed in January 2008,³⁶ and it sets out to cement between the two trusts an arrangement for joint working across projects of “mutual interest”. In particular, the trusts undertook to form strong clinical partnerships, and at an early date to establish a list of areas where joint working would be beneficial. In so doing, the memorandum expressed the mutual desire to “consider each other as the primary clinical and academic partner”. In this latter aspect the BSUH Trust would be building on its newly-acquired status as a leading teaching hospital trust.

The PCT as the major commissioner and purchaser of acute and tertiary services in West Sussex needs to ensure that this opportunity is used to its full potential, both in terms of securing value for money (by creating a series of ‘one-stop shop’ clinics and in achieving an ever-widening range of services for people living in the north-east of the county. As the campaign highlighted previously, there is already in place a two-way flow of skills:

- from the QVH to the RSCH, breast reconstructive surgery is offered off-home-site as an adjunct to the cancer care facilities in Brighton
- from the PRH to the QVH, a consultant physician provides clinical advice alongside colleagues in the sleep disorder clinic at East Grinstead.

The QVH sees that opportunities exist for the provision of plastic surgery (in conjunction with orthopaedics in the treatment of lower leg trauma), skin cancer and dermatology services at the PRH. With the previous transfer-out of services from the PRH, physical capacity is available within the PRH complex for such initiatives; and at both the QVH site (Holtye Road)³⁷ and the RSCH site (main campus) construction works are programmed to expand capacity.

Timing of the North-East review

For the sake of completeness it is right to refer to the issue of timing of the present review by the PCT, particularly in the context of maternity services.

Although the campaign understands the principles which underpinned Sir Graeme Catto’s original recommendation to the PCT that services in the North-East of the county should be revisited (primarily because the emphasis of the *FFF* exercise had been to focus on acute care on the south coast), given the shape of the PCT’s ultimate decisions and the subsequent call-in to the Secretary of State, the campaign believes that further consideration of services is premature.

The issue of maternity provision for the northern part of the county cannot properly be considered in isolation. If, as a result of the PCT’s *FFF* decision, the PRH were to lose its full range of maternity services (obstetric and midwife cover) the northern part of the county would be deprived of a significant facility, and would be dependent upon

³⁶ Agreement to the 21.12.07 draft version was signified by the Medical Director to the Queen Victoria Hospital NHS Foundation Trust by letter dated 9.1.08.

³⁷ See interview with Sharon Kearns (chief executive of the QVH Trust) in the *East Grinstead Courier* 20.9.07.

hospitals at Redhill and Brighton. At least two midwife-led units would be required to bridge (but still only partially)³⁸ that gap. On the other hand, if the Secretary of State were to overturn the PCT's decision insofar as it related to the PRH (thus ensuring the continuity of the present facility for women and their babies), the degree of impact on the northern part of the county would be lessened and the extent to which midwife-led unit cover would be required would be different. In other words, undertaking a review now of maternity-related services as part of the secondary care phase would lack rationality.

Conclusion

Fit for the Future leaves a number of issues in its wake. Two key concerns now for the North-East County review panel turn on the provision of proper midwife-led services from at least one midwife-led unit, and the exploitation of the significant clinical linkage which has developed between the BSUH Trust and the QVH Trust.³⁹

The campaign reserves its position on the issue of obstetric services for this part of the county, pending determination on the point by the Secretary of State (on the advice of his IRP following the call-in). It remains firmly of the view, however, that whatever decision emerges on obstetrics, a midwife-led maternity unit should remain at the PRH site. The campaign believes that to remove the consultant-led service would be an unnecessary step; to remove the totality of maternity services from the general hospital site would be perverse.

Finally, the review panel needs to satisfy itself (and the public) that its decisions are driven by issues of clinical need and not by financial expediency. The existence of the review has of necessity raised expectation in the public mind of enhancement of services for the north-east of the county, delivered by a combination of working with other health bodies across borders and by the freeing-up and making available of new moneys within the PCT for proven improvements. The PCT is the gatekeeper and trustee for the public's well-being and, in acknowledging that role, the review panel needs to be innovative and flexible.

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³⁸ Because of the lack of consultant obstetric facilities.

³⁹ Other issues will, of course, emerge during the panels' deliberations - such as the sexual health of young people in Crawley and beyond. But these present two issues need to be addressed thoroughly within the panel's terms of reference.