MID SUSSEX DISTRICT COUNCIL RESPONSE TO WEST SUSSEX FIT FOR THE FUTURE

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GLOSSARY OF TERMS

A&E	Accident and Emergency
ANNP	Advanced Neo Natal Nurse Practitioner
HOSC	Health Overview and Scrutiny Committee
JHOSC	Joint Health Overview and Scrutiny Committee
MSDC	Mid Sussex District Council
NHPAU	National Housing and Planning Advice Unit
NHS	National Health Service
PCT	Primary Care Trust
PPI Forum	Patient and Public Involvement Forum
PRH	Princess Royal Hospital
SCBU	Special Care Baby Unit
SME	Small and Medium Enterprises

EXECUTIVE SUMMARY

Mid Sussex District Council rejects all three options set out in the Fit for the Future Consultation. Our key arguments are set out below.

The Changes will reduce the level of healthcare provided in Mid Sussex

Fit for the Future is the latest healthcare reconfiguration which is continuing the local NHS's salami slicing of services away from the Princess Royal Hospital. Each time we are assured that the hospital has a bright future and is a key part of service delivery from the Brighton and Sussex University Hospitals NHS Trust.

The Council is no longer prepared to accept these false promises. If the Princess Royal is a key part of the Trust, then this position should be demonstrated through actions. The Trust can demonstrate it means what it says by reintroducing a full Accident and Emergency Service and bringing back a consultant led maternity service.

We are assured that improved services will be provided through better community care. Whilst in principle, we welcome an increase in community care, the PCT's vision is just that, an aspirational view of how it will be provided with no firm business case.

The Changes are not deliverable because of capacity issues

Neither East Surrey Hospital or the Royal Sussex County Hospital is able to cope with the current demands on their services. Ambulances are having to queue up outside A&E entrances[1], patients are being left in corridors and women are having to be transferred to other hospitals (including the Princess Royal) to give birth. The proposals will make the situation worse, with a poorer patient service and increased pressure on staff.

Despite the recommendations of the Clinical Reference Advisory Groups, there is a massive body of clinical opposition to the proposals, because they believe they are clinically unsafe.[2]

The Proposals take no account of the specific requirements of Mid Sussex

Our demographics differ markedly from Brighton and Hove. We have an older population profile, with our population getting older and the number of people aged over 85 expected to double in the next 20 years.

Many of those most in need of hospital treatment live in rural villages, with no public transport and without their own car. These people are going to lose out financially in terms of taxi fares etc, but more importantly, their life chances are going to be affected.

Over 14,000 people rallied in Haywards Heath on Saturday 13 October as part of the campaign to save the Princess Royal Hospital. Over 71,000 people have signed a petition against the further downgrading of the Hospital[3]. This response is not just from Mid Sussex District Council. It is from our Community. The consultation is an opportunity for the PCT to demonstrate that they listen and that they can learn. Following this consultation they can demonstrate that the future of the Princess Royal has not been pre-determined and that it can fulfil a key role in providing ongoing healthcare for the Mid Sussex of today and of future generations.

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[1] BBC News Website, http://news.bbc.co.uk/1/hi/england/southern_counties/4585692.stm, 05/01/06 and Nick Herbert MP, Hansard Commons Debate, 4 July 2007, Columns 268 – 271WH
[2] Dr Herry Ashby, a Newick GP has collated a petition signed by 180 clinicians.
[3] www.supportprh.com

THE MID SUSSEX DISTRICT COUNCIL OPINION: MINIMUM REQUIREMENTS FOR THE PRINCESS ROYAL HOSPITAL

1. Mid Sussex District Council is clear that any reduction in services at the Princess Royal Hospital is unacceptable.

2. We do not consider any of the options in the consultation as being genuine options for our community. Therefore we are not able or willing to identify one of the options as being our preferred, or 'least worst' option.

3. Mid Sussex District Council wants the PCT to revisit its options, to take into account the strength of public feeling on this issue, and create proposals that provide the whole of West Sussex (this is not just a Mid Sussex issue) with the quality and availability of healthcare services that they deserve.

4. When preparing this option, we want the PCT to ensure that the Princess Royal Hospital has the following services provided:

   - **A full accident and Emergency Unit**
   - **Level three intensive care unit**
   - **Consultant Led Maternity Unit**
   - **Emergency Surgery**

5. Furthermore, we want the PCT to:

   - **Recognise the flaws in the consultation and to take whatever steps are necessary to redress them.**

   - **Develop plans that are sustainable in the long term (for a minimum of 20 years) that take into account the fact that our population is expanding and aging. This should take into account the rural nature of Mid Sussex and the fact that rural areas cannot be treated in the same way as urban areas when devising healthcare systems.**

   - **Recognise that the proposals may well work in Brighton and Hove, but the reality for our community is reduced access, increased cost, increased stress and a reduced patient experience.**

   - **Review the arrangements for ambulance services, to engage with paramedics and to ensure that the service is properly funded.**

   - **Provide a FULL A&E service at the Princess Royal Hospital. This is to deliver services to our expanding community and that of our neighbouring authorities. The service is also required to reflect the specific needs of our rural population and its distinct needs.**

   - **Respond to our community's demand that maternity services should remain and be enhanced at the Princess Royal Hospital. We want the PCT to rethink its proposals, and produce an alternative, sustainable solution that enhances the service at the Princess Royal.**

   - **Work with the Acute Trust to set out their commitments about how effective management arrangements will be implemented.**

FIT FOR THE FUTURE – THE CONTEXT

Introduction

6. The West Sussex Primary Care Trust is leading a consultation regarding the future provision of Healthcare in West Sussex. Fit for the Future is a consultation that affects the whole of the South East and is being led at a strategic level by the South East Coast Strategic Health Authority. There are also current consultations on Fit for the Future in Brighton and Hove and West Sussex. The East Sussex Fit for the Future consultation was undertaken between 26 March and 27 July 2007. The Surrey Fit for the Future consultation is due to commence imminently.

7. The West Sussex consultation impacts beyond the West Sussex borders, and has implications on Brighton and Hove, Hampshire, Portsmouth and East Sussex. West Sussex County Council is leading the Joint Health Overview and Scrutiny Committee which comprises representatives of all of these authorities and has a statutory role in scrutinising the process and the detail of the proposals.

8. This is Mid Sussex District Council's response to the Fit for the Future consultation, which has been produced by the Council's Health Panel who have worked with the Portfolio Holder for Health and Community as well as the rest of the Council membership on the response.

Summary of changes to Healthcare Provision in Mid Sussex

9. Fit for the Future is the latest in a long line of NHS consultations which have resulted in services being taken away from the Mid Sussex community. Whilst it is not appropriate to outline these in detail, they provide a useful context for the most recent consultation and are outlined in the following paragraphs.

10. There has been a trend of significant reconfigurations in the NHS since the major reorganisation of 1974. The Mid Downs Health Authority that served the communities of Crawley, Horsham and Mid Sussex was dismantled and the West Sussex Health Authority created. By 2000 this body was "failing" and at the intervention of the Secretary of State, Michael Taylor, Chief Executive of the Oxfordshire Health Authority was brought in to advise on a number of issues, namely:

    - Declining financial performance
    - Unsatisfactory service delivery
    - Unsustainability in respect of the location of specialist services and responsiveness to medical advance and training needs

11. His report, 'West Sussex Health Authority – A Framework for Progress'[4] was published in April 2000. It was hard hitting and clear in its recommendations for improvement. In it, he made a number of recommendations concerning the configuration of services, still very relevant to today's situation. He was clear that Brighton and Worthing should develop strong and wide-ranging clinical alliances, that the Princess Royal Hospital should have a pivotal role in the foreseeable future and that the Health Authority should honour its commitment for a population needs based review. All these are at variance to the current arrangements.

[4] A Framework for Progress, by Michael Taylor, Chief Executive, Oxfordshire Health Authority and Temporary Chief Executive, West Sussex Health Authority. April 2000.

12. Following on from this a series of consultation exercises were undertaken although in isolation and to differing timetables. The most key of these was ‘Strengthening Hospital Services in Central Sussex’ carried out in 2001. The document ignored the recommendations from Taylor’s report and made recommendations for a Central Sussex area comprising Mid Sussex and Brighton. At the same time there were proposals for Crawley and Horsham to be joined up with Redhill. These consultations ignored the existing and identifiable geographical relationship between the areas in Mid Downs and recommended the creation of hospital services serving communities that were not geographically linked.

13. The consequence of this has been the concentration of resources on the centres of greatest population, namely Brighton and Redhill. This has resulted in the residents of Mid Sussex as well as Crawley and Horsham having deteriorating access to a reducing range of healthcare services.

14. In November 2004, NHS Trusts in the ‘Central Sussex Partnership Area’ (Brighton and Hove, Mid Sussex and Sussex Downs and Weald) launched a consultation on the reconfiguration of services in the region. Entitled, “Best Care, Best Place”, the consultation sought views on plans to:

    - transfer most emergency surgery from Princess Royal Hospital (PRH) to the Royal Sussex County Hospital;
    - transfer paediatric trauma, where a general anaesthetic is needed, to the Royal Sussex County Hospital;
    - transfer of elective surgery and orthopaedics to the Princess Royal Hospital;
    - transfer of certain acute and screening functions to the community setting;
    - Develop either a Advanced Neonatal Nurse Practitioner-led obstetric unit at PRH or a midwife-led unit there (with a consequent shift of high-risk births to the Royal Sussex);
    - continue to transfer neurological and neurosurgery services from Hurstwood Park to Royal Sussex; and
    - Remove acute inpatient services from Brighton General Hospital, transferring some to the Royal Sussex and others to community settings;

15. Best Care, Best Place was scrutinised by a Joint Committee comprised of East Sussex County Council, West Sussex County Council and Brighton and Hove City Council. Mid Sussex District Council expressed grave concerns about the scrutiny process and requested the Committee to refer its findings to the Secretary of State for further examination. This request was unsuccessful. This Council remains concerned that the scrutiny process involved serious omissions and irregularities, though it is pleased that the County Council have used this experience to improve their process.

16. Following Best Care Best Place, the Council was fearful that the changes would perpetuate the decline of health services in the District, and to the Horsham, Crawley and Mid Sussex area in general. Specific concerns were:

    - The removal of services from PRH would be the start of a process of downgrading provision at the hospital, as has happened at Crawley Hospital, with real concern expressed that once the transfer of services to the Royal Sussex is completed the

Princess Royal Hospital would cease to be a viable proposition both from a healthcare and financial perspective;

- the creation of a health service area that includes Brighton and Hove and Mid Sussex was artificial, and would inevitably lead to sub-standard services for residents of Mid-Sussex as services are concentrated in Brighton.

- Best Care, Best Place anticipated transfer of many major services from the PRH to Brighton, and even where services were planned to stay (maternity), the Trust's solution (a service led by Advanced Neo Natal Nurse Practitioners) is extremely fragile and unlikely to be sustainable in the medium to long term.

17. The Council's concerns following Best Care, Best Place have become reality through Fit for the Future. The proposals will see the hospital lose its maternity service. Our community will continue to receive a worsening service and experience greater transport problems and despite the words and rhetoric (which we have heard before) we do not foresee a viable long term future for the Princess Royal Hospital.

18. This response outlines the minimum standards we expect for our community, which we believe the PCT should use to revise their proposals and create a healthcare system which truly is fit for the future of Mid Sussex.

PROPOSALS FOR FUTURE SERVICE DELIVERY

The Options

19. West Sussex Fit for the Future is consulting on three options for Health provision in the County. They are summarised below:

Option A

Worthing Hospital would become the major general hospital in West Sussex providing acute medicine, accident and emergency services, inpatient paediatrics, emergency surgery and consultant-led obstetrics.
St Richard's Hospital at Chichester would become a local general hospital, providing an urgent care centre, surgical beds and surgery day cases, a range of diagnostics, outpatient clinics and rehabilitation and beds for those with some medical conditions.
The Princess Royal would become a community hospital, providing a minor injuries unit, some diagnostics, community and rehabilitation beds and integrated teams to support independent living.

Option B

St Richards would become the major general hospital providing acute medicine, accident and emergency services, inpatient paediatrics, emergency surgery and consultant-led obstetrics.
Worthing and The Princess Royal would become local general hospitals, providing an urgent care centre, surgical beds and surgery day cases, a range of diagnostics, outpatient clinics and rehabilitation and beds for those with some medical conditions

Option C

St Richards would become the major general hospital providing acute medicine, accident and emergency services, inpatient paediatrics, emergency surgery and consultant-led obstetrics.
Worthing would become a local general hospital, providing an urgent care centre, surgical beds and surgery day cases, a range of diagnostics, outpatient clinics and rehabilitation and beds for those with some medical conditions.
The Princess Royal would become a community hospital, providing a minor injuries unit, some diagnostics, community and rehabilitation beds and integrated teams to support independent living.

Under all options the Royal Sussex County Hospital at Brighton would be a Critical Care Hospital and Trauma Centre meaning that people no longer had to travel to London for treatment of the most serious injuries and illnesses.

20. Initially, the PCT had a total of eight options which were judged against three hurdle criteria:

- **Clinical Sustainability** – to judge whether the option will deliver the high quality services outlined in the PCT's vision for care and be as safe as possible for patients.

- **Deliverability** – to make sure new services are delivered by appropriately trained, high quality staff and that services will not be moved until safe alternatives are in place.

- **Financial Sustainability** – the cost of each option was worked out and assessed as to whether it would deliver a 'financial breakeven' in the long term

21. The following options were not shortlisted for consultation:

a) PRH - Local General Hospital, Worthing - Major General Hospital, St Richards – Local General Hospital (Failed on Financial Sustainability)

b) PRH - Major General Hospital, Worthing - Local General Hospital, St Richards – Local General Hospital (Failed on Clinical Sustainability)

c) PRH - Local General Hospital, Worthing - Local General Hospital, St Richards – Local General Hospital with Major General Hospitals outside West Sussex (Failed on Financial Sustainability)

d) PRH - Local General Hospital or community hospital, Worthing - Major General Hospital, St Richards – Major General Hospital (Failed on Clinical Sustainability)

e) No change (failed on Clinical Sustainability)

The New Vision of Healthcare

22. The PCT outline that although some people will have to travel further for some hospital treatment, more people will be able to access healthcare in a community setting, provided by GPs, nurses and other related professions. The consultation addresses the following areas of healthcare provision:

Accident and Emergency – The PCT argue that the majority of people attending A&E do not require the services provided there and that they should be treated closer to home. Therefore GPs will provide improved levels of service to enable them to treat many urgent problems. Nurse led Urgent Care Centres will also be able to treat many of the common reasons for A&E visits including cuts and bruises, scalds, concussion, minor head injuries and falls. There will be a centralised A&E unit at either Worthing or St Richards and an urgent care centre at Brighton and Portsmouth.

