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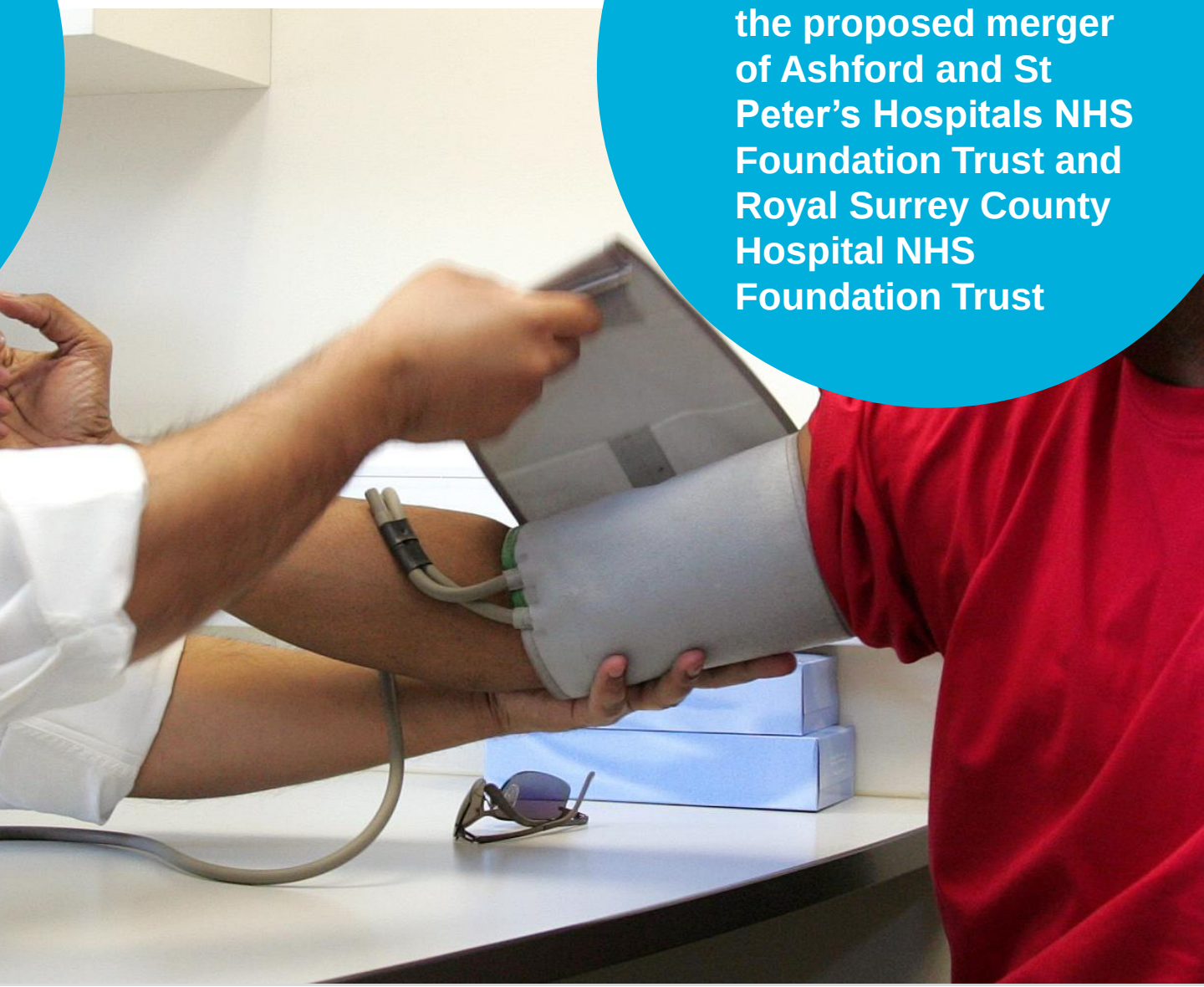
Making the health sector work for patients

Monitor's advice to the Competition and Markets Authority on the merger benefits of the proposed merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust



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About Monitor

As the sector regulator for health services in England, our job is to make the health sector work better for patients. As well as making sure that independent NHS foundation trusts are well led so that they can deliver quality care on a sustainable basis, we make sure: essential services are maintained if a provider gets into serious difficulties; the NHS payment system promotes quality and efficiency; and patients do not lose out through restrictions on their rights to make choices, through poor purchasing on their behalf, or through inappropriate anti-competitive behaviour by providers or commissioners.

Contents

1. Executive summary

This document presents Monitor's advice to the Competition and Markets Authority on the relevant patient benefits arising from the proposed merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust.

The parties submitted various proposals which we evaluated using the statutory framework for assessing relevant customer benefits.

We conclude that extending access to consultant-led care in gastroenterology, stroke and interventional radiology services should be taken into account as relevant patient benefits. These relevant patient benefits all relate to improving access to a service, and in particular extending access to senior clinicians. Improved access to a consultant out of hours and at weekends is a clinically significant service improvement in these specialties, each of which provides emergency care for acutely ill patients.

We consider the likely improvements to care, patient experience and patient outcomes to be clinically significant and of high importance and value to patients

1. On 22 December 2014 the Competition and Markets Authority (the CMA) notified Monitor that it had decided to carry out an investigation of the proposed merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust.

2. Monitor has a statutory duty under Part 3 of the Enterprise Act 2002 (the Enterprise Act) to provide advice to the CMA on the relevant customer benefits that arise from mergers involving NHS foundation trusts. This advice is provided in accordance with the statutory framework that is set out in the Enterprise Act.

3. In this document we use the term 'relevant patient benefits' instead of 'relevant customer benefit' but with the same meaning.

4. Our advice on the relevant patient benefits is one input into the decision to be taken by the CMA. The CMA has to decide whether the merger would be expected to lead to a substantial reduction in competition and patient choice. If the CMA finds such a reduction, it will take our advice into account when considering whether the relevant patient benefits outweigh the reduction in competition and patient choice.

5. While a merger may result in a number of improvements, not all such improvements would necessarily constitute relevant patient benefits for the purpose of the Enterprise Act. This advice discusses those improvements that the parties submitted as relevant patient benefits.

6. The parties told us that they plan to merge for a number of reasons. The principal reasons for merging were the need to address predicted financial deficits at both trusts and the need to meet emerging clinical standards, such as seven day working by consultants. In their submission to Monitor on the relevant patient benefits, the parties have not presented any financial benefits resulting from the merger as relevant patient benefits. In due course, should the CMA clear the merger, the financial aspects of the planned merger would be assessed by Monitor in its foundation trust governance role.

7. The parties submitted that the merger would enable them to make a number of improvements which should be taken into account as relevant patient benefits. They categorised these under three proposals:

   a) extended access to consultant-led or nurse-led care in the following services:

      - gastroenterology
      - stroke
      - interventional radiology
      - neurology
      - specialist diabetes

   b) development of a cancer diagnostic and treatment centre at Ashford Hospital

   c) improved management of neonatal services.

8. For extended access to consultant-led or nurse-led care, we assessed each service separately because the way each service is provided varies across specialties.

9. We have assessed whether each proposed improvement constitutes a relevant patient benefit for the purpose of the Enterprise Act by examining whether:

   a) the proposal is likely to represent a real improvement in quality, choice or innovation of services for patients[1] or in value for money for commissioners

   b) the improvement is likely to be realised within a reasonable period as a result of the merger

   c) the improvement is unlikely to accrue without the merger or a similar lessening of competition.[2]

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[1] 'Patients' in this context refers to people who use healthcare services provided for the purposes of the NHS. See section 79(5) of the Health and Social Care Act.

10. Three of the proposed improvements put forward by the parties should in our view be taken into account as relevant patient benefits.

11. It is our view that extended access to consultant-led care in gastroenterology would result in an improvement for about 300 emergency patients per year who present with life-threatening problems by providing a stable and formal rota out of hours and at weekends. Some of these patients are currently transferred to another hospital or have to wait until the following Monday for treatment because a consultant is not available when they arrive at hospital. The introduction of weekend ward rounds would be an improvement for a subset of around 770 gastroenterology patients per year admitted at a weekend because being seen by a consultant sooner speeds up treatment and means that patients would be able to go home more quickly. There are also patients who would be able to be discharged at a weekend because of a consultant's presence. In our view this proposal is likely to be implemented within a reasonable timeframe and would be implemented by the parties with greater certainty than through a partnership or individually, and most quickly, through this merger. We conclude that this should be taken into account as a relevant patient benefit. This relevant patient benefit is clinically significant and potentially very important for the patients it affects.

12. It is our view that the introduction of weekend ward rounds by a stroke consultant would result in an improvement for patients in hospital at a weekend. This would include about 250 patients who are admitted at a weekend and about 470 patients who are present in hospital at a weekend. In our view this proposal is likely to be implemented within a reasonable timeframe and would be implemented by the parties most quickly through this merger. A commissioner review of stroke services is underway in Surrey. We understand an outcome of this review is likely to be the provision of seven day services in stroke and therefore this improvement would, at some point, likely be realised in any event. However, we are of the view that the parties' proposal should be taken into account as a relevant patient benefit because it would be realised sooner. This relevant patient benefit is clinically significant for those patients it affects.

13. It is also our view that the introduction of a formal and stable out of hours and weekend consultant rota in interventional radiology would result in an improvement for patients requiring this service. This would affect about 75 patients at Ashford and St Peter's, and at least 23 patients at Royal Surrey County per year. We consider the likely improvement to be clinically significant

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[2] Monitor (2014). *Supporting NHS providers: guidance on merger benefits.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340823/Monitor_mergerbenefits_guidance.pdf

for each patient it affects. It is our view that this proposal is likely to be implemented within a reasonable timeframe and would be implemented by the parties with more certainty than through a partnership or individually, and most quickly, through this merger. We conclude that this should be taken into account as a relevant patient benefit.

14. Four of the proposed improvements submitted by the parties should not in our view be taken into account as relevant patient benefits.

15. In our view extended access to a consultant neurologist could be achieved in a timely way without this merger. We conclude that this should not be taken into account as a relevant patient benefit.

16. In our view the parties have not demonstrated that the introduction of extended access to a specialist diabetes nurse, in addition to the five day service already provided, would lead to a real improvement for patients. We conclude that this should not be taken into account as a relevant patient benefit.

