Initial submission to the Competition & Markets Authority

Anticipated merger of
Ashford & St Peter's Hospitals NHS Foundation Trust, and
Royal Surrey County Hospital NHS Foundation Trust

1. EXECUTIVE SUMMARY

1. Ashford & St Peter's Hospitals NHS Foundation Trust (ASP) and Royal Surrey County Hospital NHS Foundation Trust (RSC) are medium sized Acute Trusts that supply district general hospital services, including A&E, maternity and routine elective care, while also offering several specialist services (primarily cardiology-related services at ASP and cancer-related services at RSC). Both Trusts also supply a small amount of community and private patient services.

2. ASP and RSC established a partnership in November 2012, and following a review of this partnership decided, in April 2014, to merge. The decision to merge responds to the challenges facing both Trusts in terms of budgetary pressures, tightening regulatory standards and increasing demand for healthcare services.

3. The merger will enable significant cost savings so that the merged Trust will deliver a small financial surplus each year, generate significant clinical benefits, including 7 day services in several specialties and sustainable levels of safe nursing, and finance a much larger capital programme to the benefit of patients.

4. The two Trusts believe that the proposed merger should be cleared by the CMA on the grounds that it does not give rise to a significant lessening of competition (SLC) in any of the services supplied by the two Trusts. The CMA's analysis of the merger's effect on competition in Phase 1 was flawed in several important respects. In particular, it did not reflect a full understanding of how patient choice operates in routine elective care, and the implications for the merger's effect on competition. Moreover, the CMA relied heavily on the GP referral analysis as the basis for its Phase 1 decision despite there not being any evidence to support the restrictive assumptions about GP/patient switching behaviour that are embedded in this analysis.

5. In this submission, we address the points in the Phase 1 decision where we believe the CMA's reasoning to be problematic, and provide as clear an explanation as possible of the relevant factors that should be taken into account in this Phase 2 review. We also point to

those areas where we believe that the CMA could usefully collect additional evidence through its planned surveys and/or its discussions with third parties.

6. In summary, following the proposed merger, the combined Trust will still face extensive competition from other providers. GP practices in the ASP/RSC catchment area refer NHS patients to more than 50 providers of routine elective care. Patients are clearly able to choose between many different providers, and the merger will have a limited effect on the extent of choice available. This is further underlined by the analysis of catchment area overlaps set out in this submission.

7. A revised analysis of GP referrals, based on more recent data than was available in Phase 1, shows important developments in the competitive landscape over the past 2 years, with St George's Healthcare NHS Foundation Trust and several other providers capturing an increased share of patient referrals from GPs in the ASP/RSC catchment area, as well as a significant decline in the share of patients referred to West Middlesex University Hospital NHS Trust.

8. With these developments in the competitive landscape, there are now only five specialties where the Proportional Measure in the GP referral analysis is greater than 40% (ie the threshold used by the CMA at Phase 1 to identify those specialties where it considered that there was a realistic prospect of an SLC).

    - In two of these specialties, for reasons set out in this submission, patient choice does not operate (Medical Oncology and Anaesthetics).

    - In Breast Surgery, the results of the GP referral analysis are severely distorted by Frimley Park Hospital NHS FT not coding activity in this specialty, and on any reasonable assumption about the level of Frimley Park Breast Surgery activity there is no cause to believe an SLC is likely.

    - In ENT, we believe that the effect of the clinical network on patient referrals is overstating RSC’s importance as a competitor to ASP (with the apparent competitive constraint between the two Trusts being asymmetric). An analysis of catchment area overlaps at the specialty level indicates that patients will continue to have an extensive choice of ENT providers following the merger, and there is no documentary or other evidence to support a conclusion that the merger gives rise to an SLC in ENT. As a result, we do not believe that the merger gives rise to an SLC in ENT.

- In Audiology/Audiological Medicine, ASP has a Service Level Agreement (SLA) with RSC whereby RSC provides this service to ASP patients. To the extent that ASP retains an incentive to attract patients in competition with RSC, which might be lost as a result of the merger, there remains extensive choice available to patients in terms of other providers of this service.

9. While the GP referral analysis presented in this submission is significantly more up to date compared with the data that was used in Phase 1, it is important to note that it is still historical data. The counterfactual for this transaction points to a significant weakening of the competitive constraint that ASP and RSC would offer to each other as well as other providers of routine elective care if they remain separate entities. This is due to the two Trusts' inability to implement 7 day working and sustain safe levels of nurse staffing, as well as being unable to finance ongoing backlog maintenance, expenditure on clinical equipment and routine upgrades of IT software and infrastructure. The two Trusts' share of patient referrals can thus be expected to deteriorate under the counterfactual compared with the pre-merger situation.

10. In addition, barriers to entry in outpatient services – the part of the care pathway that is critical to capturing patient referrals – are low. Outpatient clinics can be readily established in new locations. The recent experience of entry/expansion by a small provider, PIMS/EDICS, and by larger Acute Trusts, such as St George's Healthcare NHS FT, demonstrates that entry/expansion is not only possible but is likely to occur. Other providers could be expected to rapidly take advantage of any deterioration in services at a merged ASP/RSC to start offering alternative services to local patients through new outpatient clinics.

11. Further, commissioners have demonstrated their ability to exercise countervailing buyer power by putting services out to tender and awarding contracts to new providers (or threatening to do so) when dissatisfied with the quality or efficiency of service provision by ASP or RSC. A recent example of this has been the re-commissioning of dermatology services by Guildford & Waverly CCG, and the award of a contract to a new provider, in response to dissatisfaction with the service provided by RSC.

12. To the extent that any SLC does arise, the parties believe that the limited extent of any adverse harm arising from an SLC and the significant Relevant Customer Benefits (RCBs) that will result from the merger mean that any remedy involving prohibition of the merger would be disproportionate.

13. The adverse effects that can be expected from an SLC in NHS services is limited as the strength of the link between competition and market outcomes is much weaker than in other sectors where the CMA would normally be reviewing mergers. This is, in part, due to the highly regulated nature of the health sector as well as the complex and indirect transmission mechanisms between market outcomes, information for patients and the exercise of choice by patients. As a result, any loss of competition as a result of the ASP/RSC merger can be expected to have a much smaller adverse effect than a merger between two similar organisations in another sector of the economy.

14. On the other hand, the merger will deliver significant RCBs in the form of 7 day consultant-led services for patients (which was accepted by Monitor and the CMA as an RCB at Phase 1), and cost savings that will convert into patient benefits in the form of capital investments that would not otherwise take place. ASP and RSC estimate that approximately £79 million more in capital expenditure would take place under the merger scenario compared with the situation in which ASP and RSC remain separate. As a result, to the extent that the merger does give rise to an SLC, then any remedy involving prohibition would be disproportionate given the extent of the RCBs that would be lost. We anticipate providing further submissions to the CMA on this issue during this review.

2. INTRODUCTION

15. ASP and RSC, two successful NHS Acute Trusts with Foundation Trust (FT) status and good track records of clinical, operational and financial performance, are planning to merge. This document provides the parties' initial submission to the CMA's Phase 2 review of their planned merger.

16. The two Trusts believe that the proposed merger should be cleared by the CMA on the grounds that it does not give rise to a significant lessening of competition (SLC) in any of the services supplied by the two Trusts. To the extent that any limited SLC does arise, the parties believe that the significant RCBs to which the merger also gives rise means that any prohibition of the merger would be disproportionate.

17. This submission uses more recent, and more detailed, data compared with that used in the Phase 1 review. This revised data shows important changes in the competitive landscape, such as increasingly strong competition for patient referrals from St George's Healthcare NHS Foundation Trust and other providers, as well as a decline in the share of patient referrals captured by West Middlesex University Hospital NHS Trust. GP practices within the

ASP/RSC catchment area send NHS patients for routine elective care to more than 50 different providers.

18. The CMA's analysis in Phase 1 of the effect of the merger on competition in routine elective care was flawed in several important respects, and in particular, did not reflect a full understanding of how patient choice interacts with patient care pathways. In this submission, we address those points in the Phase 1 decision where we believe the CMA's reasoning to be problematic and provide as clear an explanation as possible of the relevant factors that should be taken into account in this Phase 2 review. We also point to those areas where we believe that the CMA could usefully collect additional evidence through its planned surveys and/or from third parties.

19. The structure of this submission is as follows:
    - Section 3 discusses the planned transaction by providing an overview of ASP and RSC, the rationale for the merger, and its expected benefits;
    - Section 4 sets out the counterfactual to the merger; and
    - Section 5 considers the effect of the merger on competition in routine elective care services for NHS patients.

20. This submission focuses on the merger's effect on competition in routine elective care. It does not address the merger's effect on competition in non-elective, community, specialist or private services. No concerns were found in relation to these services in the Phase 1 review, and we refer the CMA inquiry team to our Phase 1 submission for our views in relation to the merger's effect on competition in these services.

3. THE PLANNED TRANSACTION

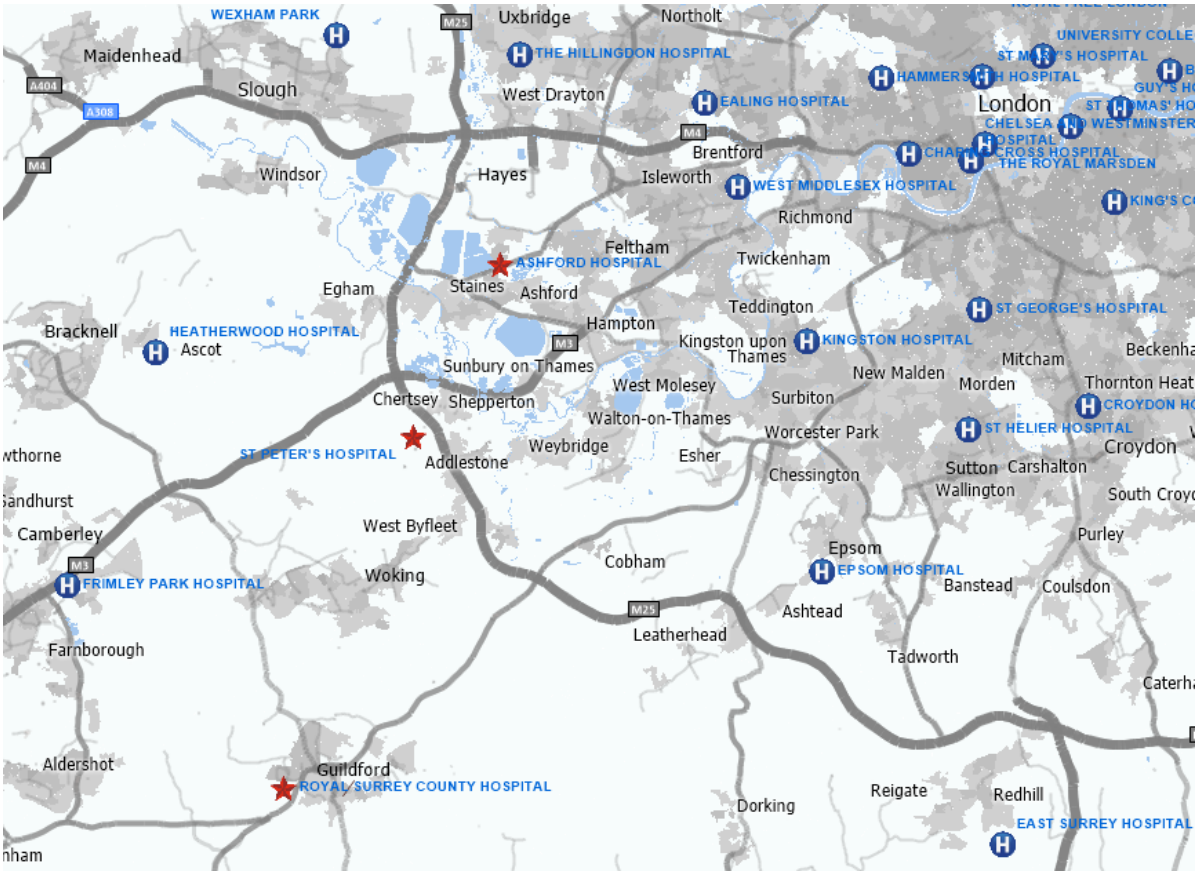
21. ASP and RSC established a partnership in November 2012, and following a review of this partnership decided, in April 2014, to merge. The decision to merge responds to the challenges facing both Trusts in terms of budgetary pressures, tightening regulatory standards and increasing demand.

22. The merger will allow the combined Trust to make significant cost savings, finance a much larger capital programme to the benefit of patients, and deliver significant clinical benefits for patients, including 7 day services in several specialties and sustainable levels of safe nursing. This section provides an overview of ASP and RSC, and describes in more detail the rationale for the merger and the expected benefits.

3.1 Overview of ASP and RSC

23. ASP and RSC are medium sized Acute Trusts that supply services typical of a district general hospital, including A&E, maternity and routine elective care services, while also having a number of specialist services (primarily cardiology-related services at ASP and cancer-related services at RSC). Both Trusts also supply a small amount of community and private patient services. In the year ended 31 March 2014, ASP had revenue of £246 million, while RSC had revenue of £281 million.

Figure 1: ASP, RSC and CCGs and neighbouring hospitals



24. Both Trusts are located in Surrey, offering services to a population that stretches across metropolitan South West London as well as commuter towns and semi-urban areas to the south west of London as well as semi-rural areas in the South of Surrey and North Hampshire. RSC's main site is Royal Surrey County Hospital (RSCH) in Guildford. ASP has two sites, St Peter's Hospital (SPH) in Chertsey, and Ashford Hospital (AH) in Ashford, Middlesex (see Figure 1).

3.1.1 Ashford & St Peter's Hospitals NHS FT

25. ASP was established as an NHS Trust in 1998, as a result of a merger between AH and SPH, and achieved Foundation Trust status in December 2010. It has 570 beds and approximately 3,100 whole time equivalent employees. ASP is rated 'Good' by the Care Quality Commission (CQC), and Monitor rates it green for governance, and 3 out of 4 for finances (ie Continuity of Services Risk Rating).

26. The focus of service provision at AH is planned care, including outpatient services and day case surgery, while more complex medical and surgical care and emergency services are delivered at SPH. Key specialist services delivered by ASP include Cardiology, Bariatric Surgery, Vascular Surgery and Neonatal Intensive Care. Private patient services at ASP are restricted to some specialised care for patients admitted to BMI Runnymede hospital, which is co-located with SPH.

Table 1: ASP commissioned income, by commissioner, 2013-14

Commissioner	Payments to ASP ('000)*	Share of ASP's commissioned income*	Share of commissioner expenditure[1]
North West Surrey CCG	£162,202	73%	41%
NHS England	£33,326	15%	0.1%
Hounslow CCG	£12,607	6%	4%
Surrey Downs CCG	£4,292	2%	1%
Windsor, Ascot & Maidenhead CCG	£4,089	2%	3%
Richmond CCG	£1,710	1%	1%
Bracknell & Ascot CCG	£1,528	1%	1%
Guildford & Waverly CCG	£1,080	0%	0%
Surrey Heath CCG	£61	0%	1%

Source: ASP, Annual Report, 2013-14, http://www.england.nhs.uk/wp-content/uploads/2012/12/ccg-allocations-13-141.pdf for CCG expenditure allocations from NHS England for 2013-14, and http://www.england.nhs.uk/allocations-2013-14/ for NHS England specialised commissioning budget for 2013-14 (ie £25.4 billion).
Note: (1) This column shows the proportion of total expenditure by each commissioner that is directed towards ASP.

27. The main commissioner of NHS services at ASP is North West Surrey CCG, while specialist acute services at ASP are commissioned by NHS England through the Surrey and Sussex Area Team. The largest commissioners of clinical services at ASP are set out in Table 1.

3.1.2 Royal Surrey County Hospital NHS FT

28. RSC was established as an NHS Trust in 1991 and achieved Foundation Trust status in December 2009. It has around 520 beds and 3,300 whole time equivalent staff. In the year to 31 March 2014, RSC's revenue was £281 million. RSC is rated 'Good' by the Care Quality Commission (CQC), and Monitor rates it green for governance, and 4 out of 4 for finances (ie Continuity of Services Risk Rating).

29. RSC is the lead specialist centre for cancer patients in Surrey, West Sussex and Hampshire. Nearly 40% (around £85 million) of commissioned income at RSC is derived from its cancer services.[1] Cancer services are predominantly purchased by NHS England, but also by the CCGs.

Table 2: RSC commissioned income, by commissioner, 2013-14

Commissioner	Payments to RSC ('000)*	Share of RSC's commissioned income*	Share of commissioner expenditure[1]
Guildford & Waverly CCG	£103,063	44%	45%
NHS England	£75,555	33%	0.3%
North West Surrey CCG	£14,870	6%	4%
South Eastern Hampshire CCG	£9,240	4%	4%
North East Hampshire & Farnham CCG	£7,743	3%	3%
Surrey Downs CCG	£7,379	3%	2%
Coastal West Sussex CCG	£3,988	2%	1%
Horsham & Mid Sussex CCG	£2,693	1%	2%
Surrey Heath CCG	£2,121	1%	1%
East Surrey CCG	£1,715	1%	1%
North Hampshire CCG	£1,381	1%	1%
Crawley CCG	£919	0%	0%

Source: RSC, Annual Report, 2013-14, http://www.england.nhs.uk/wp-content/uploads/2012/12/ccg-allocations-13-141.pdf for CCG expenditure allocations from NHS England for 2013-14, and http://www.england.nhs.uk/allocations-2013-14/ for NHS England specialised commissioning budget for 2013-14 (ie £25.4 billion).
Note: (1) This column shows the proportion of total expenditure by each commissioner that is directed towards RSC.

30. RSC provides oncology services through the St Luke's Cancer Alliance working in its partner Trusts, namely ASP, Frimley Park Hospital NHS Foundation Trust (Frimley Park Hospital), Surrey and Sussex Healthcare NHS Trust (Surrey & Sussex

[1] See RSC, *Achieving 2 Million: Cancer Strategy 2014-19*, September 2014, p.15.

Healthcare), and Hampshire Hospitals NHS Foundation Trust (in relation to Basingstoke Hospital).

31. RSC has developed a wholly-owned outreach radiotherapy treatment centre at East Surrey Hospital (the main site for Surrey & Sussex Healthcare NHS Trust), which opened in July 2014. It has an agreement to provide cancer services at Western Sussex Hospitals NHS Foundation Trust, and these services are now in development.

32. Other key specialist services delivered by RSC, in addition to cancer services, include Maxillo-Facial Surgery and ENT inpatient services. Private patient services at RSC are limited to cancer services, primarily radiotherapy and some complex cancer services.

33. The main commissioner of services at RSC is Guildford & Waverly CCG, while specialist acute services at RSC are primarily commissioned by NHS England through its Surrey and Sussex Area Team. The largest commissioners of clinical services at RSC are set out in Table 2.

Table 3: Key data for ASP and RSC

	ASP	RSC
Hospital sites	2	1
Local catchment population	410,000	320,000
Key specialist services	Neonatal ICU, Cardiology, Bariatric Surgery, Vascular	Cancer, Maxillo-Facial Surgery, ENT
Annual turnover	£246m	£281m
Beds	570	520
Employees	3,100 whole time employees	3,300 whole time employees
Annual admissions	68,000	67,000
A&E attendances	92,000	71,000
FT Authorisation Date	1 December 2010	1 December 2009
CQC rating	Good	Good
Monitor Continuity of Service Risk Rating	3	4
Monitor Governance Rating	Green	Green

Note: Monitor ratings are for Q1, FY14-15.

3.2 Rationale for the merger

34. ASP and RSC established a partnership in November 2012. Its purpose has been to enable the two Trusts to jointly deliver clinical and support services so as to improve services for patients and maximise value for taxpayers.

35. The decision to merge, taken in April 2014, stemmed from a review of this partnership, the results of which were presented in an Outline Business Case (OBC). The OBC assessed options for developing the partnership, including continuation of the partnership in its existing form, a merger and other possible forms of collaboration.