Ambulance Services – Paramedics will have an enhanced role in assessing and managing patients and where appropriate referring them to other healthcare professionals to avoid the need to visit A&E. When patients do need intensive medical care, treatment will begin as soon as the ambulance arrives on the scene. The ambulance service is introducing a number of highly qualified critical care paramedics to provide the best possible treatment for patients with life threatening conditions.

Maternity – Maternity services will be provided at a consultant led service at the Major General Hospital and also at the Royal Sussex County Hospital. An additional midwife led service may be provided elsewhere in West Sussex and women will have the opportunity of home births.

Paediatrics – This service will be provided through acute specialist care (such as that provided at the Royal Alexandra Children's Hospital in Brighton) and increased community based assessment and care.

Surgery – The PCT argue that centralising emergency surgery into one West Sussex hospital and the Royal Sussex County Hospital, patients will have better services through focusing surgery on areas with experienced surgeries and specialist equipment. In the future more surgery will be carried out as day cases and in a less invasive way, which will

result in faster recovery times.

Acute Medicine – This is concerned with the immediate treatment of adults with a range of medical conditions, such as strokes or heart attacks. The PCT argue that there is evidence that it is better to travel further to get the right specialist care.

Improved Self Care – The PCT will support more self care by providing information about people's health and conditions and enable them to live more independently. The PCT will also provide additional support schemes such as 'information cafes' where information and support can be accessed.

Improved Community Care – The PCT's document 'A Breath of Fresh Air' sets out proposals to deliver more care in the community, including 24/7 care, routine medical advice being available at evenings and weekends, and in home nursing support, meaning people can spend less time in hospital.

Mid Sussex District Council's Response to the Options

23. This Council rejects all three options promoted under this consultation. The remainder of our response will set out the reasons, explanations and alternative proposals, but in summary, the Council is unable to support any of these options because:

    - They will result in our community having poorer access to healthcare.
    - The South East Coast Ambulance Service will be unable to provide sufficient paramedic cover
    - The Royal Sussex County Hospital is already unable to cope with demand and these proposals will only exacerbate this.
    - There is **no** unequivocal evidence that larger hospitals provide better care, and studies have shown that they can lead to a worsening patient experience
    - The Council believes that the proposals are financially driven, and are not primarily about improving patient care.
    - Whilst the Council supports the increase in community care, the proposals are highly aspirational, with no detailed business case about how the 'A Breath of Fresh Air' strategy will be delivered.

THE CONSULATION PROCESS

24. The PCT and Strategic Health Authority have put a great deal of work into these proposals, and the Council recognises that this work has formed the culmination of at least two years worth of work, which commenced with a review of healthcare systems undertaken by McKinsey and Company in 2005, the 'pre consultation conversation' in the summer of 2006, followed by a series of co-design events through 2006 and 2007. However, this has not culminated in a consultation exercise that is itself fit for purpose.

25. Although this Fit for the Future consultation is being led by the West Sussex PCT it is part of a regional consultation which has included East Sussex (where Fit for the Future was consulted upon earlier in 2007), Brighton and Hove (which is being consulted on at the same time as the West Sussex consultation) and in Surrey (where the consultation is expected to commence imminently).

26. The Council calls into question the role of the Strategic Health Authority, which we believed had a role to take a strategic lead on health issues in the South East Coast Region, but which is allowing a series of Fit for the Future consultations to be undertaken in a piecemeal manner. These consultations will result in significant changes to the way that healthcare services are provided and accessed. It is the Council's belief that a co-ordinated, single Fit for the Future consultation should have been undertaken to ensure patients and communities could take into account and understand the full implications of the proposals.

27. The Strategic Health Authority has not recognised that there is a significant amount of cross boundary access to healthcare. For example, people in the north of Mid Sussex, as well as in Horsham and Crawley access acute services at East Surrey Hospital, Redhill and many people in Lewes and Wealden Districts access their health services at the Princess Royal Hospital. The East Sussex consultation was undertaken with no apparent recognition of the number of East Sussex women who give birth at the Princess Royal Hospital and the Royal Sussex County Hospital. In this consultation we are being consulted on proposals where a significant number of the population are being expected to form a view, before they know what the implications of the proposals for their 'local hospital' will be.

28. Fit for the Future is a fundamental long term redesign of how healthcare services will be provided. It is not tinkering around the edges and as such the SHA should have been required to undertake the consultation in a structured, co-ordinated and well thought out manner. They have failed to do this.

29. The second area of concern relates to the publication of the consultation documentation. The formal consultation document was not available until a number of weeks after the consultation commenced. The document was then found to contain a number of inaccuracies and had to be re-printed. Whilst the Council accepts that the consultation period was extended by two weeks, it does not give the community any confidence in the ability of the PCT to lead this key consultation. People are entitled to think that if the PCT can't get the detail of the consultation right, how can they be expected to deliver first class healthcare.

30. The PCT set out that it had learned from the mistakes of previous consultations in terms of public awareness of the proposals and that it would send a summary of the consultation to every household in West Sussex. Whilst some copies have been distributed, straw polls at public meetings suggest that significantly less than 50% of the population have received summaries. This again calls into question the ability of the PCT to undertake this consultation in a proper manner, certainly the confidence of the

Council and our community in the PCT is further downgraded. Promises about involving every household in the District (in fact the whole County) therefore came to nothing

31. The District Council supports the action taken by the Joint Health Overview and Scrutiny Committee (JHOSC) in requesting the Secretary of State to call in the consultation due to inadequacies in the consultation. The JHOSC supplied the Secretary of State with a detailed analysis setting out why the consultation should be called in, but in the covering letter from the Chairman (Councillor Peter Griffiths) he stated[5]:

    "...there is a long history of failure by the West Sussex Primary Care Trust (WSPCT) to follow both the regulations and guidance in terms of engaging with health overview and scrutiny committees in the early stages of the development of their proposals and that this has been compounded by their failure to provide adequate consultation materials at the start of their formal consultation process. It is not insignificant that the first time any Joint HOSC members or officers had sight of the PCTs' proposals was in the WSPCT Board papers which were leaked to the press and were not copied by the PCTs to any Joint HOSC members or officers. The impact of this has been to impede the work of the Joint HOSC, preventing it from having any input to the consultation process or content prior to the launch of the consultation, and reducing the time it has available for scrutinising the proposals."

32. The PCT have consistently stated that the Fit for the Future website should be the main source of information about the consultation. However, a number of pieces of information have been unavailable for a period following the commencement of the consultation. Furthermore, the site has been difficult to navigate and find information and much of the data provided is incredibly complex and is incredibly difficult (if not impossible) for most people to interpret. Furthermore, the level of support provided through email enquiries has been inadequate. This Council waited over two weeks for answers to a set of enquiries that should have been relatively straightforward to provide.

33. In addition to information on the website being too complex, the Council has concerns about its accuracy, most notably around the interactive travel times database, which is not only complex, but we also believe to be inaccurate. Our assumptions seem to have been evidenced by an admission from the PCT at a public meeting in Balcombe on 2 November that some of their figures had been revised. Travel time issues are examined in further detail in that part of our response.

34. Finally, the arrangements for public meetings have been inadequate. The consultation meeting at the Clair Hall, Haywards Heath on 26 September saw around 200 people locked out and unable to attend, and there have been similar situations elsewhere, notably at a consultation event in Chichester. Again, this highlights the failure of the PCT to judge the mood of the community on this issue. People are not prepared to roll over and accept the consequences.

35. We accept that in the NHS, as in any other industry, change has to happen. The PCT and SHA do not appear to have understood or recognised the personal relationship that people have with their healthcare providers. High quality, effective and structured communication is vital to getting the message across and the PCT have failed to do this, which has added to the public anger and concern about these proposals.

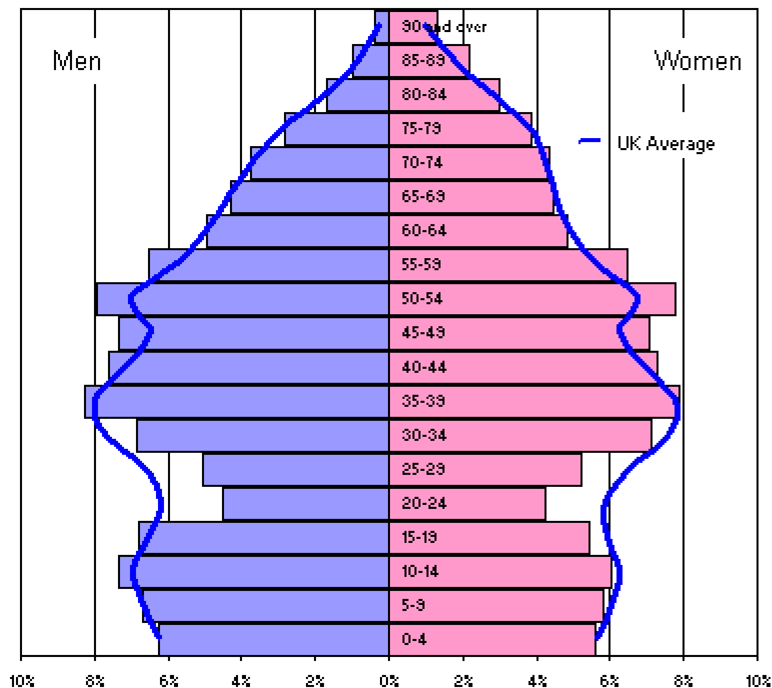
36. **We therefore ask the PCT and SHA to recognise the flaws in the consultation and to take whatever steps are necessary to redress them.**

[5] Letter from County Councillor Peter Griffiths, Chairman of the JHSOC to the Rt Hon Alan Johnson MP dated 24/08/07

THE MID SUSSEX PROFILE

Age Profile

37. The age profile for Mid Sussex is set out below (based on the 2001 Census). What is most striking is the larger than average number of people aged between 40 and 60, who will put significant additional demands on the healthcare system over the next 20 – 40 years.



38. It is clear that we have an increasingly aging population. We believe that the PCT should take greater account of local demographics when devising healthcare configurations rather than just looking at numbers. The impact of the aging population will place increased demands on the healthcare services, particularly in the areas of acute medicine, in handling issues such as heart attacks and strokes.

39. Furthermore, within this growth in the over 60 population, the number of people aged over 85 is predicted to double over the next 20 years (an increase from around 2,500 to 5,000 people)[6], and this age group create significant added demands on the healthcare system. This group of people will place increased demands on people in terms of community care at home and acute care in hospital. The PCT does not appear to understand the complex demographics of Mid Sussex and how they compare and contrast with those in Brighton and Hove. The health needs of our community require specific solutions and the Princess Royal Hospital has to be a fundamental part of those.

40. The age profiles for Crawley, Horsham, Lewes and Wealden are set out at appendix one. An analysis of their population profiles clearly sets out a regional trend of an aging population, particularly in Horsham, Lewes and Wealden, where all Districts have a population of 40 – 60 year olds that is above the national average and which in 20 to 40 years time will create a significant demand for hospital services.

[6] Mid Sussex District Council Older Persons' Housing Strategy, adopted by Council on 25/09/07

Population Growth

41. The PCT often appears to operate under the misapprehension that the Princess Royal Hospital only serves Mid Sussex. However, the PCT's own analysis of A&E admissions highlights a population of over 300,000 is served by the A&E service at the Princess Royal Hospital (analysis at appendix two) including residents from Crawley, Horsham, Lewes and Wealden Districts. All of these districts, apart from Crawley have a similar population profile to Mid Sussex and in the next 30 years will experience an increasing population, where demands on healthcare services (particularly acute services) will increase.

42. The consultation analysis focuses on the population growth through to 2016, which is extremely short termed thinking. Whilst it is accepted that firm figures and analysis are only available for this period, the PCT itself talks of a lead in time of 5 years for Fit for the Future to take effect, so the impact on the changes will only be fully felt in 2013. This will no doubt lead to a further reconfiguration of services to take into account the post 2016 growth. Perhaps the PCT that is in place at the time will identify Haywards Heath as an appropriate location!

43. In his first week as Prime Minister, Gordon Brown outlined his desire to increase housebuilding in the South East and this has become reality in a short space of time through the increased housing numbers announced through the draft South East Plan which sets out housing growth through to 2026. An analysis of the five key Districts that are served by the Princess Royal Hospital (Mid Sussex, Crawley, Horsham, Lewes and Wealden) highlights that in the 20 year period 2006 – 2026 an additional **FIFTY THREE THOUSAND, TWO HUNDRED AND NINETY ONE** houses will have to be developed, which is comprised as follows[7]:

Proposed Housing Growth Figures Through to 2026	
Crawley	7,500
Horsham	15,791*
Lewes	4,400
Mid Sussex	16,000
Wealden	9,600
TOTAL	**53,291**

* Extrapolated figure

44. Even these numbers may not be sufficient. In a report published in October 2007, the National Housing and Planning Advice Unit stated that a further 270,000 homes were needed year on year in order to meet requirements[8].

45. The total population of these areas based on the 2001 Census was 581,410 with a total of 240,390 houses. This averages out at 2.42 people living in each household. It can be calculated that an increase of this size will **increase the population by 128,964**. Alternatively, it can be looked at as a **22% population increase**.

46. To put that growth into context. The increase in housing growth to 2026 will result in new settlements equivalent to that of the existing Mid Sussex being treated within the catchment area of the Princess Royal Hospital. Such growth demands an increase in

[7] Draft South East Plan
[8] NHPAU response to the Government's Green Paper 'Homes for the Future' published 25/10/07

healthcare provision, not a reduction.

47. The PCT cannot allow the Fit for the Future proposals to be constrained by a short term view of the population in 2016. Our evidence[9] shows that the population is aging and is growing. The health needs are going to therefore increase. There are going to be increased demands on all aspects of healthcare and it is wrong to take short term healthcare decisions, when it is clear that in the long term they are going to have to be reversed at significant additional cost.