17. We are of the view that reducing travel time to cancer services by developing a cancer centre at Ashford Hospital would be an important development and improvement for patients. However, there are significant uncertainties which mean we are not persuaded that the proposal would be implemented. We conclude that this should not be taken into account as a relevant patient benefit.

18. In our view the issues around management of neonatal services should be resolved regardless of the merger. We conclude that this proposal should not be taken into account as a relevant patient benefit.

2. Introduction

2.1. The merger process

19. On 22 December 2014 the CMA notified Monitor, under section 79(4) of the Health and Social Care Act (the 2012 Act) that the CMA had decided to carry out an investigation under Part 3 of the Enterprise Act of the proposed merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust (the parties).

20. Under section 79(5) of the 2012 Act, as soon as reasonably practicable after receiving a notification under section 79(4), Monitor is required to provide the CMA with advice on:

    a) the effect of the merger on benefits, as defined in section 30(1)(a) of the Enterprise Act (relevant patient benefits), for people who use healthcare services provided for the purposes of the NHS

b) such other matters relating to the proposed merger as Monitor considers appropriate.

21. Our advice on the relevant patient benefits is one input into the decision to be taken by the CMA. The CMA has to decide whether the merger would be expected to lead to a substantial reduction in competition and patient choice. If the CMA finds such a reduction, it will take our advice into account when considering whether the relevant patient benefits outweigh the reduction in competition and patient choice.

22. While a merger may result in a number of improvements, not all such improvements would necessarily constitute relevant patient benefits for the purpose of the Enterprise Act.

23. This document and Annex 1 constitute the advice that we must provide under section 79(5) of the 2012 Act. An explanation of the process we undertook to prepare this advice is set out in Annex 1. A non-confidential version of this advice will be published on Monitor's website in due course.

2.2. The parties

24. Ashford and St Peter's Hospitals NHS Foundation Trust (Ashford and St Peter's) is a two-site hospital trust that provides a full range of district general hospital services. Its two sites are St Peter's Hospital in Chertsey, which provides a range of acute services including accident and emergency, and Ashford Hospital in Ashford, which primarily provides elective services. The trust also provides some specialist services from St Peter's Hospital including neonatal intensive care, cardiovascular services, vascular services, bariatric surgery and limb reconstruction.

25. Royal Surrey County Hospital NHS Foundation Trust (Royal Surrey County) is a single-site hospital trust based in Guildford that provides a full range of district general hospital services. It is also a specialist tertiary centre for cancer, oral and maxillo-facial surgery and ear, nose and throat services.

2.3. The decision to merge

26. In November 2012, Ashford and St Peter's and Royal Surrey County entered into a partnership arrangement known as Surrey Health Partners. The parties told us the purpose of the partnership was to enable them to deliver clinical and support services jointly in order to improve services for patients and maximise value for taxpayers. They also told us the partnership had been delivering improvements, such as an outreach chemotherapy service.

27. In October 2013, the two trusts appraised how this partnership should develop. As a result of this the parties' boards decided that a full merger was the

preferred option. The rationale for merger is that as a merged entity the parties would be better placed to meet challenges, including:

a) predicted financial deficits in 2016/17 for both trusts

b) increased competitive pressure (eg including from the Frimley Park NHS Foundation Trust merger with Heatherwood and Wexham Park Hospitals NHS Foundation Trust)

c) the need to meet emerging clinical standards (eg seven day working) the desire to be designated as a specialist emergency centre.[3]

3. Framework for analysing the parties' proposals

28. Monitor assesses whether any improvements proposed by the merger parties would be a relevant patient benefit by examining the following three questions:

    a) is the proposal likely to represent a real improvement in quality, choice or innovation of services for patients[4] or in value for money for commissioners?

    b) is the proposal likely to be realised within a reasonable period as a result of the merger?

    c) is the proposal unlikely to accrue without the merger or a similar lessening of competition?

29. Detailed information on our approach to assessing merger benefits is set out in our guidance *Supporting NHS providers: guidance on merger benefits.*[5]

4. Analysis of the parties' proposals

4.1. The proposals

30. The parties submitted that the merger would enable them to make a number of improvements which should be taken into account as relevant patient benefits. They categorised these under three key proposals:

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[3] NHS England (2013). *Urgent and Emergency Care Review end of phase 1 report.* The Urgent and Emergency Care Review states that there will be two levels of hospital-based emergency care, which it has called 'emergency centres' and 'major emergency centres' (now called specialist emergency centres). Specialist emergency centres are described as being larger units that provide a range of specialist emergency services, which some patients attending emergency centres may need to be transferred to.

[4] 'Patients' in this context refers to people who use healthcare services provided for the purposes of the NHS. See section 79(5) of the Health and Social Care Act.

[5] Monitor (2014). *Supporting NHS providers: guidance on merger benefits.* Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/340823/Monitor_mergerbenefits_guidance.pdf

a) extended access to consultant-led or nurse-led care in the following services:

- gastroenterology
- stroke
- interventional radiology
- neurology
- specialist diabetes

b) development of a cancer diagnostic and treatment centre at Ashford Hospital

c) improved management of neonatal services.

31. In the rest of this section we assess each proposal, and each service set out at paragraph 30(a), against the framework for analysing whether each proposal is a relevant patient benefit.

32. Extended access to consultant-led or nurse-led care relates to the five services set out in paragraph 30(a). In relation to each service, the proposal is to combine consultants or nurses from the two merger parties and implement a cross-site rota to deliver extended consultant or nurse cover. The way each service is provided varies across specialties and between the trusts. For this reason we have assessed each service separately.

4.2. Gastroenterology

33. Gastroenterology is a medical specialty focused on the digestive system and its disorders. Hospital-based gastroenterology services comprise diagnostic and treatment care for patients with upper and lower gastrointestinal disorders, such as peptic ulcers, inflammatory bowel disease and abdominal pain. More specialist care can include conditions such as pancreatitis and hepatitis C.

34. Gastroenterologists are usually general consultant physicians who have undertaken additional training to become experts in gastroenterology. Many of them participate in providing care to general medical patients as well as specialist gastroenterology patients.

35. Acute upper gastrointestinal bleeding (upper GI bleeding) is a medical emergency that requires an endoscopy to treat.[6] The national mortality rate for

[6] The parties told us that an oesophago-gastro duodenoscopy is the primary diagnostic investigation and treatment for patients presenting with upper GI bleeding. It can stop bleeding and reduce risk of re-bleeding. This is a form of endoscopy and for the purpose of this analysis we refer to it as an endoscopy.

patients presenting with upper GI bleeding is 10%.[7] Endoscopies can only be performed by gastroenterologists with relevant training. It is recommended that endoscopies are offered immediately for patients with severe bleeding, and within 24 hours for all other patients presenting with upper GI bleeding.[8]

36. In 2013/14 gastroenterology non-elective inpatients accounted for approximately 6.5% of the parties' total non-elective admissions. Of all gastroenterology non-elective inpatients in 2013/14, 2,050 were either admitted or spent time in hospital at the weekend. This was around 66% of total gastroenterology patients.[9] Of the 2,050 gastroenterology patients who spent time in hospital at the weekend, around 770 were admitted at the weekend. About 300 patients were upper GI bleeding patients who presented out of hours or at the weekend. This was made up of about 160 patients at Ashford and St Peter's, and about 140 patients at Royal Surrey County.

37. Ashford and St Peter's currently has three whole time equivalent (WTE) consultant gastroenterologists who:

    a) work on weekdays and are responsible for gastroenterology patients

    b) are part of a 1:14 rota treating acute medical patients admitted into hospital as an emergency, ie not just patients with gastrointestinal problems; this is called the general medical on-take rota and is also an out of hours rota[10,11]

    c) work on an ad hoc basis out of hours[12] on weekdays by coming into hospital to treat emergency gastroenterology patients (ie upper GI bleeding) when they are not covering a general medical on-take rota

    d) work at the weekend on a shared rota with upper gastrointestinal and colorectal consultant surgeons.

38. The parties told us that a number of patients at Ashford and St Peter's did not have immediate access to a consultant gastroenterologist trained in

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7 Acute upper gastrointestinal haemorrhage, *British Medical Bulletin* (83), 2007:1

8 National Institute for Health and Clinical Excellence (2012). *Acute upper gastrointestinal bleeding: management,* NICE clinical guideline 141.

9 Monitor calculations: 6.5% was calculated using the parties' estimate of the number of non-elective inpatients at both trusts in 2013-14 (3,125), and dividing it by Dr Foster data on all non-elective admissions excluding maternity (around 48,000); 66% was calculated by taking the parties' estimate of the number of non-elective gastroenterology inpatients present at weekends (2,050) and dividing it by the total number of non-elective gastroenterology inpatients (3,125).

10 This is called the general medical on-take rota and is an on-call rota between general medical consultants and some specialist consultants. When working on call the consultants will be responsible for accepting acute medical patients who require emergency admission into hospital.

11 A 1:14 rota means that there are 14 consultants on the rota and each one works 1 in every 14 days or weekends.

12 Out of hours refers to 5pm to 8am.

endoscopy.[13] This was because they were admitted at a time when a consultant gastroenterologist was not covering on the rota or the ad hoc arrangement did not work. These patients would have been either transferred to another hospital if unstable or, if more stable, would have had to wait until a consultant gastroenterologist was available. For some patients admitted over a weekend, the length of their wait would be contrary to the recommendation set out in paragraph 35.

39. Royal Surrey County currently has 4.3 WTE consultant gastroenterologists who:

    a) work on weekdays and are responsible for gastroenterology patients

    b) are part of a 1:13 rota treating acute medical patients admitted into hospital as an emergency, ie not just patients with gastrointestinal problems; this is the general medical on-take rota, as described above in 37(b)

    c) work on a 1:4 on-call rota out of hours on weekdays for emergency treatment of gastroenterology patients

    d) work on a 1:4 on-call rota at weekends for the emergency treatment of gastroenterology patients.

40. The parties submitted that since the 1:4 on-call rota was implemented at Royal Surrey County in 2012 the requirement for consultants to be on site when on call has increased. The parties also told us that the NHS Consultant Contract requires employing organisations to take any practicable steps to reduce the frequency of 1:4 or more frequent out of hours rotas and to review arrangements annually.[14] They submitted a report from the Royal College of Radiologists which recommends that consultants should not be on call on a rota more onerous than 1:6.[15]

41. The parties do not currently operate consultant weekend ward rounds in gastroenterology.

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[13] The parties said that they were unable to provide the number of patients that this applied to.