36. In reviewing these options, the Boards identified a number of challenges facing the two Trusts. These include:

- First, unprecedented and continuing pressure on health spending as a result of the broader state of public finances. The impact of this pressure is being exacerbated for Acute Trusts by the focus on shifting care into the community, which is underpinned by a number of financial initiatives such as emergency and elective marginal tariff thresholds, and the Better Care Fund.

- Second, a strong national focus on improving quality and standards (eg following the inquiry into the failings at Mid-Staffordshire Hospital NHS FT as well as other reviews, such as the one into 7 day services in the NHS), to both implement the best levels of care by reducing variations in quality and safety, and meet the changing needs of patients. Significant investment in nursing and consultant staff is required by providers to comply with the more demanding standards that have emerged.

- Finally, increasing demand for healthcare as a result of a growing and ageing population, with an increasing proportion of patients living with long term conditions. These circumstances are common across the NHS, but given added impetus in Surrey by a local population that is rapidly ageing compared with the rest of England.[2] Moreover, the costs associated with delivering healthcare to this population are increasing, as new and often expensive treatment options become available.

[2] The population of the catchment area served by the two Trusts is expected to grow by 7% between 2013 and 2023 during which time the proportion and absolute number of older people is expected to grow substantially. See ASP and RSC, *The development of the Partnership between Ashford & St Peter's NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust, Outline Business Case*, April 2014, pp.16-17.

37. We discuss the financial challenges faced by the two Trusts, and the impact of tightening regulatory standards on ASP and RSC in more detail in the following paragraphs.

3.2.1 Financial challenges facing ASP and RSC

38. The scale of the financial challenge facing Acute Trusts nationally is reflected in recent planning guidance issued by Monitor. Monitor estimates that each Trust needs to realise efficiencies of 4-4.5% per year for the next 5 years. This is an unprecedented level of efficiency and productivity gain that needs to be found on an annual basis, and follows from a number of years of finding similar levels of efficiencies. An annual tariff deflator will continue to be in place for each of the next 5 years. This is shown in Table 4 along with national assumptions about the level of efficiency savings to be achieved by Acute Trusts.

39. ASP and RSC believe that the figures presented in Table 4 underestimate the scale of the challenge felt by providers. They expect that Acute Trusts will face an efficiency challenge in the order of 5-6% for the foreseeable future. ASP and RSC have been successful in delivering significant cost savings to date. From 2010/11 to 2013/14 ASP delivered £42 million, and RSC delivered £37.5 million in cost improvements. However, for both Trusts the traditional opportunities to generate efficiency savings through various small scale programmes have largely been delivered, and increasingly a transformational approach is required to address the challenge.

Table 4: Tariff and efficiency assumptions for Foundation Trusts over the next 5 years

	FY 14/15	FY 15/16	FY 16/17	FY 17/18	FY 18/19
Secondary care cost inflation	2.3%	2.2%	3.0%	3.4%	3.4%
Provider sector efficiency	4.0%	4.0%	4.0%	4.0%	4.0%
Tariff uplift	-1.7%	-1.8%	-1.0%	-0.6%	-0.6%

Source: Guidance for the Annual Planning Review 2014/15 (2013) Monitor, London: Monitor
Note: the efficiency factor for 2015/16 has subsequently changed and is now 3.8%.

40. The finance regime that the Foundation Trusts operate within is such that they are required to make savings (through Cost Improvement Programmes or CIPs) in order to meet the efficiency factor set by Monitor and allow for the cost inflation impact on pay and non-pay costs.[3] The CIP programme gives the Trusts the headroom required to deliver a balanced income and expenditure position, which in turn generates the cash required (through

[3] For 2015/16, the efficiency factor is 3.8% with underlying inflation of 1.93% this gives a tariff deflator of 1.8%, which was subsequently adjusted for the above inflation rise in Clinical Negligence Schemes for Trusts (pooled medical litigation insurance) premiums to give a tariff deflator of 0.8%. Thus, if the Trust carried out the same activity in 2015/16 as 2014/15 it would receive 0.8% less income than the previous year.

surplus and depreciation) to finance the capital programme. Should the Trusts slip into deficit this restricts the cash available to invest in equipment infrastructure, or major new developments.

41. The challenge faced by ASP and RSC is compounded by the uncertainty around planning that is created by the financial constraints facing the Trusts' two main commissioners, North West Surrey CCG and Guildford & Waverley CCG. Both CCGs are financially constrained and have laid out ambitious plans to reduce costs and increase efficiency and productivity. These plans have achieved varying degrees of success to date, and this brings with it uncertainty around planning. In particular, expected activity in ASP and RSC contracts with the two CCGs is below the levels delivered in previous years based on CCG efficiency plans but, where these efficiency plans do not work as envisaged, this has a significant impact on the two Trusts.

42. The financial situation facing ASP and RSC has changed significantly since the Phase 1 review commenced. In our Phase 1 submission to the CMA, ASP and RSC were forecasting that they would be in deficit by 2016-17. However, the financial situation for both Trusts has deteriorated since then, with ASP entering deficit in 2014-15 and RSC expected to do so in 2015-16. The deteriorating financial situation has reinforced the rationale for the merger, due to the urgent need to ensure that both Trusts are on a sustainable financial and clinical footing.

3.2.2 Impact of tightening regulatory standards on ASP and RSC

43. In the past two years, four major reviews have driven an increasing focus on the quality of care that the NHS provides to patients. These are:
    - the Francis investigation into events at Mid Staffordshire NHS Foundation Trust;[4]
    - the Berwick review into patient safety;[5] and
    - the Keogh reports on 14 failing Trusts as well as on the delivery of 7 day services in the NHS.[6]

44. As a result, there has been an increasing level of public interest and regulatory scrutiny around the quality of care, underpinned by a growing array of standards for the provision of acute care, many of which require additional expenditure.

[4] Francis (2013), *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*, HMSO, London.
[5] Berwick (2013), *A promise to learn - a commitment to act: Improving the Safety of Patients in England*, National Advisory Group on the Safety of Patients in England, London.
[6] Keogh (2013), *Review into the quality of care and treatment provided by 14 hospital trusts in England: overview report*, NHS England, London, and Keogh (2013), *High quality care for all, now and for future generations: Transforming urgent and emergency care services in England*, NHS England, Leeds.

45. The Keogh report highlighted that a common factor among the 14 Trusts that were investigated was inadequate nursing numbers, particularly out of hours and at weekends. The Keogh report and a report by the Academy of Medical Royal Colleges *Seven Day Consultant Present Care*[7] both address the importance of seven day consultant-led care for patients. Further, an increasing range of clinical specialist bodies (including the Royal Colleges or equivalent) are setting challenging clinical standards for high quality care at the specialty and sub-specialty levels.[8]

46. Guidance on minimum safe staffing numbers for adult acute inpatient wards has also recently been released by the National Institute for Health and Care Excellence (NICE).[9] While the guidance stops short of setting a national minimum nurse to patient ratio, it does suggest that in most circumstances a minimum ratio of 1:8 be maintained.

47. ASP and RSC face significant and continued expenditure pressures to comply with these standards. It remains a challenge to fund and recruit the right numbers of staff, with the right skills, particularly in Surrey. Across a range of measures, the cost of living in the county is amongst the highest nationally. However, as wages are not subject to London weighting, staff working in Surrey can be worse off than in other areas of the country due to the nationally agreed pay scales in the NHS.

3.2.3 ASP's and RSC's response to the financial, quality of care and demand challenge

48. Given the challenges that ASP and RSC face in terms of Trust finances, tightening regulatory standards and increasing demand, the Boards of ASP and RSC concluded - based on the analysis in the OBC - that a merger of their two Trusts would be the most effective way of responding. In contrast, a continued partnership between the two Trusts would only deliver some of the benefits of a merger, and at a considerably slower pace.[10]

49. During the development of the Full Business Case in support of the merger, NHS England published its Five Year Forward View, and the Dalton Review of different organisational

[7] Academy of Medical Royal Colleges (2014), *Seven Day Consultant Present Care*, London.
[8] For example: *Facing the Future 2014* (2014) Royal College of Paediatrics and Child Health, London: Royal College of Paediatrics and Child Health; *Emergency Surgery: Standards for scheduled and unscheduled care* (2011) Royal College of Surgeons, London: Royal College of Surgeons; *Emergency Medicine Operation Handbook: The Way Ahead* (2011) College of Emergency Medicine, London: College of Emergency Medicine.
[9] *Safe staffing for nursing in adult inpatient wards in acute hospitals* (2014) National Institute for Health and Care Excellence, London: National Institute for Health and Care Excellence
[10] Compared with ongoing partnership, a merger will better align incentives across the merged organisation and provide the unified management with the directional authority that is required to, for example, implement the joint rotas necessary to deliver 7 day clinical services. Further details on the benefits of a merger compared with a continued partnership are set out in ASP/RSC's patient benefits submission to Monitor.

models.[11] Both reports highlighted a range of organisational models applicable to NHS providers. The models discussed in these two reports were reviewed by ASP and RSC to ensure that the merger decision remained robust. The conclusion was that the merger decision is consistent with the Dalton Review, and that alternative models set out in these reports are unsuitable to the local context in which ASP and RSC provide services or not sufficient to provide a route to clinical and financial sustainability. (Further details of this assessment are contained in the Full Business Case for the ASP/RSC merger.)

3.3 Expected benefits from the merger

50. As part of the Phase 1 review, a submission was made to Monitor outlining the RCBs that are expected from the ASP/RSC merger. Monitor concluded in its advice to the CMA at Phase 1 that "the likely improvements to care, patient experience and patient outcomes to be clinically significant and of high importance and value to patients".

51. In this section the expected benefits from the merger are set out, including those judged as RCBs by Monitor at Phase 1. We also indicate where additional evidence is likely to be provided to the CMA regarding RCBs during this Phase 2 review.

52. The expected benefits from the merger fall into two broad categories:
    - financial benefits; and
    - clinical benefits.

3.3.1 Financial benefits from the merger

53. Significantly more detailed evidence is available for this Phase 2 review regarding the financial impact of the merger compared with Phase 1. This reflects the more detailed financial assessments that have taken place in recent months as the Full Business Case for the merger has been prepared.

54. The financial analysis that has been prepared as part of the merger planning shows that the merger will bring significant financial benefits to the combined Trust. Cost savings, and to a lesser degree, additional income, that result from the merger will allow the merged ASP/RSC to realise an annual financial surplus and, as a result, achieve the clinical staffing levels that are required under emerging regulatory standards, and finance an investment programme that will bring significant benefits to patients.

[11] *Five Year Forward View* (2014) Stevens, S. London: Department of Health, and *New Options for Providers: Emerging Thinking* (2014) The Dalton Review, London: Department of Health.

55. Without the merger, each Trust will go into deficit and this will impact on both Trusts' ability to maintain staffing levels and/or meeting emerging staffing requirements, finance new investments and maintain existing facilities. (We discuss this counterfactual further in the following section.)

56. We appreciate that the CMA will want to scrutinise the financial analysis that underpins the merger, particularly given its potential contribution to arguments around:
    - the competitive situation that will prevail under the counterfactual;
    - rivalry enhancing efficiencies that arise from the merger; and
    - RCBs arising from the merger.

    ASP and RSC welcome this scrutiny, and would encourage the CMA to discuss the robustness of the Trusts' analysis with Monitor.

57. The Full Business Case, which contains this analysis, will be presented to Monitor as part of its merger oversight process, and the combined Trust will subsequently be held accountable against this analysis and the plans to which it gives rise. As a result, there is no question of the financial analysis, which is summarised in this section, having been somehow influenced by the CMA review process.

58. The financial impact of the merger is summarised in Table 5. This starts by showing the combined deficits of ASP and RSC that are expected in the standalone (counterfactual) scenario. The financial impact of the merger is then captured in terms of:
    - *synergies*: cost savings that result from the merger, which include: (i) integration of back office functions such as estates, finance, HR and information and procurement savings; (ii) savings in core clinical services due to improvements in length of stay as a result of 7 day working and improved theatre utilisation rates at ASP arising from sharing of best practice; and (iii) savings in senior management and Board functions.[12]
    - *seven day working*: cost savings compared with the standalone case as a result of combined consultant and clinical nurse specialist teams reducing the need for additional recruitment to deliver 7 day working;
    - *transition costs*: these costs include programme management of the merger process, legal advice and due diligence and various integration costs, such as workforce restructuring and technology integration; and
    - *impact of inflation* on merger benefits/costs.

[12] These synergies are in addition to the cost improvement programmes that the combined Trust, and the standalone Trusts, are both assumed to deliver under both the merger and standalone (counterfactual) scenarios.

59. In summary, the merger allows the combined Trust to achieve a net surplus of £7-8 million per annum by years 4 and 5, compared with a combined deficit at the two standalone Trusts of £4-5 million per annum.

Table 5: Financial impact of the merger - overview

	2015/16 £ m's	2016/17 £ m's	2017/18 £ m's	2018/19 £ m's	2019/20 £ m's
Net Surplus / (Deficit)					
ASP	(1.3)	(1.2)	(8.8)	(2.0)	(3.1)
RSC	(0.5)	(5.4)	(2.7)	(2.3)	(2.1)
	(1.7)	**(6.6)**	**(11.5)**	**(4.3)**	**(5.2)**
Financial impact of merger benefits					
Synergies	1.3	7.5	8.9	10.1	10.1
Seven-day working	0.2	3.4	3.4	3.4	3.4
Transition costs	(2.7)	(1.9)			
Impact of inflation on merger benefits/costs	0.3	0.1	(0.4)	(0.8)	(1.1)
Net Surplus / (Deficit) - Merger	**(2.6)**	**2.6**	**0.5**	**8.4**	**7.2**

Source: ASP and RSC, The merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust: Full Business Case, 19 February 2015, p.89.

60. There is a question about the extent to which these savings are specific to the merger or might be achieved in other ways. Savings that are related to 7 day working (cost savings from reduced recruitment, reductions in length of stay) and reductions in senior management costs are all specific to the merger. We appreciate, however, that a portion of the back office savings could potentially be achieved without the merger, although delivery would be slower and of a lesser scale.

61. The original OBC gave details of the potential benefits from synergies arising from the two Trusts working in Partnership, rather than a full merger. These were calculated as being £3.4 million by year 5 as opposed to the merger synergies of £10 million that are presented in the FBC. The issues with working in partnership is that both organisations have to agree the scope and process for synergies and this takes a far longer time and is more difficult to ensure clinical engagement than one organisation setting out its vision for the future.

62. The back office functions, such as finance, HR and procurement, will generally be more straightforward to implement but will not make as great a saving as under merger. There is the possibility of operating a 'shared service' model for corporate services but this will take some time to deliver, and each Trust would need to retain its own core service for example in Finance. Some Procurement savings on clinical and non-clinical supplies will be

possible under partnership due to greater leverage on suppliers, but it is not until combined contracts are in place that full savings will be realised. As a result, partnership can offer some benefits in back office savings but not to the same extent or with the speed and robustness that a merger will ensure.

63. The merged Trust will have £158 million available for capital expenditure in the five years following the merger (see Table 6). The capital programme for the merged Trust includes vital expenditure on backlog maintenance, clinical equipment and IT as well as:

- a new A&E and ITU (Major Emergency Centre) at SPH (£30m);
- refurbishment of St Luke's cancer centre at RSCH (£8m);
- the chemotherapy and endoscopy elements of the Ashford Cancer Diagnosis and Treatment Centre (£3m); and
- a new HDR theatre at RSCH (£2m).

Table 6: Capital funding and expenditure at the merged Trust

Merged Trust

Source of capital funding - Merged Trust	2015/16 £ 000's	2016/17 £ 000's	2017/18 £ 000's	2018/19 £ 000's	2019/20 £ 000's	TOTAL £ 000's
Net surplus / (deficit) - incl. b/fwd	(2,599)	2,560	489	8,421	7,170	16,042
Depreciation	16,809	17,373	17,306	18,029	18,704	88,222
Donated assets	1,500	400	400	400	400	3,100
PDC and Loans	15,000	21,500	11,500	1,500	1,500	51,000
Funding available for capex	**30,709**	**41,834**	**29,695**	**28,350**	**27,775**	**158,363**

Capital Programme Merged Trust	2015/16 £ 000's	2016/17 £ 000's	2017/18 £ 000's	2018/19 £ 000's	2019/20 £ 000's	TOTAL £ 000's
Building backlog maintenance	13,808	8,374	9,550	4,854	6,754	43,340
Equipment (replacement and new)	3,803	5,266	2,800	3,150	6,150	21,168
I.T. (maintenance and infrastructure development)	4,189	3,614	1,589	3,089	5,089	17,570
Service development - Diagnostic Treatment Centre (DTC)	3,000	-	-	-	-	3,000
Capital integration costs (e.g. relocation, telecoms, signage)	1,595	1,200	250	-	-	3,045
Major transformation projects						-
Major Emergency Centre (MEC) - Chertsey	2,000	14,000	14,000	-	-	30,000
St Lukes refurbishment	4,000	4,000	-	-	-	8,000
ICO- Day unit on site	1,500	-	-	-	-	1,500
Digital Hospital	2,950	3,450	5,290	2,970	2,280	16,940
Total Capex Merged Trust	**36,845**	**39,904**	**33,479**	**14,063**	**20,273**	**144,564**
c. Capital funding surplus/(shortfall)	**(6,136)**	**1,930**	**(3,784)**	**14,287**	**7,502**	**13,800**

	2015/16 £ 000's	2016/17 £ 000's	2017/18 £ 000's	2018/19 £ 000's	2019/20 £ 000's
Merger cash position	**7,710**	**8,679**	**8,151**	**13,649**	**17,087**

64. The merged Trust will be able to finance capital expenditure of £79 million more over 5 years than ASP and RSC would be able to afford under the counterfactual. A significant part of this difference is due to the much greater affordability of loan finance for the merged Trust compared with ASP and RSC continuing as separate entities. The deployment of this

capital into the various projects planned by ASP and RSC constitutes an RCB in that this capital expenditure would not be available in the absence of the merger.

65. A comparison with the capital programmes for the ASP and RSC under the counterfactual (see Section 4) shows that the additional or incremental capital expenditure of £79 million as a result of the merger would be allocated to:
    - building backlog maintenance (£15.0 million);
    - clinical equipment (£10.9 million);
    - chemotherapy and endoscopy elements of the Ashford Cancer Diagnosis and Treatment Centre (£3 million);
    - IT maintenance and infrastructure development (£10.4 million);
    - refurbishment of St Luke's cancer centre (£4 million);
    - development of the digital hospital (primarily, a new patient administration system and clinical support IT) (£8.8 million); and
    - a new Major/Specialist Emergency Centre at SPH (£24 million).[13]

66. The Competition Commission, at paragraph 9.52 of its decision on the proposed merger between Royal Bournemouth & Christchurch Hospitals NHS FT and Poole Hospital NHS FT stated that while it does not expected the parties to have publicly consulted on projects that are expected to deliver benefits, to have taken a firm decision to proceed with them, or to have implemented them, it does expect the parties to have:
    - determined the preferred proposals and provided evidence of the need for change;
    - established the groups necessary to evaluate the benefit, for example, a clinical advisory group; and
    - produced an assessment of the clinical benefits (and any dis-benefits) as well as a robust assessment of the financial or economic viability of the plans.

67. Consistent with this, a capital and estates strategy has been developed for the merged Trust that is aligned with the overall strategy for the merged organisation. All proposed capital and estates schemes have been prioritised, and the outputs from the capital and estates strategy have been aligned with the Long Term Financial Model that has been developed.

[13] In some cases, this additional expenditure means that projects that would not proceed without the merger would be able to go ahead, while in other cases it means that these projects are able to be significantly larger in scope. For example, ASP considers that £6m would be spent on developing A&E services under the counterfactual, while a total of £30m (ie additional expenditure of £24m) would be available for a major upgrade to emergency services with the merger.

68. The highest priority schemes are those that require investment in several 'must do' categories: backlog maintenance; equipment replacement; IT replacement and upgrades; and integration costs. Additional schemes that are included in the capital programme include developing A&E at SPH, refurbishment of the St Luke's cancer centre at RSCH, and the digital hospital programme. These were identified for funding on the basis of their overall fit with the merged Trust's strategy, the impact on the clinical sustainability of the Trust, the impact on the financial sustainability of the Trust, and whether they addressed regulatory or licence to operate issues.