Town/Village Issues

48. Around 74,000 people currently live in our three main towns of Burgess Hill (28,000), East Grinstead (23,000) and Haywards Heath (23,000). This leaves a rural population of around 54,000. The population breakdown of towns and villages differ quite significantly, in that people in our villages have an older age profile, typically have more health problems, and perhaps most importantly, are not served by adequate public transport and have relatively low levels of car ownership.

49. The 2001 Census shows that our rural areas have an older population than in the three towns. For example, the three wards with the highest average age are Hassocks (46.3), Lindfield (45.4) and Hurstpierpoint and Downs (40.6). The rural wards also have the highest numbers of people with life limiting illnesses. So, whilst an increase in community care would be welcome, people in these wards will continue to have the greatest need to make use of acute medical facilities, and will experience a significantly worse service if they have to access acute services in Redhill or Brighton, rather than at Haywards Heath.

50. Transport is a theme throughout the Council's response. We make no apologies for this as it is an absolutely fundamental issue. Whilst it affects the whole community, we do recognise that people living in our three main towns do have access to better public transport in terms of buses and trains. Our rural communities do not have this benefit and the table on the next page compares our rural communities, setting out the average age, percentage of people with a limiting long term illness and the number of households that do not own a car.

[9] Mid Sussex Community Profile and Mid Sussex 2007 Profile, available at http://www.midsussex.gov.uk/page.cfm?pageID=4314

Ward	Average Age	% of people with a limiting long-term illness	% of households (people aged 65+) that do not own a car	% of households (people aged 85+) that do not own a car
Ardingly & Balcombe	40.1	15.01	19.5	26
Ashurst Wood	38	11.21	17	20
Bolney	40	13.08	13.2	34
Copthorne & Worth	38.9	11.48	17	46
Crawley Down & Turners Hill	38.9	11.28	20.2	60.4
Cuckfield	39.6	12.44	19.3	32.8
Hassocks	46.3	17.5	28.3	59.2
High Weald	40.5	13.92	16	32.8
Hurstpierpoint & Downs	40.6	13.69	22.3	43.5
Lindfield	45.4	16.38	24.4	41.5

51. These figures are masked in the PCT's documentation. They raise a number of questions. How should a frail pensioner, living in a rural community, managing on a low income get to hospital? Public transport and driving are unlikely to be the solutions. Should they get a taxi? And how should their husband or wife be able to visit them? Or maybe they shouldn't? The Royal Colleges recognise that there is a need to treat urban and rural areas differently[10], so why don't the PCT?

52. Another fundamental issue that is often ignored is the fact that visitors, as well as patients will be disadvantaged through the proposals. Patients being visited in hospital by loved ones plays a key role in developing their 'feel good' factor and aiding their overall recovery. In some ways visitors will be more disadvantaged as they will have to make a number of trips to hospitals, and the stark reality is that a number of people will be unable to visit their friends or relatives. Does this really deliver a better patient experience?

53. These statistics illustrate the significant problems that people in our rural communities will experience in accessing services and being able to visit the hospital. We recognise that the percentage of people in Brighton and Hove with limiting long term illnesses is at a higher level than in Mid Sussex[11], but the crucial difference is that those people live

[10] Report of a Working Party of the Academy of Medical Royal Colleges entitled 'Acute Health Services', September 2007
[11] 2001 Census Analysis

closer to their hospital with significantly better public transport provision.

54. The PCT should better understand the community served. Brighton cannot serve our population, we are different communities that have the misfortune to be served by the same Acute Trust.

Gatwick Diamond

55. Mid Sussex, and therefore the Princess Royal Hospital is a key component of the Gatwick Diamond. The Gatwick Diamond is an economic sub region that includes the following district authorities: Crawley, Horsham, Mid Sussex, Mole Valley, Reigate and Banstead and Tandridge as well as West Sussex and Surrey County Councils. It is also comprised of the South East England Development Agency (SEEDA), the West Sussex Economic Partnership and the Surrey Economic Partnership, as well as individual business representatives.

56. The Vision for the Gatwick Diamond is that 'By 2016 the Gatwick Diamond will be a world class, internationally recognised business location achieving sustainable prosperity'[12].

57. The Gatwick Diamond Economic Strategy sets out a framework of how this will be achieved, and it sets out that to create success the following conditions have to be created:

   - A corresponding step change in the quality, aspirations and skills of the area's workforce.
   - The productivity and competitiveness of local businesses, particularly SMEs is measurably enhanced.
   - Important local businesses with growth potential are retained and their expansions encouraged.
   - The infrastructure and operating environment conducive to the attraction of investment from leading edge business activities is created.
   - Higher rates of business start up, growth and survivability are achieved which diversify and enhance the vibrancy of the local economy.
   - Businesses will have become more socially and environmentally responsible and grow sustainably.
   - The town centres of the Diamond area are modernised to meet the future needs of residents, employers, employees and visitors.
   - Fast and efficient access to, from and within the area.
   - The quality of life of the area is enhanced and sustained as a catalyst for investment and for the attraction and retention of high quality staff.
   - Encouraging those not working back into the workforce increases economic activity rates.
   - A cohesive programme of development activities which business, local authorities and delivery agencies sign up to in order to propel the area forward.
   - Clear recognition by investors, government bodies and funding bodies of the Gatwick Diamond's growth and sustainability needs, potential and capacity to move forward.

58. The Strategy will not be achieved simply through the members of the Gatwick Diamond partners. In particular, support will be needed from the Government in terms of supporting the delivery of infrastructure requirements, in terms of roads and railways, as well as through the delivery of other supports such as schools, community facilities and

[12] Gatwick Diamond Regional Economic Strategy, January 2007

of course, first class healthcare.

59. To be competitive and achieve its goals, the Gatwick Diamond has to have first class healthcare, and although East Surrey Hospital is located to the north of the Diamond, it is not equipped to serve the significantly expanding population. Potential investors could be put off investing in the area because of the gaping black hole of acute healthcare facilities which could potentially exist.

60. The Gatwick Diamond Economic Strategy (paragraph 4.2.5) refers to the need for healthcare to support businesses. We believe that the PCT should be more conscious of its significant role in contributing to the economic development of the area, and be aware that these proposals could have significant long term, negative implications for the Gatwick Diamond.

Land Availability

61. The issues around housing development stretch far beyond the demands that it will create on health provision and infrastructure requirements. Over 60% of Mid Sussex is designated as an Area of Outstanding Natural Beauty. This creates additional pressures on the Council to accommodate housing development, but also places increased demands on other bodies, including the NHS to identify land for development.

62. There is a current example of how the land availability issue in Mid Sussex is affecting local health services. The Judges Close and Ship Street Doctors Surgeries in East Grinstead want to merge their surgeries and build new purpose built facilities which will enable them to provide more services, increase capacity and even provide accommodation for nurses. This is no doubt in line with the ethos of Fit for the Future. However, the Doctors and Practice Managers have spent two years looking for land (a 2,100m² building on a one acre site with 100 car parking spaces), and have even appointed a project manager to lead on this, who has been unable to identify an appropriate site.

63. **We want the PCT to develop plans that are sustainable in the long term (for a minimum of 20 years) that recognise the fact that our population is expanding and aging. This should take into account the rural nature of Mid Sussex and the fact that rural areas cannot be treated in the same way as urban areas when devising healthcare systems.**

TRAVEL TIMES AND ACCESS

64. The PCT have presented extremely detailed information regarding accessing services at hospitals, and the Council objects strongly to this aspect of the consultation. The PCT set out that the increased focus on community services will reduce the need for people to make journeys to hospitals, and so the need to make journeys for treatment and the overall journey time will decrease. This logic skews the reality of life for the people who require acute care, and who in Mid Sussex face a reality of longer journey times, increased stress and greater personal expense.

65. The PCT set out that 100% of patients will be able to access services within 42 minutes. This is an extremely simple statement, as the analysis includes access to all health services, including GP services. The fact that GP services are generally very local to where people live and account for the majority of individual treatments is another example of the PCT using factually correct statistics that mask the reality.

66. The PCT have received significant criticism about their transport analysis and have now even recognised the flaws themselves. The interactive travel database now includes the statement *"This information does not necessarily mean that this is the time it will take you to travel between the locations. This website merely provides an indication of likely travel times and may e.g. be useful for visitors when visiting friends and relatives in hospital who have been taken there in an emergency or to patients choosing in which hospital they would like to have their operation where this is able to be planned."*

67. The reality for our community is increased journey times. The PCT recognise that for Major Accident and Emergency treatment our community will have travel times that are increased as follows:

    - Burgess Hill – an increase of 14 minutes (to 24 minutes)
    - East Grinstead – an increase of 12 minutes (to 37 minutes)
    - Haywards Heath – an increase of 29 minutes (to 32 minutes)
    - Mid Sussex District – an increase of 12 minutes (to 28 minutes)

68. The PCT therefore recognise that our community will have to travel further to access these services. However, their assessment leads us to our first criticism, that the travel times analysis is inaccurate.

69. The journey times assessed by the PCT do not reflect the experience of Mid Sussex residents. The District Council has undertaken its own analysis with the details set out at appendix three from a number of the Council's wards. We accept it is not scientific, but it does show that at a cross section of times, the PCT analysis does not reflect real life experiences. In fact, no journeys were undertaken within the timescales suggested by the PCT.

70. The travel times provided by the PCT must not be used as evidence of how accessible services will be, for three key reasons:

    - Peak time travel is only recognised as being between 8am and 9 am on weekdays and even this analysis of peak time travel only refers to West Sussex as the information for Brighton is insubstantial
    - There is no analysis of the impact on the Ambulance Service.
    - The particular difficulties experienced by public transport users are not recognised.

Peak Time Travel and Car Parking

71. The analysis of travel is amateurish at best. The PCT has assumed peak time travel as being between 8am and 9am, which clearly does not reflect the fact that in the morning peak time travel lasts from 7.30 – 9.30 and in the afternoon from 4.00 to 6.30 as a minimum level. Furthermore it does not take into account the impact of travel times during peak seasons such as during the peak holiday season, bank holidays, summer weekends or peak time shopping periods. To suggest that the roads are busy for one hour a day is naïve in the extreme.

72. Furthermore, the PCT have not had any peak time information outside of West Sussex. The Assistant Head of Highways and Transport at West Sussex County Council set out in the supporting documentation on the Fit for the Future website that the level of detail for roads in Brighton was insubstantial.[13]

73. The PCT is creating a false impression. As our analysis sets out, the PCT assessment does not reflect real life. We may well have world class health services in Brighton, but the fact is that many people will have serious difficulty in accessing them.

74. The PCT have stated that many of the arguments about car parking are not relevant, as major accident and emergency cases will be transferred by ambulance. Again, this is a statement that bears no relation to reality. Patients regularly quote the need to queue for 45 minutes to an hour to get parked (as admitted by one of the Trust's car park inspectors), so the actual journey time from the patients house to the clinician can be over an hour and a half, as a minimum for Mid Sussex patients.

75. A more sophisticated analysis of travel times would have produced a realistic assessment of the situation. Whilst it is impossible to ever be precise, better indications of minimum and maximum transport times, including car parking and taking into account seasonality and tourism/shopping implications on a month by month basis would give the community confidence in the PCTs ability to honestly assess the situation. However, it is our belief that such an analysis would have undermined the consultation process.

Ambulance Services

76. Specific issues relating to our concerns about the ability of the ambulance service to support the delivery of Fit for the Future are set out in paragraphs 83 – 92. However, with regard to access times, we have specific concerns at the ability of the Ambulance Service to transfer seriously ill patients from Mid Sussex to Brighton or Redhill. The PCT assume that ambulances will be able to reach the Royal Sussex County Hospital within the non peak travel times set out in the consultation. Whilst ambulances will be able to by pass some of the traffic problems in the city, the fact is that Brighton is an extremely congested city and seriously ill patients will take longer to access their A&E services.

77. Ambulances essentially have one route into Brighton from Mid Sussex, the A23. If there is an accident on that road which closes it (as happened in the summer of 2005) the only alternative is by travelling over the South Downs, which will have a serious impact on travel times and on the safety of patients.

[13] http://www.southeastcoastfff.nhs.uk/getdoc/91038a44-2331-4245-90a5-640d77d848fc/Accessibility,-travel-times-and-transport---te-(1).aspx

Public Transport

78. In reality, public transport is not a realistic option for the majority of our population. Following Best Care, Best Place the 40X bus service was introduced from the Princess Royal Hospital to the Royal Sussex County, via Haywards Heath and Burgess Hill. Whilst it has proved popular, it does not serve larger villages in the south of the District (such as Hassocks and Hurstpierpoint) and the fact that it is only an hourly service means that patients often face a long wait for the next bus. Whilst people can travel to Haywards Heath or Burgess Hill from their village and use the 40X, the various bus routes are not linked up with the 40X, making journey times even longer and public transport even less of a realistic option.

79. It is very often the frail and elderly who rely on public transport. These people are more likely to live in rural locations, and this is where the real life implications of the proposals can be demonstrated, where people have to rely on friends or family or use taxis (one frail Hassocks patient had to pay £40 for a return taxi trip to Brighton).[14]

80. Even if a patient wanted to use public transport, many patients cannot and so have to rely on taxis or friends or family. For example, if a patient has been under general anaesthetic or sedation, they are advised not to use public transport for their return journey.

81. **We want the PCT to recognise that Mid Sussex is a rural district that has specific needs. The proposals may well work in Brighton and Hove, but the reality for our community is reduced access, increased cost, increased stress and a reduced patient experience.**

[14] West Sussex PPI Forum: Travel Survey on the accessibility of the Brighton NHS Hospitals to People Living in Mid Sussex. April 2007

AMBULANCE SERVICES

82. It is our belief that as a direct consequence of Fit for the Future, people will die.

83. Our view is backed up by the report 'The relationship between distance to hospital and patient mortality in emergencies: an observational study', published by academics at Sheffield University in August 2007. This report concluded that an increased journey time to hospitals appeared to be associated with increased risk of mortality. Their evidence illustrated that a ten kilometre increase in straight line distance is associated with around a 1% absolute increase in mortality.[15]

84. The distance from the Princess Royal Hospital to the Royal Sussex County Hospital is 31.5 kilometres and so in real terms patients, face the prospect of a **3% increase in chance of death**.