[14] NHS Consultant Contract (2013) says: 'Where a consultant or consultants are on [an on-call] rota of 1 in 4 or more frequent, the employing organisation will review at least annually the reasons for this rota and for its high frequency and take any practicable steps to reduce the need for high-frequency rotas of this kind.' Version 9 of the terms and conditions.

[15] Royal College of Radiologists. *Standards for providing a 24-hour interventional radiology service*, 9.

The proposal

42. The parties submitted that they would operate a cross-site 1:8 rota[16] out of hours and at weekends at St Peter's Hospital and Royal Surrey County Hospital sites by combining their respective teams of consultant gastroenterologists.[17]

43. This would mean that a consultant gastroenterologist would be available for evening and weekend emergencies and there would also be consultant-led ward rounds on Saturdays and Sundays.[18] This would be in addition to the weekday service already provided by consultant gastroenterologists. These consultants would no longer work on the general medical on-take rota described at paragraph 37(b) and 39(b).

Is the proposal likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?

44. The parties told us that providing earlier and more regular access to a consultant by extending working out of hours and at weekends would be an improvement for all gastroenterology patients and would:

    a) reduce patient mortality rates – in particular for patients presenting with upper GI bleeding at the weekend or out of hours, and other gastrointestinal patients who are admitted at weekends

    b) reduce patient length of stay and increase the number of discharges at a weekend because of weekend ward rounds.

45. We set out below our assessment of the impact on patients and the number of patients affected.

Upper GI bleeding patients

46. As set out in paragraph 36, the parties told us that around 160 upper GI bleeding patients at Ashford and St Peter's and around 140 at Royal Surrey County would have improved quality of care through access to a consultant out of hours and at the weekend on a formal and stable rota.

47. The parties referred to the NHS Services Seven Days a Week Forum (the Forum report) which, in the first stage, focused on seven day provision of

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[16] This means that each consultant will be on call one in every eight weekends (including Friday, Saturday and Sunday night) and one weekday night every two weeks.

[17] The parties told us that the number of WTE consultants at Ashford and St Peter's is expected to increase to 3.6 WTE in the coming months. This means that the combined number of WTE consultants will be 7.9.

[18] The parties intend that responsibility for weekend ward rounds and out of hours on-call at the weekend will be combined, so that one consultant would cover both on any given weekend.

urgent and emergency care and the supporting diagnostic services. Following its review, it recommended that the NHS adopt seven day working for 10 clinical standards by 2016/17 (the clinical standards).[19] NHS England has set the objective in its 2014/15 – 2016/17 business plan to implement the clinical standards by 2016/17 and for appropriate contract sanctions to be in place for non-compliance by March 2017.[20]

48. The Forum report points to a range of evidence demonstrating that patients, admitted as a medical emergency at the weekend where consultant cover is not provided, have a significantly greater risk of dying in hospital than those admitted on a weekday.[21]

49. The parties referred to the National Patient Safety Agency's finding that between 2004 and 2008 there were 28 patient safety incidents relating to patients with upper GI bleeding who were admitted to hospital out of hours nationally. This included nine reports of patients who died from upper GI bleeding after problems accessing emergency investigation or treatment. The problems included informal or goodwill arrangements for out of hours consultant cover that failed to cover all dates and times.[22]

50. Our view is that at Ashford and St Peter's there would be an immediate improvement for some emergency upper GI bleeding patients if this proposal was implemented. This would benefit those patients who would otherwise have been transferred to another hospital or would have had delayed access to a consultant gastroenterologist at the weekend and out of hours. Our view is also that there is a risk that the current ad hoc arrangement would not continue in the future. We therefore expect that a formal rota would be a real improvement for all patients who present with upper GI bleeding out of hours and at weekends. On the basis of the data provided by the parties, this would apply to around 160 patients per year.

51. The current situation at Royal Surrey County is contrary to the recommendation that consultants should not be on call on a rota more onerous than 1:6 (see paragraph 40). Implementing a 1:8 rota reduces the risk that the arrangement would not continue in a way that would have an impact on all upper GI bleeding patients presenting out of hours and at weekends. We

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[19] These standards relate to patient experience, time to first consultant review, multidisciplinary team review, shift handovers, diagnostics, intervention/key services, mental health, ongoing review, transfer to community, primary and social care, and quality improvement. See NHS England board paper, December 2013: *NHS Services, Seven Days a Week*.

[20] NHS England (31 March 2014), *Putting patients first: the NHS England business plan for 2014/15-2016/17*: 54

[21] NHS Services Seven Days a Week Forum. *Evidence base and clinical standards for the care and onward transfer of acute inpatients*, 9

[22] Academy of Medical Royal Colleges (2011). *Scope for improvement: a toolkit for a safer upper gastrointestinal bleeding services*, 10.

therefore expect that a less frequent rota would be an improvement for all patients presenting with upper GI bleeding out of hours and at weekends. On the basis of the data provided by the parties, this would apply to around 140 patients per year.

All gastroenterology patients admitted at a weekend

52. The parties told us that about 770 gastroenterology patients per year are admitted as an emergency to the two providers at the weekend (this includes those patients who present at weekends with upper GI bleeding). They said that these patients would benefit from earlier access to a consultant and this would reduce mortality rates.

53. The Forum report (paragraph 47 above) states that early consultant involvement in the management of patients admitted as an emergency is one of the most important factors in patient care.

54. We expect that for gastroenterology patients admitted at the weekend there would be a real improvement because of earlier consultant review. The parties told us that around 770 patients were admitted at the weekend. This number includes those patients with upper GI bleeding (ie some of those already accounted for in paragraphs 50 and 51). The parties have not told us how many of the 770 this would apply to, so we take it to apply to a subset of the group of 770 patients identified by the parties.

Length of stay and discharge rates

55. The parties told us that introducing consultant-led weekend ward rounds would potentially reduce length of stay for all gastroenterology patients in hospital at the weekend because of more regular reviews. They said that this would apply to about 2,050 patients per year (this is around 770 patients admitted at a weekend and 1,280 patients who are present at a weekend). They referred to the clinical standards (paragraph 47), which specify that patients should be reviewed during a consultant-delivered ward round at least once in every 24 hours.[23]

56. The parties said that the introduction of weekend ward rounds would lead to more patients being discharged at a weekend rather than having to wait until the following Monday. They told us that this was reflected in their discharge rates where there are more discharges during weekdays relative to weekends.

57. The current situation at both providers is that patients who arrive at the weekend have to wait until the following Monday for a review because there

[23] These services relate to standards 2, 5, 6 and 8. See NHS England board paper, December 2013: NHS Services, Seven Days a Week.

are no weekend ward rounds by consultants at the two providers. We recognise that early review by a gastroenterology consultant would result in a patient being able to go home sooner because they are treated more quickly. This would be an improvement for the 770 patients per year who are admitted at the weekend. We also recognise that more regular access to a gastroenterology consultant would be an improvement for some patients whose health deteriorates at the weekend. We are unable to quantify the number of patients this might apply to but it is likely to be a small number.

58. We note there a number of factors that influence the timeliness of discharges for gastroenterology patients such as access to other health professionals, or the availability of suitable social care following discharge. The data provided by the parties did not show a spike in the number of discharges on a Monday relative to other days of the week. We would expect such a spike if a number of patients were waiting until a Monday to be discharged. We are of the view that this is likely to be because there are other care processes that affect when a patient is discharged. Even when a consultant decides to discharge a patient on a Monday this does not mean that all the other care processes would be in place to enable their discharge to happen on that Monday. This means that it is unlikely that all patients identified by the parties would be able to be discharged at the weekend because of access to a consultant. Our view is therefore that the presence of gastroenterology consultants at weekends is likely to increase the number of discharges of gastroenterology patients where it is clinically appropriate to do so. However, this would apply to a small subset of the 2,050 patients identified by the parties.

Is the proposal likely to be realised within a reasonable period as a result of the merger?

59. The parties expect to implement the consultant gastroenterology rota on a permanent basis within six to nine months of completion of the merger. They provided us with:

    a) a plan to implement the proposed change based on a series of key milestones and an indicative rota demonstrating the feasibility of the proposal

    b) details on how consultant gastroenterologists' other rota commitments (eg the general medical on-take on-call rota) will be managed.

60. The parties told us that the proposal had been discussed at workshops with clinical leads and clinicians from both providers and that it has the support of staff.

61. The parties did not provide details about other aspects of the delivery of extended consultant-led services, such as details of how other staff (eg

nurses) will fit within the new arrangement. We recognise that the plans may need refinement over time but are of the view that the consultant rotas are a fundamental building block to this proposal. We would expect planning of other delivery aspects to happen in line with the parties' implementation milestones. Based on the information provided by the parties in our view it is likely that this proposal would be realised within six to nine months following the merger.

Is the proposal unlikely to accrue without the merger or a similar lessening of competition?

62. The parties submitted that in order to deliver consultant-led care at weekends and out of hours they would need to operate a minimum of a 1:6 rota because this is the most frequent rota that is acceptable for consultants to work (see paragraph 40). The parties said that that they could not achieve this without the merger, either independently or in a partnership with each other.

63. We have separately assessed the parties' ability to deliver this proposal independently and by working in partnership.

Independently

64. The parties told us that the cost of each implementing a 1:6 rota independently would be too high because of the need to recruit additional consultants. They based this on the total cost of recruitment needed to achieve 1:6 rotas across all of the specialties identified in paragraph 30(a). They also said that even if funding were available, it would be highly unlikely that they would be able to recruit enough consultants. This was for a number of reasons including the high intensity of rotas at the two providers. The parties provided evidence of vacancies in non-elective services across the two providers.

65. By merging, the parties would be able to implement a 1:8 rota. They would therefore not have to recruit additional consultants to meet the Royal College of Radiologists' recommendation that a 1:6 rota is the minimum frequency for this type of rota (see paragraph 40).

66. While the parties did not illustrate that they have faced particular difficulty in recruiting gastroenterology consultants, we think that recruitment into this specialty is likely to be difficult and may take a long time to achieve. It is our view therefore that delivering this proposal through a merger would be less costly, quicker, more certain and more efficient than delivering it independently.