69. Extensive detail on the proposed capital programme for the merged Trust is set out in the Full Business Case for the merger, including the basis for scoring and prioritising different capital schemes.

70. A significant part of the capital expenditure that the combined Trust would be able to carry out as a result of the merger does not require any business case beyond the usual internal planning and budgeting mechanisms. This includes backlog maintenance, equipment replacement and IT. In terms of projects that require a business case, their status is as follows:

- St Luke's refurbishment: an Outline Business Case was approved by the Board in and permission given to progress to a Full Business Case, which is scheduled for presentation in October this year.

- Ashford DTC: a business case is currently in preparation to be presented to June Board. This business case will address the radiotherapy services to be delivered by the DTC in addition to the planned endoscopy and chemotherapy services that have been budgeted.

- Major/Specialist Emergency Centre: a significant amount of work has been undertaken to develop this plan.

71. We believe that the project identification and business case development process for the projects that are made possible by the merger should be sufficient to the meet the tests set out by the CC in the Bournemouth/Poole decision to qualify as RCBs.

3.3.2 Clinical benefits from the merger

72. In terms of the clinical benefits from the merger, a clinical strategy has been developed to guide the establishment of the merged Trust. The overall vision is that patients will be able to access the highest quality local and specialist health services as close to home as

possible. It has been developed through extensive engagement with senior clinicians across ASP and RSC in joint workshops.

73. More specifically, the merged Trust will be able to achieve a step change improvement in patient outcomes and experience through the following merger-enabled improvements (many of which are linked to the capital expenditure programme discussed in the previous section):

- delivery of 7 day working;
- improvements and enhancements to specialist services;
- forming a sustainable urgent and emergency care network;
- delivery of integrated care;
- supporting the deployment of digital technology;
- accessing cutting-edge innovation and research; and
- standardisation of care.

74. Further details on the clinical benefits that are enabled by the merger are set out in Table 7. This maps six high level benefits (in the left hand column) to the strategic benefits (middle column) and the prioritised specialty-specific benefits (right hand column). The prioritised specialty-specific benefits cover the top 20 prioritised projects that were identified through the process of clinical engagement across the two Trusts.

Table 7: Merger-enabled clinical benefits, by site

Merger Enabled Improvements	Strategic Benefits	Specialty Level Benefits	AH	SPH	RSCH
New care models: Seven day working	1. Seven day working across the main specialties	***Gastroenterology and GI bleed:*** ▶ Out of hours on call rota formation to support seven day working (including joint, cross-site, out-of-hours emergency endoscopy services		✓	✓
		▶ Endoscopy support for seven day Gastroenterology/GI Bleeds working and out of hours on call rota formation		✓	✓
		Stroke: ▶ Out of hours on call rota formation to support seven day working		✓	✓
		Interventional Radiology: ▶ Provision of a 24/7 service		✓	✓
		Specialist Diabetes: ▶ Provision of a seven day consultant-led service		✓	✓

Merger Enabled Improvements	Strategic Benefits	Specialty Level Benefits	AH	SPH	RSCH
		Supportive and Palliative Care: ▶ Seven day working rota and seven day ward review	✓	✓	✓
New care models: Consolidation of specialist services	2. Development of Ashford Diagnostic & Treatment Centre (Ashford DTC)	***Cancer Services:*** ▶ Increase diagnostic capacity and catchment area for cancer services with haematology, oncology and chemotherapy services as key beneficiaries	✓		
	3. Expansion of endoscopy service provision	***Endoscopy:*** ▶ Expansion of endoscopy service provision at Ashford ▶ Establishment of Bowelscope service	✓		
	4. Ashford Hospital: development as a hub for outpatients, day surgery, elective orthopaedic surgery	***Trauma and Orthopaedics:*** ▶ Developing foot and ankle surgery at Ashford Hospital *Note: other specialties may additionally benefit from the development of this hub*	✓		
	5. Enhancement of emergency and urgent care by designation as a Specialist Emergency Centre (SEC)	***Emergency Care:*** ▶ Enhancement of emergency and urgent care by designation as a Specialist Emergency Centre (SEC) Cardiology***:*** ▶ Provision of a 24/7 PCI service on the Royal Surrey site Vascular: ▶ Provision of a 24/7 service to meet the requirements of an SEC		✓ ✓	 ✓ ✓
	6. Increasing patients' access to a greater range of high quality specialist services locally	***Hepatology:*** ▶ Increase service provision at St Peter's site ***Children and Young People:*** ▶ Development of a Paediatric High Dependency Unit	✓	 ✓	 ✓
New care models: Integrated care	7. Ensuring seamless care in collaboration with community and social services	***Older Person's Care:*** ▶ Delivering care in the community ***Specialist Diabetes:*** ▶ Increased use of diabetic nurses to improve outcomes and reduce length of stay	✓ ✓	✓ ✓	✓ ✓
Exploiting innovation	8. Digital hospital project	▶ Successful Implementation of Electronic Patient Records and digital hospital	✓	✓	✓

Merger Enabled Improvements	Strategic Benefits	Specialty Level Benefits	AH	SPH	RSCH
and technology	9. Improving innovation, links to research and links to local universities	▶ Improve access to cutting edge treatments and innovative "best in class" care pathways, enabling improved research and clinical education	✓	✓	✓
	10. Standardised service across all specialties	***A&E and Assessment Units:*** ▶ Improving flow through departments		✓	✓
		Anaesthetics and Theatres: ▶ Standardise theatre utilisation - increased efficiency and productivity	✓	✓	✓
		GI Surgery: ▶ Emergency pathway ▶ Discharge co-ordination	✓	✓	✓
		Level 3, 2 and 1+ Critical Care Beds: ▶ Harmonisation of governance and education practices	✓	✓	✓
		Supportive and Palliative Care: ▶ "Last days of life" pathway	✓	✓	✓

Source: ASP and RSC, The merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust: Full Business Case, 19 February 2015, p.75-77.

75. Further details on the clinical benefits that are enabled by the merger are set out in the Full Business Case for the merger. We would note that since these benefits are only able to be delivered as a result of the improved financial situation of the merged Trust, these benefits are specific to the merger, and are thus RCBs. In the previous section we outlined how the improved financial performance of the merged Trust will allow a significant capital programme to proceed.

76. At Phase 1, Monitor advised the CMA that the delivery of 7 day working in stroke, gastroenterology and interventional radiology as a result of the merger constituted an RCB due to the clinical benefits that this would deliver in terms of reduced patient mortality and shorter lengths of stay. Monitor did not, however, accept that RCBs would arise from 7 day working in neurology or specialist diabetes care, nor did it accept that the planned Ashford Cancer Diagnosis & Treatment Centre (DTC) would deliver an RCB.

77. During this Phase 2 review, we do not intend to submit any further evidence in relation to the 7 day working benefits that Monitor has already concluded constitute RCBs other than some further views on the quantification of these benefits. Of course, if the CMA - on reviewing this information - has any questions we would be happy to respond. We would

also encourage the CMA to continue to consult with Monitor regarding the RCBs arising from this merger.

78. Regarding the Ashford DTC, as set out in the previous section the capital programme includes financing for chemotherapy and endoscopy services at the DTC, and we may be in a position to submit further evidence relevant to the certainty of an investment in radiotherapy services at the DTC. However, the business case is currently under development as part of the planning process, and will only be available for submission to the CMA later in the Phase 2 review (assuming that the analysis being undertaken for the business case continues to support the development of this facility). We may also be submitting additional evidence in relation to an RCB that arises from planned changes to the merged Trust's cardiology service.

4. COUNTERFACTUAL

79. ASP and RSC have carried out extensive analysis of the counterfactual, where the merger does not proceed, as part of the Trusts' decision making process on the merger. In particular, the Trusts have built a Long Term Financial Model (LTFM) to evaluate the impact of the merger. This analysis is reflected in the Full Business Case for the merger.

Table 8: ASP and RSC finances as separate Trusts

£ m	2014/15 Forecast	2015/16 Plan	2016/17 Plan	2017/18 Plan	2018/19 Plan	2019/20 Plan
ASP						
EBITDA	13.3	13.8	14.7	13.9	14.1	13.4
Surplus	(1.3)	(1.3)	(1.2)	(8.8)	(2.0)	(3.1)
RSC						
EBITDA	11.9	10.4	8.3	10.6	11.2	11.7
Surplus	1.7	(0.5)	(5.4)	(2.7)	(2.3)	(2.1)

Source: ASP and RSC, The merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust: Full Business Case, 19 February 2015, p.88.

80. The Full Business Case states that without the merger "there is a risk that services at each organisation will degrade as a result of the need to reduce costs, and that neither Trust will be able to deliver high quality, safe services to its patients and the local population" (paragraph 3.3.11). This conclusion is based on the finding that both Trusts will enter deficit without the merger (see Table 8). Even allowing for the significant cost improvement

programmes that are planned at each Trust, ASP and RSC will have ongoing deficits for the foreseeable future without the merger.

Table 9: RSC capital expenditure, standalone scenario

RSCH stand-alone

	2015/16 £ 000's	2016/17 £ 000's	2017/18 £ 000's	2018/19 £ 000's	2019/20 £ 000's	TOTAL £ 000's
Source of capital funding						
Net surplus / (deficit) - incl. b/fwd	1,210	(5,436)	(2,688)	(2,308)	(2,099)	(11,321)
Depreciation	7,435	7,823	8,234	8,456	8,656	40,603
PDC and Loans	5,000	11,500	6,500	1,500	1,500	26,000
Funding available for capex	**13,645**	**13,887**	**12,046**	**7,648**	**8,056**	**55,282**
Capital Programme RSCH						
Building backlog maintenance	5,300	1,500	5,500	2,104	3,104	17,508
Equipment (replacement and new)	2,365	3,400	1,400	1,400	1,400	9,965
I.T. (maintenance and infrastructure development)	1,839	1,589	1,589	2,589	2,589	10,195
Service development - Diagnostic Treatment Centre (DTC)	3,000	-	-	-	-	3,000
Capital integration costs (e.g. relocation, telecoms, signage	1,150	1,000	-	-	-	2,150
Major transformation projects - St Lukes, ICO Day unit, Digital hospital						-
St Lukes refurbishment	4,000	4,000	-	-	-	8,000
ICO- Day unit on site	1,500	-	-	-	-	1,500
Digital Hospital	2,950	3,450	5,290	2,970	2,280	16,940
Total Capex ASPH	**22,104**	**14,939**	**13,779**	**9,063**	**9,373**	**69,258**
Capital funding surplus/(shortfall)	**(8,459)**	**(1,052)**	**(1,733)**	**(1,415)**	**(1,317)**	**(13,976)**
Capital reductions if no merger						
Building backlog maintenance	(500)	(500)	(500)			(1,500)
Equipment (replacement and new) - Da Vinci Robot	-	(2,000)	-	-	-	(2,000)
I.T. (maintenance and infrastructure development)	(438)	(375)	(375)	(375)	(375)	(1,938)
Capital integration costs (e.g. relocation, telecoms, signage	(1,150)	(1,000)	-	-	-	(2,150)
Major transformation projects - Digital hospital	(325)	(725)	(2,645)	(1,485)	(1,140)	(6,320)
Total capex reductions RSCH	**(2,413)**	**(4,600)**	**(3,520)**	**(1,860)**	**(1,515)**	**(13,908)**
Revised capital funding surplus/(shortfall)	**(6,046)**	**3,548**	**1,787**	**445**	**198**	**(69)**

Cash impact of capital reductions if no merger	2015/16 £ 000's	2016/17 £ 000's	2017/18 £ 000's	2018/19 £ 000's	2019/20 £ 000's
Base case cash	(1,015)	(2,084)	(5,264)	(9,333)	(12,474)
Capital reductions cash	2,413	7,013	10,533	12,393	13,908
Revised cash position	**1,397**	**4,929**	**5,268**	**3,060**	**1,434**

Further capital reductions taking account of reduced loan affordability	2015/16 £ 000's	2016/17 £ 000's	2017/18 £ 000's	2018/19 £ 000's	2019/20 £ 000's	TOTAL £ 000's
Building backlog maintenance	(700)	(700)	(700)	(700)	(700)	(3,500)
Equipment (replacement and new) - Da Vinci Robot	(500)	(400)	(400)	(400)	(400)	(2,100)
I.T. (maintenance and infrastructure development)	(1,000)	(1,000)	(1,000)	(1,000)	(1,000)	(5,000)
Service development	(3,000)					(3,000)
Major transformation projects						-
St Lukes refurbishment	(4,000)					(4,000)
Digital hospital	(1,475)	(225)	(770)			(2,470)
Total capex reductions RSCH	**(10,675)**	**(2,325)**	**(2,870)**	**(2,100)**	**(2,100)**	**(20,070)**
Revised capital programme	**9,017**	**8,014**	**7,389**	**5,103**	**5,758**	**35,281**

81. The deficits that will be incurred by each Trust will have a significant impact on the ability of each Trust to maintain staffing and finance capital expenditure, and thus deliver high quality services to patients. We believe that this would be a worse outcome in terms of the quality of services offered to patients than anything that could be envisaged from an SLC.

82. On entering deficit, ASP and RSC are obliged to take steps to bring themselves back into financial balance. Given the importance of staffing costs to the two Trusts, there would be pressure on both organisations to either deliver existing services with fewer staff (ie fewer nurses and/or consultants), or to withdraw from certain services, particularly those where tariff income does not cover the cost of the service. One specific effect is that the Trusts would not be able to deliver 7 day working under the counterfactual (which Monitor agreed with in advising the CMA in Phase 1 that 7 day working qualified as an RCB).

83. Further, ASP and RSC believe that it would not be possible to sustain safe levels of nursing over time, consistent with the latest guidance, under the counterfactual. If regulatory standards regarding nursing posts were strictly enforced, then ASP and RSC would need to make other savings in order to maintain nursing levels, such as further cutting capital expenditure over and above the scenarios set out below.

84. Not being able to deliver 7 day working or to maintain safe levels of nursing would significantly impact on the quality of services offered by ASP and RSC, and could be expected to impact on the competition that these two Trusts offer to other providers. Further, as patients choose other routine elective care providers, the two Trust's financial positions would worsen due to lost income.

85. An analysis of capital expenditure at ASP and RSC under the counterfactual shows that RSC would have £35 million of funding available for capital expenditure in the 5 years following the merger (see Table 9). In order to bring capital expenditure plans into line with the available funding, RSC would need to reduce expenditure on backlog maintenance, clinical equipment and IT and would not be able to afford an upgrade to hospital IT systems.

86. Similarly, ASP would have £30 million of funding available for capital expenditure in the 5 years following the merger (see Table 10). To bring its existing capital programme into line with the available funding, it would have to reduce backlog maintenance expenditure and purchases of clinical equipment as well as significantly scale back the planned investment in a new Major / Specialist Emergency Centre at SPH.

Table 10: ASP capital expenditure, standalone scenario

ASPH stand-alone

	2015/16 £ 000's	2016/17 £ 000's	2017/18 £ 000's	2018/19 £ 000's	2019/20 £ 000's	TOTAL £ 000's
Source of capital funding						
Net surplus / (deficit) - incl. b/fwd	(2,606)	(1,158)	(8,788)	(2,031)	(3,103)	(17,686)
Depreciation	9,374	9,551	9,072	9,574	10,048	47,619
PDC and Loans	10,000	10,000	5,000	-	-	25,000
Funding available for capex	**16,768**	**18,392**	**5,284**	**7,543**	**6,946**	**54,933**
Capital Programme ASPH						
Building backlog maintenance	8,508	6,874	4,050	2,750	3,650	25,832
Equipment (replacement and new)	1,438	1,866	1,400	1,750	4,750	11,203
I.T. (maintenance and infrastructure development)	2,350	2,025	-	500	2,500	7,375
Capital integration costs (e.g. relocation, telecoms,	445	200	250	-	-	895
Major transformation projects - Major Emergency Centre (I	2,000	14,000	14,000	-	-	30,000
Total Capex ASPH	**14,741**	**24,965**	**19,700**	**5,000**	**10,900**	**75,306**
Capital funding surplus/(shortfall)	**2,027**	**(6,572)**	**(14,416)**	**2,543**	**(3,954)**	**(20,372)**
Capital reductions if no merger						
Building backlog maintenance						-
Equipment (replacement and new)		(555)				(555)
I.T. (maintenance and infrastructure development)						-
Service development						-
Capital integration costs (e.g. relocation, telecoms, signage	(445)	(200)	(250)	-	-	(895)
Major transformation projects - Major Emergency Centre (MEC)		(5,500)	(14,000)			(19,500)
Total capex reductions ASPH	**(445)**	**(6,255)**	**(14,250)**	**-**	**-**	**(20,950)**
Revised capital funding surplus/(shortfall)	**2,472**	**(317)**	**(166)**	**2,543**	**(3,954)**	**578**

Cash impact of capital reductions if no merger	2015/16 £ 000's	2016/17 £ 000's	2017/18 £ 000's	2018/19 £ 000's	2019/20 £ 000's
Base case cash	9,604	2,508	(6,912)	(10,082)	(15,882)
Capital reductions cash	445	6,700	20,950	20,950	20,950
Revised cash position	**10,049**	**9,208**	**14,038**	**10,868**	**5,068**

Further capital reductions taking account of reduced loan affordability	2015/16 £ 000's	2016/17 £ 000's	2017/18 £ 000's	2018/19 £ 000's	2019/20 £ 000's	TOTAL £ 000's
Building backlog maintenance	(2,000)	(2,000)	(2,000)	(2,000)	(2,000)	(10,000)
Equipment (replacement and new) - Da Vinci Robot	(438)	(866)	(400)	(750)	(3,750)	(6,204)
I.T. (maintenance and infrastructure development)	(1,000)	(1,000)			(1,500)	(3,500)
Major transformation projects - MEC		(4,500)				(4,500)
Total capex reductions ASPH	**(3,438)**	**(8,366)**	**(2,400)**	**(2,750)**	**(7,250)**	**(24,204)**
Revised capital programme	**10,858**	**10,344**	**3,050**	**2,250**	**3,650**	**30,152**

87. These two standalone scenarios for capital investment at ASP and RSC compare with the total of £145 million that would be spent under the merge Trusts' capital programme (see Section 3). That is, £79 million more compared with the counterfactual. The deficit incurred by each Trust as a stand-alone organisation means they would be unable to raise loan funding for their respective capital programmes (and in any event would wish to avoid the financial pressure from interest payments associated with these loans). This would require

reductions in their respective capital programmes by the amount of loans as set out Tables 9 and 10.

88. The decline in services that can be expected at ASP and RSC as a result of moving into a sustained deficit can be seen by the experience at Heatherwood & Wexham Park Hospitals NHS FT (prior to its merger with Frimley Park Hospital NHS FT). Recent reports indicate that the sustained deficits at this Trust resulted in a 'significant historic underinvestment in estates' that is only now being addressed as part of a £328 million subsidy that is being provided to the combined Trust.[14]

89. A decline in services at ASP and RSC can be expected to result in patients switching to other financially stronger providers that are able to maintain services, including those that have been created nearby such as Frimley Health and the merged West Middlesex / Chelsea & Westminster.

90. In summary, two conclusions can be drawn from the counterfactual. First, services at ASP and RSC will be worse under the counterfactual compared with the merged Trust as a result of both reduced staffing and capital expenditure. The competition that the two Trusts offer to neighbouring providers of acute services will be significantly weaker compared with the situation in which the merger takes place. Second, additional investment and better services can be expected by the merged Trust compared to the counterfactual, and this will deliver significant benefits to patients, including the RCBs discussion in Section 3.

91. This counterfactual has important implications for how the competitive effects of the merger are analysed. In particular, the GP referral analysis – which is based on historical referral data – will overstate the share of referrals that ASP and RSC can be expected to capture in the future under the counterfactual. As a result, the strength of the competitive constraint that RSC imposes on ASP, in particular, will be considerably weaker under the counterfactual than is implied by a simple reading of the GP referral analysis results (and putting to one side the other factors discussed in Section 5 that render the GP referral analysis problematic).