85. This is why, whatever hospital configuration is agreed on, an effective, well resourced ambulance service is crucial. We set out in the previous section the access problems that the Mid Sussex community has in accessing the Royal Sussex County Hospital and we are deeply concerned that despite the assurances, there is no evidence that Mid Sussex patients will have better survival chances following a heart attack, stroke or other medical emergency.

86. It appears to be a significant weakness in the preparation of the consultation that paramedics have not been consulted on the proposals, or involved in the emerging plans. This is a major oversight, as an effective and well resourced ambulance service will become the glue that holds the future health service arrangements together.

87. We have received information from paramedics on a confidential basis about their concerns with the proposals. We share these concerns, which are set out below:

    - In any 24 hour period, ambulances spend 8 hours driving to or from their base in Brighton (e.g. not transferring patients)
    - The result of this, is that Mid Sussex is regularly without paramedic cover
    - Patients have to be diverted away from Brighton (to Eastbourne, Redhill, Chichester or Portsmouth) on an average of three days a week, because Brighton does not have the capacity to handle the demand.
    - Because of the lack of capacity, patients are frequently left in corridors

88. We understand that there are a total of 15 qualified paramedics operating in the Mid Sussex area as well as 22 qualified technicians and 8 trainee technicians. However, we also understand that in real terms, taking into account shift patterns and annual leave there is probably only ever a maximum of five on duty at any one time. Within this 15 there are four Paramedic Practitioners that are currently being trained and 8 trainee technicians.

89. The technicians only fulfil a limited role. For example, they are unable to undertake thrombalytics. Also, if a woman gives birth they are able to deliver the baby but not cut the cord.

90. This creates an interesting dichotomy in that the argument for centralisation is that people will be accessing better healthcare at centres of excellence yet will be receiving

[15] Pre-hospital care: The relationship between distance to hospital and patient mortality in emergencies: an observational study. Emergency Medical Journal, August 2007. Jon Nicholl, James West, Steve Goodacre, Janette Turner.

services in ambulances, moving at high speed, swaying round bends in the roads etc, which is surely not a best care solution for the patient.

91. **We therefore ask the PCT and the South East Coast Ambulance Trust to provide a written business plan setting out how they ensure that the ambulance services will be fir for purpose under the Fit for the Future proposals.**

ACCIDENT AND EMERGENCY

Requirements for the Princess Royal Hospital

92. Ever since Best Care, Best Place the PCT have assured us that the A&E unit at the Princess Royal was a full service that had not been downgraded. However, during this consultation the truth has been acknowledged that the A&E service at the Princess Royal Hospital has been downgraded and that patients already have to visit Brighton for a full A&E service.

93. When the Princess Royal Hospital opened in 1991, a comprehensive range of services were provided there - full accident and emergency services (including orthopaedic and trauma surgery) and a paediatric accident and emergency service, vascular surgery, full maternity services, neonatal services, a special care baby unit (SCBU), a paediatric outpatient clinic, and a low-risk in-patient paediatric service (with high-risk in-patient paediatric care readily accessible at Crawley). There was a full range of in-patient adult mental health facilities and a long-established and renowned neurosciences centre – Hurstwood Park Hospital.

94. What is left - and what has been lost - comprises:

    1. Only a virtual walk-in minor accident and medical emergency unit at the Princess Royal Hospital.
    2. Vascular surgery already moved to Brighton **before** Best Care, Best Place.
    3. Polytrauma and orthopaedic emergency moved to Brighton.
    4. All paediatric services requiring an anaesthetic moved to Brighton, **without** consultation.
    5. High-risk in-patient paediatric care moved to Brighton.
    6. The consultant led midwife service was reduced to an ANNP service and will now probably be reduced to a midwife–led service, if it stays at all.
    7. Hurstwood Park Hospital will be moved to Brighton as soon as it can be accommodated there (the current buildings are earmarked for demolition by 2011), against the recommendations of Mid Sussex District Council (a position statement the Council provided to West Sussex Health Select Committee in 2004 is attached at appendix five).
    8. Adult psychiatric in-patient services will soon go to Crawley.
    9. Warninglid Day Hospital for patients of retirement age with mental health problems, will be moved to Burgess Hill soon.
    10. The following categories of patients with abdominal pain, and likely to require an operation with a general anaesthetic, are now sent to Brighton, as the Princess Royal Hospital can no longer treat them:
        - All children aged 15 and younger
        - All patients aged 70 and over
        - All patients with a temperature over 37.5 degrees Centigrade
        - All patients with pain in the centre of the abdomen radiating to the back
        - All GP adult admissions where the GP suspects bowel perforation, pancreatitis (an ‘acute abdomen’), appendicitis or bowel obstruction
        - All patients with trauma and orthopaedic problems
        - All patients with a lower limb injury who cannot walk
        - All trauma calls
        - Most spinal injuries
        - All open fractures (which include obvious deformity with a nearby graze or wound).
    11. Urology surgery at the PRH is now entirely non-emergency.

95. All of the above has taken place – or, in the case of Hurstwood Park and the maternity services, the decisions affecting them have been made - after the urgent publication of the 2000 Taylor Report. The loss of services highlights how systematically that Report's recommendations were ignored.

96. Thus the worrying fact is that **the already inadequate A&E services that remain at the PRH fall well short of a full medical and surgical provision; as they stand, they would be unsustainable**. Frequent mention is made by other opponents of Fit for the Future of an alternative of "retaining" and then "enhancing" those services. That alone will not do.

97. The Council is aware that the PRH serves **at least** 319,000 people (appendix two). Equally - and this too is crucial - it is aware that the Fit for the Future consultation, like its immediate predecessors, starts out from a configuration of services based on an area that has a large enough population to provide clinical sustainability but one that geographically prevents safe and convenient access to those services not only for the people of Mid Sussex but also for the people of Crawley and Horsham. The geographical configuration that Fit for the Future perpetuates is artificial and must be changed - to provide the vital combination of clinical and financial sustainability and safe accessibility of services for patients. The Council therefore demands that the first required step is to **restore** what has been salami-sliced away - only then would any **enhancement** be possible (and it is certainly needed). The context must be a geographical re-configuration different from what is being pursued at present in any of the unviable "options" proposed. The time is ripe to **restore** the vision of Michael Taylor, who identified the obvious strategic importance of the PRH in 2000.

98. Unless this twofold restoration takes place, the PRH will very soon have to be downgraded to a cottage hospital (politely referred to as "community hospital" in Fit for the Future) - whether or not that "option" appears in NHS consultation documents.

99. The Royal College of Surgeons recommends a catchment population of 300,000[16] for A&E Units and a conservative analysis of admissions to the Princess Royal Hospital identifies a catchment area of over 306,000. This analysis has been based on the PCT's own travel data which maps out where A&E patients travel from. Details of this are attached at appendix two.

100. Furthermore, the population of this area is going to grow significantly over the next 20 years (paragraphs 41 – 47) and the age profile of the whole area is rising (paragraphs 37 – 40). This is another example of the short sightedness of the PCT in the population data it is using to justify the proposals. The population is going to increase significantly and the age profile is going to rise and we need a local NHS that understands this and ensures that it is reflected in the arrangements for the delivery of healthcare.

101. Since Best Care, Best Place the Acute Trust and the PCT have glibly bandied around the term 'one hospital over two sites'. Now is the time to deliver on that catchphrase and make it a reality to work with the Royal Sussex County Hospital, to better manage capacity, and most importantly, provide an accessible, first class service to the 306,000 and growing residents that are supported by its Accident and Emergency Unit.

102. We want the PCT to retain and develop A&E services at the Princess Royal. Developing the role of the Princess Royal will be the first commitment from the local NHS to the patient. We don't doubt that the Royal Sussex County Hospital could be one of the best hospitals in Europe, but if nobody can reach it, what's the point?

[16] Delivering High Quality Surgical Services for the Future. March 2006

Academy of Medical Royal Colleges Report

103. In September 2007 a working party of the Academy of Medical Royal Colleges issued a report entitled 'Acute Health Services'[17]. The report was written as the NHS is embarking on a further series of changes and to respond to three challenges, the most important being 'To ensure that the main driver of any change should be the safety and quality of patient care'.

104. The working party identified three key issues which are relevant to the Fit for the Future proposals:

- No single model of provision will suit all localities and the principles need to be sufficiently flexible to adapt to local needs.
- Although there is evidence to suggest that the centralisation of services to deal with complex or specialised work provides better outcomes for patients, evidence for centralisation of non-complex and high volume cases does not exist.
- Centralisation may have disadvantages for remote and rural communities

105. The West Sussex PCT appears to have fallen into the trap of 'one size fits all' approach to service reconfiguration. Similar proposals, including the development of polyclinics are being developed in London, and they may be appropriate due to the large number of hospitals in the city. West Sussex (and in particular Mid Sussex) do not fall into the same category and therefore the proposals should reflect the local circumstances, as recommended by the Academy of Medical Royal Colleges.

106. The PCT have placed great weight on Royal College reports in justifying their proposals, and the publication of this report during the consultation process suggests that the proposals should be re-thought. The entire premise of the proposals is that centralisation of cases will improve patient care, yet here, the Colleges are questioning that assumption.

107. Paragraph 5.7 of their report highlights a crucial point around the rural issue:

"While centralised schemes may work well in urban areas, they may diminish access in rural areas. This should be addressed through careful planning and engagement of communities. Arrangements must be tailored to local needs. Better and wider use of technology such as telemedicine can be helpful."

108. The PCT has undertaken planning and engagement with our community, but with insufficient care and attention to detail. There has been a detailed consultation process, but there has been no significant effort to engage with individual communities and listen to their concerns and local knowledge in developing proposals that meet our local needs in Mid Sussex and the needs of neighbouring local authority areas that the Princess Royal Hospital continues to serve.

109. The working party recognised the need for service provision to reflect local circumstances and that configurations should be different in rural areas than in urban areas. It recommended (paragraph 3.8.5, model A) that in rural settings, hospitals

[17] Report of a Working Party of the Academy of Medical Royal Colleges entitled 'Acute Health Services', September 2007

should have a full medical and surgical Accident and Emergency Unit. Again, this is not in line with the proposals from the PCT. In making this recommendation the report states that there are two options to achieve improved service provision in rural areas: "*Firstly, that small places are networked into larger centres with the capacity to support clinicians through the development of management protocols, education and training, assurance and improvement programmes; secondly, rotation of staff between large and small places."*

110. In September 2007 the Kings Fund published a report 'Our Future Health Secured?[18] A review of NHS funding and performance' which set out:

"In many parts of the country, a drive for better quality and lower costs, combined with other factors, such as the European Working Time Directive, is leading to plans for substantial reconfiguration of services. During the 1990s, reconfiguration had focused on the need for fewer hospital sites, presumed to enjoy lower costs and produce better quality care. But the evidence base for justifying change in terms of cost, quality and access was, and remains, weak. The series of papers issued on the clinical case for change (Department of Health 2007f,l,m,n,w) contained very little evidence to justify their proposed change of direction in terms of potential benefits. The one piece of statistical evidence cited in these papers – relating to improved care for heart patients – was based on clinical judgement rather than research (Hansard 2007a). The recent review of London's health service (Darzi 2007) contains more evidence, but only for a limited number of services; and the case for its main proposal, that a network of polyclinics' should be established, has yet to be fully demonstrated. A critical evidence gap therefore remains."

111. The Council strongly supports the need for reconfiguration, and accepts the overwhelming clinical evidence for the benefits of centres of excellence. However, the geographical and demographic contexts are key to deciding where such centres are situated. In rejecting the Fit for the Future proposals the Council is not seeking to throw out the (clinically well delivered) baby with the (administratively convenient but life-threatening) bath water.

112. The PCT and the Brighton and Sussex University Hospitals NHS Trust persist in their experiments with the lives of people in Mid Sussex and of the wider area that the PRH serves so well. There is no evidence that the "options" they propose will work to the benefit of those people, or contribute to better health care in West Sussex as a whole. There are other viable alternatives that will deliver holistic patient care solutions. The Council urges the authors of Fit for the Future to consider its submissions, taking into account the PRH's unique strategic location for a large area of West and East Sussex (as did the Taylor Report in 2000), and its consequent ability to deliver full, safe, accessible and financially viable medical and surgical Accident and Emergency services that meet the needs of the population.

[18] Kings Fund: Our Future Health Secured? A Review of NHS Funding and Performance. Derek Wanless, John Appleby, Anthony Harrison, Darshan Patel. September 2007

MATERNITY SERVICES

113. Best Care, Best Place delivered the reduction of the consultant led service at the Princess Royal and introduced the Advanced Neo Natal Nurse Practitioner (ANNP) service. The Council accepted the ANNP model in 2004, recognising that it was an innovative solution that provided an acceptable level of service. Our concern was about its sustainability, as there are only a small number of ANNPs in the UK, and are therefore in demand for employment.

114. The Council's concerns about the long term future of the maternity service were evident during our input to the Best Care, Best Place Scrutiny process being led by West Sussex County Council. The Council's response to those aspects of the proposals are attached at appendix four.

115. It appears that our concerns about the sustainability of the ANNP model have been realised, as through this consultation we are now faced with the prospect of all consultant led maternity services being moved to Brighton.

116. The NHS has undergone countless reconfigurations since 1974 and looking back through history it appears that each one has been a 'botch job' to fix a current problem – certainly Best Care, Best Place could easily be seen in the light of a mechanic doing what he needs to do to get a car through its MOT.

117. However, Fit for the Future is presented as the longer term, strategic solution to our NHS services, delivering better care, better prospects at lower cost. This could be acceptable if we were focusing our services on a high class, CENTRALLY LOCATED, hospital. Instead, expectant mothers are being expected to understand an argument which will see them benefit in:

- Having to travel further to a difficult to access hospital
- Facing the risk of being transferred to Eastbourne, Worthing or Chichester as the hospital does not have the capacity to cope
- In a worst case scenario, being more likely to die and lose their baby as a result of inadequate Paramedic support, inappropriate infrastructure and accessibility problems.
- Possibly being able to access a midwife led service, somewhere in West Sussex (maybe at the Princess Royal)

118. The key argument being put forward by the PCT is that 'big is best'. A larger maternity unit would enable a more resilient service to be provided, clinicians would be able to better develop their skills and there would be only an additional 20 hours of consultant cover. The evidence for this assumption is sketchy and our arguments are set out below.

