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

Summary of hearing with NHS Guildford and Waverley Clinical Commissioning Group on 22 April 2015

Background

1. NHS Guildford and Waverley Clinical Commissioning Group (G&W) told us that it was a clinically led membership organisation established under the Health and Social Care Act 2012 and made up of general practices (GPs). Its functions included planning, organising and buying certain healthcare and health services that met the needs of residents within its area.

2. G&W held contracts for the provision of treatment and healthcare with hospitals, community and mental health trusts, ambulance trusts and other organisations. It hosted the contract with Royal Surrey County Hospital NHS Foundation Trust (RSC). It was its main acute contract. It also had private contracts with BMI Mount Alvernia Hospital, Nuffield Hospital and with Optegra Eye Hospital. It was an associate to other contracts that were listed on its website.

Views on the proposed merger

3. G&W supported the merger between RSC and Ashford and St Peter's Hospitals NHS Foundation Trust (ASP), in principle, and considered the merger held the best chance of securing healthcare stability in G&W's and ASP's areas going forward. In its opinion, the merger enabled RSC and ASP (the trusts) to become more financially secure and to take on more activity that currently went out to the London trusts. The market forces factor was currently around 21% at St Georges compared to 16% for ASP and RSC respectively.

4. G&W said the merger would also enable the trusts to reduce their agency nursing spend through having a greater critical mass and with greater credibility as an organisation, an ability to recruit good people. A merged trust would be able to potentially pay a higher premium as a result of the cost savings from merging and therefore not lose good staff who were attracted to the higher rates of pay from London weighting.

5. G&W also thought that the cancer treatment centre would happen without the merger but be stronger with the merger. It explained that this came down to the critical mass of consultants and being able to tie-in referrals from the wider hinterland of ASP.

Location of services

6. G&W had not had conversations with either of RSC or ASP regarding moving certain services from one site to another. It had had those discussions with the trusts in relation to strategic clinical network specialist areas unrelated to the merger. If one of RSC or ASP became a designated hyper-acute unit, transport would be provided for the patient between sites.

7. G&W said that in its experience it could be beneficial to focus a particular elective service on a single site. It gave the example of Epsom Orthopaedic Centre in South West London as very successful in terms of outcomes and transport arrangements for its elective care. In the event of a merger of ASP and RSC any service change, depending on the size of the change, would be subject to consultation and agreement with the commissioners under NHS rules.

Repatriation of specialised services

8. G&W explained that specialised commissioning arrangements were changing and that co-commissioning committees between clinical commissioning groups (CCGs) and NHS England were being set up. It considered that a number of services were now recognised as being more appropriately dealt with at the local level, such as oncology, bariatric surgery and renal, and were therefore likely to be repatriated with an associated repatriation of income. Chemotherapy, for example, was funded by NHS England under specialist commissioning rules but it made sense for it to be commissioned jointly. It considered a merged trust would assist in bringing some of the capability back to Surrey.

Patient choice

9. G&W told us that it had a Referral Support Service that was managed by the local GP Federation as of 1 April 2015. This had been created to support referral decisions but also to support patients in the choice decisions. They provided a triage service that included giving patients information about the choice of providers. The activity profile showed that the overwhelming choice of G&W patients was to go to RSC.

10. G&W considered that patient choice was generally guided by GPs. CCGs could drive choice by making sure local service providers provided a particular service. It did see examples of patients choosing to wait for an appointment at their local provider, RSC, rather than opting for a sooner appointment at an alternative. It also explained that referrals could change due to issues of quality or organisational changes, giving the example of dermatology at RSC being recommissioned to a community service and medical audiology ceasing to be offered at RSC.

11. G&W considered Frimley to be the second provider of choice for its patients and explained that it also offered both Mount Avernia and the Nuffield to NHS patients (where these providers agreed to NHS tariff conditions).

Patient flows

12. G&W tracked patient flows by surveying its GP members. In 2013/14, 84% of its patients chose to go to RSC with 1% going to ASP and the others split between Frimley Park (4%) and St George's, Epsom and St Helier, Surrey and Sussex (1 to 2%). In 2014/15, 81% of its population went to RSC, 4% to Frimley and an increase to 2% of patients to ASP. It explained that the increase to ASP was connected with a backlog clearance for the referral to treatment time in trauma and orthopaedics. For emergency care the majority of its residents went to RSC. Patients who tended to choose ASP were usually at that end of the G&W boundaries.

13. G&W stated that currently about 30% of its residents who received treatment were private hospital or private care users, reflecting the demography of the area. Consistent with national trends this number had fallen in the last three years. This had coincided with a change in insurance company policy where there could be cash incentives to go for NHS treatment, particularly for elective specialties.

Remuneration

14. G&W told us that its main acute contract was with RSC and it was an associate to other contracts. It was moving away from a straight payment by results contract to a variable baseline arrangement with an agreed risk share regarding the delivery of the CCG and trust joint service transformation programme, while staying within the confines of what was permitted by Monitor. This tied in with a wider NHS landscape transformation of moving to a more integrated service provision between primary care, secondary care and community provision.

15. G&W's plan was to reduce follow-up outpatient appointments by up to 30% (varying by specialty) and it saw the risk share arrangement as assisting with this. In this year's contract (negotiated on the basis of RSC being a stand-alone trust and without regard to the merger) there was a change in the marginal rate to 70/30 in RSC's favour and this single level would apply to all non-elective income. It anticipated that as part of the joint focus on service transformation, non-elective activity would fall below the trigger point for the marginal rate.

Community care

16. G&W considered that some work should not take place in an acute hospital. Over time it would like to see acute hospitals doing a deeper range of activities whereas a greater volume of work (where appropriate and economically worthwhile) would be provided through community provision, whether by GP or other practitioners.

17. G&W had established a joint strategy and a joint programme management office with GP clinical leaders and with consultants and clinical directors at RSC to deliver the service transformation towards community provision.

Quality levers

18. G&W explained that the standard NHS contracts had a number of levers that were set centrally to secure quality and there was also the Commissioning for Quality and Innovation framework. The personal relationship between RSC's consultants and local GPs could not be underestimated and if there were quality issues it would lose the NHS referral but also any private referral. This applied to the choice areas of surgical specialties but also to medical specialties for non-elective admissions.

Seven day working

19. G&W explained that, as part of the quality measures an additional key performance indicator had been added to the 2015/16 contract with RSC in relation to emergency medicine and emergency surgery over weekends. It explained that this fitted with the national guidance on the 2015/16 contract where it was required to work with RSC to prepare for what was looking likely to be a mandatory contract requirement for 2016/17.