5. COMPETITION IN ROUTINE ELECTIVE CARE

92. This section discusses the effect of the merger on competition in routine elective care. In summary, following the proposed merger, the combined Trust will still face extensive

[14] Health Service Journal, *Exclusive: FT to receive £328m as part of takeover of neighbour*, 12 March 2015 available at http://www.hsj.co.uk/hsj-local/acute-trusts/frimley-health-nhs-foundation-trust/-exclusive-ft-to-receive-328m-as-part-of-takeover-of-neighbour/5083182.article#.VQk-nPmsV8E.

competition from other providers. GPs in the combined ASP/RSC catchment area refer NHS patients to more than 50 providers of routine elective care. This demonstrates patients' ability to choose between many different providers, and the limited effect of the merger on the extent of choice available to patients. This is further underlined by the analysis of catchment area overlaps in this submission.

93. A revised analysis of GP referrals, based on more recent data than was available in Phase 1, shows important developments in the competitive landscape, with St George's Healthcare NHS Foundation Trust and several other providers capturing an increase share of patient referrals from GPs in the ASP/RSC catchment area, as well as a significant decline in the share of patients referred to West Middlesex University Hospital NHS Trust.

94. With these developments in the competitive landscape, there are now only five specialties where the Proportional Measure in the GP referral analysis is greater than 40% (ie the threshold used by the CMA at Phase 1 to identify those specialties where it considered that there was a realistic prospect of an SLC).

- In two of these specialties, for reasons set out in this submission, patient choice does not operate (Medical Oncology and Anaesthetics).

- In Breast Surgery, the results of the GP referral analysis are severely distorted by Frimley Park Hospital NHS FT not coding activity in this specialty, and on any reasonable assumptions about the level of Frimley Park Breast Surgery activity (discussed below) there is no cause to believe an SLC is likely.

- In ENT, we believe that the effect of the clinical network on patient referrals is overstating RSC's importance as a competitor to ASP (with the constraint being asymmetric). In any event, an analysis of catchment area overlaps at the specialty level indicates that patients will continue to have an extensive choice of ENT providers following the merger. As a result, we do not believe that it is possible to conclude that the merger gives rise to an SLC in ENT.

- In Audiology/Audiological Medicine, ASP has a Service Level Agreement with RSC whereby RSC provides this service to ASP patients. To the extent that ASP retains an incentive to attract patients in competition with RSC, which might be lost as a result of the merger, there remains extensive choice available to patients in terms of other providers.

95. We are concerned that the CMA's analysis of the merger's effect on competition in routine elective care in Phase 1 was flawed in several important respects. In particular, it did not

reflect a full understanding of how patient choice operates in the routine elective care pathway for patients, and the implications for how the merger's effect on competition should be analysed. It also overly relied on the GP referral analysis as the basis for its findings despite there not being any evidence to support the restrictive assumptions about GP/patient switching behaviour that are embedded in this analysis.

96. The section is set out as follows:

- the exercise of patient choice in routine elective care, and how providers compete for patients, is discussed (Section 5.1);
- the implications for product market definition of how routine elective care is provided are set out (Section 5.2);
- other providers of routine elective care in the vicinity of ASP and RSC are identified (Section 5.3);
- patients' ability to choose between different providers of routine elective care is discussed (Section 5.4);
- our analysis of GP referral patterns is then set out, including a discussion of individual specialties of particular interest (Section 5.5);
- entry and expansion in routine elective care services is considered (Section 5.6); and
- countervailing buyer power is discussed (Section 5.7).

5.1 Patient choice and competition in routine elective care

97. This section discusses patient care pathways and patient choice of provider for routine elective care in the NHS, the implications for how providers compete, and what this means for how competition between providers should be analysed in the context of the proposed ASP/RSC merger. The six key points in this section are that:

- First, *patients choose a provider of routine elective care services without knowing their treatment requirements* (eg whether surgery, anaesthetics, radiotherapy services, or diagnostic services will be needed, or whether they will be treated as an outpatient, or will need to be admitted as a day case or overnight patient). Patients' treatment requirements are only decided at, or following, the first outpatient appointment that is always the first interaction that a patient has with a routine elective care provider. *This means the patients' choice of provider will be based on all aspects of a provider's offering that the patient might access, without knowing which elements will eventually be used*.

As a result, it is not possible to meaningfully analyse the choice of provider made by subsets of patients based on the services these patients have ended up using (eg inpatients). This is because these patients will not have known whether they would use these services when choosing their provider. In other words, the quality of inpatient services would have been no more important to those patients that ended up being inpatients than it was to all other patients that would have thought, when they were being referred, that they too might end up using inpatient services. That is, all patients in specialties that offer inpatient services would have taken the quality of these services into account when selecting a provider given that all patients are potential consumers of these services.

- Second, *patients can have multiple 'first outpatient appointments' within a single care pathway*. This is because each time a patient meets a different consultant that is contributing to their care, a 'first outpatient appointment' will be recorded in hospital administration systems for billing purposes. However, it is only the initial 'first outpatient appointment' in each care pathway that results from a GP referral and a choice of provider. As a result, in analysing hospital data *care must be taken to only analyse those first outpatient appointments that directly stem from a patient's choice of provider*, and to exclude those first outpatient appointments that occur later in the care pathway that is administered by the routine elective care provider. In other words, first outpatient appointments are a good, but not perfect, proxy for when a GP referral, and choice of provider, has occurred.

- Third, *all patients start their routine elective care with a first outpatient appointment, and all providers offer outpatient services. This means that all providers compete for all referrals (in the specialties in which they offer services)*. (Where a provider is referred a patient that eventually requires services the provider does not offer, the patient will be referred to another provider, either directly or via their GP.)

- Fourth, one aspect of how providers compete is through establishing outpatient clinics in more convenient locations for patients. Barriers to entry in establishing new outpatient clinics are low, and evidence from the parties' internal documents show that *new providers of outpatient services can have a significant competitive impact on ASP and RSC*.

- Fifth, we are concerned that there may have been an unstated concern by the CMA at Phase 1 about the effect of the merger on patients in Woking and West Byfleet, two urban areas situated between RSCH at Guildford and SPH at

Chertsey (see Figure 1). However, this geographic area does not constitute a relevant market, and *it is not possible for providers to discriminate between patients based on their location or in relation to the GP practice from which the patient has been referred*. The services that ASP and RSC (or a merged Trust) offer to patients in any specialty will be the same for all patients. As a result, any deterioration in services as a result of an SLC would have to affect all patients in a specialty, not just those from a particular area.

- Finally, *the strength of the link between competition and market outcomes in NHS services is much weaker than in other sectors* where the CMA would normally be reviewing mergers. This means that any loss of competition as a result of the ASP/RSC merger could be expected to have a much smaller adverse effect than a similar merger between two organisations in another sector of the economy.

5.1.1 GP referrals, patient care pathways and patient choice of provider

98. Under the NHS Constitution, patients requiring a routine elective care referral have the right to choose any clinically appropriate provider that has a contract with a commissioner (as well as any clinically appropriate named consultant-led team employed or engaged by that provider). This right in the NHS Constitution is underpinned by the NHS Responsibilities and Standing Rules Regulations.

99. Most referrals for routine elective care are made by GPs and the choice of provider is often, in effect, made jointly by the patient and GP. Referrals for routine elective care may also be made dentists, and by clinicians working in community-based health services.[15] These different referral pathways for patients to providers of routine elective care are depicted in Figure 2.

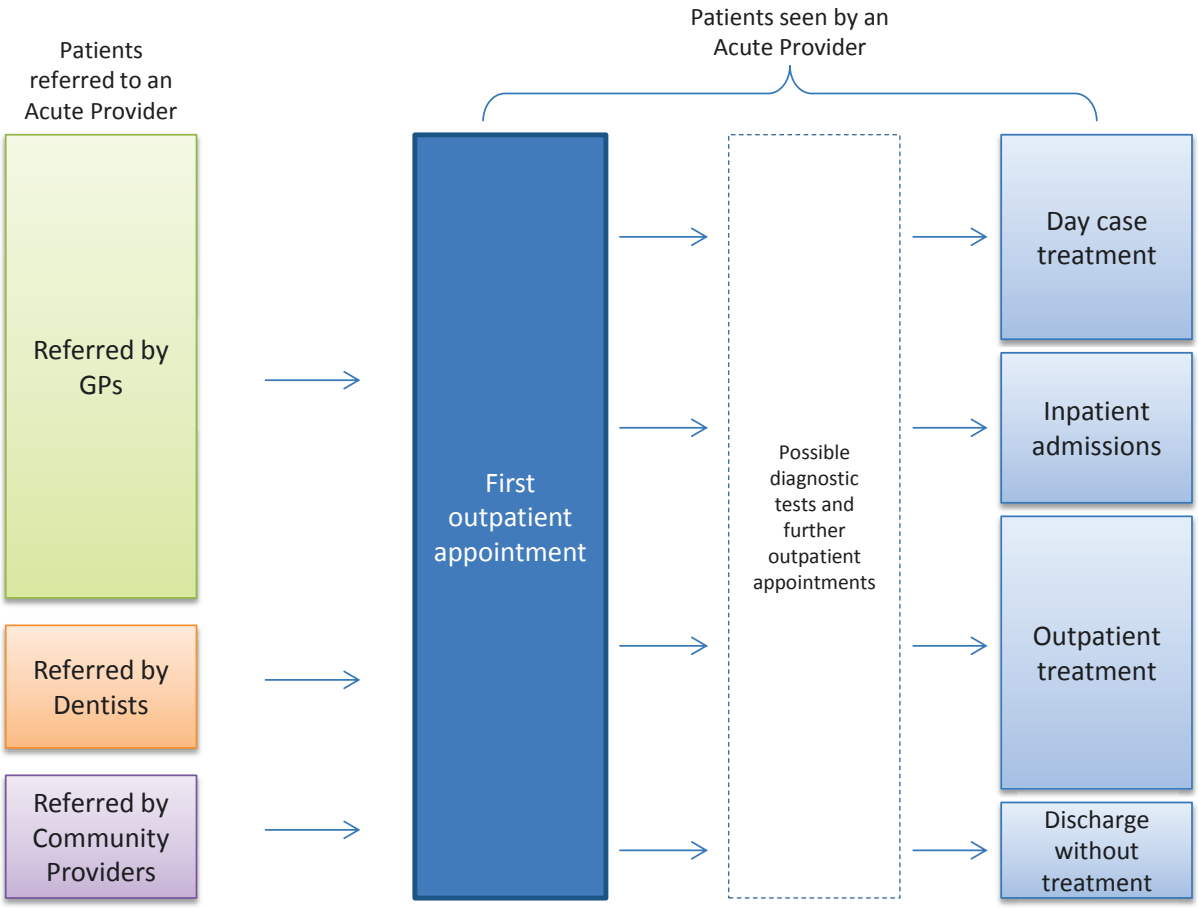
100. Referrals may also, in theory, be made between providers of routine elective care. For example, where a provider does not offer a particular service that a patient needs to access, then it is possible for a patient to be referred from one provider of acute care to another. In practice, however, there are relatively few provider to provider referrals. Most CCGs require that patients are passed back through their GP for onward referral to a new provider. (This addresses a previous budgetary problem where the effectiveness of the GP

[15] For example, patients experiencing skin problems might initially be referred by their GP to a community-based dermatology service where certain interventions may be offered. If it becomes clear that a patient needs to be seen by a consultant at an acute provider (eg due to concerns about cancer), then a referral is made by a clinician in the community-based dermatology service, and a choice of provider must be offered to the patient at this point in the process (ie rather than on the initial referral to the dermatology service by the GP).

gatekeeper function was being undermined by a proliferation of consultant to consultant referrals.)

101. All patients that are referred by their GP to a routine elective care provider will have a first outpatient appointment as their first interaction with their provider. At this appointment tests will be ordered, and either at this appointment or a follow up outpatient appointment, a decision is made regarding whether or not the patient can be discharged, treated as an outpatient or needs to be admitted (either as a day case procedure or for an overnight stay). The majority of patients that are referred to a provider of routine elective care services will either be treated as outpatients or discharged without treatment. A much smaller number will be treated as day case patients, and a smaller number again will be admitted for treatment that requires an overnight stay. (We are aiming to provide the CMA in due course with an estimate of the number of patients in each category at ASP and RSC.)

Figure 2: Flow of patients from referral to outpatients to inpatients



102. As set out above, patients' treatment requirements are only decided at, or following, the first outpatient appointment that occurs when a patient is referred to an acute provider. This means that patients (and their GP) choose their acute care provider without knowing for certain what treatment, if any, will be required. As a result, the choice of provider must be based on all aspects of a provider's offering that a patient might potentially use, without knowing which components will eventually be used.

103. For example, a patient may (or may not) need to access inpatient services, cancer treatment services, diagnostic services, pre-operative anaesthetics services and other diagnostic and treatment services. The choice of provider has to take in account the possibility of having to use these services, and reflect the patients' (and/or GPs') preferences in relation to the different offers made by different providers in relation to each of these services. Ultimately, however, the patient is likely to end up consuming only a small subset of these services. However, at the time of choosing their provider, the patient does not know which services will be required, and so it is not possible for the patient to base their choice of provider only on those services that they eventually consume.

104. Of course, in some cases, the patient and/or their GP may have a good idea that a particular form of treatment is likely to be required, and the choice of provider may be influenced by this knowledge. For example, if a patient has previously been admitted for treatment for the same condition, then the patient and/or GP may be able to accurately anticipate a further admission for similar treatment.

105. However, the accuracy of any foresight about the treatment that will eventually be required is likely to vary significantly across patients, GPs and specialties. One example of how patients/GPs do not always have foresight of their treatment requirements relates to cancer. Where a patient is referred to an acute care provider with suspected cancer, then the patient must - according to NHS rules - have their first outpatient appointment within two weeks. This compares with the 18 week Referral To Treatment target for other patients. A large proportion of patients, however, are diagnosed with cancer without having been referred under the two week rule. That is, at the point of referral the GP did not suspect that the patient had cancer, and this is demonstrated by the GP not taking advantage of the accelerated access to a first outpatient appointment that the NHS provides for such patients.

106. In conclusion, analysing the choice of provider made by patients based on services they used (eg inpatient services) assumes that the *actual* users of these services

patients behaved differently to other *potential* users of these services at a point when neither group knew whether they would use this service. This is even though both groups can be equally expected to have taken into account the quality of all services they might use at different providers when choosing a provider.

107. The key manifestation of this issue relates to inpatient services, and the CMA's separate analysis of these patients in its GP referral analysis. We do not believe that the separate analysis of those patients that ended up as inpatients can be regarded as robust, and we were disappointed that in the Phase 1 review the CMA did not engage with us regarding this issue despite our submissions on this point.

5.1.2 Patient care pathways can have multiple 'first outpatient appointments'

108. A patient may have more than one first outpatient appointment with different hospital consultants as part of the same care pathway. For example, if a consultant decides that patient needs to be operated on, then the consultant may refer the patient for a pre-operative consultation with an anaesthetist (eg because the patient has a heart condition that makes such an operation particularly high risk). This means that the patient will have had a first outpatient appointment with a consultant following their referral, and a first outpatient appointment with the consultant anaesthetist later in their care pathway after the consultant that is coordinating their care has decided to operate.

109. Similarly, if a cancer diagnosis is made, then a patient will have a first outpatient appointment with, say, a Breast Surgery consultant following their initial GP referral, and will later have a first outpatient appointment with a consultant oncologist about their radiotherapy/chemotherapy treatment. The multiple first outpatient appointments are recorded as such because each appointment represents a patient's first appointment with a particular consultant, not because they are the first appointment that a patient has following a GP referral (although in many cases they will be this too). The label 'first outpatient appointment' is essentially for billing purposes as first outpatient appointments are charged at a different tariff compared with follow up outpatient appointments.

110. The fact that a patient can have multiple first outpatient appointments within their care pathway has important implications for how data on patient choice is analysed. In particular, it means that *not* all first outpatient appointments can be linked back to a patient choice about their provider. We were disappointed that in the Phase 1 review

the CMA did not engage with us regarding this point, and as a result, drew erroneous conclusions regarding the effect of the merger in certain specialties, namely Medical Oncology and Anaesthetics. (We further discuss the implications of this point for the GP referral analysis in Section 5.5.)

5.1.3 Service offerings by acute care providers

111. As set out in the previous section, all patients that are referred for routine elective care start with a first outpatient appointment with a consultant. At this first meeting, the consultant will start to diagnose the patient's illness. Tests may be ordered for the patient, and then decisions will be made about whether the patient can be discharged, treated as an outpatient or requires an admission - perhaps for a surgical procedure - either as a day case patient or for an overnight admission.

112. All providers offering services within a specialty will offer outpatient clinics at which first outpatient appointments, and any follow up outpatient appointments, can be held. Some providers only offer outpatient services, while other providers also offer day case services and some providers also offer elective inpatient services that require an overnight stay.

113. For example, Virgin Care - which has the main contract for community health services in Surrey - offers outpatient clinics in several specialties, but does not offer day case or inpatient services. Patients that require these services are referred on to another provider.

114. A provider does not have to offer day case and/or elective inpatient services to be an effective competitor for patient referrals. Internal documents at ASP show how one particular provider, PIMS, had a highly effective strategy for competing with ASP for patient referrals. ASP's January 2013 Marketing Report states that the PIMS patient care model:

> "includes triaging and checking referrals, choosing the most suitable care pathway for the patient’s clinical problem, tracking and monitoring the entire pathway for patients and GPs using a unique pathway number, referring patients to their community clinics if suitable or on to secondary care if clinically required. (Note that complex patients would not be treated in their community clinics but would be referred directly to ASP as the community clinics would not have the capability to manage them. This takes the ‘less

complex' activity away from ASP. Given that we only get a standard outpatient tariff for each specialty this will begin to adversely affect our financial position."[16]

115. New providers only need to capture a relatively small number of referrals in order to have a significant competitive effect on providers like ASP and RSC, given the tight overall margins at which ASP and RSC operate. Moreover, the impact of this entry can be even greater given that outpatient services can be the most profitable part of the care pathway. This shows that new entrants, or expansion by existing providers, can have a significant competitive effect, even when only capturing small volumes of patient referrals.[17]

116. We discuss the competition provided by new entrants further in our review of barriers to entry and expansion in Section 5.6.

5.1.4 Outpatient clinic locations

117. Providers may offer outpatient clinics at either their main hospital site or at other locations (eg community hospitals and GP practices). It is relatively easy to secure suitable premises for outpatient clinics.