Standards Across Europe

119. The 'big is best' argument has not stretched beyond the English Channel through to other European countries.

120. The largest English maternity unit is the Liverpool Women's hospital which in 2003 delivered 8,084 babies. The largest maternity unit in Germany is the Humboldt Unit in Berlin which delivers just over 3,000 babies per year (it recently increased to this figure after the closure of two smaller units). Few hospitals in Germany have more than 2,000

deliveries per year and the Hochst hospital, Frankfurt's largest hospital delivered only 1,800 babies in 2004.[19]

121. France's largest maternity hospital, the Jeanne de Flandre Hospital in Lille has just over 4,000 births per year.

122. So the Princess Royal Hospital, which delivered just under 1,500 births in 2006 is not out of step with European equivalents.

123. Furthermore, a 2003 study of perinatal deaths in a selection of countries in Europe showed England as performing worst. The headline results were:[20]

Numbers and percentages of evaluated cases of perinatal death graded as "suboptimal factor(s) identified which might have contributed to the fatal outcome" or "suboptimal factor(s) present which are likely to have contributed to the fatal outcome"

Country	**Total deaths evaluated**	**Substandard care might have caused the death**	**%**	**95%confidence interval**
Finland	163	52	32	25 – 39
Sweden	129	46	36	28 – 44
Norway	139	55	40	32 – 48
Spain	102	45	44	35 – 54
Netherlands	157	76	48	41 – 56
Scotland	85	43	51	40 – 61
Belgium	188	96	51	44 – 58
Denmark	260	133	51	45 – 57
Greece	105	54	51	42 – 61
England	215	115	54	47 – 60
Total / Average	1543	715	46	44 – 49

124. Of all of the countries set out above, England already had the most centralised maternity services and whilst it is acknowledged that these figures cannot be directly used to infer that sub-standard practice is more common in England, it is still not a good indication that the centralisation of maternity services achieves better standards. The statistics bring into question that the centralisation of maternity services (big is best) is the way forward.

[19] Maternity Services in the NHS. Published by Reform. Prof. Nick Bosanquet, Jen Ferry, Christoph Lees, Prof Jim Thornton. December 2005.
[20] Differences in perinatal mortality and suboptimal care between 10 European regions: results of an international audit, Richardus, J et al, BJOG: An International Journal of obstetrics and Gynaecology, 2003, Vol 110, No 2

Princess Royal – Innovator

125. The Princess Royal provides a quality, respected and loved service to the Mid Sussex community as well as people from Horsham, Lewes and Wealden Districts. However, it is also placed in a strategic location that allows mothers in these areas to access quality, local services.

126. But the local support for the maternity unit is about more than convenience, it provides a first class, and often innovative, service. The unit already demonstrates excellence in a number of areas:

- It was one of the first maternity units to introduce nuchal scanning for Downs Syndrome, which is now being introduced across the UK.
- Its Mother and Parent support for bereaved families provides excellent ongoing support for parents who lose their babies. This has recently been recognised with the midwife who introduced this initiative being awarded an MBE for her work.
- The Mental Health wellbeing clinic, where mothers can be referred to psychiatric support enables an improved service to the needs of women throughout their pregnancy
- The introduction of the day assessment unit has also reduced ante natal referrals and reduces the pressure on the delivery suites

Brighton – Capacity Issues

127. Brighton does not have the capacity to cope with the current number of births (1,965 in 2006) , with the unit having to close its doors to new admissions and mothers being told to use the Princess Royal or other hospitals on a regular basis[21]. In fact the Brighton and Hove PCT admit this in their Maternity Services fact sheet, which is available on the Fit for the Future website.[22]

128. The capacity problems will be exacerbated by the fact that many women attend the hospital early in labour and are advised that they can return home. As the Princess Royal is more accessible, most women do return home before returning to hospital later in the labour. If women attend the Brighton maternity unit, they are more likely to wait in the hospital, rather than return all the way home, which will place additional strain on services.

129. The Council is further concerned that should Worthing hospital not become the Major General Hospital in West Sussex, a further demand on capacity at the Royal Sussex County Hospital will be created by mothers from Worthing being forced to travel to Brighton.

Potential Midwife Led Service – Limitations

130. The consultation talks about a midwife led service being provided somewhere in West Sussex, and potentially it could be sited at the Princess Royal. We do not consider this a solution or acceptable in any way. Midwife led units can fulfil a role in some areas, such as in London, where women can access an obstetric led unit relatively quickly, women in Mid Sussex would not. The Golden Period between a decision being taken that a woman needs a caesarean section and starting the operation is 30 minutes.

[21] Example illustrated in Brighton Argus, 6/4/07 'Celebrity clairvoyant in unforeseen birthing drama'
[22] http://www.southeastcoastfff.nhs.uk/getdoc/c3d6d51a-2d19-4a47-ae37-f2462ed72759/B-H-Fact-Sheet-Maternity-5.aspx

There is no way that when such a decision was taken in Mid Sussex, that a woman could be on the operating table in Brighton within that timescale.

131. This could result in lives being lost. A woman could give birth in a natural way, with no problems until the last moment. The case study below shows an example of a situation that has happened before. Our question to the PCT is, what would happen under Fit for the Future to this woman?

Case Study

A woman gives birth at a midwife led unit and unfortunately experiences a tear in her uterus. She would need to be immediately moved to an intensive care unit for blood and plasma and the ambulance service would be unable to cope. Not only would the woman need blood, but the blood loss would make it very difficult to get a line in a vein. She would not make it to Brighton alive.

132. Furthermore, the fact that there is no business case or an evidenced medical case for a midwife led unit, is evidence of the consultation being ill thought out and incomplete. Our community is being asked to comment on proposals that are not yet complete.

Alternative Service Provision – Cost Savings

133. There is a concern amongst existing maternity staff that cost is the primary driver of the changes, with the fact that it will be easier to manage a single unit, rather than two. Clearly, the ‘salami slicing’ approach is one way of creating savings, reducing cost and increasing throughput at a single unit will deliver a cheaper (and worse) service.

134. At a superficial level, this is fact. However, the worsening service opens the NHS up to increased costs through negligence. The growing ‘no win no fee’ compensation culture in the UK, creates the view that people can expect to be financially compensated when something goes wrong, and an increase in deaths through maternity services will create significant costs for the NHS. Already over 50% of claims for negligence in the NHS arise from maternity care, and if our concerns about the ability of the Royal Sussex County Hospital to cope with increased admissions are real (and as they are shared by clinicians, we have every reason to believe they are), the Trust is facing serious long term financial implications of its proposals.

135. Furthermore, there appears to be no consideration of one of the most significant cost centres in the maternity unit which is the cost of caesarean sections. The case study below highlights one potential solution.[23]

[23] Albany Midwives. www.albanymidwives.org.uk

Case Study – The Albany Maternity Service, Peckham

This is a small maternity service in Peckham, South East London. In terms of the numbers of births per annum, and the composition of its population, it is not comparable with Mid Sussex. However, if one steps away from that and looks at their achievements, then considers what could be achieved locally, and why such a model of care does not appear to have been considered locally, then questions have to be asked.

Only 15% of births delivered through the unit are caesarean sections, compared to the national average of 24%. 47% of births are home births compared to a national average of 2% and the breastfeeding rate 28 days after birth is 78% compared to a 20% national average.

The unit achieves things that every Trust in the country would want to achieve. Mothers work with the same midwife from their first visit through to birth, so the level of patient care and support is higher than typical.

A higher level of patient care is achieved, and the service is delivered at a lower cost than typical maternity services, and this is achieved through the reduction in caesarean sections.

136. Clearly the example above will not be appropriate for everybody, but it shows what innovation can achieve. The World Health Organisation recommends a rate of caesarean sections of 15%[24]. Whilst this method of delivery is necessary in some cases, it is not without risk and is more likely to lead to maternal death, injury, and infection. In some cases, scheduled caesarean sections can result in babies being delivered prematurely, with undeveloped lungs. Furthermore, they result in longer hospital stays, which as well as increased cost, affects the mother/baby bonding which is so crucial as the mother is recovering from major surgery.

137. We are not clinicians, and so will not build on this argument. However, we are community leaders. All Councillors are elected by local residents and we are representing that strength of feeling. And our community wants to see the maternity service retained.

138. Therefore we are representing our community's demand that consultant led maternity services should remain and be enhanced at the Princess Royal Hospital. We want the PCT to rethink its proposals, and produce an alternative, sustainable solution that enhances the service at the Princess Royal.

[24] World Health Organisation, 1985. www.who.int/en

MANAGEMENT ARRANGEMENTS

139. Centralisation of hospital services and the 'big is best' approach of hospital management brings challenges to management teams and clinicians that do not appear to have been considered.

140. The premise of the consultation seems to be 'trust me, I'm a doctor' and we do not have a level of Trust in our local NHS to enable us to do this. There is real and significant evidence that larger hospitals with centralised services deliver a worse patient experience.

141. In 2005, Sir Ian Kennedy, Chairman of the Healthcare Commission led three reviews published into hospitals where services had been centralised (Northwick Park in London, New Cross in Wolverhampton and Ashford St Peters in Chertsey)[25]. Serious deficiencies were identified in all three, including poor incident reporting, poor complaint handling, poor staff working relationships, inadequate training and clinical staff supervision. Although he was investigating these three hospitals, there is no reason to believe that they were unique and similar findings would no doubt have been found in other hospitals.

142. The key failings that he identified were:

- weak risk management with poor reporting of incident and handling of complaints
- poor working relationships and working in multidisciplinary teams
- inadequate training and supervision of clinical staff
- poor environment with services isolated geographically or clinically
- shortages of staff coupled with poor management of temporary employees.

143. So therefore, our questions to the Brighton and Sussex Universities Hospitals NHS Trust and the West Sussex PCT are:

- What have they learned from this?
- What are they going to do differently?
- How are they going to monitor these issues?
- What plans do they have in place to achieve this?

144. The Healthcare Commission undertakes an annual survey of NHS Staff, and the 2006 survey makes for worrying reading about the ability of the Brighton Trust to manage competently and therefore implement these changes. The Trust was in the bottom 20% of Trusts for the following areas[26]:

- Percentage of staff working extra hours due to pressure and demands of job
- Percentage of staff suffering work related stress in previous 12 months
- Percentage of staff witnessing potentially harmful errors, near misses or incidents in previous month
- Percentage of staff experiencing harassment, bullying or abuse from staff in previous 12 months
- Work pressure felt by staff
- Staff intention to leave jobs
- Quality of work life balance
- Percentage of staff appraised within previous 12 months
- Percentage of staff having well structured appraisal reviews within previous 12 months

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[25] www.healthcarecommission.org.uk
[26] www.healthcarecommission.org.uk

- Percentage of staff appraised with personal development plans within previous 12 months
- Quality of job design (clear job content, feedback and staff involvement)

- Support from immediate managers
- Extent of positive feeling within organisation (communication, staff involvement, innovation & patient care)
- Perceptions of effective action from trust towards violence and harassment
- Staff job satisfaction

145. If Fit for the Future is to work effectively, it needs these management arrangements in place and the issues resolved. The PCT are silent on this issue. Perhaps they are hoping for the best, but we do not want to hear statements from them in ten years saying they will learn lessons following a series of incidents such as those experienced at Northwick Park (referred to in paragraph 143).

146. Whilst the management arrangements of the Trust are a matter for the Trust itself, the implications of good or bad management will directly impact on the level of care that patients receive, and as Sir Ian Kennedy set out in his 2005 report, the implications of bad management can be life and death.

147. We therefore want commitments from the Acute Trusts about how effective management arrangements will be implemented.

FINANCIAL ISSUES

The West Sussex Financial Settlement

148. Financial issues are a crucial argument in the future of the NHS in West Sussex. The Primary Care Trust continually assure us that the proposals are not financially driven, yet despite this, the evidence points towards the fact that they are.

149. In their document 'Taken for Granted: Why Britain needs a fair deal for the South East'[27] the South East County Leaders set out that the South East is deemed to receive funding that is £23.2 million above target and therefore West Sussex PCT will receive a lower year on year increase in funding in order to rectify this until it reaches its target level of funding (which is at 94% of the national average).[28]

150. A key part of the NHS funding system is based on so called 'additional needs' which takes into account the age of the population and levels of deprivation. Because West Sussex is, on the whole, a prosperous County and despite the County's older population, the County does not fare well in the grant distribution. West Sussex County Council commissioned a firm called RAE Consulting to undertake an analysis of the finances of the NHS in West Sussex and they state that West Sussex 'fits the description of a PCT that is being disadvantaged by the current formula'.[29]

151. The Council supports the South East County Leaders recommendation that the NHS funding formula be reviewed in the light of demographic trends showing that people are living longer.

152. The South East Coast is the first Strategic Health Authority to produce proposals along the lines of those contained in Fit for the Future, and this is no doubt in part due to the funding formula, which sees 65% of the 60 most affluent areas PCTs being in deficit, compared to only 8% in the most deprived. There is clearly a funding formula problem that has to be rectified.[23]

153. In fact, the West Sussex County Council study concludes, that a dispassionate assessment of the County's funding highlights that the healthcare economy is in fact underfunded by around £42million when compared with the assessed incidence of illness in the County.[23]

The Fit for the Future Proposals

154. The consultation document compares the 2007/08 budget breakdown with that for 2012/13 (which includes an allowance for inflation, so is not real increases in funding) and this is set out overleaf:

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[27] Taken for Granted: Why Britain Needs a fair deal for the South East: Research Report by Local Government Futures Ltd. and Oxford Economics Ltd. September 2007
[28] West Sussex County Council Briefing Note: NHS Resource Allocation: Does West Sussex get its 'fair share'?
[29] West Sussex County Council Briefing Note: Fit for the Future – The Financial Case: Comments

	2007/8		2012/13	
	£m	% of budget	£m	% of budget (and increase from 2007/8)
Ambulance	25	2%	30	2% (+20%)
Acute Services	358	35%	388	31% (+8%)
Specialist Services	49	5%	71	6% (+45%)
Contingency	34	3%	54	2% (+20%)
Primary Care	119	12%	145	12% (+22%)
Prescribing	132	13%	172	13% (+30%)
Community/Social Care and Dental	88	9%	120	10% (+36%)
Mental Health and Learning Disabilities	116	11%	134	11% (+15%)
Other	106	10%	137	11% (+29%)
TOTAL	**1027**	**100%**	**1251**	**100 (+22%)**

155. Whether or not the proposals are financially driven the financial plan for the PCT highlights a key failing in that budgets have been outlined with no detailed proposals whatsoever as to how they are to be financed. It is a basic fundamental in budget and business planning that a business has a five year plan outlining what it wants to achieve and then sets out how the finances will enable those goals to be achieved.

