ASHFORD AND ST PETER'S/ROYAL SURREY COUNTY MERGER INQUIRY

Summary of hearing with Epsom and St Helier University Hospitals NHS Trust on 5 May 2015

Background

1. Epsom and St Helier University Hospitals NHS Trust (E&H) told us that it was a medium-sized acute trust, providing a range of services to people living and working in south-west London and north-central Surrey, with a combined turnover of over £360 million. It had been formed in 1999 as the result of a merger between Epsom Health Care NHS Trust and The St Helier NHS Trust.

2. E&H's two principal sites were St Helier Hospital in Carshalton, in the London Borough of Sutton, and Epsom Hospital in the Borough of Epsom and Ewell in Surrey. While both sites had an A&E as well as an obstetrics department and a number of other services, there was a degree of specialisation at each site that had gone on over a number of years. The Epsom site did not do acute emergency surgery, which was instead focused on the St Helier site. Epsom had a focus on inpatient elective care.

3. E&H had a full range of district general hospital services, but it did not have some specialised services, for example cardiac or neurological. Most of that work would be referred onwards to St George's University Hospitals NHS Foundation Trust in south-west London as the major trauma centre, or to other centres where those core services took place.

4. E&H had broken even in 2014/15 and the NHS Trust Development Authority had now given it permission to work towards foundation trust status.

Remuneration

5. E&H's populations were served by three main Clinical Commissioning Groups (CCGs): Sutton CCG, Surrey Downs CCG and Merton CCG. In addition to these three main CCGs its income was derived from NHS England as well as other CCGs. Sutton CCG was the lead CCG for its south-west London contracts. Surrey Downs CCG was its lead commissioner in Surrey.

6. E&H's contracts were very much standard. It did not have cap or collar type arrangements. There were only one or two areas where it might have agreed

a local tariff but that was very much at the margin. Contracts for 2015/16 were in the process of being signed on that basis.

7. E&H was talking to its CCGs about alternative models of care in line with NHS England's Five Year Forward View. For example how elderly care pathways might be reorganised around the Epsom area. This in time might lead to a different pricing structure, whether local pricing or potentially even outcome based commissioning.

Relationship with the merging parties

8. E&H said that in 2010 its board were concerned that it did not have a sustainable future and were looking to demerge. Ashford and St Peter's Hospitals NHS Foundation Trust (ASP) put themselves forward as a merger partner for Epsom Hospital but any discussions on demerger had fallen away by 2012. One of the reasons this did not proceed was because a condition of the transaction process was that this would not entail major service reconfiguration that would require consultation. Ultimately parties could not see how they could make that work without significant financial transitional support that was not available.

9. E&H participated in a number of clinical networks of which ASP and Royal Surrey County Hospital NHS Foundation Trust (RSC) also participated, including stroke, cardiology and vascular surgery. It provided outpatient clinics for renal services at both St Peter's Hospital and RSC as well as specialist input into renal-related aspects of the care of inpatients at these hospitals.

Stroke and cardiology services

10. Surrey had a stroke network covering all five hospitals in the county. Each of the five hospitals had a hyper-acute stroke unit on their own site but their stroke physicians worked together to provide a telemedicine out-of-hours service across the network.

11. Surrey commissioners had been reviewing stroke arrangements and they had concerns that a hospital needed a sufficient volume of patients for its services to be effective and therefore safe. Given the Keogh recommendation was to move towards a seven-day manned service, reviewing the acutely sick patients every twelve hours and in person, there was a question of whether all five Surrey sites were sustainable.

12. Due to geographies and risks in travel times E&H did not think that commissioners were going to pick just one hyper-acute stroke unit. The precise configuration of stroke care could affect St Peter's Guildford and

Epsom Hospitals differently; all trusts were working closely with the commissioner-led review to ensure effective care was providing into the future.

13. At least one of its Epsom cardiologists participated in a rota to man the cardiac catheter laboratory at St Peter's. If an Epsom patient needed a stent or pacemaker inserted, on an elective basis, Epsom would then refer that patient to St Peter's and Epsom's consultant would probably do the procedure in the St Peter's laboratory.

14. Generally, a patient who presented at St Helier might be referred to St George's University Hospitals NHS Foundation Trust or to the Royal Brompton & Harefield NHS Foundation Trust. An Epsom patient would almost certainly go to St Peter's.

Renal services

15. E&H was the main provider of specialist renal services to the Surrey population, providing renal outpatient services at both St Peter's and at RSC. It also provided outpatient services at East Surrey Hospital in Redhill, and Frimley Park Hospital, near Camberley, and haemodialysis services in Farnborough (Hampshire), West Byfleet, Crawley and Epsom. Furthermore, it provided outpatient and haemodialysis services at Croydon University Hospital in south-west London, as well as other dialysis units in south-west London.

16. E&H said that renal services might well move towards a hub and spoke arrangement where you would have an inpatient centre dealing with the most complex cases but you would have more of the normal patients being treated in their local hospital. There had been various discussions in Surrey over the last few years about whether this should be a commissioner led process, or whether this was more of a provider-to-provider conversation, about what were the most appropriate places for care and what made business sense. E&H had held discussions with the merging parties about potential future arrangements but had not yet reached any agreement on the way forward.