Partnership

67. The parties told us that implementing this proposal as separate organisations working in partnership with each other would be unmanageably complex. They told us that the level of consensus and co-operation across the two trusts

needed to achieve this proposal in partnership would be very difficult to maintain. The reasons they identified that would make a partnership more difficult than a merger include:

a) the need to implement appropriate governance (including performance management and accountability) and reporting arrangements

b) the instability of a partnership arrangement

c) the parties having different incentives

d) the difficulty in achieving clinical support.

68. The parties estimated that it would take around 12 months to develop a joint rota in gastroenterology in partnership but it would be achieved more quickly through a merger.[24] However, in practice we note that trusts can experience considerable difficulty in enacting such arrangements. The parties told us that they have been trying to set up a partnership in interventional radiology for the last five years and have not been able to achieve this.

69. In our view achieving this improvement through a partnership would be more difficult than achieving it through this merger. From a practical perspective we recognise that appropriate governance and reporting arrangements would be likely to be more difficult to put in place where there are two organisations and two sets of service management teams that would need to agree and co-operate to make the partnership work. We recognise that substantial managerial input would be needed from both parties to design effective and satisfactory working arrangements. We also recognise that clinical commitment would also be essential to implement the partnership. In our view, achieving clinical commitment to work at another organisation's site is difficult in high-risk services such as gastroenterology.

70. Where commissioners intend to change a service, parties would be likely to prioritise and direct resource to that service. We note that local commissioners have no current plans to change how gastroenterology services are provided in the area. As noted in paragraph 47, however, NHS England has set the objective to implement the clinical standards relating to seven day services by 2016/17.

71. In our view there are considerable practical difficulties in setting up a partnership in gastroenterology, not least obtaining agreement from clinicians - a challenge that had thwarted a partnership between the parties in

[24] GE Healthcare Finnamore, *Surrey Health Partnership OBC - Supporting Information, Work in progress discussion paper: Implementing seven day [Keogh] standards.* This is a draft report which assesses the potential for achieving the seven day Keogh standards under partnership and merger in 10 key specialties.

interventional radiology for over five years. While our view is that it is possible that this improvement could be implemented through a partnership between the two parties, we think that there is less certainty that it would happen. We are also of the view that if it were to be achieved through a partnership, the implementation of this improvement would take longer than it would through this merger.

Conclusion on gastroenterology

72. In our view, introducing a formal rota for consultant gastroenterologist cover out of hours and at weekends would be an immediate improvement for those upper GI bleeding patients who present during these times and would otherwise not have immediate access to a consultant gastroenterologist. This would apply to a subset of the group of around 160 patients who are currently treated at Ashford and St Peter's. This is a significant clinical improvement and potentially very important for the patients it affects.

73. It is also our view that the proposal to implement a 1:8 rota would reduce the risk that the current arrangements at the two providers would not continue. This is because the new arrangement would be provided on a more formal and less onerous rota. This would be an important improvement for around 160 patients per year at Ashford and St Peter's, and around 140 patients per year at Royal Surrey County who present with upper GI bleeding out of hours and at the weekend.

74. In our view the introduction of weekend ward rounds by a consultant gastroenterologist would be a significant improvement for:

    a) about 770 patients per year admitted to hospital at a weekend because they would be treated more quickly and would be able to go home sooner

    b) a subset of the group of 1,280 patients per year present in hospital at a weekend because these patients would be able to go home sooner.

75. In our view the proposed improvements are likely to be implemented within six to nine months following the merger. It is also our view that implementing out of hours and weekend consultant cover, as well as weekend ward rounds, would be achieved with a greater degree of certainty than through partnership or independently, and most quickly through a merger.

76. For the reasons set out above, we therefore conclude that this proposal should be taken into account as a relevant patient benefit.

4.3. Stroke

77. A stroke is a medical emergency that occurs when blood flow to a part of the brain stops.

78. Both Ashford and St Peter's and Royal Surrey County consultants are part of the Surrey Telestroke Network.[25] This is an out of hours and weekend service for remote clinical decision making relating to the appropriate form of emergency treatment for a patient.[26] Once emergency treatment has been administered, the patient is admitted to hospital for ongoing care.

79. In 2013/14 stroke inpatients accounted for approximately 2% of the parties' total non-elective admissions.[27] This was about 1,000 patients a year and about 720 of these stroke patients were in hospital at a weekend. About 250 of these patients were admitted at a weekend.

80. Ashford and St Peter's currently has one WTE stroke consultant and one vacancy for a WTE stroke consultant. Royal Surrey County has two WTE stroke consultants and one WTE consultant geriatrician with stroke training. At both providers, stroke consultants currently:

    a) work on weekdays

    b) are part of an on-call rota treating acute medical patients admitted into hospital as an emergency, ie patients with stroke as well as others[28,29]

    c) are members of the Surrey Telestroke Network on-call rota.

81. Neither provider currently operates consultant-led weekend ward rounds for stroke patients.

The proposal

82. The parties submitted that they would implement weekend ward rounds at the Royal Surrey County Hospital and St Peter's Hospital sites on a 1:6 rota[30] by combining their respective teams of stroke consultants. The combined team would comprise three existing stroke consultants, a new stroke consultant yet

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[25] The Surrey Telestroke Network was established in September 2011, between Ashford and St Peter's, Royal Surrey County, Surrey and Sussex Healthcare NHS Trust, Epsom and St Helier University Hospitals NHS Trust and Frimley Health NHS Foundation Trust. It ensures 24/7 access to out of hours remote clinical decision making, by stroke consultants using telemedicine equipment, on the need for emergency thrombolysis.

[26] This is the decision on whether or not to thrombolyse the patient. Thrombolysis is the administration to a patient of a thrombolytic drug, able to dissolve a clot (thrombus) and reopen an artery or vein.

[27] Monitor calculations: 2% was calculated using the parties' estimate of the number of stroke inpatients at both trusts in 2013/14 (1,000), and dividing it by Dr Foster data on all non-elective admissions excluding maternity (around 48,000).

[28] See footnote 8 for a description of a general medical on-take on-call rota.

[29] At Ashford and St Peter's the one stroke consultant works on a 1:14 general medical on-take rota. At Royal Surrey County the two stroke and one geriatric consultant work on the 1:13 general medical on-take rota.

[30] This means that each consultant would provide a ward round at St Peter's Hospital and one at Royal Surrey County Hospital on a Saturday and Sunday every six weeks.

to be recruited, a consultant neurologist from Ashford and St Peter's and one consultant geriatrician with stroke training from Royal Surrey County.

Is the proposal likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?

83. The parties submitted that weekend ward rounds by a stroke consultant would improve the care of stroke patients leading to reduced patient mortality rates, reduced length of stay for patients and an increased number of discharges at a weekend. We have assessed this submission below.

84. The parties also submitted that combining their stroke consultants would reduce the parties' reliance on the Surrey Telestroke Network, which they have said is vulnerable to other providers leaving. The parties did not provide supporting evidence to substantiate this claim and we have not assessed it further.

85. We set out below our assessment of the impact on patients and the number of patients affected.

Stroke patients admitted at a weekend

86. The parties told us that around 250 stroke patients per year are admitted to the two providers at the weekend. They said that following emergency treatment, these patients would benefit from earlier access to a stroke consultant and this would reduce mortality rates.

87. The parties referred to research which showed that being seen by a stroke consultant (or associate specialist) within 24 hours of admission is associated with reduced mortality.[31]

88. In our view, once stroke patients admitted at the weekend have received emergency treatment, an earlier consultant review would be a clinical improvement for them. This would affect around 250 patients admitted at the weekend per year.

Length of stay and discharge rates

89. The parties told us that consultant-led weekend ward rounds would lead to a potential reduction in length of stay and more discharges at a weekend because of early and more regular reviews. They told us that this would be an improvement for the 720 stroke patients in hospital at weekends (this is 250 patients admitted at the weekend and 470 who are present at the weekend).

[31] Bray BD (2013). Associations between the organisation of stroke services, process of care and mortality in England: prospective cohort study, *British Medical Journal*.

90. We recognise that an early review by a stroke consultant would result in patients being treated more quickly and being able to go home sooner as a result of earlier treatment. We also recognise that earlier treatment can be expected to reduce mortality rates. Earlier treatment by a consultant would be an improvement for the 250 patients per year who are admitted at the weekend. It is also likely that access to a consultant at a weekend could improve the care of patients whose health or condition changes over a weekend. This is likely to apply to a small subset of the group of 470 patients who are present in hospital at the weekend.

91. We note that a number of factors will affect discharges, such as the availability of suitable social care following the stroke patient's discharge, and therefore not all patients will be ready to be discharged at a weekend. We did not see a spike in the parties' discharge data on stroke patients on a Monday relative to other days of the week. It is our view therefore that the number of patients who would be discharged at a weekend would be small relative to the total number of patients identified by the parties.

Is the proposal likely to be realised within a reasonable period as a result of the merger?

92. The parties expect to implement the revised consultant stroke rota on a permanent basis within six to nine months following completion of the merger. They provided:

    a) a plan to implement the proposed change based on a series of key milestones and an indicative rota demonstrating the feasibility of the proposal

    b) details on how stroke consultants' other rota commitments (eg the general medical on-take on-call rota) will be managed.

93. The parties told us that the proposal had been discussed at workshops with clinical leads and clinicians from both providers, and has the support of staff.

94. The parties did not provide details about other aspects of the delivery of extended consultant-led services, eg details of how other staff will fit within the new arrangement. We recognise that the plans may need refinement over time but are of the view that the consultant rotas are a fundamental building block to this proposal. We would expect planning of other delivery aspects to happen in line with the parties' implementation milestones.

95. We note that Ashford and St Peter's currently has a vacancy for a WTE stroke consultant and has had difficulty in recruiting an additional stroke consultant. The parties told us there is a plan in place to recruit for that vacancy. However, we note that the merged provider may initially need to operate a 1:5 rota for

weekend ward rounds. We are satisfied that this could be achieved on a temporary basis.[32]

Is the proposal unlikely to accrue without the merger or a similar lessening of competition?

96. The parties told us that they would not be able to deliver weekend ward rounds either independently or in a partnership with each other.

97. We have assessed separately the parties' ability to implement this proposal independently and by working in partnership. We set out our assessment below.