156. In this consultation, we have the budget outlined, but with so many facets of the consultation failed to be backed up by a business plan. For example, Community/Social Care and Dental will receive a 36% increase in funding. This could well be right, as the increase in community based services is a fundamental part of the proposals, but the ‘A Breath of Fresh Air’ document remains an aspiration and is not backed up with a business case and so therefore one has to question the realism of the figures. The assumption that has to be made is that the services will be designed to spend the money available rather than design the right services for patients.

157. Furthermore, an effective, well resourced ambulance service is vital if Fit for the Future is to be implemented properly, yet the increase for the Ambulance Service is less than the PCT average (only 20%). The investment proposed does not match up with the increased demands on the Ambulance Service and therefore leads to significant concerns about the ability of the service to cope.

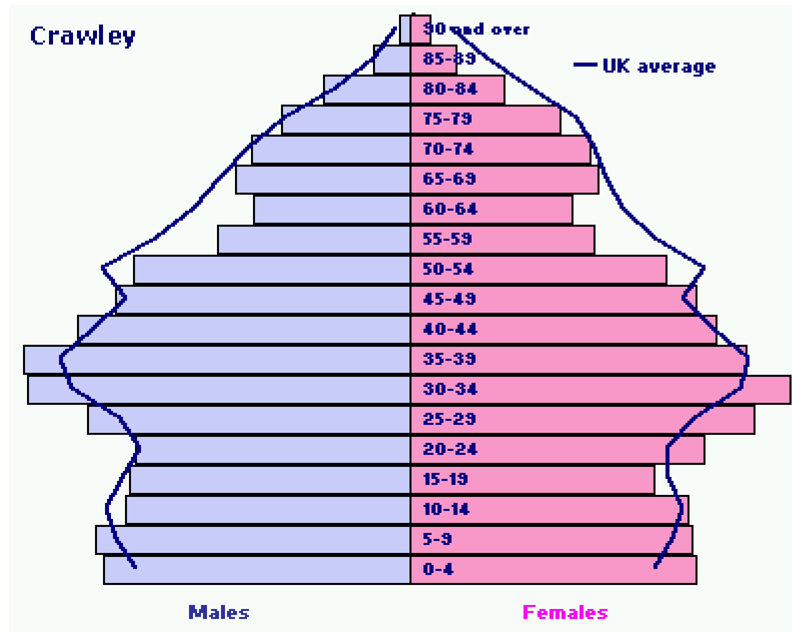
Comprehensive Spending Review 2007

158. The financial analysis assumes a requirement to make 2.5% year on year efficiency savings. However, in the Comprehensive Spending Review announced in October 2007 the Chancellor announced that the NHS would have to make 3% year on year savings in common with other public services. The PCT have not set out how the implications of this will be dealt with, or the impact on their financial analyses.

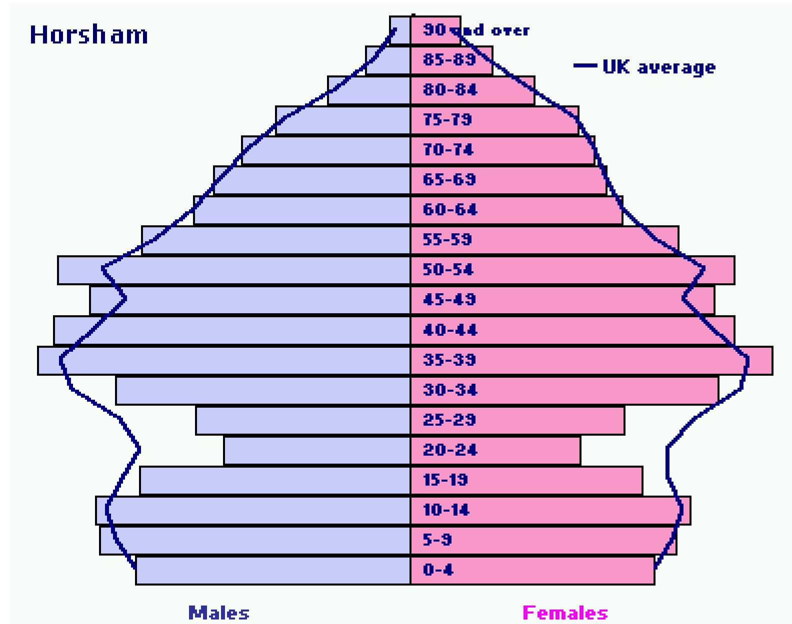
APPENDIX ONE

AGE PROFILES FOR THE PRINCIPLE DISTRICT AUTHORITIES THAT ARE SERVED BY THE PRINCESS ROYAL HOSPITAL, BASED ON THE 2001 CENSUS.

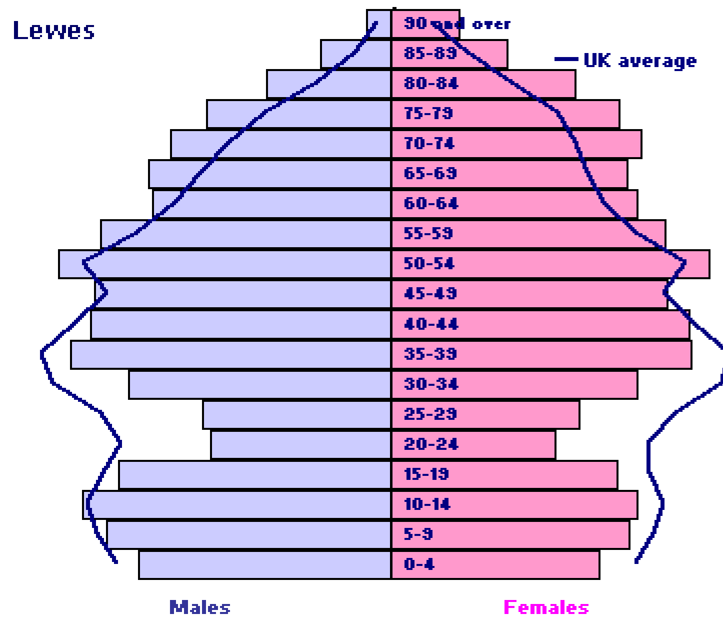
CRAWLEY BOROUGH



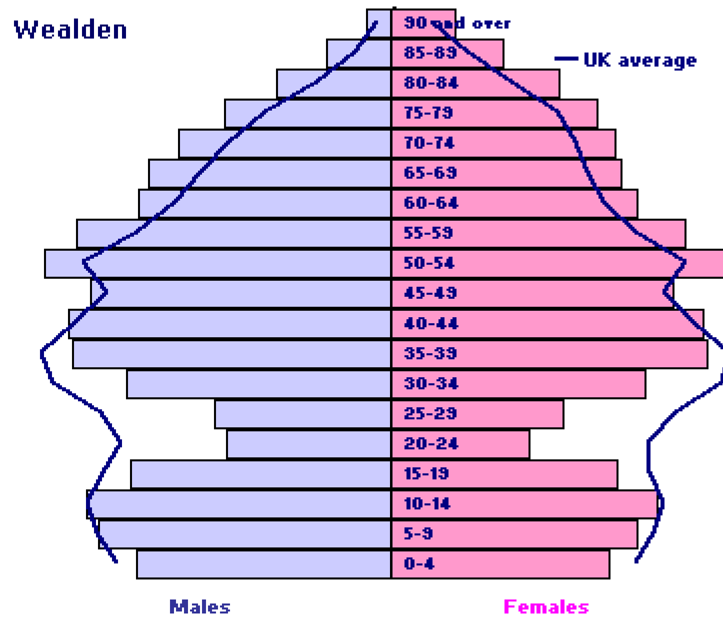
HORSHAM DISTRICT



LEWES DISTRICT

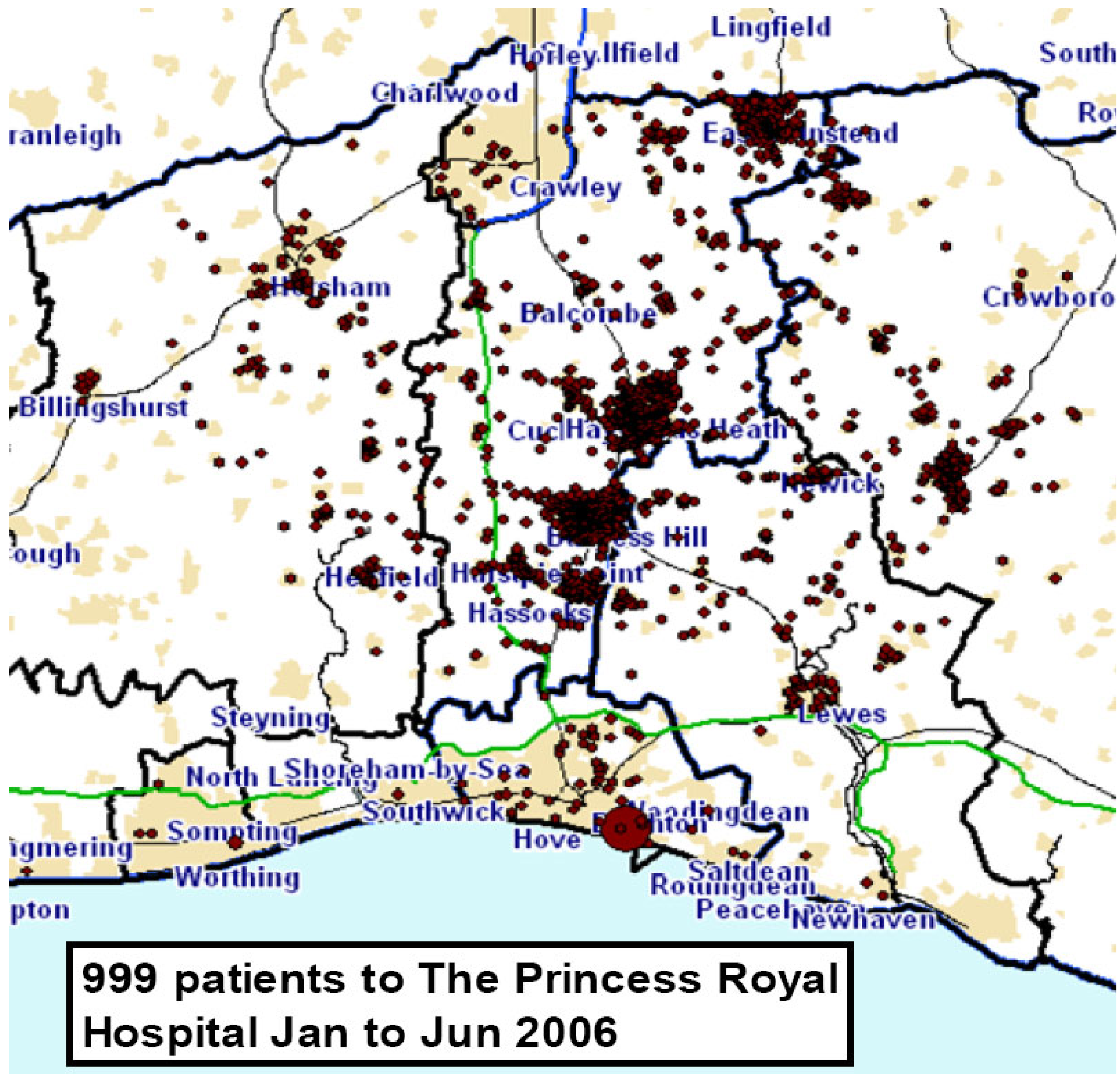


WEALDEN DISTRICT



APPENDIX TWO

ANALYSIS OF AMBULANCE JOURNEYS TO PRINCESS ROYAL HOSPITAL DURING JANUARY TO JUNE 2006[30]



[30] Fit for the Future Travel Times, Summary of Findings, 14 September 2007, Long Version

POPULATION BREAKDOWN OF THE WARDS SERVED

A population analysis of the wards served above identifies enables us to calculate the figure of 319,911.

Mid Sussex (whole District)	**127,378**
Crawley (Wards detailed below)	**46,799**
Bewbush	9081
Broadfield North	6340
Broadfield South	6326
Furnace Green	5734
Gossops Green	5014
Southgate	8106
Tilgate	6198
Horsham (Wards detailed below)	**80,482**
Billingshurst and Shipley	7606
Bramber, Upper Beeding and Woodmancote	5235
Cowfold, Shermanbury and West Grinstead	5252
Denne	4831
Forest	3469
Henfield	4810
Holbrook East	5648
Holbrook West	5394
Horsham Park	7548
Roffey North	6197
Roffey South	6096
Rusper and Colgate	2508
Southwater	10025
Trafalgar	5863
Lewes (Wards detailed below)	**33,816**
Chailey and Wivelsfield	4684
Newick	2318
Ditchling and Westmeston	2099
Plumpton, Streat, East Chiltington and St John	2306
Lewes Bridge	4255
Lewes Castle	4571
Lewes Priory	7162
Ouse Valley and Ringmer	6421
Wealden (Wards detailed below)	**31,436**
Hartfield	2523
Danehill, Fletching, Nutley	5049
Forest Row	5198
Buxted and Maresfield	4969
Uckfield Central	2792
Uckfield New Town	2559
Uckfield North	5372
Uckfield Ridgewood	2974

APPENDIX THREE

REAL LIFE JOURNEY TIME EXPERIENCES

Travel Times to Royal Sussex County Hospital/East Surrey Hospital

Ward	Destination	Time Taken (mins)	Peak/ Off Peak	PCT calculation	Difference
Ardingly and Balcombe	RSCH	52	Off Peak	35	+17
	ESH	28	Off Peak	25	+3
	ESH	34	Off Peak	25	+9
Burgess Hill Franklands	RSCH	28	Off Peak	21	+ 7
	RSCH	32	Off Peak	21	+ 11
Burgess Hill Leylands	RSCH	32 minutes	Off peak	20	+ 12
		40 minutes	Off peak	20	+20
Burgess Hill St. Andrews	RSCH	47	Peak	23	+ 24
East Grinstead Ashplats	RSCH	90	Off Peak	42	+ 48
Hassocks	RSCH	31 minutes	Peak	23	+ 8
Haywards Heath Ashenground	RSCH	35 minutes	Off Peak	25	+10
Haywards Heath Heath	RSCH	34 minutes	Off Peak	26	+8
High Weald	RSCH	60 minutes	Off Peak	41	+ 19
	ESH	45 Minutes	Off Peak	29	+ 16
Lindfield	RSCH	50	Off Peak	35	+ 15
	RSCH	37	Off Peak	35	+2

APPENDIX FOUR

PROVISION OF PAEDIATRIC AND MATERNITY SERVICES AT PRINCESS ROYAL HOSPITAL, HAYWARDS HEATH – POSITION STATEMENT FROM A LOCAL PERSPECTIVE

1.0 BACKGROUND

1.1 GENERAL SERVICE PROVISION

1.1.1 Maternity Services - Princess Royal Hospital

- Princess Royal Hospital (PRH) opened in 1991. All maternity services transferred to PRH from Cuckfield Hospital.
- The services transferred included the provision of neonatal care and the special care baby unit (SCBU).
- On 1st February 2000 PRH ceased to provide maternity services for mothers-to-be of high-risk babies because there were no facilities for neonatal intensive care at the hospital, following withdrawal of that aspect of the service.

