

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

### **Summary of hearing with West Middlesex University Hospital NHS Trust on 8 May 2015**

#### **Background**

1. West Middlesex University Hospital NHS Trust (West Middlesex) told us that it was a small district general hospital (DGH) and the only acute hospital in Hounslow. It was a core district general hospital with a lot of expertise around sexual health. It had a longstanding, essentially structural, deficit over about the last ten years and it was one of the smallest trusts in London. It had about £150–160 million of income a year, of which a relatively small amount was from NHS England for specialist services. [✂]
2. West Middlesex was planning to merge with Chelsea and Westminster Hospital NHS Foundation Trust (Chelsea and Westminster) and would be acquired by it, as it was a foundation trust. This was expected to happen on 1 September 2015.

#### **Funding and structure of contracts**

3. [✂]. West Middlesex's lead commissioner was Hounslow Clinical Commissioning Group (CCG), from which the majority of its work was commissioned. Last year it was block contracted through the North West London CCGs. Contract negotiations for 2015/16 would conclude soon. [✂]
4. West Middlesex said that the default funding mechanism for the NHS (acute sector) was Payment by Results (PbR). Last year, the contract negotiations with North West London CCGs had resulted in a block contract that effectively meant that there was expected activity reimbursed and if there were changes, either up or down, then the trust was not reimbursed/did not lose the additions/losses. [✂]
5. West Middlesex said that the block contract was applied to the North West London CCGs only. In South West London, West Middlesex remained on a PbR. It said that the local authority contract, where sexual health was commissioned from, was also a separate contract. It had not signed its new

contract but that it was expecting to be on a PbR contract this year on the enhanced tariff option.

6. West Middlesex said it received small levels of income of about £[redacted] from Surrey CCGs but tended to have very little direct relationship with them. In response to a question about Surrey commissioning intentions, it said that any future commissioning by Surrey of low value, high complexity services would not be expected to have a significant effect on it as its focus was as a DGH in Hounslow. [redacted]

### **Competing for patients with merging parties**

7. West Middlesex said that Hounslow was a long, thin borough and both Ashford and St Peter's Hospitals NHS Foundation Trust (ASP) and West Middlesex overlapped to an extent to provide services within it, particularly at the Feltham end of the borough. [redacted]
8. West Middlesex said that ambulances would normally go to the nearest hospital unless it was for stroke or cardiac treatment, for example, where they would go to stroke or cardiac centres. It said that around 65% of its activity was non-elective and the majority of those non-elective patients did not come by ambulance.

### **Referrals**

9. West Middlesex was a DGH that had most of its activity from Hounslow and North West London CCGs and about 17% of its activity from Richmond. [redacted]

### **Marketing**

10. West Middlesex's focus currently was on the Chelsea and Westminster merger. It said that it had been, for example, to Healthwatch (a local consumer group for health and social care) and described and discussed the merger with them.
11. [redacted]
12. [redacted]

### **Community outpatient clinics**

13. West Middlesex said that there were two areas for the Trust where it had got a lot of focus around community outpatients, including at the community

hospital in Teddington (Teddington Memorial Hospital (Teddington)), and generally in sexual health.

14. West Middlesex said that Richmond CCG had been proactive over the last few years about ensuring as many services were at Teddington as possible and West Middlesex consultants were providing care within that location. It said it was a good model of care and helped to manage people away from the hospital in a locality that was more convenient for them.
15. West Middlesex said that at Teddington there were community beds that were run by the Community Trust, which was part of Hounslow and Richmond Community Healthcare. There were breast surgery clinics; diabetic clinics; ear, nose and throat clinics; gastroenterology; general surgery; some maternity clinics; orthopaedics; orthotics; podiatry; colorectal and urology.
16. West Middlesex said that the difference between West Middlesex outpatients services (OP) and Teddington OP was that the diagnostics were more limited at Teddington OP, so West Middlesex clinicians would not, for example, do endoscopies at Teddington and so on. In terms of the outpatients, there was not a big difference in terms of the complexity of the patients that were being reviewed.
17. West Middlesex said that the other areas where it had a strong community presence was in sexual health. The direction of sexual health and the way it was commissioned was proactively supporting care outside hospitals. Its own sexual health clinic was not in the main building of the hospital but in a separate building.
18. [redacted]. West Middlesex said that it was working with Hounslow CCG in relation to integrated care, which was about making existing providers work more coherently together.

## Networks

19. West Middlesex said it was part of the North West London Clinical Network, for which the main networks were in cancer, stroke, neonatal and critical care. There tended to be a hub of care and then a more local site. Imperial College Healthcare NHS Trust (Imperial) was the stroke centre in the network and West Middlesex was a stroke unit. For cancer, Imperial as well as The Royal Marsden were the cancer centres and West Middlesex was a cancer unit. These were very longstanding networks. [redacted]

## Views on the merger

20. West Middlesex said that, overall, in terms of the acute provider landscape at the moment, the merged organisations, with their larger scale, would probably have more stability in the longer term. [✂]
21. [✂]
22. West Middlesex was not clear what the optimum size of a DGH was but it considered small. Many acute hospitals were now at about £300 million and that was a better starting point, enabling service scale.