Independently

98. The parties said that the costs of implementing this proposal independently would be too high because of the need to recruit additional stroke consultants. They also said that it would be too difficult to recruit the number of stroke consultants needed to implement weekend ward rounds.

99. By merging, the parties would be able to implement weekend ward rounds through a 1:5 rota in the short term which would decrease in frequency to a 1:6 rota once they had successfully recruited one additional stroke consultant (paragraph 95).

100. The parties illustrated the difficulty they have had in recruiting stroke consultants by providing details of vacancies at the two providers. For example, at Ashford and St Peter's there has been an ongoing vacancy for a stroke consultant since December 2013.

101. It is our view therefore that achieving weekend ward rounds through a merger would be less costly, more certain, more efficient and quicker than trying to implement the rota independently.

Partnership

102. Similarly to the points raised in gastroenterology, the parties told us that implementing this proposal in partnership would be more difficult than in merger because of:

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[32] Ashford and St Peter's and Royal Surrey County (2013). *Outline business case: future model of care for stroke services.* The parties say that, 'A hyper-acute stroke unit requires at least 5 Stroke Consultants [to operate] Consultant Stroke Physician ward rounds and specialist nursing to support rapid thrombolysis 24/7.'

a) the need to implement appropriate governance (including performance management and accountability) and reporting arrangements

b) the instability of a partnership arrangement

c) the parties having different incentives

d) the difficulty in achieving clinical support.

103. The parties also told us that they had put together a business case for an integrated stroke model across the two sites (Royal Surrey County Hospital and St Peter's Hospital) in August 2013.[33] This proposal was to establish a stroke unit[34] which would meet a number of service specifications, including seven day consultant cover. The proposed implementation date for this partnership was April 2014. The parties submitted that the plans for the partnership did not progress because they were unable to resolve a number of complexities satisfactorily or in a timely way.

104. As set out in our discussion of gastroenterology, we recognise that from a practical perspective appropriate governance and reporting arrangements would be likely to be difficult to achieve where there are two organisations and two sets of service management teams that need to agree and co-operate to make the partnership work. We recognise that substantial managerial input would be needed from both parties to design effective and satisfactory working arrangements. We also recognise that clinical commitment would also be essential to implement the partnership. As with the gastroenterology service, in our view achieving clinical commitment to work at another organisation's site is particularly difficult in high-risk services.

105. We are aware that commissioners have recently initiated a review of stroke services, including the location and number of hyper acute stroke units (HASUs) across Surrey. The outcomes of this review will be known in 2015 and any implementation is expected to take one to two years. We understand the outcome of this review is likely to require designated HASUs to provide weekend ward rounds.[35,36] This review is therefore likely to result in the proposed improvement for stroke patients in Surrey whether or not the merger goes ahead. It appears to us, however, that the parties' proposal is likely to be

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[33] Ashford and St Peter's and Royal Surrey County (2013). *Outline business case: future model of care for stroke services*.

[34] The exact term for this was hyper acute stroke units (HASUs). The parties submitted that this would bring clinical experts, specialist teams and equipment under one roof to provide 24 hours a day assessment and treatment for acute stroke patients.

[35] We also expect that stroke consultants would work on a 24/7 basis to provide emergency clinical decision making.

[36] This is part of the service provided by HASUs in London. See Healthcare for London, *Stroke strategy for London*, 2008.

implemented at least one year before any implementation arising from the commissioner review.

106. Our view is that weekend ward rounds for stroke patients by consultants are likely to be implemented as an outcome of the commissioner review of stroke services in Surrey. However, this merger would enable consultant weekend ward rounds to be implemented sooner.

Conclusion on stroke

107. It is our view that the introduction of weekend ward rounds by a stroke consultant would be a significant improvement for:

    a) about 250 stroke patients admitted to hospital at a weekend, whose mortality rates and length of stay would be expected to reduce; some of these patients may also be discharged at the weekend

    b) a subset of the group of about 470 stroke patients who are present in hospital at a weekend whose length of stay would be reduced; some of these patients may also be discharged at a weekend.

108. In our view this proposal is likely to be implemented within six to nine months of the merger. It is also our view that implementing weekend ward rounds would be achieved most quickly through a merger. Commissioners are currently reviewing stroke services in Surrey. A likely outcome of this review is seven day services and therefore the proposal is likely to be implemented in any event. However, the parties' proposal is likely to be implemented at least one year before any implementation arising from the commissioner review.

109. For the reasons set out above, we therefore conclude that weekend ward rounds by a stroke consultant at St Peter's Hospital and Royal Surrey County Hospital sites should be taken into account as a relevant patient benefit.

4.4. Interventional radiology

110. Radiology is the branch or specialty of medicine that deals with the study and application of imaging technology, like x-ray, to diagnose and treat different diseases.

111. Interventional radiology is a rapidly expanding branch of radiology. This is a procedure that involves making only a small puncture in the skin to undertake complex surgical procedures for the treatment of specific conditions and medical or surgical emergencies. Interventional radiology minimises physical trauma, reduces the need for open surgery, avoids general anaesthetic,

reduces infection rates and shortens recovery time and hospital stays.[37] According to the Royal College of Radiologists, this is a less invasive technique which replaces major surgery.[38]

112. Ashford and St Peter's currently has four WTE interventional radiologists who:

    a) work on weekdays conducting interventional radiology procedures

    b) are part of the general radiology out of hours reporting rota

    c) work on a 1:4 on-call rota for out of hours weekdays and at weekends for emergency treatment of patients requiring interventional radiology.

113. Royal Surrey County has three WTE interventional radiologists who

    a) work on weekdays conducting interventional radiology procedures

    b) are part of the general radiology out of hours reporting rota

    c) work on an ad hoc basis out of hours and at weekends by coming into hospital to treat emergency patients requiring interventional radiology when they are contactable and available.

114. The parties have told us that a number of patients at Royal Surrey County did not have immediate access to an interventional radiologist and were either transferred to another hospital or given a different type of procedure or treatment.

The proposal

115. The parties submitted that they would operate a cross-site 1:7 rota out of hours and at weekends at St Peter's Hospital and Royal Surrey County Hospital sites by combining their respective teams of interventional radiologists.

116. This would mean that an interventional radiologist would be available for evening and weekend emergencies. This is in addition to the weekday service already provided by interventional radiologists.

Is the proposal likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?

117. The parties told us that the current arrangements at Ashford and St Peter's and Royal Surrey County are unsustainable. They said that if interventional

[37] NHS Services (2014). Seven Days a Week Forum. Evidence base and clinical standards for the care and onward transfer of acute patients.
[38] Royal College of Radiologists website. Available at: http://www.rcr.ac.uk/index.aspx

radiology was not provided out of hours and at weekends at the two trusts then all patients requiring interventional radiology would be transferred to another hospital. On the basis of this, the parties told us that providing out of hours and weekend consultant cover on a sustainable rota would be an improvement for around 10,000 patients per year including:

a) all hepatobiliary patients admitted out of hours or at a weekend who needed interventional radiology; the parties did not tell us how many patients this would apply to

b) all surgical patients and obstetric patients admitted out of hours or at a weekend who may need interventional radiology, including those who require interventional radiology and those who may require the procedure; the parties did not tell us how many patients this would apply to.[39]

118. The parties also identified the number of patients who received interventional radiology at the two trusts last year as 75 patients at Ashford and St Peter's and 23 patients at Royal Surrey County. The parties told us that when a formal rota was put in place at Ashford and St Peter's the number of patients receiving interventional radiology increased. They said that they would also expect an increase in the number of patients receiving interventional radiology at Royal Surrey County once a formal out of hours and weekend rota is put in place.

119. The parties submitted that the Royal College of Radiologists said that failing to provide interventional services 24/7 puts patients at risk because this interventional radiology technique is at the forefront of managing certain life threatening emergencies. The parties also submitted that every acute provider has a duty to ensure that there are formal arrangements in place to secure the provision of emergency interventional radiology services.[40]

120. The parties told us that one of the standards set out in the Forum report (see paragraph 47) is that hospital inpatients must have timely 24-hour access, either on-site or through formally agreed arrangements with clear protocols, to interventional radiology. Also, providers should have plans in place to implement seven day working models in interventional radiology as a matter of

[39] In a later submission to Monitor, the parties also identified accident and emergency trauma patients, gastro-intestinal hematoma patients and urology patients experiencing stents or obstructed kidney function as whose who may require interventional radiology at the merged trust in the future.

[40] Royal College of Radiologists, *Standards for providing a 24-hour interventional radiology service.*

priority.[41] The Forum report adds that providing this service on an ad hoc basis at weekends puts patients at risk and is neither sustainable or reliable.[42]

121. The current situation at Ashford and St Peter's is contrary to the recommendation that consultants should not be on call on a rota more onerous than 1:6 (see paragraph 40). For this reason, it is our view that this rota proposal reduces the risk that the arrangement would not continue (ie because it is a less intense rota) in a way that would have an impact on all patients requiring interventional radiology out of hours and at weekends. We therefore expect that a less onerous rota would likely be a real improvement for about 75 patients requiring interventional radiology out of hours and at weekends per year.

122. The current arrangement at Royal Surrey County means that some patients do not have access to an interventional radiologist and will be transferred to another hospital, or will be given open surgery as an alternative form of treatment. It is our view that introducing a formal rota would be an immediate improvement for these patients. As set out in paragraph 119, ad hoc arrangements can put patients at risk. It is our view therefore that providing a rota on a formal basis would likely be an improvement for at least 23 patients per year requiring interventional radiology out of hours and at the weekend. We are persuaded that providing this service on a formal basis would lead to an increase in the number of patients receiving interventional radiology. This number is likely to be small relative to the total number of patients identified by the parties as comprising those patients potentially requiring interventional radiology.

Is the proposal likely to be realised within a reasonable period as a result of the merger?

123. The parties expect to implement out of hours and weekend consultant cover on a permanent basis within six to nine months following completion of the merger. They provided:

    a) a plan to implement the proposed change based on a series of key milestones

    b) details of how the interventional radiologists' other rota commitments will be managed

    c) an indicative rota demonstrating the feasibility of the proposal.

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[41] NHS Services (2013), Seven Days a Week Forum, *Summary of initial findings*.
[42] NHS Services (2014), Seven Days a Week Forum*, Evidence base and clinical standards for the care and onward transfer of acute patients*.