1.1.2 Paediatric Services - PRH

- In addition to neonatal and the SCBU, the paediatric service at PRH consisted of a paediatric outpatient clinic, a low-risk in-patient service and Paediatric Accident and Emergency (A&E). High-risk in-patient Paediatric care was carried out initially in Brighton and later (from 1993) in Crawley. In 2002 this service was transferred back to Brighton. This transfer was carried out after full public consultation (see "strengthening hospital services in Central Sussex" 2001 consultation paper).
- The Mid Sussex PCT has stated that whilst the paediatric services were provided at PRH, these were as an outreach service initially provided from Brighton Hospital and from 1993 by Crawley Horsham NHS Trust and that no stand-alone paediatric service has operated from PRH.
- In 1998 the Royal College of Paediatricians and Child Health removed the accreditation for training posts at PRH. The Royal College also recommended that in-patient paediatric care at PRH should be discontinued. Accordingly the use of Senior House Officer (SHO) trainee doctors at PRH was phased out although limited in-patient care continued until February 2004. Emergency paediatric medical cases continued to be taken to PRH. Cases requiring in-patient treatment or day surgery were then transferred to Brighton.
- In 2002, the services provided by the Surrey and Sussex NHS Trust to the PRH transferred to Brighton Health Care NHS Trust.
- In February 2004, the practice of taking Emergency paediatric medical cases to PRH was discontinued and all of these cases are now taken by ambulance direct to Brighton.

1.2 CURRENT POSITION

1.2.1 Maternity and Neonatal Services

- In 2003 there were a total of 2172 births at PRH, of which 1183 were mothers from within the Mid Sussex PCT area. Mid Sussex PCT area covers the whole of Mid Sussex and a small part of Horsham District in the Cowfold area.
- The level of provision of maternity and neonatal provision at present remains as that stated in 1.1 above.
- It is the stated intention of the PCT to attempt to retain this level of service although the method by which this is to be achieved is to alter, by changing the medical support from paediatric doctor to nurse practitioner support. It is intended to recruit

Advanced Neonatal Nurse Practitioners (ANNPs) to support the Consultant led service at PRH. The required number of ANNPs is eight to provide the necessary level of cover. Four are currently in post. The PCT is attempting to recruit to the remaining posts. If they are unable to do this there will be implications for the service at PRH. This is referred to as option Mi.

- It is stated that if the preferred option referred to above is not achievable, then the preferred solution would be for PRH to become a low risk midwifery led maternity service. There would be no SCBU at PRH. Higher risk births would be at Brighton or other Trusts. It is stated that this option would require full public consultation. This is referred to as option Mii. The PCT anticipates that a midwife led unit would handle between 400 and 800 births.

1.2.2 Paediatric Services

- The current level of Paediatric service at PRH is a Consultant led outpatients service and other ambulatory care services. The ambulatory care service includes the treatment of children with minor injuries or conditions who do not require inpatient care or surgery.
- The current level of paediatric care represents a reduction in service since the hospital opened. No inpatient care is now available and paediatric A&E is no longer provided for more serious cases.
- The current proposals from the PCT do not anticipate any further changes to the Paediatric service at PRH. There is the possibility of enhanced community provision in the future.
- The paediatric A&E service was withdrawn as part of the service Changes in February of this year. These changes were put in place in response to service requirements and were not a planned change and were not consulted upon.

2.0 CURRENT LOCAL NEED

- In 2001 the Office of National Statistics recorded the population of Mid Sussex as 127,383. 18.82% (23,973) of this population is aged 0-14. This is above the average for West Sussex. 64.58% (82,266) are recorded as being in the age range 15-64. This is well ahead of the average for West Sussex Districts of 61.77% and second only to Crawley.
- The population profile, which shows that there is an above average proportion of children and adults of working age, suggests that the demand for paediatric and maternity and neonatal services is likely to be significant. This is borne out by figures produced by West Sussex Public Health Observatory which records the number of live births per 1,000 women aged 15-44 as being 58.1, comfortably the highest in West Sussex, compared with a County average of 54.6 per 1000 (see Community Profile for Mid Sussex).

3.0 FUTURE NEED

- The statistical data in the Community Profile shows an increasing population in Mid Sussex. Whilst it is predicted that the rate of increase will slow, this is likely to be offset by the requirements for new housing in the Local and Structure Plans, set out below. The high birth rate is likely to mean that the need for paediatric and maternity and neonatal services will be maintained.
- The Local Plan for Mid Sussex sets targets for the period 2002-2006 for 3,100 additional homes in Mid Sussex. The West Sussex Structure Plan sets further targets for the period 2001 to 2016 of a further 10,175 homes to be built in Mid Sussex. This increase in homes in the District will inevitably lead for an increase in demand for all services. It is likely that the new residents of these properties will continue the trend for Mid Sussex of a lower age profile and consequently generating a higher degree of demand for maternity, neonatal and paediatric services.

4.0 ACCESS TO SERVICES

- Haywards Heath commands a central position in the heart of Sussex. The town has excellent road communication in all directions. Access to the PRH by road does not in normal circumstances present any difficulties. Adequate parking is provided at the hospital, with a charge of £1.00 per hour.
- Access to PRH for the emergency ambulance service would appear to be correspondingly good. The hospital also has helicopter access allowing rapid transfer of the most urgent cases. There is no helicopter access to the Brighton hospitals.
- Rail access to Haywards Heath from the south of the District is good, with main line stations at Hassocks, Wivelsfield and Burgess Hill. Frequent buses operate between Haywards Heath railway station and PRH. There is also a good taxi service based at the station. To the north, mainline train services to Haywards Heath operate from Balcombe and a regular bus service operates between East Grinstead Station and PRH.
- Access by road from Mid Sussex to the Brighton hospitals is difficult. Whilst the A23 runs through Mid Sussex to Brighton, the final part of the journey within Brighton is through streets that are frequently congested. Parking is limited at the Brighton hospital sites. There is local concern about the time that ambulances will take to transfer patients from Mid Sussex to Brighton if this is required.
- Public transport access to Brighton Station from Mid Sussex is adequate from the central and southern parts of the District with a regular rail service from the stations mentioned above. No public transport is readily available from the north of the District. The Hospitals are situated some distance from the station and onward transport is an issue for people visiting.
- The position of Brighton hospitals at the coast disadvantages them in terms of access compared to PRH. They do not enjoy a central location with clear access from all directions. Whilst acceptably placed for access from the population that they serve in the Brighton and Hove area, there would appear to be little to recommend them in terms of access for users travelling from further away.
- One particularly major area of concern would be the access for families of babies who need to remain in a SCBU after the mother has been discharged. The needs of such families to regular and straightforward access to the hospital must be a high priority.

5.0 USER PERSPECTIVE

The timescale for production of this position statement has not enabled a separate study to be carried out on users' views of the service. However a survey of birth services in Mid Sussex has recently been commissioned by the PCT and carried out by the National Childbirth Trust. Over 5,400 women participated in the survey. The following findings appear in the executive summary of the survey:

- Women wanted to be able to give birth locally, with specialist staff and equipment on hand in case of emergency. Many women praised the care they had received at Princess Royal Hospital in the past, and were strongly opposed to travelling for up to an hour to reach another hospital with specialist birth services.
- Women's top three choices for where they would like to give birth were:
  - a local hospital with specialist facilities (Princess Royal)
  - a freestanding midwife-led birth centre
  - at home, with midwife support
- Women prioritised small birth centres and home births ahead of both local hospitals without specialist facilities and specialist hospitals further from home. A

midwife-led unit in a hospital without specialist facilities was women's least preferred place to give birth.

- Women were especially keen for Princess Royal Hospital to contain facilities for sick babies. In fact, this was one of women's highest priorities, second only to having a hospital within a 20 minute drive from home. Women's top five priorities around the time of birth were:
  - a hospital within a 20 minute drive of home;
  - immediate access to specialist baby care;
  - continuity of care from a small team of midwives;
  - familiarity with midwives and the place of birth;
  - choice of different types of birth units, including birth centres as well as a large hospital.

6.0 CONCLUSION

6.1 Paediatric Services

- The continued downgrading of the paediatric service at PRH is a matter that needs to be the subject of full public consultation. The changes introduced in February were as a short-term response to service need at the time. They should not be made permanent without consultation. The public should be fully involved in a debate as to the level of service required and how and where this is to be provided. The County Health Scrutiny Select Committee is recommended to press for urgent full public consultation on this issue.

6.2 Maternity and Neonatal Services

- The proposals, by which the service is to be maintained by the recruitment of ANNPs, represent a change in the service in terms of the level of medical support at PRH. This needs to be clearly understood and even if it does prove possible to recruit the necessary ANNPs, full public consultation will be required as to the future direction of the service at PRH.
- There is at present no evidence to suggest that capacity exists at other hospitals to cope with a major downgrading of PRH as envisaged in option Mii. The County Health Scrutiny Select Committee is recommended that if option Mi fails that they should pursue with the Health Trusts, full public consultation, with the foremost objective of that consultation to investigate ways in which the service at PRH can be maintained at least at its current level.

6.3 Matters requiring to be Addressed in the Health Scrutiny Process

The following issues are identified as matters of high priority to be addressed further in the scrutiny process:

- The effects of any changes on the emergency ambulance services and the time taken to transfer emergency cases to the appropriate hospital, including from rural villages in Mid Sussex.
- Access to services both for patients and their families from all parts of Mid Sussex
- The capacity of hospitals in the region to cope with the increased demand caused by any proposals and the resultant effects on service users in those areas as well as those travelling to use the services.
- The issue of unit closures, when the unit concerned is not available for admissions, leading to mothers being moved to units in locations even more remote from their homes.
- The involvement of authorities whose population are likely to be affected by any proposals to downgrade PRH. This includes not only those areas where patients would normally look to PRH for acute services, but also those in areas where the

service is likely to be put under strain by increased demand, including the Brighton Hospitals and East Surrey Hospital areas.

- The population and other demographic trends affecting service use in the region.
- Whether service provision issues are being driven by the demands of the Royal Colleges, rather than patient need.
- If there is to be consideration of downgrading the maternity service in line with option Mii, whether the investment that would be necessary to create additional capacity at other hospitals would be better utilised in investing in PRH to avoid the necessity of downgrading the service.

APPENDIX FIVE

PROVISION OF NEUROSCIENCE SERVICES HURSTWOOD PARK, HAYWARDS HEATH – POSITION STATEMENT PREPARED BY PERFORMANCE AND SCRUTINY COMMITTEE AT REQUEST OF WEST SUSSEX COUNTY COUNCIL HEALTH SELECT COMMITTEE

BACKGROUND

HISTORY OF THE HURSTWOOD PARK UNIT

- The Hurstwood Park Neurosciences Centre was originally built in 1938 as an acute psychiatric admissions unit. In 1941, full neuroscience services were relocated to Hurstwood Park. These services have remained at the Unit ever since, a total of 63 years.
- Neuroscience services are defined as those which meet the needs of patients suffering disorders of the brain and nervous system. Historically, Hurstwood Park has provided a full range of services, including surgery.

CURRENT POSITION

- It is generally accepted that the facilities at Hurstwood Park are not up to the standard required at a modern neurosciences unit. The buildings are in need of updating and there needs to be an expansion in the beds available and a significant improvement in the accommodation available for the staff working in the unit.
- The population served by Hurstwood Park is mainly confined to patients from PCT areas within Sussex. This excludes patients from the Western Sussex PCT area, which refers patients to Southampton. This means that the population served by the Unit is smaller than average for a neurosciences centre, which has possibly led to a reluctance to invest in a long-term future for the Unit.
- The services currently provided at the unit are as stated in the attached document provided by the Brighton and Sussex University Hospital Trust (Appendix A).

CURRENT REGIONAL NEED

- The report on the Review of Neuroscience Services in Sussex sets out in some detail the catchment area of Hurstwood Park and referral patterns to the hospital. The report states that the catchment area for Hurstwood Park and any replacement unit, either at Hurstwood or Brighton, is East and West Sussex, with the exception of the Western Sussex PCT area, which refers its patients to the Wessex Neurosciences Centre in Southampton.
- The report states that there would not be any intention either from Western Sussex PCT or other neighbouring PCTs in Kent and Surrey to change this pattern of referral even if a "state of the art" neurosciences unit was created in Brighton or at Haywards Heath. Further investigation on this point has confirmed this and apart from limited emergency referrals from these areas it is unlikely that the Sussex Unit will draw significant numbers of NHS patients from outside areas of Sussex currently referring to Hurstwood.
- The arguments for retaining a full neurosciences unit in Sussex are compelling. The catchment area of Hurstwood is stated by the unit to serve a population of 1.4 million. This is very slightly under the level stated to be ideally required to support a full

neurosciences service. However, both reports on Neuroscience Services in Sussex which were compiled in 1996 and 2003, strongly concluded that to sustain an acceptable standard of neuroscience services for the people of Sussex such a unit needs to be provided locally. The difficulty of access to units based outside Sussex is crucial. The objective of retaining a fully functioning neuroscience service within Sussex must be fully supported.