118. The rationale for opening outpatient clinics in locations other than a provider's main hospital site is that patients value being able to access services as close to home as possible. As a result, providing outpatient clinics at places other than the main hospital site meets the overarching public service requirements of NHS providers to offer the best possible service to patients. There is, in addition, a competitive element in that locating clinics closer to patients should encourage more patients to choose that provider (even if any subsequent day case or elective inpatient services need to be provided back at the main hospital site).[18]

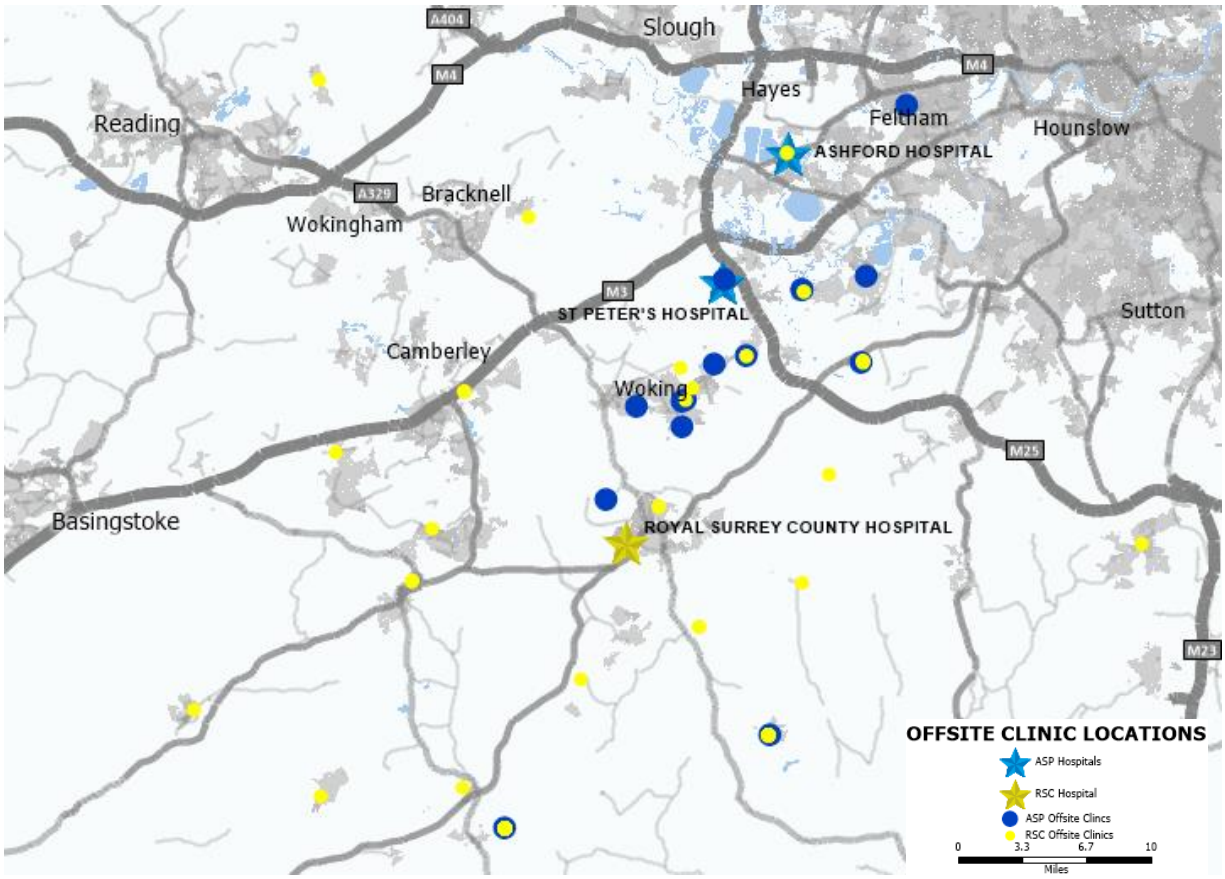
[16] There were some aspects of the PIMS business model that ASP felt were questionable, such as the influencing of patient referral decisions by GPs linked to PIMS, and PIMS has now exited the market. However, other aspects of the PIMS model, such as keeping overheads low, and offering higher payments to consultants that operate on PIMS referred patients seem replicable by other independent sector providers. EDICS/PIMS exit from the market appears to relate to financial irregularities at the provider rather than problems with its underlying business model. However, ASP and RSC do not have definitive information on the reasons for EDICS/PIMS closure.

[17] The OFT in its review of competition on quality stated that: "It is important to stress, however, that it might not need many patients to be sensitive to quality for providers to take it seriously, and to plan performance improvements. For some hospitals, indeed, even small shifts in elective patients could constitute an incentive to compete on quality, given the implications for income" (OFT (2014), *Competing on Quality – Literature Review*, OFT1531, paragraph 5.5).

[18] There is substantial evidence that supports this view. For example, in Working Paper No.4 published by the former Cooperation and Competition Panel, the co-authors - Kate Collyer, Walter Beckert and Mette Christiansen - in reviewing the relevant literature state that: "Universally, all studies find that distance or travel time matters to patients. This finding

119. ASP holds outpatient clinics at both AH and SPH as well as holding 47 different outpatient clinics at 14 other locations across Surrey and South West London. RSC holds outpatient clinics at RSCH as well as holding 79 different outpatient clinics at 26 other locations across Surrey and further afield (see Figure 3). Full details of these clinics are being provided to the CMA as part of our response to the Market Questionnaire.

Figure 3: Outpatient clinics for ASP and RSC



120. The relevance of opening new outpatient clinics as a competitive strategy is set out in ASP's July 2013 Marketing Report:

> "Our comprehensive strategic approach identifies 3 key actions to support our competitive position. These were approved by the Board in Sept 2012 and

is the same regardless of whether they use data on patients from the US, England or Europe" (paragraph 34), and when reviewing patient choice patterns in the NHS using HES data, the authors go on to say that this "shows that slightly more than 60 per cent of patients went to their nearest hospital" (paragraph 50 of working paper available at http://www.healthcare-today.co.uk/doclibrary/documents/pdf/714_Choice_of_NHS_hospital.pdf).

are being incorporated into plans for 2013/14. (1) More community clinics to be closer and more convenient for the patient; (2) Reduce waiting times to be more competitive and patient seen faster; (3) Provide triage services to reduce patient 'bounce' and inappropriate referrals."

121. Other Acute Trusts appear to have similar strategies. For example, the July 2013 Marketing Report at ASP stated that Frimley Park Hospital NHS Foundation Trust has "now opened a large number of OP [outpatient] clinics at the Bracknell Clinic reinforcing their strategy to grow in Berkshire".

122. The implications of this for analysing the competitive effects of this merger are that:

- patients' ability to access services from other providers needs to be thought about in terms of not only their main hospital sites, but also in relation to any outpatient clinics they may operate; and
- the ease with which competing providers can establish new outpatient clinics as a means of competing with a merged ASP/RSC needs to be taken into account.

123. We note that the CMA's Phase 1 decision does not consider this issue in any detail, and the longer period of time available to the CMA during its Phase 2 review provides the opportunity for this issue to be properly explored. We would encourage the CMA to request information from other providers regarding their intentions in relation to opening new outpatient clinics in the areas served by ASP and RSC.

5.1.5 Providers' ability to discriminate between patients

124. Routine elective care providers, in treating patients, do not have the ability to discriminate between patients based on their location or the GP from which the patient has been referred.

125. Providers must offer all patients the same quality of clinical care, and access to the same range of treatment and support services. Any discrimination between patients, based on their location or the GP practice from which the patient has been referred, would be highly unethical as well as a major breach of the obligations that are placed on both providers and individual clinicians.

126. The CMA, in its Phase 1 decision, did not explicitly state that it had concerns about the impact of the merger on services to patients in particular locations (eg Woking and West Byfleet - which are located between ASP and RSC – see Figure 1). However, we are concerned that such a concern may have informed the CMA's decision.

127. We would stress, therefore, that such a limited geographic impact is not possible. Any deterioration in the quality of services as a result of an SLC could only manifest itself as a deterioration in the quality of services to all patients in the specialty. Further, ASP and RSC are strongly of the view that the extent of any adverse effect that might arise from an SLC is very limited as we discuss in Section 5.1.6.

5.1.6 Competition versus other factors that influence the quality of routine elective care services

128. If the CMA concludes that the proposed merger will give rise to an SLC in one or more specialties, then it will need to consider the extent of the adverse harm that arises from the SLC, and thus whether – for example – prohibiting the merger would be a proportionate response given the loss of RCBs that a prohibition would entail.

129. We do not believe that the evidence in this case supports an SLC finding in any specialty. However, we believe that it is important to engage at early stage with the CMA on discussing the extent of any adverse harm that might arise from an SLC in the same way that we wish to make a positive contribution to the CMA's assessment of RCBs ahead of its Provisional Findings on the competitive effects of the merger.

130. In considering the potential size of any adverse impact from an SLC, this section summarises the key points from the OFT's 2014 review of the literature on competing on quality.[19]

131. The OFT concludes that NHS hospitals are incentivised to compete on quality for many healthcare services, and that the studies reviewed by it show a positive effect of competition on managerial quality, AMI and overall mortality, AMI mortality and length of stay. However, the OFT also states that it is not easy to assess the existence of a causal link between competition for routine elective care and a measure of quality for emergency procedures like AMI, especially because the various studies that it

[19] OFT (2014), *Competing on Quality – Literature Review,* OFT1531, London.

reviewed do not model explicitly the relationship between competition and quality. The OFT review then goes on to explore the evidence in relation to this link.

132. In terms of measuring the size of the effect that competition has on quality, the OFT review cites two studies. In relation to the first study[20] it states that the "authors perform some basic analyses of the impact of competition on quality, estimating that the pro-competitive reforms saved 10 lives per year, and led to a 7.68% increase in patient welfare" (para 5.42). In relation to the second study[21], the OFT review states that the "estimation outcomes suggest that hospital quality responds positively to the quality of rival providers for seven out of the 16 indicators, and does not respond to the others. Results are especially significant for the measures related to patients' experiences. When an effect is present, an increase in rivals' quality by 10 per cent increases quality by 1.7-2.9 per cent" (para 5.75).

133. There are three conclusions that can usefully be drawn from the OFT's review as well as more generally that would be relevant to the CMA's decision making if an SLC is found. First, while there is evidence of a positive link between competition and the quality of services offered at routine elective care providers, the evidence from the studies reviewed by the OFT does not show competition as having a large overall impact in terms of increasing quality. It follows from this that the adverse effects for patients that could be expected to arise from a loss in competition are not particularly significant.

134. Second, there is clearly more to the balancing of adverse effects arising from a loss of competition against RCBs than the simple counting of patient numbers that the CMA carried out in deciding not to exercise its discretion not to refer this merger to Phase 2.

135. Finally, in the experience of ASP and RSC, competition is much less important than other factors in driving quality at Acute Trusts. As set out in Section 3, regulation plays a critical role in determining how services are provided by Acute Trusts, and responding to tightening regulatory standards is one of the key drivers for the proposed merger. A review of the papers seen by the Boards at ASP and RSC would show that both organisations devote comparatively little time to considering their competitive environment compared with other factors critical to overseeing each

[20] Gaynor, Propper, Seiler (2012) 'Free to Choose? Reform and Demand Response in the English National Health Service', NBER Working Paper No.18574.
[21] Gravelle, Santos, Siciliani (2013) 'Does a hospital's quality depend on the quality of other hospitals? A spatial econometrics approach to investigating hospital quality competition', CHE Research Paper 82.

Trust's operations. Further, the public service motivations of NHS organisations, clinicians and other staff should also not be underestimated in terms of thinking about how a merged Trust would be motivated to offer services to patients.

136. In summary, the strength of the link between competition and market outcomes in NHS services is weaker than in other sectors where the CMA would normally be reviewing mergers. It follows that any loss of competition as a result of the ASP/RSC merger could be expected to have a much smaller adverse effect than a merger between two similar organisations in another sector of the economy. We anticipate making further submissions to the CMA on the adverse effects that might arise from an SLC.

5.1.7 Conclusions

137. The key conclusions from this discussion of how patient choice and competition operates in routine elective care in the NHS are as follows:

- First, patients choose their provider without knowing what treatment will be required, and as a result, will take into account all facets of the services offered by each provider when making their choice. It is not possible to meaningfully analyse patients' choices based on those services that the patient ultimately consumes (eg looking at inpatients separately from other patients) because the patient does not know which services will be used when they choose their provider.

- Second, all providers compete for all referrals, regardless of whether each provider offers a full range of inpatient services. This is because all patients start their routine elective care pathway with a first outpatient appointment, and all providers offer outpatient services. Providers that do not offer a full range of inpatient services will refer patients that require these services on to other providers.

- Third, a new provider of outpatient services can have a major competitive effect on Acute Trusts like ASP and RSC due to the narrow overall margins at which these Trusts operate.

- Fourth, outpatient services can be offered from a variety of locations, not just the main hospital site. One aspect of how providers compete is through opening outpatient clinics in new locations. Barriers to entry in outpatient

services are low. The analysis of the merger needs to take into account the availability of services from these locations and the possible establishment of new outpatient clinics by other providers in the areas served by ASP and RSC.

- Fifth, providers are unable to discriminate between patients based on their location or the GP practice from which they have been referred. As a result, it is not possible for any SLC to manifest itself as specific to a sub-group of patients within the specialty where that SLC arises (eg patients from Woking).

- Finally, the strength of the link between competition and market outcomes in NHS services is much weaker than in other sectors where the CMA would normally be reviewing mergers. This means that any loss of competition as a result of the ASP/RSC merger could be expected to have a much smaller adverse effect than a merger between two similar organisations in another sector of the economy.

5.2 Implications of patient choice and care pathways for product market definition

138. The way in which patient choice and care pathways operate (as set out in Section 5.1) also interacts with the definition of the relevant product markets affected by the ASP/RSC merger, and how competition in these product markets is analysed. The CMA's approach in previous cases, and its guidance (*CMA guidance on the review of NHS mergers*, published on 31 July 2014) is that within each specialty the CMA may treat outpatient and inpatient activities as separate markets.

139. The discussion in the previous section highlights that analysing competition in outpatient and inpatient services is not a simple matter of identifying those patients that have used inpatient services, and analysing their choice of provider separately from other patients. This is because patients, at the time of choosing their provider, do not know whether they will use inpatient services. As a result, all patients will take into account the quality of inpatient services when selecting a provider, given the possibility that all patients may need to use inpatient services.

140. Separately analysing the choice of provider made by those patients that ended up using inpatient services assumes that patients had perfect foresight as to whether they would need inpatient services. This is self-evidently not the case, and the experience of cancer

referrals (discussed at paragraph 103) underlines the point that patients do not know what treatment will be required at the point of referral.

141. We believe that there is a complex interaction between the quality of inpatient and outpatient services in a specialty, and how this influences patient choice. Patients (and/or GPs) will take the quality of inpatient services into account when choosing a provider.[22]

142. However, from a demand-side substitution perspective, a deterioration in the quality of inpatient services at a provider may result in a patient switching to another provider that only offers outpatient services. This is because the patient will be taking into account the combined quality of inpatient and outpatient services when selecting their provider. The provider to which the patient switches will depend on the relative weighting that the patient/GP attaches to all the different aspects of the service quality offered by different providers. That is, from a demand-side perspective, outpatient and inpatient services could form part of the same market.

143. From a supply-side substitution perspective:
    - providers of outpatient services cannot readily start offering day case and elective inpatient services; and
    - providers of outpatient and day case services cannot readily start offering elective inpatient services.

    In both cases, substantial investments are likely to be required in new facilities and in recruiting staff. This points to separate product markets with the asymmetric constraint that the CMA identifies in its guidance on NHS mergers.

144. Ultimately, the precise definition of the product market does not particularly matter if the nature of patient choice and the competitive interaction between providers is properly taken into account in analysing the competitive effects of the merger. However, it is clear that the CMA's approach in Phase 1, where it analysed competition in inpatient services by reviewing the choice of provider made by patients that ended up using inpatient services is not robust given the way in which patient choice operates. The CMA must use an alternative approach to analysing competition in inpatient services, such as reviewing the number and location of providers of inpatient services in a specialty.

145. We encourage the CMA to use the patient and GP surveys to collect evidence on the extent to which patients/GPs take into account the quality of inpatient services when

[22] This assumes that it is a specialty in which inpatient services are offered.

choosing between providers, and the weight that is attached to different aspects of the services offered by providers in choosing a provider.

5.3 Other providers of routine elective care near ASP and RSC

146. This section provides an overview of other providers of routine elective care services in the vicinity of ASP and RSC. This information is relevant to assessing the extent of competition that will exist after the proposed merger of ASP and RSC.

147. Other providers of routine elective care services fall into three categories: (i) NHS Acute Trusts that offer a wide range of routine elective care services; (ii) NHS Acute Trusts that offer routine elective care services in a limited number of specialties; and (iii) private providers of routine elective care services to NHS patients.

148. We have identified nearly 100 providers that have received referrals in the two years to 31 March 2014 from the 290 GP practices that are located within an 80% catchment area for a combined ASP/RSC. This, however, includes a very long tail with a large number of providers only receiving a small number of referrals. There are 43 providers that received more than 0.1% of all referrals, and 12 providers that received more than 1% of all referrals.

149. Table 12 sets out those providers that receive more than 0.1% of referrals from the 290 GP practices in the combined catchment area, and their distance (as measured by drive-times) relative to AH, SPH and RSCH. Figure 4 maps the providers set out in Table 12 relative to AH, SPH and RSCH.

Table 12: Routine elective care providers near AH, SPH and RSCH

Acute Trust (Hospital)	Drive time from:		
	Ashford Hospital (minutes)	St Peter's Hospital (minutes)	Royal Surrey County Hospital (minutes)
Chelsea and Westminster Hospital NHS FT			
Chelsea and Westminster Hospital	32	36	42
West Middlesex University Hospital NHS FT	17	23	36
Hillingdon Hospitals NHS FT	17	19	32
London North West Healthcare NHS Trust			
Ealing Hospital	20	27	39
Northwick Park	31	34	47
Epsomedical			
Cobham	20	11	14
Epsom	31	22	26

Virgin Care Services			
Woking Community Hospital	21	11	16
Weybridge Hospital	16	7	21
Wolton Community Hospital	21	18	24
Milford Specialist Community Hospital	37	29	14
Haslemere Hospital	43	34	19
Cranleigh Village Hospital	46	37	24
Caterham Dene Community Hospital	39	31	34
PIMS/EDICS			
Woking	21	11	15
Epsom	31	22	26
Frimley Park Hospital NHS FT / Heatherwood & Wexham Park NHS Trust			
Frimley Park Hospital	24	19	20
Heatherwood Hospital	20	20	28
Wexham Park Hospital	23	25	38
Imperial College Healthcare NHS Trust			
Charing Cross Hospital	25	31	39
Ramsay			
Ashtead	25	17	20
North Downs	38	29	32
Kingston Hospital NHS FT	27	28	31
BMI			
Mt Alvernia	27	19	8
Runnymede	14	2	18
Princess Margaret Hospital	15	17	30
Hampshire Clinic	37	34	33
Shelbourne Hospital	31	32	45
Bishops Wood Hospital	31	34	46
Nuffield			
Guildford	29	21	4
Woking	18	7	18
Your Healthcare (Kingston head office)	29	21	24
Epsom & St Helier University Hospitals NHS Trust			
Epsom Hospital	31	23	26
St Helier Hospital	41	33	36
Royal Brompton & Harefield NHS FT			
Royal Brompton Hospital	32	38	43
Harefield Hospital	28	29	42
Royal Brompton & Harefield NHS FT	32	36	42
Royal Berkshire Hospital NHS FT	34	30	38
University College London Hospitals NHS FT	38	42	55
Guy's and St Thomas' Hospitals NHS FT			
St Thomas Hospital	39	45	49
Guy's Hospital	47	52	55
Spire			
Clare Park	40	35	22
Gatwick Park	43	34	38
Thames Valley			
Hampshire Hospitals NHS FT			
Basingstoke Hospital	40	35	36
Winchester Hospital	58	53	50
Dorking Healthcare	41	32	36
St George's Healthcare NHS Trust	41	33	36
Royal Marsden NHS FT			
Royal Marsden Hospital (Surrey)	41	33	36

Great Ormond Street Hospital NHS FT	42	46	54
Surrey & Sussex Healthcare NHS Trust East Surrey Hospital	44	35	39
East & North Hertfordshire NHS Trust Hertford County Hospital Lister Hospital Queen Elizabeth II Hospital	46 52 44	49 54 47	61 67 59
Queen Victoria Hospital NHS Foundation Trust	55	47	51
Brighton & Sussex University Hospitals NHS Trust Princess Royal Hospital (Haywards Heath)	62	54	57
Maidstone & Tunbridge Wells Hospitals NHS Trust Maidstone Hospital Tunbridge Wells Hospital	64 59	56 50	60 54
Bedford Hospital NHS Trust	65	67	80
Circle (MSK services Bedford)	65	67	80
Horder Healthcare Crowborough Tunbridge Wells	76 63	68 54	71 58
Cambridge University Hospitals NHS FT	84	92	98
Portsmouth Hospitals NHS Trust	71	63	48
University Hospital Southampton NHS FT	72	64	61
Medway NHS FT	79	70	72
Western Sussex Hospitals NHS FT St Richard's Hospital (Chichester) Worthing Hospital	79 76	70 68	56 65
East Kent Hospitals University NHS FT William Harvey Hospital Queen Elizabeth the Queen Mother Hospital Kent and Canterbury Hospital	82 109 92	75 101 83	78 106 87
Benenden Hospital	85	76	81
East Sussex Hospitals NHS Trust Conquest Hospital Eastbourne District General Hospital	91 91	83 83	88 87
Provide	101	102	106

150. RSCH is 22 minutes drivetime from SPH and 33 minutes drivetime from AH. In Table 12 we have highlighted those providers that are:

- closer to AH than RSCH (ie within 33 minutes) - 16 providers;
- closer to SPH than RSCH (ie within 22 minutes) - 9 providers; and
- closer to RSCH than SPH (ie within 22 minutes) - 7 providers.