124. They told us that the proposal had been discussed at workshops with clinical leads and clinicians from both providers, and has the support of staff.

125. The parties did not provide details about other aspects of the delivery of extended consultant-led services, eg details of how other staff will fit within the new arrangement. We recognise that the plans may need refinement over time but are of the view that the consultant rotas are a fundamental building block to this proposal. We would expect planning of other delivery aspects to happen in line with the parties' implementation milestones.

Is the proposal unlikely to accrue without the merger or a similar lessening of competition?

126. The parties told us that they would not be able to deliver out of hours and weekend consultant cover in interventional radiology either independently on a sustainable basis, or in partnership.

127. We assessed separately the parties' ability to implement this proposal independently and by working in partnership. We set out our assessment below.

Independently

128. The parties submitted that they would need to implement at least a 1:6 rota as a minimum as this is what is recommended by the Royal College of Radiologists (see paragraph 40). They said that the costs of doing this independently would be too high because of the need to recruit additional consultants. They have also said that it would be too difficult to recruit the number of interventional radiologists needed to achieve a 1:6 rota.

129. By merging, the parties would be able to implement a 1:7 rota and therefore they would not have to recruit any additional consultants for this rota to meet the recommendation of the Royal College of Radiologists.

130. The parties do not currently have any vacancies for interventional radiology consultants. As is the case for gastroenterology, however, we think that recruitment into this emergency service is likely to take a long time to achieve because of a general shortage of interventional radiologists in the UK.

131. It is our view therefore that achieving this rota proposal through a merger would be less costly, more efficient, more certain and quicker than trying to implement the rota independently.

Partnership

132. As set out in gastroenterology and stroke, the parties told us that implementing this proposal in partnership would be more difficult than in merger because of:

a) the need to implement appropriate governance (including performance management and accountability) and reporting arrangements

b) the instability of a partnership arrangement

c) the parties having different incentives

d) the difficulty in achieving clinical support.

133. The parties have also told us that they have been trying to set up a joint rota in interventional radiology for the last five years and have not been able to achieve this.[43]

134. As set out in our discussion of gastroenterology, we recognise that from a practical perspective appropriate governance and reporting arrangements will be more difficult to achieve where there are two organisations and two sets of service management teams that need to agree and co-operate to make the partnership work.

135. As with the gastroenterology service, we recognise that substantial managerial input would be needed from both parties to design effective and satisfactory working arrangements. We also recognise that clinical commitment would be essential to implement the partnership. In our view, achieving clinical commitment to work at another organisation's site is particularly difficult in high risk services such as interventional radiology. In this case, we understand that this is the principal reason for why the parties have been unsuccessful in their attempts to implement a joint rota across the two trusts.

136. We note that there are examples of interventional radiology cross-site rotas through partnership or networks, including in London. We understand that one of the London networks came about because commissioners were mandating 24/7 interventional radiology for certain emergency services and an increasing number of patients were being transferred to other providers to access interventional radiology services. Consultants also had appropriate contracts already in place to enable them to work across multiple providers. The same circumstances do not apply here because currently commissioners are not planning to change the service in Surrey.

137. In our view there are considerable practical difficulties in setting up a partnership in interventional radiology, not least obtaining agreement from clinicians - a challenge that has thwarted a partnership between the parties in this service for over five years. While our view is that it is possible that this

[43] We note that the parties intend to put an interim rota in place from January 2015. The parties told us this is a temporary measure in contemplation of the merger to ensure a safe environment for Royal Surrey County hepatobiliary patients. We agree with the parties that this interim measure would be unlikely to happen as quickly without the merger.

improvement could be implemented through a partnership between the two parties, we think that there is less certainty that it would happen. We are also of the view that if it were to be achieved through a partnership, the implementation of this improvement would take longer than it would through this merger.

Conclusion on interventional radiology

138. In our view this proposal would be an immediate improvement for at least 23 patients per year at Royal Surrey County who currently do not have access to an interventional radiologist out of hours or at the weekend. These patients would currently be transferred to another hospital or have another, more invasive, form of treatment. We consider this improvement to be clinically significant and of high importance to patients it affects. In our view, the absence of interventional radiology places patients at risk.

139. There is a risk that the current out of hours arrangements at both providers would not continue. This would result in all patients requiring interventional radiology either having to be transferred to another hospital or being treated with another, more invasive, form of treatment. This would affect about 75 patients at Ashford and St Peter's, and at least 23 patients at Royal Surrey County per year.

140. In our view this proposal would likely be implemented within six to nine months following the merger. It is also our view that this proposal would be implemented with a greater degree of certainty than through partnership or independently, and most quickly through this merger.

141. For the reasons set out above, we conclude that this proposal should therefore be taken into account as a relevant patient benefit.

4.5. Neurology

142. Neurology is a branch of medicine concerned with the study and treatment of disorders of the nervous system. Consultant neurologists diagnose and treat conditions and disorders such as multiple sclerosis and epilepsy.

143. The most common treatment for neurological conditions and diseases is medication, and the long-term nature of many of the diseases involved means care can mostly be outpatient clinic and community based. A consultant neurologist may also provide a neurological opinion at the request of another consultant.

144. Ashford and St Peter's has 2.8 WTE consultant neurologists and Royal Surrey County has 2.3 WTE consultant neurologists[44] who work on weekdays leading:

    a) outpatient clinics providing treatment for patients with neurological problems

    b) ward rounds providing a neurological opinion to patients under the care of a consultant from another specialty.

145. The parties do not currently provide consultant-led ward rounds at weekends for neurology. If a neurological opinion is needed at the weekend it is provided by St George's Healthcare NHS Trust (St George's Trust) mainly by telephone. St George's Trust is a specialist neuroscience centre that provides a full range of neurology and neurosurgical services.

The proposal

146. The parties submitted that they would operate weekend ward rounds at Royal Surrey County Hospital and St Peter's Hospital sites on a 1:6 rota by combining their respective teams of consultant neurologists. The parties told us that they would recruit an additional consultant to achieve the 1:6 rota.

147. This would mean that patients under the care of a consultant in another specialty needing a neurological opinion on a Saturday and Sunday would be able to have a consultation with a neurologist in person.

Is the proposal likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?

148. The parties submitted that implementing consultant neurologist weekend ward rounds would improve the quality of care for patients needing a neurological opinion at weekends by:

    a) providing more timely assessment for patients admitted at the weekend

    b) reducing a patient's length of stay and increasing the number of patients discharged at the weekend.

149. The parties estimated that 300 patients admitted at weekends would benefit from this proposal.[45]

150. The parties submitted an example where a patient at Ashford and St Peter's was transferred to St George's Trust for diagnosis and then transferred back to

[44] The parties state that this will be the number of consultants in post by February 2015.

[45] Based on the trusts' consultant records, 1,000 patients per year have a neurological assessment across the two trusts. The parties assumed that these patient admissions are roughly evenly spread across the seven day week, and therefore approximately 300 patients requiring a neurological assessment are admitted at the weekend per year.

St Peter's Hospital. As it was a weekend, the patient was under the medical supervision of the general medical on-call team. The patient's condition deteriorated and this was not fully recognised. The parties said that if a consultant neurologist had been available, the deterioration would have been recognised and treated sooner.

151. The parties submitted that access to a neurological opinion at the weekend, where needed, could reduce a patient's length of stay if provided sooner than would otherwise be the case. The parties also told us that medical consultants often seek the opinion of a consultant neurologist before discharging a patient.

152. Our view is that an examination in person rather than by telephone would be an improvement for some patients because it would involve a physical examination. We have not assessed the impact this would have on patients in terms of reduced length of stay or the number of discharges. This is because it does not materially affect our conclusion which we set out below.

Is the proposal likely to be realised within a reasonable period as a result of the merger?

153. The parties submitted that the development of a combined neurology rota to enable weekend ward rounds is at an earlier stage of planning compared to other services but they expect to implement it on a permanent basis within six to nine months following the merger. They provided an indicative rota demonstrating the feasibility of the proposal. They did not provide further details relating to the possible impact on the consultants' work patterns or commitments, nor how this proposal impacts on the arrangement with St George's Trust.

154. They told us that the proposal has been discussed at workshops with clinical leads and clinicians from both providers and has the support of staff.

155. We note that the parties would need to recruit an extra consultant neurologist at the merged organisation in order to deliver 1:6 weekend ward rounds. It should be possible for the parties to implement this proposal post-merger within the timeframe the parties have proposed. We have not assessed this further as it does not materially affect our overall conclusion which we set out below.

Is the proposal unlikely to accrue without the merger or a similar lessening of competition?

156. The parties told us that they would not be able to deliver weekend ward rounds either independently or in a partnership with each other.

157. We have first assessed whether the parties could implement weekend ward rounds independently through some arrangement other than by implementing

a 1:6 rota (eg by reorganising the existing workforce). This proposal relates to extending the current weekday service (which includes some weekday ward rounds) to include weekend ward rounds at the merged trust.

158. We understand that consultant neurologists have less intense work commitments and patterns than consultants in some of the other specialties. For example, consultant neurologists do not generally provide non-elective care for emergency patients and do not participate in the general medical on-take rota or other specialist out of hours or weekend rotas. It is not clear to us why the parties could not reorganise their existing consultants' job plans to enable weekend ward rounds. It is also not clear to us why the parties could not recruit additional resource to have enough clinicians to enable weekend ward rounds independently. We note that in any event this proposal requires an additional one WTE consultant. Accordingly, we are of the view that the proposal could be achieved independently and in a timely way without the merger.

Conclusion on neurology

159. In our view the parties could implement weekend ward rounds by consultant neurologists in a timely way without the merger.

160. We therefore conclude that this proposal should not be taken into account as a relevant patient benefit.

4.6. Specialist diabetes

161. Diabetes is a common life-long health condition where the amount of glucose in a person's blood is too high. It develops when glucose cannot enter the body's cells to be used as energy because the pancreas either does not produce any insulin (which is known as Type 1 diabetes) or does not produce enough insulin, or the insulin is produced but is not effective (which is known as Type 2 diabetes).

162. This proposal relates to diabetes specialist nurses (diabetes nurses). Diabetes nurses provide support in diabetes management for patients with Type 1 and Type 2 diabetes, who are newly diagnosed or need more specialist advice, intervention, training and support.