FUTURE NEED

- Structure Plans for both East and West Sussex show significant growth in housing provision in the forthcoming years. The population of Sussex is therefore likely to continue to grow and demand for all health services across the county will increase accordingly. Many of the most serious cases dealt with by the neurosciences unit are as a result of road traffic accidents and with the increasing pressure on local roads, it would unfortunately seem likely that there will be a corresponding rise in the demand for neurosurgical services.
- The long-term viability of a Sussex based neurosciences unit can only be strengthened by the proposals for further development.
- Generally there would seem to be considerable potential for the Sussex unit to provide services to a wider catchment area and it is considered that this is something that needs to be addressed by the Strategic Health Authority as a matter of urgency, in order to feed into the current considerations.

ACCESS TO SERVICES

- As noted above, the great majority of NHS work of the neurosciences unit comes from within Sussex. In overall terms, the difference in access between Haywards Heath and Brighton from other parts of Sussex is marginal. There are however concerns about the road infrastructure within Brighton and the access to the Royal Sussex County Hospital.
- The ambulance service has not identified any specific difficulties in transferring patients to Hurstwood from other hospitals including Royal Sussex County.

CONSULTATION PROPOSALS

- The proposals in the Best Care, Best Place consultation are based around two reports on the future of neurosciences in Sussex compiled in 1996 and 2003. The 1996 report stated that the maximum project life of the exisitng unit was five to ten years. The 2003 report again refers to maintaining the service at Hurstwood for a further five to ten years. The Best Care, Best Place consultation document refers to a life of seven to ten years for Hurstwood Park.
- Both reports endorse as their main finding the need to maintain a fully operational neurosciences unit in Sussex.
- Both reports conclude that the long-term objective will be to establish a new unit at the Royal Sussex County Hospital in Brighton. The premise for this proposed relocation is that neurosciences and other services will benefit from being located with other specialisms. The 1996 report, which is quoted in the 2003 report, specifically makes reference to burns unit, orthopaedic, maxillofacial and plastic surgery as being those that would particularly benefit from being located with neurosciences.
- The 1996 report identifies the option of redevelopment of Hurstwood Park to provide a full service at that site and refers to this as one of the options for retaining the service within Sussex. The report however subsequently states “It should be noted that this option was not formally short listed and therefore was not formally appraised with regard to its non-financial benefits”. It would appear at the time that this option was the least

expensive of those that would retain a full neuroscience service in Sussex and the reason for the decision not to short list is not immediately apparent. It would seem that the option of redeveloping a new neurosciences unit at Hurstwood has not been the subject of a full evaluation for some time.

- The Best Care, Best Place document states in the section what could happen if we don't make these changes "in order to provide safe services next to a full range of hospital specialities we either need to move these services to Brighton or close the unit and move them to a London hospital".

CONCLUSIONS

- It is considered that the case for retaining a fully functioning neurosciences unit in Sussex is overwhelming and should be fully supported.
- The benefits of location with other specialisms is understood but do not appear on the evidence to be so compelling as to rule out any other option. Of the four services mentioned in the 1996 paper as particularly benefiting from being located with neurosciences, two of the regional facilities, maxillofacial and burns unit are located at East Grinstead and not Brighton. Brighton does have a maxillofacial unit but the major facility is in East Grinstead and it does not appear that there are currently any plans to relocate these services to Brighton. There are no plans to provide a burns unit at Brighton. Elective orthopaedic services will continue to be provided at the Princess Royal. This tends to suggest that the case for relocation rather than full redevelopment of Hurstwood is more marginal than has been suggested.
- Hurstwood is a highly regarded facility with an outstanding multi-disciplinary team. The future of the unit has been in doubt for a very considerable period of time. The current proposals do not envisage the final redevelopment of a new Sussex unit taking place for a number of years. It is considered that the most important consideration is to safeguard the provision of these services and to provide a state of the art facility in Sussex as soon as possible. Cost is another factor that is likely to be crucial.
- Given the timescales involved in the final redevelopment of a neurosciences unit, there does not seem to be any difficulty that would preclude a full evaluation of the Hurstwood option as identified in the 1996 report (redevelopment of a full neurosciences centre at Hurstwood Park) from being carried out. Any such evaluation should take into account the timescales within which redevelopment could be carried out and the cost of providing the unit, as well as the non-quantifiable benefits such as keeping the multi-disciplinary team together at its current location, weighed against the perceived drawbacks.
- The apparent failure to fully evaluate the possible benefits of redeveloping the existing site rather than relocation to the Brighton site is of concern and should be addressed. The statement in the consultation document that the only options are relocation to Brighton or closure of the unit and transfer of services to London is surprising, particularly as the evidence suggests that there is not the capacity in London at present to meet the resultant demand. There is a danger that the impression given is that the motivation for the proposed transfer to Brighton is dogmatic rather than reasoned.
- Concerns remain about centralising so many services at the Brighton site. The road infrastructure is poor and at present parking wholly inadequate. Whilst the aspiration of locating services together is understandable, it is not an end in itself and should be justified by rigorous testing against other sustainable options to ensure that the best service provision results.
- It is considered that it is important for the reasons behind the proposals for neurosciences should be clear and seen to be justified. Since the 1996 report was prepared the Brighton and Sussex Universities Hospital Trust has been formed,

effectively unifying Royal Sussex County Hospital and Princess Royal Hospital, including Hurstwood Park into a single operational unit. The services provided at Hurstwood have been provided as part of a unified service and the case for relocation has altered since the 1996 report. This does not appear to have been acknowledged to date, or addressed. It is strongly recommended that the response to the consultation on the neurosciences should press for a full evaluation of the option of redeveloping the existing site and retaining services at Hurstwood.

APPENDIX A

HURSTWOOD PARK NEUROSCIENCES CENTRE
BSUH NHS Trust

The Neurosciences Unit is part of Specialised Services Directorate of Brighton and Sussex University Hospitals NHS Trust. This Directorate includes Cardiology, Cardiothoracic Surgery, Renal Medicine and HIV - GUM.

The main Neurosciences Centre is based at Hurstwood Park on the Princess Royal Campus at Haywards Heath. Significant Neurology out-patient services are also provided in Brighton, Worthing, Eastbourne and Hastings.

Facilities include: Neurosurgical Ward (22 beds), Neurology Ward (17 beds), 6 bedded Neuro-ITU/HDU, twin operating theatres (opened in April 2000), Neurophysiology Department, Out-patient suite, a range of clinical support facilities (e.g. Physio Gym, Occupational Therapy facilities) and Neuroradiology Department providing both diagnostic and interventional treatments.

In 2003/4 the Unit completed over 1,350 Neurosurgical Finished Consultant Episodes (FCEs), 820 Neurology FCEs and in excess of 4000 Neurosurgical and 5,500 Neurology out-patient consultations.

In addition over 3,000 Neurophysiological investigations, 2,500 MRI scans and 5,000 CT Scans are performed each year together with over 450 Neuropsychology assessments.

The Neurosciences Unit serves a population of approximately 1.4 million in East and West Sussex (excluding the Chichester area, Western PCT) but extending into parts of Surrey and Kent. Links are established with acute hospitals in Haywards Heath, Brighton, Crawley, Redhill, Eastbourne, Hastings and Worthing. For more specialist work and SpR training, close links exist with Neurosurgical Units at the National Hospital for Neurological Diseases at Queens Square, King's College and St George's in London.

The Unit is working with Other Neuroscience Units (at King's and George's) the relevant Specialist Commissioning Groups and the Strategic Health Authorities to develop robust and sustainable Network of sub-specialist Neurosurgical and Neurovascular services in SE England.

There is already a well developed network of Neurology Services throughout Sussex. All the Neurologists have sessional commitments at Hurstwood Park and they all contribute to the Sussex wide on call service.

CONSULTANT STAFF

NEUROSURGERY

Mr C Hardwidge	Lead Clinician
Mr J Norris	
Mr P Ward	
Mr G Critchley	
Mr L Gunasekera	
Mr J Akinwunmi	
Dr S Naik	Associate Specialist

NEUROLOGY	
Dr R Chalmers	based at Worthing
Dr M Chowdhury	based at Hastings
Dr R Clifford-Jones	based at Worthing
Dr P Hughes	based at HPNC
Dr W Macleod	based at Eastbourne
Dr P Morrish	based at Brighton
Dr A Nisbet	based at Brighton
Dr A N Other	based at Crawley/Redhill
Dr A N Other	based at Brighton & Sussex Medical School
Dr S Tisch	based in Brighton (part time)

Neuropathology

Dr P Rose	Full time

Neuropsychology

Dr V Bradley	Full time

Neurophysiology

Dr C Chandrasekera	works at Worthing 1 day/week

Neuroradiology

Dr M Jeffrees	Also works in Brighton
Dr J Olney	Also works in Brighton
Dr C Good	Also works in Brighton

In addition the Anaesthetic Department provides Consultant Anaesthetists to support Neurosurgical Theatres, Neuro ITU and Neuroradiology 24/7.

THE WORK OF THE NEUROSCIENCES UNIT

Hurstwood Park Neurological Centre provides a full adult Neurosurgical and Neurological service including assessment, advice, elective and emergency admissions.

The Unit does not currently provide a Neuro-paediatric service, but it is intended that this be reconsidered when existing Paediatric and Neurosciences facilities are co-located on the Royal Sussex County site.

The Acute Hospitals throughout the County have close working relationships with the Neuroscience Unit and all are linked via ISDN Image Link (RadWorks). The image link systems are currently being reviewed.

The majority of the Neurosurgical outpatient sessions are carried out at the centre, with outreach clinics in Brighton and Eastbourne. There are strong, well-established links with a range of other specialities (see below).

All Neurologists provide local (in their host Acute Hospital) OP and ward referral services, with some specialist clinics. All have access to in-patient beds at Hurstwood Park. They are supported by a range of Nurse Specialists in Acquired Brain Injury, Epilepsy, Multiple Sclerosis and Parkinsons Diseases. Three additional newly funded posts are currently being recruited to.

The Neurophysiology Unit provides a full range of Electroencephalography (EEG), Electromyography (EMG), Nerve Conduction Studies (NCS) and Evoked Potentials (EPs).

Satellite EMG services are provided in Worthing and satellite EEG services are provided in Shoreham. Emergency mobile EEG service is also available to all Sussex Hospitals to avoid sick patients (including babies) being transferred to Hurstwood park for assessment.

The Neurosurgical Unit is involved in developing Networking arrangements with Neurosciences Units at King's and George's. The aim being to configure sub-speciality services to ensure that the combined catchment (about 7.5M) has appropriate access to these services. These will include, but not be restricted to, Neurovascular Services and Interventional Neuroradiology.

ASSOCIATED DEPARTMENTS

Neurosurgery
Based at Hurstwood Park. Specialist interests include Neurovascular Surgery, Skull base surgery, Pituitary surgery, CNS tumours and spinal surgery. Theatre sessions are available for each Consultant to have three half day sessions including a full day of operating. All Neurosurgical OP Clinics are supported by Middle grade staff. There are 3 Specialist Registrars and 2 SHOs in approved training posts.

Clinical Neurology
The eight Neurologists (soon to be nine) carry out most of their clinics at their district hospitals but admit in-patients/Day cases to Hurstwood Park for assessment, treatment and review. The Special interests of the current consultants include movement disorders, neuro-opthalmology, and stroke. There are s Specialist Registrars and 2 SHOs in approved training posts.

Neuro-anaesthetics
There are currently twelve Consultant Anaesthetists based at the Haywards Heath site. Five undertake regular Neuro-anaesthetic sessions. Three Anaesthetists have special interests in Neuro-intensive care and two other consultants run the Pain Clinic. The Neuro ITU facilities take up to 4 ventilated patients.

Neuropathology
A full-time Consultant providing a complete service including intraoperative smears when required. He provides regular clinico-pathological meetings and has established links with other Neuropathologists.

Neurophysiology
There is a full-time Consultant, and SpR undertaking EEG, Evoked Potential studies and EMGs, NCSs supported by 3.6 wte Neurophysiology technicians.

Neuropsychology
There is one full time Neuropsychologist who undertakes assessments and one part time Neuropsychologist that provides some treatment of patients within the Unit and those referred by the Neurologists and Neurosurgeons.

Neuroradiology
There are three Consultants providing a total of 30 sessions including 6 in Brighton with emergency cover at the Neurosciences Unit. Two radiologists undertake a range of interventional procedures. Over 250 angiograms are performed at Hurstwood Park per annum. There is a CT scanner with separate workstation facilities, which last year performed 3,500 Neuro and 2,000 body scans. The Sussex MRI Unit, a partnership arrangement with Lister BestCare, is in the Princess Royal Hospital attached to Hurstwood Park Neuroscience Centre. Neuroradiologists report over 85 % of the MRI service (about 2,700 patients per annum).

Endocrinology
Joint clinics for patients with pituitary problems are undertaken with the Endocrinologists at both Brighton and Haywards Heath.

ENT
An ENT Surgeon has Neurosurgical sessions related to acoustic neuroma and other temporal bone lesions.

Maxillofacial and Plastic
There is a regular association with the local team and in addition there are links with the maxillofacial and plastic team at The Queen Victoria Hospital, East Grinstead some 15 miles distant, with joint procedures being undertaken at both units.

Neurochemistry
The Biochemistry Department has specialist research interests in Neurobiochemistry.

Nursing
The Neurosciences Unit has it own Nursing Manager. Currently there are approximately 116 wte nursing and theatre staff including a range of specialist nurses.

Occupational Therapy
An Occupational Therapist is in regular attendance, with facilities on site.

Ophthalmology
An Ophthalmologist from Brighton Eye Hospital has a specific interest in Neuro-ophthalomological problems and undertakes a regular weekly clinic in addition to seeing ward patients.

Physiotherapy
The Unit is well staffed and has a well-equipped gym within HPNC, with access to hydrotherapy at the Princess Royal Hospital.

Radiotherapy
The Radiotherapy services are based in Brighton. There are regular weekly sessions for ward visits and a joint Glioma Clinic monthly. There is a Brain and CNS cancer multidisciplinary team meeting monthly and strong links with the Sussex Cancer Network.

Speech and Language Therapy
A half-time speech & Language Therapist with a particular interest in swallowing problems is available.

Dietetics
A half time dietician works in the Neurosciences Unit.

Clinical Pharmacy
A clinical Pharmacist works in the Neurosciences Unit

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