Figure 3: Routine elective care providers near AH, SPH and RSCH

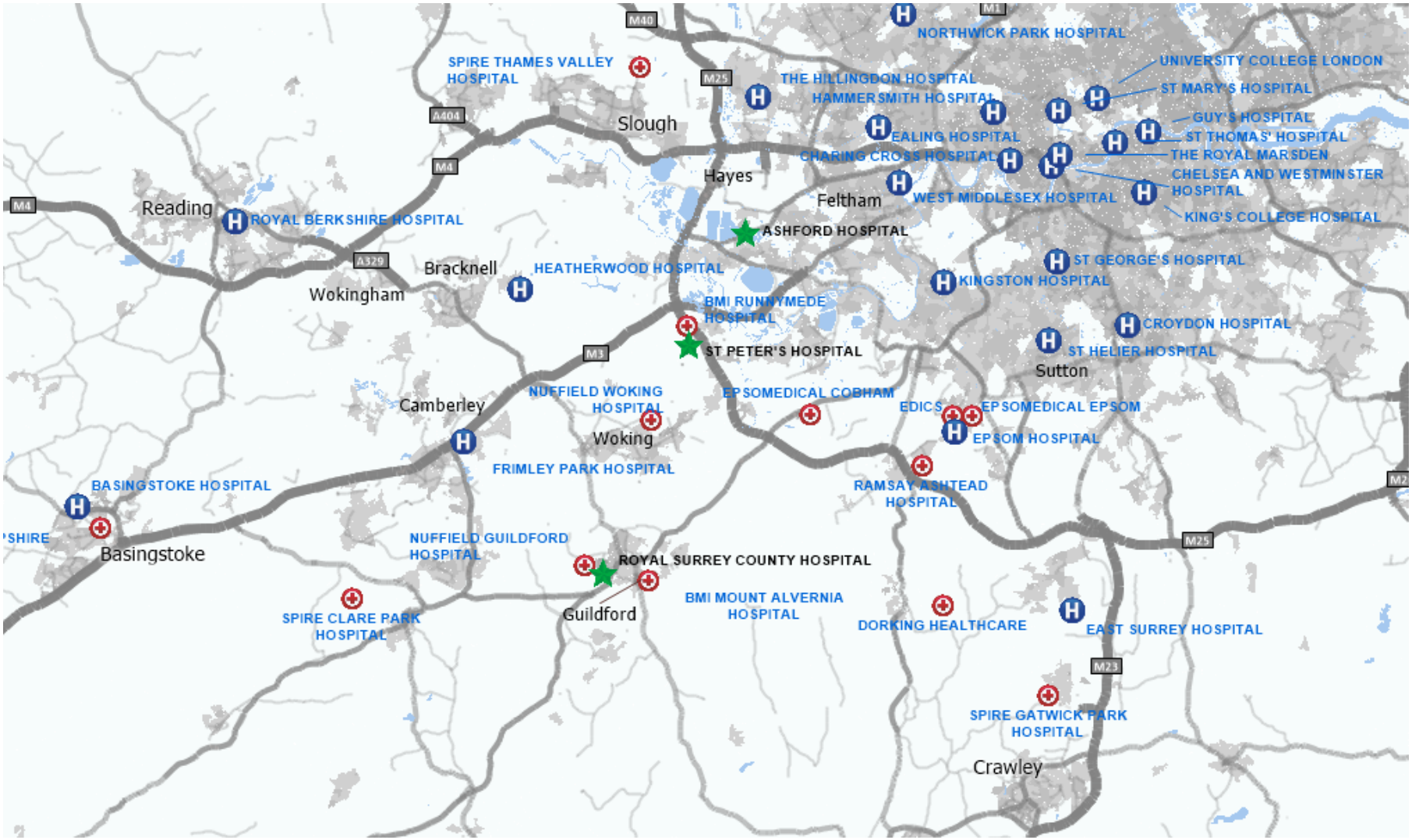


Table 13: Routine elective care providers near AH, SPH and RSCH

Row Labels	ASHFORD AND ST PETER'S HOSPITALS NHS TRUST	ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST	HEATHERWOOD AND WEXHAM PARK HOSPITALS NHS FOUNDATION TRUST	FRIMLEY PARK HOSPITAL	WEST MIDDLESEX UNIVERSITY HOSPITAL NHS TRUST	HAMPSHIRE HOSPITALS NHS FOUNDATION TRUST	KINGSTON HOSPITAL NHS TRUST	EPSOM AND ST HELIER UNIVERSITY HOSPITALS NHS TRUST	LONDON NORTH WEST HEALTHCARE NHS TRUST	BEDFORD HOSPITAL NHS TRUST	BRIGHTON AND SUSSEX UNIVERSITY HOSPITALS NHS TRUST	CAMBRIDGE UNIVERSITY HOSPITALS NHS FOUNDATION TRUST	EAST AND NORTH HERTFORDSHIRE NHS TRUST	EAST KENT HOSPITALS UNIVERSITY NHS FOUNDATION TRUST	EAST SUSSEX HOSPITALS NHS TRUST	GUY'S AND ST THOMAS' NHS FOUNDATION TRUST	IMPERIAL COLLEGE HEALTHCARE NHS TRUST	MAIDSTONE AND TUNBRIDGE WELLS NHS TRUST	MEDWAY NHS FOUNDATION TRUST	PORTSMOUTH HOSPITALS NHS TRUST	ROYAL BERKSHIRE NHS FOUNDATION TRUST
ANAESTHETICS	643	609	26	29	4	5,769	8	284	20		5					26	362			946	13,183
ANTICOAGULANT SERVICE	1,699	313	5		697	94	1,320	2,325	615		653					986	495			777	1,463
AUDIOLOGICAL MEDICINE		1,201		3,624		4,375		14,167	3,438								6,385			2,545	16,709
AUDIOLOGY	6,472					2	13,399				5										1,262
BREAST SURGERY	6,279	4,176	5,783		3,627	5,938	4,659		5,506		7,005				1	6,424	11,059			7,136	6,447
CARDIAC REHABILITATION	428					232											1,834				
CARDIOLOGY	15,227	6,735	20,543	14,397	6,232	20,741	6,842	14,497	29,961		15,666					13,479	51,646			15,180	17,990
CARDIOTHORACIC SURGERY	73	97			15		33				119						348				
CHEMICAL PATHOLOGY		456	102	187	120		6	2,950	381		328						208			6	119
CLINICAL HAEMATOLOGY	4,631	1,952	3,699	8,970	3,035	7,106	5,020	6,828	9,102		7,729					10,577	15,098			5,787	6,276
CLINICAL IMMUNOLOGY and ALLERGY		1,639		1,261		228	110				1,216						14				
CLINICAL NEUROPHYSIOLOGY	1,241			361	1,335			3,667			1						11,245				
CLINICAL ONCOLOGY (previously RADIOTHERAPY)	604	8,366	2,387	960	392				996		4,229				1	10,775	1,929			6,592	30,086
CLINICAL PSYCHOLOGY	79		71	15		296		11			258										10
COLORECTAL SURGERY	10,004	1,123	354		2,893	5,340	5,484		7,364		23,539					11,981	5,925		815	10,040	3,365
CRITICAL CARE MEDICINE	614		22		609		10		494		1,660					182	37			345	954
DERMATOLOGY	8,712	5,043	3,933	9,398	4,654	9,250	8,250	9,310	10,001		11,700					13,709	14,649			12,127	10,061
DIABETIC MEDICINE	702	1,513	101		508	904	1,710	2,526	2,375		5,362					3,547	1,781			1,413	487
DIETETICS	2,538		304	1,084		1,364	1,970		1,869		3,366					3,733	1,634				38
ENDOCRINOLOGY	1,462	1,238	879	330	1,157	2,332	1,474		3,359		2,348					2,428	8,340			2,580	1,476
ENT	9,126	10,710	6,995	11,482	11,244	14,635	7,356	8,480	14,941		14,675	218	329			18,445	22,730			18,994	12,148
GASTROENTEROLOGY	9,144	8,840	11,734		12,443	18,364	8,988	7	29,442		16,039				204	16,409	23,888			19,389	12,940
GENERAL MEDICINE	17,874	196	22,652	17,335	20,396	23,012	18,006	45,515	39,552		8,607	2				12,819	2,470			24,864	13,595
GENERAL SURGERY	2,195	17,162	12,957	29,974	8,879	16,478	6,157	20,108	24,032		549		368		94	1,262	17,185			9,097	11,850
GERIATRIC MEDICINE	2,537	6,770	424	6,328	3,354	3,811	2,176	3,368	7,346		14,379					7,020	8,947			5,531	6,631
GYNAECOLOGICAL ONCOLOGY	1	1,027				50		324	1,193		835					2,510	1,594			1,185	
GYNAECOLOGY	11,672	9,619	12,545	10,665	12,423	17,740	13,544	18,689	22,095		19,438		371		16	24,512	45,576			16,483	13,196
HAEMOPHILIA		1				98										998	282				
HEPATOBILIARY & PANCREATIC SURGERY		67				942											2,215				
HEPATOLOGY		532	29	2		49	198										3,084			1,349	
INTERVENTIONAL RADIOLOGY		60		51		692	50	250			2,192					408	39			45	674
LEARNING DISABILITY	1					438															
MAXILLO-FACIAL SURGERY	9,560	13,836	5,907			4,826			13,310											2,831	694
MEDICAL ONCOLOGY	1,095	11,386	1,749	2	985	7,985	418	30	3,272		1,507					20,031	22,400			9,130	7
MEDICAL OPHTHALMOLOGY		1,509														654					
MIDWIFE EPISODE	8,155	5,103	7,592	3,736		7,993	8,843	12,095	10,637		21,473					23,523	22,599			8,073	8,627
NEONATOLOGY	802	724	504	794	1,221	919	1,203	3,055	1,076		3,194					933	1,112			572	1,250
NEPHROLOGY	94		419	364	189	157	485	7,958	1,312		4,289					93,985	11,743			6,032	2,309
NEUROLOGY	2,922	2,227	3,341	3,154	2,296	2,879	2,468	3,548	5,961		7,695					7,627	23,715				5,872
OBSTETRICS	7,390	7,375	8,859	15,156	24,362	9,365	28,360	14,726	22,864		14,381					25,315	42,705			12,235	10,077
OCCUPATIONAL THERAPY	1,786		737	1,289		1,426					1,124					8,144	1,817				4
OPHTHALMOLOGY	19,359	10,194		18,309		20,379	17,573	28,791	6,677		17,847		3,243		1	24,567	25,876	86		23,158	39,119
OPTOMETRY		545																			
ORAL SURGERY	1	2,453	254	2,609	5,307	1	8,560	6,173	3,139		9,738					25,608	4,358			7,043	5,671
ORTHODONTICS	702	793	357			576	815	94	1,385		1,310					1,976				789	243
ORTHOPTICS	1,170	1,121				1,581	3,775				3,462					527					4,090
PAEDIATRIC CARDIOLOGY	212	217	176		339	81		314	308		637					4,907	401				
PAEDIATRIC CLINICAL HAEMATOLOGY	7		22		51	19		68			32					350	2,079				27
PAEDIATRIC CLINICAL IMMUNOLOGY AND ALLERGY	510	46			486	107		212	401		819					4,322	3,995				
PAEDIATRIC DIABETIC MEDICINE	28	9	60		60	69		4			52					23	55			12	
PAEDIATRIC ENDOCRINOLOGY	152	116	230		197	6		203	111		366					297	47				
PAEDIATRIC GASTROENTEROLOGY	7		43		184	34		776	569		1,466					465	22				
PAEDIATRIC INFECTIOUS DISEASES		1							319								725				
PAEDIATRIC MEDICAL ONCOLOGY		51	17			44			408		734						7				
PAEDIATRIC NEPHROLOGY		121			156	7		324	79		17					3,804	175				
PAEDIATRIC NEURO-DISABILITY		594				433		562	458							331					
PAEDIATRIC NEUROLOGY		16	31		249			235	85		121					3,508	475				
PAEDIATRIC OPHTHALMOLOGY	2,032					1,048			114		125					2,378	1,787				514
PAEDIATRIC RESPIRATORY MEDICINE	49	44	329		642	14		239	152		922					313	613				3
PAEDIATRIC RHEUMATOLOGY		28	54			43			34		205						153				
PAEDIATRIC SURGERY	138	272	765		701	141		797	112		3,646					1,768	1,043			217	171
PAEDIATRIC TRAUMA AND ORTHOPAEDICS	1,504	12	726			1,464			309		3,989					2,394	661				91
PAEDIATRIC UROLOGY	159		69			57		421	262		515					1,611	992				243
PAEDIATRICS	9,785	6,088	12,453	11,868	7,963	19,319	12,375	10,647	21,414		8,765			1		6,252	17,982			16,120	17,200
PAIN MANAGEMENT	4,241	2,475	2,192	5,644		3,101	4,957	3,928	64		4,989		499			6,751	5,037			1,997	1,700
PALLIATIVE MEDICINE		27	110			228		1,313	11		90					220				1	
PHYSIOTHERAPY	11,479		5,983	14,818		15,719	12,102				19,685					33,698	10,673				5
PLASTIC SURGERY		832	10,960	174	1,037		3,241	740			477	25				14,140	5,654			4,324	1,495
REHABILITATION	857		12,144		22	594			1,023		366					66	494			1,673	549
RESPIRATORY MEDICINE	4,707	4,633	3,058	10,252	5,449	5,107	4,751		8,591		9,447					6,240	14,064			13,149	9,381
RESPIRATORY PHYSIOLOGY		875			332											6,484	1,356			1,057	37
RHEUMATOLOGY	2,760	3,733	2,059	1,464	2,182	5,184	3,008	2,926	5,678		4,490					6,803	6,103			7,915	6,068
SPEECH AND LANGUAGE THERAPY	210		101	201		775	139				385					722	545				17
TRANSIENT ISCHAEMIC ATTACK	171	307	133	590		599		865			644									1,247	
TRAUMA & ORTHOPAEDICS	30,546	21,632	18,869	33,615	18,264	31,576	25,573	45,388	30,357	72	36,721	153	1,137	288	1	22,428	28,333	45		34,424	35,337
UPPER GASTROINTESTINAL SURGERY	6,239	37				3	2,350									5,288	1			4,630	474
UROLOGY	8,596	9,325	11,063	11,776	6,097	13,483	6,894	12,428	14,523	19	12,405	4			3	15,258	18,609			12,541	12,059
VASCULAR SURGERY	4,421		274	2,519	724	1,493	1,404		3,007		6,474					4,587	7,630			2,937	410
WELL BABIES	3,453	2,993	3,025	5,155	3,830	5,172	5,265	4,081	5,401		4,878					6,595	8,411			6,162	17
Grand Total	**263,091**	**204,496**	**226,459**	**303,896**	**186,251**	**335,444**	**277,478**	**332,956**	**404,512**	**91**	**393,493**	**417**	**5,947**	**289**	**321**	**617,499**	**673,967**	**131**	**815**	**410,808**	**402,250**

Note: Where a provider has only received referrals from GP practices in the combined ASP/RSC catchment areas at one of its outpatient clinics, we have only counted activity at that outpatient clinic in the table below.

Table 14: Routine elective care providers near AH, SPH and RSCH

Row Labels	SOUTHAMPTON UNIVERSITY HOSPITALS NHS TRUST	ST GEORGE'S HEALTHCARE NHS TRUST	SURREY AND SUSSEX HEALTHCARE NHS TRUST	THE HILLINGDON HOSPITAL NHS TRUST	UNIVERSITY COLLEGE LONDON HOSPITALS NHS FOUNDATION TRUST	GREAT ORMOND STREET HOSPITAL FOR CHILDREN NHS TRUST	QUEEN VICTORIA HOSPITAL NHS FOUNDATION TRUST	ROYAL BROMPTON AND HAREFIELD NHS FOUNDATION TRUST	THE ROYAL MARSDEN NHS FOUNDATION TRUST	BENENDEN HOSPITAL	BMI HEALTHCARE	CARE UK	CIRCLE	EDICS	HORDER HEALTHCARE	NUFFIELD HEALTH	PENINSULA COMMUNITY HEALTH C.I.C	PROVIDE (CIC)	RAMSAY HEALTHCARE UK OPERATIONS LIMITED	SPIRE HEALTHCARE	VIRGIN CARE SERVICES LTD	YOUR HEALTHCARE
ANAESTHETICS	324	1,299	14	322		430			1	119	1,523	106	193			12				94		
ANTICOAGULANT SERVICE		7,485	6		555			27														
AUDIOLOGICAL MEDICINE		10,884	3		1,196															4		
AUDIOLOGY		8,292			3,115								1						2			
BREAST SURGERY	8,436	10,163	4,894	2,646	3,407		2		6,789										1	6		
CARDIAC REHABILITATION																						
CARDIOLOGY	23,755	78,994	9,678	4,844	16,781		295	19,337			1		1,591	262			1		1,445	13		3
CARDIOTHORACIC SURGERY		233	397		2,541														1	149		
CHEMICAL PATHOLOGY	822	87																				
CLINICAL HAEMATOLOGY	7,110	15,661	4,452	3,487	21,608			16	8,885													
CLINICAL IMMUNOLOGY and ALLERGY	3,725																					
CLINICAL NEUROPHYSIOLOGY	7,166	1,275	878			2,267														1		
CLINICAL ONCOLOGY (previously RADIOTHERAPY)	5,217	100	473	437	1,581				15,770											5		
CLINICAL PSYCHOLOGY	54	327	45		77			69														
COLORECTAL SURGERY	67	12,496	7,692	945	4,917				143				14,091					37				
CRITICAL CARE MEDICINE		69	506		76			850														
DERMATOLOGY	9,861	27,886	7,580	7,314	6,360		142	72	329	35	21	61	23,610	526		1	1,650	1,534	1,362	11		
DIABETIC MEDICINE	151	6,926	1,451	952	643									21								
DIETETICS	1,081	2,834	949	1,156	1,421	192	297	60					263									20
ENDOCRINOLOGY	1,024	6,418	4,007	1,424	2,643				5				2,430	31			94		1			
ENT	13,553	26,610	13,791	4,067	22,912		1	629	797	186	8,611	5,992	1,979	431		276		734	4,356	5,718		
GASTROENTEROLOGY	4,946	19,865	11,363	9,575	18,308				1,630	140	2,532	3,586	11,493	111		9		6,265	15,592	871		
GENERAL MEDICINE	24,909	20,125	10,180	7,143	12,281		93			1	2	895		17			1,496	541	90	389		1,301
GENERAL SURGERY	22,175	9,724	13,503	19,218	5,961			54	4,537	262	13,858	9,629	4,379	227		191		3,244	13,311	10,188		
GERIATRIC MEDICINE	8,731	3,525	7,086	2,584	1,638		87							1			1,508	75				
GYNAECOLOGICAL ONCOLOGY	2,602	3,741	228		1,419				183													
GYNAECOLOGY	21,650	37,053	15,194	10,405	19,340				851	13	7,677	2,813	14,002	150		258		862	6,399	4,515		
HAEMOPHILIA	103	55																				
HEPATOBILIARY & PANCREATIC SURGERY	9																					
HEPATOLOGY	4,979	3,689		216	318								3,922									
INTERVENTIONAL RADIOLOGY	3,186	154			902																	
LEARNING DISABILITY																						48
MAXILLO-FACIAL SURGERY		11,759	1,886		2,392		11,002				269		194						2,978	35		
MEDICAL ONCOLOGY	6,067	15,148	2,289	20	19,921				35,978													
MEDICAL OPHTHALMOLOGY					51																	
MIDWIFE EPISODE	8,695	4,336	10,863	8,803	2,923																	
NEONATOLOGY	1,150	2,201	180	426	5,487																	
NEPHROLOGY	766	21,733	390	475	157			59												279		
NEUROLOGY	19,093	23,921	2,129	2,865	43,337		267	89			88			332		13		536	22	6		
OBSTETRICS	14,635	30,776	9,954	12,818	29,813																	
OCCUPATIONAL THERAPY			673		482	84	2,143						9					4				211
OPHTHALMOLOGY	23,655	1,767	19,847	9,325	3,032		4,897		1	1,084	8,871	10,755	1,685	197		613		2,810	8,144	4,953		
OPTOMETRY																						
ORAL SURGERY	7,804	6,467	1,270	5,123	9,842		5,900		43		2,308	10,507						1,639	347	59		
ORTHODONTICS	700	3,675	296	373	2,004		1,503												6			
ORTHOPTICS				2,113														23				
PAEDIATRIC CARDIOLOGY	3,063	353	336			7,458		4,558														
PAEDIATRIC CLINICAL HAEMATOLOGY	1,358	1,118	7	174	198	4,113																
PAEDIATRIC CLINICAL IMMUNOLOGY AND ALLERGY	1,715		48			924																
PAEDIATRIC DIABETIC MEDICINE	33			39	128																	
PAEDIATRIC ENDOCRINOLOGY	865	1,389	37		965	2,903			8													
PAEDIATRIC GASTROENTEROLOGY	1,733	2,055	65			4,440																
PAEDIATRIC INFECTIOUS DISEASES		770				417																
PAEDIATRIC MEDICAL ONCOLOGY	2,278	99			1,537	3,357			4,052													
PAEDIATRIC NEPHROLOGY	1,594					4,276																
PAEDIATRIC NEURO-DISABILITY						1,369																
PAEDIATRIC NEUROLOGY	1,429	1,077	14			5,334																
PAEDIATRIC OPHTHALMOLOGY	4,902			676		7,642	237															
PAEDIATRIC RESPIRATORY MEDICINE	941	1,797	24	304	415	3,374		2,633														
PAEDIATRIC RHEUMATOLOGY	357	36	22		188	5,455																
PAEDIATRIC SURGERY	5,685	3,938	886	432	1,936	3,205	22	242		91									2			
PAEDIATRIC TRAUMA AND ORTHOPAEDICS	11,637	187	457	19		2,727	101															
PAEDIATRIC UROLOGY	1,573	3,339	24	82	3	4,536																
PAEDIATRICS	11,004	9,480	13,318	6,595	4,740	566	99		745	252				177				235				
PAIN MANAGEMENT	1,013	5,134	1,990	5,122	6,797			108	417		8,969	123	3,269	355	136	153		1	3,631	2,371		
PALLIATIVE MEDICINE	2,190	8		108	14	190		2	14													
PHYSIOTHERAPY	8,419	48,093	1,903		9,513	544	4,977	187		31	53		1,059		114		8,854	3,916	71	31	6,207	1,008
PLASTIC SURGERY		23,928		215			21,508		682		744		26	118		74		1,376	1,118	918		
REHABILITATION	232	3,091	22	800	1,806			100									76	1				
RESPIRATORY MEDICINE	9,527	12,771	9,482	3,497	4,913			21,861					3,691				62					
RESPIRATORY PHYSIOLOGY		2,548	399		2,131		2,827															
RHEUMATOLOGY	4,825	14,974	7,497	1,477	7,935		129				15		5,710	68	77			914	6			
SPEECH AND LANGUAGE THERAPY		963	129		791	849	333	2														242
TRANSIENT ISCHAEMIC ATTACK	763		647	130																		
TRAUMA & ORTHOPAEDICS	27,571	35,138	28,225	20,175	14,501		1,451			905	30,362	25,626	24,381	824	2,618	2,043		1,826	57,174	35,376	8,364	
UPPER GASTROINTESTINAL SURGERY	2	6,088	4,331		99				425	1										2		
UROLOGY	11,525	26,392	10,590	4,277	16,110				2,068	150	7,853	2,314	5,706	63		399	317	743	7,763	3,142		
VASCULAR SURGERY	2,927	12,953		60	2,008								2,945					1	382	764		
WELL BABIES	6,505	4,708	4,443	3,738	6,651																	
Grand Total	**416,043**	**715,198**	**258,976**	**175,024**	**401,965**	**104,700**	**63,134**	**64,883**	**88,890**	**3,330**	**95,803**	**72,496**	**138,082**	**3,911**	**2,948**	**4,199**	**14,059**	**45,981**	**126,534**	**70,296**	**15,332**	**5,069**