163. Ashford and St Peter's has four WTE diabetes nurses and Royal Surrey County has two WTE diabetes nurses. The diabetes nurses at both providers work on weekdays. The parties do not currently provide any weekend ward rounds by diabetes nurses.

The proposal

164. The parties submitted that they would operate weekend ward rounds at the sites by implementing a 1:6 rota by combining their respective teams of diabetes nurses.

165. This would mean that diabetes patients in hospital on a Saturday or Sunday would have access to a diabetes nurse.

Is the proposal likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?

166. The parties submitted that weekend ward rounds by diabetes nurses would be an improvement for patients for reasons including reduced length of stay and an increase in the number of discharges at weekends.

167. The parties referred to a Norfolk and Norwich University Hospital study which concluded that introducing a diabetes inpatients specialist nurse service reduced diabetes excess bed occupancy.[46] It is not clear whether this service included weekend working by diabetes nurses because the paper only refers to one diabetes nurse providing the service. It therefore appears unlikely that the service was provided on a seven day basis.

168. While this study indicates that access to a diabetes nurse improves the care of patients, it is our view that it does not demonstrate that this service is needed on a seven day basis. It also does not demonstrate whether providing this service on a seven day basis would result in any incremental improvement in length of stay or discharge rates. We are therefore not satisfied that the parties' proposal would result in a real improvement in terms of reduced length of stay or increased discharges at the weekend.

Is the proposal likely to be realised within a reasonable period as a result of the merger?

169. The parties said that implementing weekend ward rounds by diabetes nurses at the merged organisation's hospital sites would take the same effort and time to implement as the changes they propose for the other services. They said that the information provided for the other services could be used to assess whether this proposal would be implemented within a reasonable timeframe.

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[46] Sampson MJ, Crowle T, Dhatariya K, Dozio N, Greenwood RH, Heyburn PJ, Jones C, Temple RC, Walden E (September 2006). Trends in bed occupancy for inpatients with diabetes before and after the introduction of a diabetes inpatient specialist nurse service*, Diabetic Medicine* 23 (9).

170. We are not satisfied that the information provided for the other services can be used to assess this proposal. We are also not satisfied that the parties have demonstrated that this proposal will be a priority for them. They did not provide indicative rotas or provide any information that would enable us to assess what impact, if any, the implementation of cross-site working at weekends will have on diabetes nurses' weekday workload.

171. It is our view that the parties have not demonstrated that this proposal is likely to be implemented within a reasonable timeframe.

Is the proposal unlikely to without the merger or a similar lessening of competition?

172. For reasons set out above, we are not satisfied that the proposal is a real improvement for patients. We are also not satisfied that the proposal is likely to be implemented within a reasonable timeframe. On this basis, we have not examined in detail whether the improvement would arise from the merger as any conclusion on this point would not materially affect our overall conclusion.

Conclusion on specialist diabetes

173. In our view the parties have not demonstrated that introducing weekend ward rounds, in addition to the weekday service currently provided, represents a real improvement in the quality care of patients. It is also our view that the parties have not demonstrated that the proposal is likely to be implemented within a reasonable timeframe.

174. For the reasons we set out above, we conclude that this proposal should not be taken into account as a relevant patient benefit.

4.7. Developing cancer services at Ashford Hospital

175. NHS cancer services in England are arranged into 28 cancer networks. Each network has one central specialist cancer centre and a number of non-specialist acute providers. The non-specialist providers provide outpatient care and diagnostic services[47] and, where a cancer is diagnosed, will carry out low complexity surgical procedures to remove tumours and provide some chemotherapy. The specialist cancer centre leads the network and provides more specialist surgery, complex chemotherapy and radiotherapy in addition to the more routine services provided by other acute trusts within the network. Under these network arrangements, patients who require complex cancer care will typically receive it from the cancer centre leading their local network.

[47] Outpatient services are diagnostic and treatment services provided by hospitals to patients who access them by appointment and do not stay in hospital overnight.

176. Ashford and St Peter's provides acute outpatient care and diagnostics in a number of cancer-related specialties. Where a cancer diagnosis is made, Ashford and St Peter's will carry out low complexity surgical treatment. Ashford Hospital, and to a lesser extent St Peter's Hospital, may also carry out chemotherapy, depending on the complexity of treatment required. Ashford and St Peter's does not carry out any radiotherapy.

177. Royal Surrey County provides cancer services from its St Luke's Cancer Centre, which leads the St Luke's Cancer Alliance. St Luke's Cancer Alliance is the cancer network covering Surrey, Hampshire and West Sussex. As the cancer centre for the Alliance, Royal Surrey County provides specialist complex surgery and chemotherapy as well as radiotherapy. These services are in addition to routine diagnostic services and the less complex chemotherapy and surgical activity related to cancer care and services. Royal Surrey County also provides services at the cancer centre at Surrey and Sussex Hospital. This is in partnership with Surrey and Sussex NHS Trust.

178. Ashford and St Peter's is also part of St Luke's Cancer Alliance. This means that under network arrangements, most Ashford and St Peter's patients who require complex cancer care will generally receive this at Royal Surrey County. The parties told us that some patients will be referred to a London hospital for certain more specialist cancer surgical procedures.

179. The parties told us that patients who live near Ashford Hospital may choose to be referred to a range of non-specialist providers for a first outpatient appointment, including Ashford and St Peter's, Frimley Health NHS Foundation Trust and West Middlesex University Hospital NHS Trust.[48] Under cancer network arrangements, patients initially referred for a first outpatient appointment to Heatherwood and Wexham Park Hospitals NHS Foundation Trust (now Frimley Health NHS Foundation Trust) will generally receive their complex cancer care at Royal Berkshire NHS Foundation Trust, a cancer centre in Reading. Patients initially referred to West Middlesex University Hospital NHS Trust will generally receive their complex cancer care at Charing Cross Hospital, part of Imperial College Healthcare NHS Trust in Hammersmith.

[48] For example, the parties told us that patients whose GP was within [redacted]' drive time of Ashford Hospital, and who had a first outpatient appointment in the [redacted] in 2013/14 chose to go to [redacted]

The proposal

180. The parties submitted that they intend to develop a cancer diagnosis and treatment centre at Ashford Hospital as part of the specialist cancer unit of St Luke's Cancer Centre. The unit would provide radiotherapy and complex chemotherapy services in addition to the existing diagnostics, less complex cancer surgery and chemotherapy services currently provided on the site.

181. The parties told us that the proposed cancer centre at Ashford Hospital would provide services for patients with cancers including breast and prostate, as well as head and neck, lung, lower gastrointestinal and gynaecology related cancers.

182. The parties submitted there would initially be [redacted] for the provision of radiotherapy,[49,50] but [redacted]

Is the proposal likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?

183. The parties submitted that the development of the cancer centre at Ashford Hospital would lead to an improvement in the care of cancer patients by reducing their travel times for cancer treatment. They said that this would apply to patients already treated at Royal Surrey County and patients already treated at other specialist cancer centres who would find it more convenient to be treated at the proposed cancer centre at Ashford Hospital. We set out our analysis of this below.

184. The parties also submitted that the development of the proposed cancer centre at Ashford Hospital would lead to improved quality of care for patients treated at other providers because they would improve their services as a competitive response to the proposed cancer centre at Ashford Hospital. The

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[49] A linear accelerator device is most commonly used for external beam radiation treatments (radiotherapy) for patients with cancer. It delivers high-energy x-rays to the region of the patient's tumour.

[50] The parties submitted that the operating capacity [redacted]

[51] LINAC machines are housed within a linear accelerator bunker. These are designed to prevent unintentional exposure to the radiation produced by the LINAC machine.

parties did not provide detailed information to substantiate this point and we have not considered it further.

Reducing travel times

185. The parties submitted that it is reasonable to assume that patients have a strong preference for accessing care as close to their home as possible.

186. The parties told us that patients currently treated at Royal Surrey County who are registered with a GP within a 13 minute drive time of Ashford Hospital would access care at the proposed cancer centre at Ashford Hospital.[52] They estimated that this would apply to around [redacted] radiotherapy patients and [redacted] chemotherapy patients per year.

187. They also told us that some of the patients currently travelling to other sites who are registered with a GP within a 13 minute drive time of Ashford Hospital would access care at the proposed cancer centre at Ashford Hospital.[53] They estimated that this could apply to around [redacted] radiotherapy patients and [redacted] chemotherapy patients per year. They submitted that if the cancer centre at Ashford Hospital were to attract this many patients, Ashford Hospital could expect to have at least [redacted] additional patients attending its outpatient clinics, on the basis that [redacted] of these patients would go on to be diagnosed and treated for cancer.[54]

188. The parties told us that patients receiving radiotherapy or chemotherapy may require a significant number of visits to hospital. They submitted that on average, a medical oncology (chemotherapy) patient at the two providers has [redacted] attendances,[55] while a clinical oncology (radiotherapy) patient will have [redacted] attendances.[56] The parties submitted that patients in the vicinity of Ashford

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[52] The parties submitted that the drive time between Ashford Hospital and Royal Surrey County is around 26 minutes and therefore 13 minutes is the mid-point between the two sites.

[53] The parties based this on their drive time analysis from Ashford Hospital to other sites. They submitted the drive time from Ashford Hospital to Charing Cross Hospital site is 26 minutes; Royal Berkshire Hospital site is 35 minutes and University College London Hospitals NHS Foundation Trust is 39 minutes.

[54] The parties submitted that the proportion of referrals which result in cancer diagnosis and treatment tends to range from 2% to 10% depending on the specialty and the incident of cancer in any particular geographical area. Based on this range, [redacted] is the minimum number of additional patients the parties would need to attract into outpatient clinics.

[55] The parties submitted that this is a conservative estimate based on data for patients receiving medical oncology (chemotherapy) treatment at Royal Surrey County in 2011/12. They submitted that this estimate is below the mean of [redacted] and median of [redacted] episodes that are observed in the data.

[56] This is based on the England average as stated in the National Radiotherapy Data Set Annual Report 2009/10.

Hospital may therefore currently have to undertake a significant amount of travel to receive cancer care.[57]

189. The parties also submitted that the proposed cancer centre at Ashford Hospital would offer the same high quality cancer services that are already provided by Royal Surrey County.