17. E&H expressed concern that a merged trust, having a greater critical mass and serving a larger collective population, might have increased influence with commissioners and/or in provider-to-provider relationships and that this might impact on existing clinical networks and partnership working arrangements.

Community services

18. E&H considered that economies of scale and efficiency could be driven through integration with community care to provide better patient care in a more effective way and not have patients spending more time than they needed to in a hospital bed.

19. E&H did not currently provide community services. The bulk of Epsom based community services were provided by Central Surrey Health. However, around Epsom, E&H was working closely with local general practices (GPs), Central Surrey Health and commissioners to develop a different model of care for the frail, the elderly, to help them sustain a high quality of life in their own homes and spend less time in hospital.

20. The community services around St Helier were provided by The Royal Marsden as part of the Sutton and Merton Community Services and these were currently out to tender. E&H would be bidding for this work.

21. E&H believed that if ASP or RSC were to integrate with community services, whether on their own or as a merged trust, then they were largely, going to do this with local services for their local community. There was a potential risk this would lead to reduced choice because there would be fewer providers providing a broader range of services but, if you got patient benefit from that, then that made sense.

22. E&H had no plans to provide community services outside of its core catchment area.

Seven day working

23. E&H referred to its own experience of running services at both Epsom and St Helier sites. If you combined the services into a single rota and the sites were close enough together, you could potentially provide seven day review without any additional investment in consultant staff.

24. It said that one of the Keogh standards was a 12 hourly review for acutely sick patients, which was more challenging to meet across two sites when using the same team to cover both sites. Delivering to this standard could be made easier through a consolidation of services for these patients at one site. In the context of the proposed merger (or through strategic partnership working) these were considerations that could lead to improved patient outcomes, but with potential reduction in access or choice.

Competition with the merging parties

25. In E&H's experience, most patient, GP or ambulance choice of hospital was determined by geography and travel times. It was about 15 miles (30 minutes' drive) from Epsom to St Peter's, 9 miles (30 minutes' drive) from Epsom to St Helier, and 20 to 25 miles (40 minutes' drive) from St Helier to St Peter's.

26. While its catchment area abutted those of ASP and RSC, there was very little overlap; where there was overlap there would be some competition. There was very little competition for emergency services, as most patients would go directly to the nearest hospital, but there was some competition for elective services, reflecting patient choice, at the margins and where there was overlap in services.

Referral patterns

27. E&H said that the strength of established GP referral lines were also important in determining where patients were referred for hospital treatment. A GP's default position was usually to refer patients to their local hospital unless there was a very good reason not to – possibly patient choice or perceived quality issues.

28. E&H did not routinely monitor referral patterns, eg on a monthly basis, but it might investigate patterns from time to time where it believed there had been a shift in activity or a change in profitability (picked up through service line reporting), and through its annual business planning cycle. Generally, however, referral patterns had been stable for some time.

29. If a noticeable change did occur it might be because commissioners had decided to tender or decommission a service, redirecting flows.

30. It was hard to influence referral patterns and a GP's or a patients' choice. It understood the merged trust would wish to attract referrals from other trusts for specialist services and, in effect, repatriate these from London trusts. This could be done as a combined trust or through a strategic partnership, but influencing another trust to change from its current referral partner would require real evidence of better patient care, investment in better and newer equipment and better services.

Capacity and utilisation

31. E&H said that Epsom had relatively little spare capacity at the moment. Assuming there was demographic growth and increased pressure on

demand, Epsom would have to adapt to manage the flow through the hospital and any rise in activity levels.

32. E&H was working in partnership with other providers and commissioners to help develop new models of care and out of hospital schemes. There was a challenge to ensure such schemes did not drive activity out of the trust altogether and deprive it of income.

33. It said that NHS finances were finely balanced and it was important to maintain the viability of the local health economy as a whole, rather than providers seeking to grow services at the expense of CCGs, beyond that which they could afford.

Views on the merger

34. E&H said it was difficult to predict what might happen if the merger did or did not proceed.

35. If the merger went ahead and was successful, the merged trust would have a greater scale and might be a more dominant player in the marketplace and able to exert influence over CCGs. ASP/RSC's scale might drive efficiencies with more money to invest (in people and capital), but also meant it was potentially more capable to capture market share from other providers.

36. Should Surrey CCGs act in concert and decide to only commission a particular service from a single Surrey provider, the combined trust might be in a stronger position to make the case for it as a louder voice on behalf of a larger population. It might also be able to invest more, potentially in capital or people, to deliver that service. Thus it might gain a competitive advantage over other Surrey providers.

37. The combined trust might have a stronger influence over Surrey CCGs partly due to its catchment area in that ASP and RSC both mainly served the Surrey population whereas the three other Surrey hospital trusts were more peripheral and drew much of their work from neighbouring areas – eg E&H also served part of south-west London.

38. A further potential impact was on various regional/specialist service providers if the merged trust wanted to change the way these services were delivered locally.

39. The merged trust might have ambitions to grow services such as cardiology and vascular, which could impact on other trusts. The impact might be the same if, for example, RSC and St Peter's Hospital decided to act in a strategic partnership way, though the merged trust might have more purchasing power.

40. E&H saw these as hypothetical risks rather than that there was concrete evidence that this would happen and outcomes would be dependent on how other providers decided to act and also what CCGs wanted to commission.