Note: Where a provider has only received referrals from GP practices in the combined ASP/RSC catchment areas at one of its outpatient clinics, we have only counted activity at that outpatient clinic in the table below.

151. Clearly, the importance of these different providers varies in terms of the number of referrals that each provider has gained from the 290 GP practices within the 80% combined catchment area for ASP/RSC. Tables 13 and 14 set out the number of referrals to each provider in each of the routine elective care specialties where ASP and/or RSC offer services.

152. Internal documents at ASP and RSC provide an indication of the extent to which these different providers might be considered close competitors to ASP or RSC. In general, board papers at ASP and RSC that discuss competitors to ASP and RSC identify a range of alternative providers of NHS acute services as key competitors. There are no instances in these documents of ASP or RSC specifically identifying the other Trust as their closest competitor. The CMA agreed with this conclusion at Phase 1.

153. At ASP, the relevant internal documents primarily take the form of a quarterly marketing report to the Board, which discusses: developments at commissioners, competitors and partners; internal changes at ASP relevant to ASP's competitive position; market share trends; patient experience metrics; and updates on actions relevant to ASP's market position. At RSC, reports to the Board that identify and discuss RSC's competitors tend to be more strategic rather than routine, and include RSC's Strategic Marketing Report and its 5 year Cancer Services Strategy report.

154. ASP's quarterly marketing reports have a section in each report on competitors/partners that discusses a range of providers, including RSC, Virgin Care, Frimley Park Hospital NHS FT, West Middlesex University Hospital NHS Trust, Surrey and Sussex Healthcare NHS Trust, Epsom & St Helier University Hospitals NHS Trust, PIMS/EDICS, and Epsomedical (Cobham Day Surgery). There is no indication in these reports that ASP considers RSC to be its closest competitor, and no greater attention is paid to RSC than to any other provider.

155. A further indication of who ASP considers as it competitors arises from the set of Trusts with which it compares its Friends and Family Test scores and other patient feedback indicators (eg NHS Choices patient recommendations). These Trusts include: Brighton and Sussex University Hospitals NHS Trust, East Sussex Hospitals NHS Trust, Frimley Park Hospital NHS FT, Queen Victoria Hospital NHS FT, RSC, Surrey & Sussex Healthcare NHS Trust, Western Sussex Hospitals NHS FT, West Middlesex University Hospital NHS Trust, Epsom & St Helier University Hospitals NHS Trust, Kingston Hospital NHS FT, Royal Berkshire NHS FT, and Heatherwood & Wexham Park Hospitals NHS Trust.

156. ASP's clear sense that it faces competition from a range of competitors is reinforced by statements such as the one in the January 2013 Marketing Report that "we [ie ASP] now operate in an increasingly competitive environment where we need to meet the

needs of our customers better than our local competitors to be their first choice healthcare provider".

157. RSC's Strategic Marketing Plan dating from March 2014 states that "RSCH serves a number of different markets with different competitive forces operating in each. RSCH want to become more systematic in our analysis and tracking of service offerings from our main competitors." It then identifies a list of Acute Trusts and private providers of NHS services that it considers to be its main competitors. These include:

    - Acute Trusts: Royal Berkshire NHS FT; Heatherwood & Wexham Park Hospitals NHS Trust; Hampshire Hospitals NHS FT; The Hillingdon Hospital NHS FT; Buckinghamshire Healthcare; Kingston Hospital NHS FT; Epsom & St Helier University Hospitals NHS Trust; North West London Hospitals NHS Trust; St George's Healthcare NHS Trust; West Middlesex University Hospital NHS Trust; Ealing Hospital NHS Trust; West Hertfordshire Hospitals NHS Trust; and Oxford University Hospitals NHS Trust; Frimley Park Hospital NHS Foundation Trust; and

    - Private providers of NHS services: Ramsay Ashtead; BMI (Princess Margaret Hospital, Hampshire Clinic, Shelbourne Hospital, Bishops Wood Hospital, Mt Alvernia Hospital) and Spire Thames Valley.

158. We note that while the internal documents at ASP and RSC identify and discuss competitors to the two Trusts, none of these documents shed any specific or direct light on the extent to which competition influences performance at the two Trusts, or the relative importance of competition versus other factors that influence Trust performance, such as regulation.

159. In summary, patients within the combined ASP/RSC catchment area are referred to more than 50 different providers of routine elective care services. These providers are distributed across a wide area, including Surrey, London, Sussex, Berkshire, Hampshire and beyond. Further, there are a significant number of providers to which patients are referred that are closer to either ASP or RSC than these two Trusts are to each other. This indicates that following the ASP/RSC merger, the combined Trust will still face extensive competition from other providers.

160. The evidence from these referral patterns is consistent with internal documentation at the two Trusts, which identifies a large number of competing providers, and does not

indicate that ASP or RSC are closer competitors to each other than other providers of routine elective care services.

5.4 Patients' ability to choose between providers of acute services

161. This section presents a preliminary analysis of the extent to which patients are able to choose between providers of routine elective care services based on the number of catchment areas in which those GP practices that are in the combined 80% catchment area for ASP/RSC reside, and how this would change with the proposed merger.

162. The CMA, in its Phase 1 decision, placed little if any weight on this analysis. This was explained in terms of the CMA:
    - not considering the methodology we used for identifying catchment area overlaps as robust (but not taking any steps to refine the analysis according to its preferred methodology); and
    - considering that the GP referral analysis is better evidence of potential switching behaviour by patients and/or GPs.

163. In this section we present a revised version of this analysis using the CMA's preferred methodology for identifying catchment area overlaps (although it not clear to us that the CMA's preferred methodology for identifying catchment area overlaps is superior analytically).

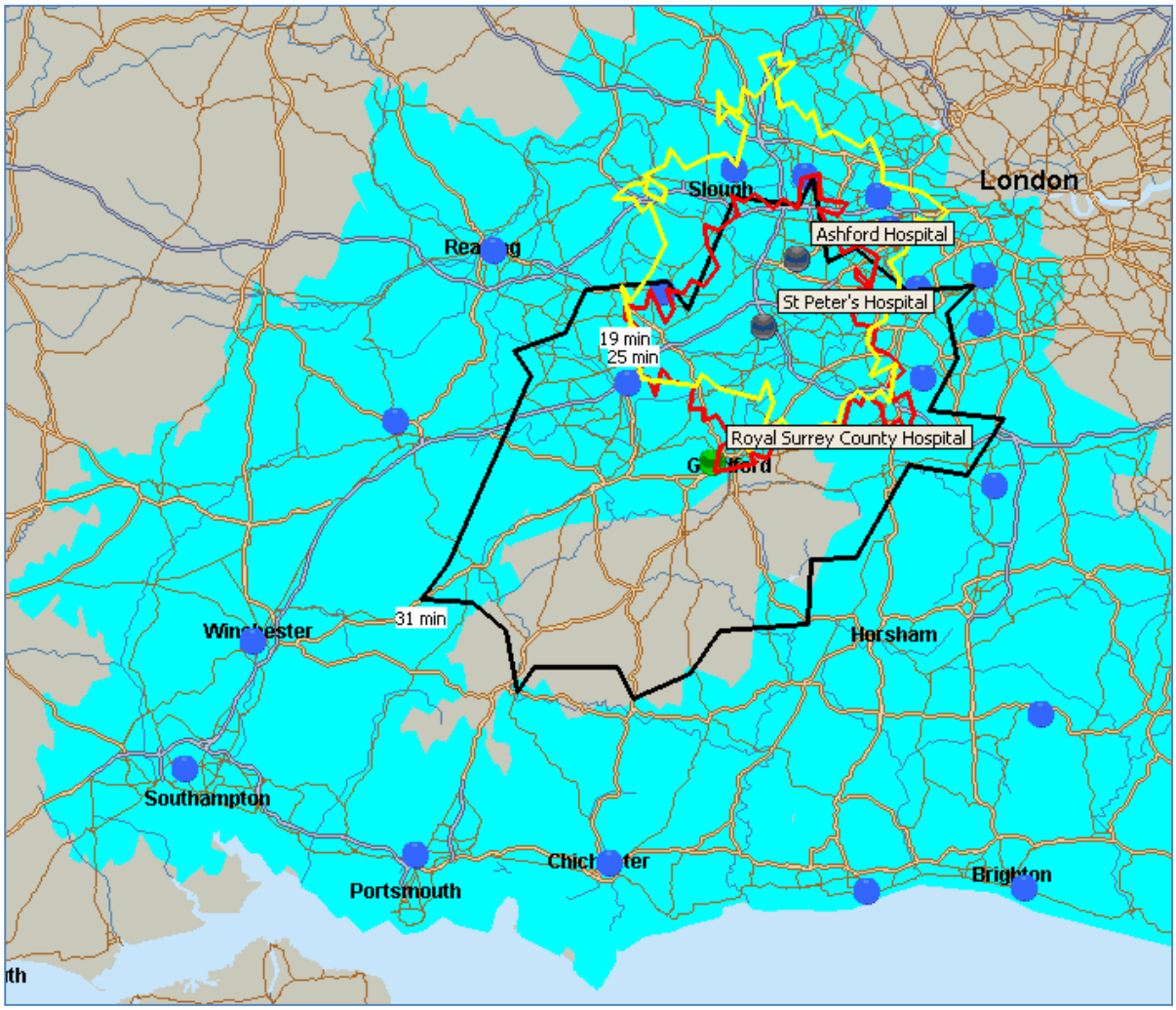
164. We believe that the catchment area overlap analysis remains relevant to the CMA's consideration of whether an SLC arises from this merger, given the restrictive assumptions in the GP referral analysis about how GPs/patients might switch between providers. The catchment area overlap analysis provides a better indication of how this switching might take place under what we believe to be more realistic assumptions about switching behaviour. We discuss these assumptions in more detail in Section 5.6.

165. The analysis in this section is based on the same GP referral data that was used in Phase 1 (ie the 3.5 year period until October 2012). We will, however, provide the CMA with an updated version of this analysis based on the more recent data in the next few days.

166. Figure 5 shows catchment areas for AH, SPH and RSCH and a number of NHS Acute Trusts in the vicinity of ASP and RSC. (Catchment areas for specialist NHS Trusts and private providers of NHS routine elective care services have not been included.) The

purpose of this map is to provide a high level indication of the extent to which the catchment areas for ASP and RSC overlap with other Trusts.

Figure 5: Catchment area overlaps between AH, SPH, RSCH and other NHS Acute Hospitals (80% catchment areas, first outpatient appointments)



Legend: Yellow line: AH catchment area. Red line: SPH catchment area. Black line: RSCH catchment area. Light Blue shaded area: catchment areas for neighbouring Acute Trusts. Blue dots: Neighbouring NHS Acute Trusts

167. Using the older dataset, there are 232 GP practices in the 80% catchment area for the combined Trust. (Using the newer dataset, the equivalent figure is 290 GP practices – see paragraph 148.) Prior to the merger, 77 GP practices are in the catchment area of 5 or more Acute Trusts, 30 are in the catchment area of four Acute Trusts, 42 are in

the catchment area of three Acute Trusts, 43 are in the catchment area of two Acute Trusts, and 40 are in the catchment area of one Acute Trust.[23]

168. The effect of an ASP/RSC merger would be to increase by six the number of GP practices that were in three or fewer GP practice areas (ie 2.5% of GP practices in the combined catchment area). That is, the CMA's preferred methodology for measuring catchment area overlaps results in a much smaller increase in the number of GP practices have three or fewer Acute Trusts to choose from than the methodology that we submitted at Phase 1, which had an increase of 34 GP practices.

Table 15: Distribution of GP practices in the ASP and RSC catchment areas

GP Practices in catchment area for ...	80% catchment areas	
	Pre-merger	Post-merger
5 or more Trusts	77	71
4 Trusts	30	30
3 Trusts	42	28
2 Trusts	43	51
1 Trust	40	52
Total	232	232

Source: Aldwych Partners analysis of HES data.

169. This analysis clearly shows that the vast majority of patients (and their GPs) would be able to readily access a significant number of providers of routine elective care following the merger. Moreover, it understates the extent of the choices available to patients/GPs given that it does not include either private providers or specialist NHS Trusts. As set out above, a revised version of this analysis using more up to date referral data will be submitted shortly.

5.5 GP referral analysis

170. This section sets out an updated analysis of GP referral patterns that were reviewed by the CMA at Phase 1. The analysis has been updated since Phase 1 in two ways.

[23] This count of catchment areas treats Frimley Park Hospital NHS Foundation Trust and Heatherwood & Wexham Park Hospitals NHS Trust as a single Trust.

- First, the dataset on which the analysis set out in this section is based covers the two years to 31 March 2014. This compares with the 3.5 year period to October 2012 that was used in Phase 1.

- Second, in Phase 1 the analysis was based on a dataset that suppressed all referrals from a GP practice to a provider in a specialty where there was less than five referrals to that provider. This reflected a cautious interpretation of HSCIC rules that are aimed at ensuring patient confidentiality. Following further consideration, it has not been necessary to similarly suppress these numbers in this later dataset.

171. We have several concerns about the robustness of the results that come out of the GP referral analysis and we elaborate on these concerns below. However, we first present the results from this revised analysis, and then discuss these concerns in more detail, and why we believe this means that the CMA can only place limited weight on the GP referral analysis.

172. Overall, the GP referral analysis shows that those GP practices that refer patients to ASP also refer significant numbers of patients to five other main providers of routine elective care (RSC, St George's Healthcare NHS FT, Frimley Health NHS FT, West Middlesex University Hospital NHS Trust and Virgin Care). Similarly, the GP referral analysis shows that those GPs that refer patients to RSC also refer significant numbers of patients to four other main providers of routine elective care (Frimley Health NHS FT, ASP, St George's Healthcare NHS FT and Virgin Care).

Table 16: GP referral analysis: Trust-level results

ASP First Outpatient Appointment		RSC First Outpatient Appointment	
RSC	22%	Frimley Health	23%
St George's Healthcare	12%	ASP	14%
Frimley Health	11%	St George's Healthcare	12%
West Middlesex	10%	Virgin Care	9%
Virgin Care	9%	Epsom & St Helier	4%
Kingston Hospital	5%	Surrey & Sussex	4%
Imperial College	4%	Western Sussex	3%
BMI Healthcare	3%	Hampshire Hospitals	3%
Epsom & St Helier	3%	Guy's & St Thomas'	2%
UCLH	2%	BMI Healthcare	2%
Guy's & St Thomas'	2%	UCLH	2%

14 others	1% each	Portsmouth Hospitals	2%
		12 others	1% each

173. The specialty-level results are shown in Table 16 alongside the equivalent results from the Phase 1 analysis. These results show the proportional measure for RSC as a competitor to ASP and vice versa. We have only set out the Proportional Measure consistent with the CMA's findings at Phase 1, which used the Proportional Measure as its starting point.

174. Further, we have presented the results for first outpatient appointments, given the discussion in Section 5.1 where we set out the reasons why a figure based on inpatients cannot be robust. That is, patients in choosing their provider do not know whether they will end up using inpatient services. As a result, all patients will choose a provider based on the quality of outpatient, inpatient and any other services that they might potentially need to access at the provider they select. There is no validity in separately analysing the choice of provider made by those patients that end up being inpatients given that these patients did not know that they would be an inpatient when selecting their provider.[24]

Table 17: GP referral analysis: Proportional Methodology (excluding "anchor only" GP practices), First Outpatient Appointments

	1 April 2012 to 31 March 2014 (Updated analysis for Phase 2)		1 April 2010 to 31 October 2012 (Phase 1 results)	
	ASP	**RSC**	**ASP**	**RSC**
ENT	50%	24%	55%	25%
Joined Audiology & Audiological Medicine	50%	30%	75%	32%
Anaesthetics	57%	26%	80%	46%
Joined Oral & Maxillo-Facial Surgery	31%	21%	37%	32%
Breast Surgery	57%	37%	66%	45%
General Surgery	22%	1%	33%	7%
Medical Oncology	77%	24%	92%	36%
Gynaecology	25%	22%	33%	41%
Gastroenterology	24%	11%	33%	29%

[24] It is also worth noting that the CMA has previously presented the results of its GP referral analysis in terms of inpatients and outpatients, implying that it has separated patients into these two categories. However, in reality its analysis has been of first outpatient appointments (ie all patient referrals), which it has referred to as 'outpatients', and then a subset of this overall cohort that have gone on to be admitted as inpatients.