190. We note that national guidance[58] highlights [redacted]

191. The parties did not provide details of how they would manage [redacted]

192. It is likely that reducing a patient's travel time to receive cancer treatment is important for some patients, and we recognise that greater access to cancer services is an improvement for patients. It is our view, however, that reducing travel time would be an improvement for some patients but that location is unlikely to be the only factor that influences the choice of provider for a patient and their GP. For example, commissioners have told us that the reputation of some of the alternative providers patients currently travel to for treatment is such that in their view some patients are likely to continue to choose these existing providers even if a more convenient travel option becomes available. Commissioners have also told us that patients and their GPs may not choose to be referred to the proposed cancer centre at Ashford Hospital if patients would be required to travel to a different site to receive the full range of support

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[57] The parties calculated that a patient with [redacted] attendances who was saving [redacted] minutes per journey would save more than [redacted] in travel time over the course of their treatment.

[58] Royal College of Radiologists, Society and College of Radiographers and Institute of Physics and Engineering in Medicine, *Guidance on the management and governance of additional radiotherapy capacity,* available at: www.rcr.ac.uk/docs/oncology/pdf/BFCO(13)1_RT_capacity.pdf :10.

[59] Royal College of Radiology category 2 patients are patients with slower growing tumours, usually adenocarcinomas, being treated with radical (rather than palliative) intent. The Royal College of Radiologists. *The timely delivery of radical radiotherapy: standards and guidelines for the management of unscheduled treatment interruptions. Third edition, 2008.* Available at www.rcr.ac.uk/docs/oncology/pdf/BFCO(08)6_Interruptions.pdf 6

and rehabilitation services needed during and after cancer treatment.[60] In our view this makes it difficult to estimate how many patients would be treated at the proposed cancer centre at Ashford Hospital.

Is the proposal likely to be realised within a reasonable period as a result of the merger?

193. The parties submitted that the plan for the proposed cancer centre at Ashford Hospital has an implementation date of September 2017. They told us that the merged organisation's board would need to approve the business case for this proposal.

194. The parties told us the executive management of both trusts are committed in principle to investing in this new facility under the merged organisation's new structure, and this is reflected in the joint media statement that was made at the time of the planned merger's announcement.[61] They also said the proposed cancer centre at Ashford Hospital would not require commissioner approval.

195. The parties told us that the main risk to the success of their plan is that the proposed cancer centre at Ashford Hospital does not attract enough patients, and therefore revenues, to pay for the investment in the new facility. They provided a report setting out details of their preliminary financial modelling. The financial modelling assumes that the merged trust would be able to attract sufficient numbers of patients to make the proposed cancer centre at Ashford Hospital financially viable.[62] The parties said that a more detailed review of the assumptions underlying the financial modelling would be carried out by the cancer team before the cancer strategy is formalised and that all figures should therefore be treated as draft.[63] They also said that a more detailed evaluation of capital expenditure would be required.[64]

196. The parties also told us that Royal Surrey County has [redacted] such that it would not undertake this

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[60] For example, specialist nurse support, rehabilitation services provided by allied health professionals, counselling and clinical psychology and social worker services, including benefits advice.

[61] 'Ashford and St Peter's and Royal Surrey County boards announce merger as preferred way forward', joint media statement, 2 May 2014.

[62] They submitted that around [redacted] radiotherapy patients could be treated more conveniently at Ashford Hospital, who currently go to Royal Surrey Hospital. An increase in their share of radiotherapy patients with a GP within a 13 minute drive time, from [redacted] to [redacted], would lead to an additional [redacted] patients.

[63] 2020 Delivery (August 2014), *Ashford Diagnostic and Treatment Centre: strategic outline case supporting evidence*: 12.

[64] 2020 Delivery (August 2014), *Ashford Diagnostic and Treatment Centre: strategic outline case supporting evidence:*18.

particular proposal without the merger. They told us that the appraisals of potential investment opportunities for the merged entity are at an early stage.

197. The parties submitted that the cancer centre that Royal Surrey County developed at Surrey and Sussex Healthcare NHS Trust's hospital site shows that the merged trust would be able to deliver the project. They submitted an overview of issues that arose, how these were managed and their impact against the implementation plan.

198. It is our view that there are a number of uncertainties around the detailed assessment of the risks and viability of this proposal and there are specific downside risks that do not appear to have been reflected in the parties' financial modelling. For example, we note in particular that the parties' assumption relating to the range of cancers that would be treated at the centre is based on a wider scope of cancers than those that appear to have been treated at other centres [redacted] It is our view therefore that the evidence provided is not sufficient to persuade us that this proposal would be likely to be approved by the merged trust's board. In addition, even if the proposal were approved, given the parties plans thus far we are not persuaded that an implementation date of September 2017 is realistic.

199. It is our view therefore that because of the uncertainties we are not persuaded that this proposed change is likely to be implemented.

Is the proposal unlikely to accrue without the merger or a similar lessening of competition?

200. For reasons set out above, we have not examined in detail whether the proposal would arise from the merger as any conclusion on this point would not materially affect our overall conclusion.

Conclusion on developing cancer services at Ashford Hospital

201. There are a number of uncertainties which mean that we are not satisfied that it is likely that this proposal will be implemented.

202. For this reason, we conclude that this proposal should not be taken into account as a relevant patient benefit.

4.8. Improved management of neonatal services

203. Neonatology is a subspecialty of paediatrics which concerns the care of newborn infants, especially the ill and/or premature. It is a service delivered in hospital, usually in neonatal special care and intensive care units that cater for a range of levels of care. Capacity to treat babies in this service is measured

by the availability of a suitable level of care cots. The parties told us that there are three levels of care cots:

a) level 1 is special care (provided in special care baby units) for newborn infants who require continuous monitoring and some therapies such as oxygen and tube feeding, as well as those recovering from a period of higher level care

b) level 2 is high dependency care (provided in local neonatal units) for newborn infants who need short-term intensive care or support for their breathing

c) level 3 is intensive care (provided in neonatal intensive care units) for babies who are born before 28 weeks' gestation or who weigh less than 1,000g; this level is for newborn infants requiring the highest level of support and care, such as those who are severely ill, need full ventilation or need surgery.

204. In some instances, a suitable level of care cot is not available at the provider where an infant is a patient. The parties are currently part of the Surrey and Sussex Neonatal Network (the network). The Emergency Bed Service (EBS) facilitates cot allocation across Surrey and Sussex on behalf of the network to ensure that these patients can be transferred to another provider in the area with a suitable level of care cot.[65]

205. Ashford and St Peter's has 33 cots which are located at St Peter's Hospital (eight at level 3, four at level 2 and 21 at level 1). Royal Surrey County has 12 level 1 cots.

206. The parties submitted that providers participating in the network declare their cot capacity to the EBS on a daily basis. The parties also submitted that they each withhold declaring a certain number of cots in case their own patients need them. The parties told us that this results in less capacity being declared available than is in reality the case at each provider. They told us that patients who cannot be accommodated in a suitable level of care cot locally have to be transferred out of the network area to the nearest provider where a suitable level of care cot is available.

207. The parties told us that during 2012/13, Ashford and St Peter's declined 63 requests to accept a patient requiring a cot for level 3 care. These babies were transferred out of area.

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[65] The other members of the network are Surrey and Sussex Healthcare NHS Trust, Brighton and Sussex University Hospitals NHS Trust, Frimley Health NHS Foundation Trust and Western Sussex Hospitals NHS Foundation Trust.

The proposal

208. The parties submitted that they would better manage their neonatal cot capacity across all levels of care at the merged entity. They told us this would help to reduce the number of patients needing to be transferred out of area.

Is the proposal likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?

209. The parties told us that this would be an improvement for some patients of providers within the network who would otherwise have to be transferred out of area because a suitable level of care cot was not available. They said that better management across the merged organisation would result in fewer cots being reserved in case they are needed for their own emergency use.

210. Our view is that issues around the management of neonatal cot capacity and availability should be resolved by the network. The efficient use of critically important but scarce resources requires careful management, and we would expect this to be happening now. We note in this respect that NHS trusts and NHS foundation trusts have a duty to co-operate in the best interests of patients.

Is the proposal likely to be realised within a reasonable period as a result of the merger?

211. Given our conclusion that this is a network issue which should be addressed through the network on an ongoing basis, we have not examined in detail whether the proposed change would be realised within a reasonable timeframe. This is because any conclusion on this point would not materially affect our overall conclusion.

Is the proposal unlikely to accrue without the merger or a similar lessening of competition?

212. Neither have we examined whether this proposed change is unlikely to accrue without the merger or a similar lessening of competition, other than to note that improved management of neonatal services should be addressed by the network.

Conclusion on improved management of neonatal services

213. For the reasons set out above, in our view issues with the management of neonatal services should be resolved by the network.

214. We therefore conclude that this proposal should not be taken into account as a relevant patient benefit.

Annex 1: Outline of Monitor's process

Monitor engaged with the parties on their proposed improvements for patients during the pre-notification discussions between the parties and the CMA as well as during the CMA's Phase 1 review process.

Monitor met the parties on 25 July 2014 to discuss their rationale for merging and their proposed improvements for patients.

The parties submitted two draft versions of their proposed improvements for patients and Monitor provided feedback on each draft. Monitor also provided feedback following a site visit to the parties' hospital sites.

The parties submitted their proposed improvements for patients on 15 September 2014. Monitor shared a summary of its assessment of these proposed improvements for patients with the parties on 2 October 2014. The parties provided further comments on 7 October 2014 and a meeting was held between Monitor and the parties on 16 October 2014.

A draft of the advice was provided to the parties for comment on 15 December 2014. The parties' comments were received on 18 December 2014. Monitor took into account the comments provided by the parties before finalising its advice for the CMA.

In providing this advice, Monitor has sought the expert opinions of its Clinical Reference Group[66] as well as the views of commissioners.

On 22 December 2014 the CMA notified Monitor, under section 79(4) of the Health and Social Care Act, that the CMA had decided to carry out an investigation of the merger under Part 3 of the Enterprise Act.

[66] The Clinical Reference Group provides expert clinical advice on issues under consideration by Monitor. It consists of several clinicians with expertise in various clinical areas.

Monitor

Making the health sector work for patients

Contact us

Monitor, Wellington House,
133-155 Waterloo Road,
London, SE1 8UG

Telephone: 020 3747 0000
Email: enquiries@monitor.gov.uk
Website: www.gov.uk/monitor

 Publication code: IRREP 01/15