Colorectal Surgery	0%	20%	14%	60%
Urology	25%	16%	32%	20%
Joined Paediatrics	12%	9%	16%	15%
Endocrinology	29%	29%	40%	56%
Geriatric Medicine	34%	22%	45%	30%
Diabetic Medicine	21%	9%	43%	36%
Anticoagulant Service	26%	22%	62%	34%
Rheumatology	22%	17%	33%	20%
Trauma & Orthopaedics	19%	16%	27%	18%
Joined Ophthalmology & Orthoptics	17%	24%	18%	26%
Dermatology	19%	17%	28%	24%
Neurology	14%	10%	19%	14%
Pain Management	15%	12%	22%	14%
Clinical Haematology	14%	7%	28%	9%
Joined Midwife Episodes & Obstetrics	23%	12%	25%	10%
Respiratory Medicine	16%	13%	21%	12%
Orthodontics	0%	12%	22%	27%
Cardiology	6%	5%	9%	5%
General Medicine	1%	5%	n/a	n/a
Cardiothoracic Surgery	16%	20%	n/a	n/a
Upper Gastrointestinal Surgery	7%	38%[1]	n/a	n/a

Note:
(1) Upper Gastrointestinal Surgery figures at RSC are based on a total of 37 first outpatient appointments reflecting the fact that this activity is coded as General Surgery at RSC. For this reason we do not regarding the GP referral analysis results in this specialty as relevant or robust.

175. The eight specialties where the CMA found a realistic prospect of an SLC in Phase 1 are highlighted in dark pink, while the further 10 specialties where the CMA did not reach a conclusion are highlighted in light pink. The CMA's reasoning in its Phase 1 decision for identifying certain specialties as giving rise to a realistic prospect of an SLC and not others is not clear. However, we believe that it is consistent with the Proportional Measure in a specialty being greater than 40% (for either first outpatient appointments (shown below) or for inpatients).

176. Consistent with what we believe to have been the CMA's approach in Phase 1, we have highlighted the five specialties where the more recent data that we have now used shows a Proportional Measure that is greater than 40% for first outpatient appointments. These are: ENT, joined Audiology & Audiological Medicine, Anaesthetics, Breast Surgery and Medical Oncology. We discuss these five

specialties, and the reasons why we do not believe the merger gives rise to an SLC in any of these specialties, in detail below.

177. More generally, however, a comparison of the updated analysis with the figures from Phase 1 shows that there has been a reduction in the Proportional Measure in the later time period (ie the two years to 31 March 2014) compared with the earlier period (ie the 3.5 years to 31 October 2012). We have looked at a number of specialties in more detail to understand the reasons for this.

178. Our analysis indicates that the decline in the Proportional Measure for RSC as a competitor to ASP is driven by two factors:

    - First, the increasing importance of several competitors in different specialties. In particular, St George's Healthcare NHS Trust has significantly increased its share of referrals in several specialties in the later period. (In some specialties, there is also a noticeable decline in West Middlesex as an alternative for patients.)

    - Second, the suppression of small numbers in the dataset in Phase 1 may have removed several small competitors from the dataset, and these competitors have now re-emerged in the revised dataset where this suppression is no longer necessary. (Alternatively, these small competitors have newly emerged in the later period.)

179. To illustrate these two points, Table 18 provides a more detailed comparison of the updated results in Endocrinology, Diabetic Medicine and Gastroenterology compared with the results in Phase 1.
    - St George's increasing importance as a competitor can be seen in all three specialties. This is also true, but to a lesser extent, for Kingston Hospital, UCLH and Guy's & St Thomas.
    - West Middlesex has declined significantly as a competitor over this period, which may in part explain its recent acquisition by Chelsea & Westminster.
    - Frimley Health's weakness as a competitor - according to these figures - is exaggerated by the lack of coding in these three specialties at Frimley Park Hospital (see Table 13 and 14).[25]

[25] The figures for Frimley Health in Table 18 include activity at Frimley Park Hospital NHS FT and Heatherwood & Wexham Park Hospitals NHS FT.

Overall, these results show a picture of dynamic competition in which different Trusts wax and wane in terms of their attractiveness as an alternative for patients/GPs.

Table 18: GP referral analysis: comparison of first outpatient appointment Proportional Measure results with Phase 1 in three specialties

	Endocrinology		Diabetic Medicine		Gastroenterology	
	Updated results	**Phase 1 result**	**Updated results**	**Phase 1 result**	**Updated results**	**Phase 1 result**
RSC	29%	40%	21%	43%	24%	33%
Frimley Health	5%	3%			4%	5%
West Middlesex	7%	19%	10%	29%	17%	33%
St George's	19%	4%	15%	0%	5%	0%
Imperial	11%	29%	4%	6%	4%	3%
Kingston	8%	4%	11%	10%	8%	6%
UCLH	4%	0%	2%	0%	6%	0%
Chelsea & Westminster	6%	0%				
Royal Free	2%	0%			3%	0%
Virgin Healthcare			17%	0%		
Guy's & St Thomas			2%	0%	5%	0%
BMI Healthcare					8%	9%
London North West					5%	10%

Note:
(1) Frimley Health combines Frimley Park Hospital NHS FT and Heatherwood & Wexham Park NHS FT. Frimley Park does not code activity in any of these three specialties.

5.5.1 Methodological issues with the GP referral analysis

180. There are several critical methodological issues with the GP referral analysis that must be taken into account when interpreting the results of this analysis.

- First, given the way patient choice operates, the GP referral analysis cannot generate meaningful results in relation to inpatients. We have set out in Section 5.1.1 the reasons for this. This analysis can only be applied to the initial first outpatient appointment, as it is only this point in the patient care pathway that reflects a choice of provider. Consistent with this, we have presented the results of this analysis in relation to first outpatient appointments.

- Second, the GP referral analysis only makes sense when it is applied to specialties where patient choice is exercised. Where patients have multiple

first outpatient appointments within a single care pathway, the GP referral analysis can only be meaningfully applied to the initial first outpatient appointment, which follows the patient's choice of provider. We discuss this further below in relation of Medical Oncology and Anaesthetics, where patients have more than one first outpatient appointment with a consultant within a single care pathway. We also cover this issue in relation to Audiology & Audiological Medicine where services at ASP and sub-contracted to RSC.

- Third, the GP referral analysis makes strong assumptions about the willingness of patients/GPs to switch to other providers. In particular, the analysis assumes that GP practices are only willing to switch patients to those providers to which they are already send patients in that specialty. However, this ignores the wider relationship that GP practices will have with those providers to which they do not currently send any patients in a particular specialty, but to which they refer patients in other specialties. We raised this point with the CMA in Phase 1, but received no response. However, there is no evidence that supports the validity of the restrictive assumption about switching behaviour that is embedded in the GP referral analysis. We encourage the CMA to seek further evidence on this point through the surveys it conducts during this inquiry.

- Fourth, the assumptions in the GP referral analysis about switching behaviour are based on behaviour at the GP practice level, rather than at the level of individual GPs. There is no evidence so far as we are aware that supports conclusions being drawn about individual GPs' willingness to switch patients to other providers according to the behaviour of other GPs in the same practice. Again, we would encourage the CMA to seek further evidence in support (or otherwise) of this assumption in the surveys it plans to conduct.

- Fifth, the value of the GP referral analysis in several individual specialties, such as Breast Surgery, is severely undermined by certain providers, particularly the former Frimley Park Hospital NHS FT, not coding any activity in these specialties despite providing services. We raised this point in Phase 1 and suggested a methodology for addressing this issue, which was rejected by the CMA as lacking robustness, but without any explanation as to why the CMA reached this conclusion. We believe that it is incumbent on the CMA to adequately investigate this issue in Phase 2, and to develop its own

estimates of the missing activity in relevant specialties if it cannot agree with what we believe to be the reasonable approach set out below in our discussion of Breast Surgery.

- Finally, the presence of clinical networks in certain specialties, such as ENT and Oral & Maxillo-Facial Surgery, where RSC is the regional provider of elective inpatient services, may be distorting patient preferences such that the assumptions embedded in the GP referral analysis about likely patient switching behaviour are not valid. The CMA accepted this possibility in Phase 1, but suggested that further evidence was required on this point. We discuss this further below in relation to ENT, and would suggest that this issue be further explored in the surveys that the CMA plans to carry out.

181. Following on from the discussion of the counterfactual in Section 4, any interpretation of the results of the GP referral analysis must also take into account that it is based on historical data. As we set out in the counterfactual, ASP and RSC can be expected to offer significantly poorer services under the counterfactual as a result of an inability to offer 7 day services and maintain adequate levels of nursing. There will also be much lower levels of expenditure on building backlog maintenance, IT and clinical equipment as well as various other capital programmes. This can be expected to result in ASP and RSC receiving a smaller share of patient referrals compared with the current situation, and as a result, offering a much weaker competitive constraint to each other and to other providers of routine elective care than is implied by the results of the GP referral analysis.

182. Finally, we understand that the CMA plans to collect SUS data from individual providers for the past 5 years and combine this data into a single dataset for the purposes of carrying out the GP referral analysis (as well as other analysis relevant to this merger). We are concerned that there may be an element of hubris to this approach. As we have set out in Section 5.3, there are more than 50 providers receiving referrals just from those GP practices in the 80% catchment area for the combined ASP/RSC. As a result, to compile a full dataset, SUS data would need to be obtained from each of these providers and probably others as well.

183. Moreover, as the CMA inquiry team knows, there already exists an organisation, the Health and Social Care Information Centre (HSCIC) that is responsible for collecting SUS data from NHS organisations and compiling the returns from each provider into a

single dataset, HES. In combining the returns from each provider, the HSCIC cleans the data and makes sure that there is consistency across organisations in terms of how information is recorded making any adjustments that are needed to ensure comparability. We find it difficult to believe that the CMA can undertake an equivalent data collection, collation and cleaning exercise, and produce a robust dataset for analysis, within the timeframe allowed for this merger review. This is particularly the case given the additional complications caused by information governance issues, and the need to coordinate across each data provider to consistently pseudo-anonymise their data if the CMA wants to be able track patients across different care providers.

184. [✂] if there is any additional analysis that the Inquiry Team wishes to carry out, we would welcome a discussion as to how we might assist. Alternatively, or in addition, we would encourage the CMA to have further discussions with HSCIC about obtaining its own HES extract for it to analyse for the purposes of this merger review.

5.5.2 Medical Oncology

185. Medical Oncology, otherwise known as chemotherapy, is provided to patients that have been diagnosed with cancer. The care pathway of a cancer patient at a provider of routine elective care services can be described as follows (see also Figure 6):

- The patient is referred to a provider by their GP. The initial outpatient appointment will be with a consultant in a specialty relevant to where the patient has symptoms that require investigation. For example, a patient with a lump in their breast will be referred to a consultant in Breast Surgery, or a patient with a skin lesion that is of concern will be referred to a consultant in Dermatology.

- At their first outpatient appointment, the consultant surgeon may order various tests or procedures (eg an MRI scan) to aid with the diagnosis of the patient's illness.

- Following the receipt of these test results, the consultant surgeon may diagnose cancer, and at this point, responsibility for the patient's treatment is held by a multi-disciplinary team (MDT) that includes consultant surgeons, both medical and clinical consultant oncologists, consultant pathologists, consultant radiologists (imaging) and cancer nurse specialists. (Treatment options are discussed and agreed which become the basis of care plans for

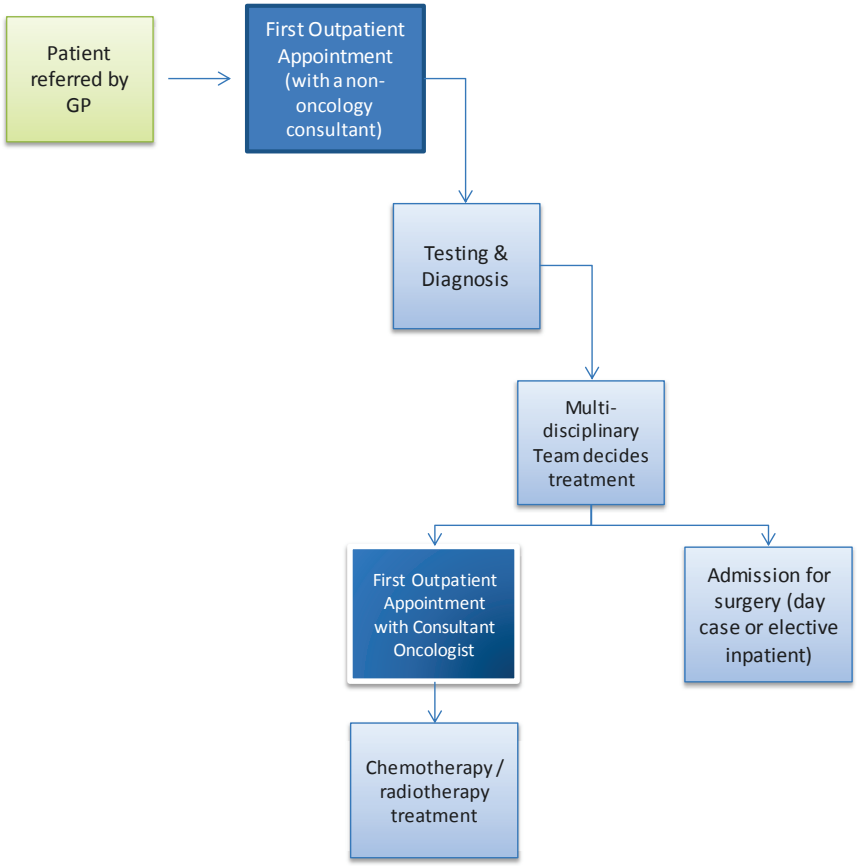
patients. Progress is monitored through the MDT. RSC employs all of the Medical Oncologists operating in the St Luke's Cancer Alliance and deploys these staff to partner Trusts sitting alongside partner Trust consultant surgeons, radiologists and pathologists.)

- The patient is likely to have a combination of surgery and radiotherapy and/or chemotherapy (ie Medical Oncology) to treat their cancer. Assuming the patient has chemotherapy, the patient will start this treatment with a first outpatient appointment with a consultant oncologist. The description of the initial meeting with the consultant oncologist as a 'first outpatient appointment' is for billing purposes for the Trust. The patient is not offered a choice of provider in relation to this service. Rather, the medical oncology service is an integrated part of the overall service that the patient is receiving following the initial referral to a surgical specialty. A course of chemotherapy is then pursued as part of the patient's treatment and offered as close to home as the patient wishes.

186. It follows from this that while it is possible to take the first outpatient appointment data for Medical Oncology from the HES and/or SUS datasets and apply the GP referral analysis methodology to this data, this does not mean that it will generate a result that has any meaning in relation to competition between different providers. For this reason, the GP referral analysis results in relation to Medical Oncology should have zero weight applied to it.

187. There are a number of further complexities associated with the provision of cancer services. This includes that cancer services are provided to patients through a cancer network (the St Luke's Cancer Alliance) that RSC leads as the Cancer Centre and in which ASP participates, and that Medical Oncology services at ASP are provided by RSC under an SLA, while RSC receives all the specialist income from NHS England for oncology. However, neither of these points are relevant given the overriding point that patients do not exercise choice of provider in relation to Medical Oncology.

Figure 6: Indicative care pathway for a cancer patient



188. We believe that this is a fundamental point, and were disappointed that the CMA did not grasp its significance at Phase 1. That said, there is a limited amount of documentary evidence in relation to this issue (although we did provide information on care pathways and clinical procedures for cancer patients at Phase 1). We would encourage the CMA to ensure that it fully understands this issue at Phase 2 by testing the information we have set out above with other NHS Acute Trusts and Cancer Centres.

5.5.3 Anaesthetics

189. The analysis of patient choice and competition between providers in relation to Anaesthetics raises similar issues to that of Medical Oncology. In this specialty, some patients require a pre-operative consultant with a consultant anaesthetist prior to surgery due to the special circumstances of the patient (eg a pre-existing heart condition that makes the operative procedure higher than usual risk).

190. The care pathway for these patients involves an initial first outpatient appointment with the consultant surgeon to which the patient has been referred. This could be in any

one of many specialties (other than Anaesthetics, to which a patient will never have an initial referral). The consultant surgeon, having decided that the patient requires surgery, may then refer the patient to the consultant anaesthetist for a pre-operative consultation to ensure that the patient is suitable for the general anaesthetic that will be required as part of their surgery. (Most patients have a nurse-led assessment, but higher risk patients will have an assessment with a consultant anaesthetist.) This is recorded in the SUS/HES data as a first outpatient appointment in Anaesthetics for billing purposes, but it is not the patient's initial first outpatient appointment following their choice of provider.

191. The fact that a first outpatient appointment has been recorded in Anaesthetics means that it is possible to apply the GP referral analysis to this data. This does not, however, mean that the results of the analysis that is applied to this data have any meaning whatsoever. The results of this analysis for Anaesthetics should have no weight attached to it by the CMA.

192. This is a similarly fundamental point to that in relation to Medical Oncology, the importance of which the CMA failed to grasp in its Phase 1 review. We encourage the CMA to test the information that we have provided in this section with other NHS Acute Trusts during this second phase review as we are confident it will correspond to the explanation we have offered.

5.5.4 Audiology & Audiological Medicine

193. The provision of audiology services at ASP has been sub-contracted to RSC. There is a formal SLA between ASP and RSC for the provision of these services, and RSC has clinical oversight of the service. This is very different to a situation in which the same consultants in a specialty might be working for both Trusts. As a result, patients when choosing their provider of audiology services are not choosing between ASP and RSC, there is only one provider of services in this specialty across the two Trusts.

194. At Phase 1, the CMA indicated that because ASP is contracted by commissioners for the provision of this service, and RSC is the subcontractor, there may continue to be an incentive for ASP to attract patients in this specialty.

195. Using the Proportional Methodology for first outpatient appointments, approximately 50% of patients attending ASP for a first outpatient appointment in Audiology/Audiological medicine are assumed to have RSC as their second

preference if ASP was no longer offering services in this specialty. This conclusion is based on the restrictive set of assumptions that are applied to patient/GP switching behaviour in this analysis (see the third and fourth bullet points in paragraph 180). We have some concerns that these results are also being skewed by the community-based nature of a lot of service provision in this specialty, which may not be being recorded consistently in the HES data.

196. In any event, we do not believe that the GP referral analysis, on its own, is sufficient for the CMA to conclude that an SLC in Audiology/Audiological Medicine is more likely than not. Audiology services are widely offered by other providers, including both Acute Trusts and private providers.

197. Further, an analysis of catchment area overlaps (using the CMA's preferred methodology) indicates that of those GP practices that account for 80% of Audiology/Audiological Medicine referrals to the merged Trust, there would only be one additional GP practice that is in three or fewer catchment areas for Audiology/Audiological Medicine services following the merger (based on data up to October 2012) – see Table 19. (Revised numbers based on the more recent GP referral dataset will be submitted shortly.)

Table 19: Catchment areas for GP practices that account for 80% of Audiology/Audiological Medicine referrals to the merged Trust

GP practices in catchment area for …	Pre-merger	Post-merger
5 or more Trusts	0	0
4 Trusts	1	0
3 Trusts	6	6
2 Trusts	43	21
1 Trust	74	97
Total	124	124

198. Finally, there is nothing in the internal documents of either Trust that indicates that Audiology/Audiological Medicine is somehow different to the other specialties in which ASP, RSC and other providers of routine elective care compete for patients.

199. In conclusion, while the Proportional Measure indicates a high rate of diversion for ENT patients from ASP to RSC, the direction of this possible competitive constraint is asymmetric. Further, for the reasons set out in paragraph 180, the results of the GP

referral analysis must be treated with caution. It embeds highly restrictive assumptions about patient switching for which there is no supporting evidence. Moreover, there is no other evidence in the internal documentation at either Trust or elsewhere to support an SLC finding in Audiology/Audiological Medicine.

5.5.5 Breast Surgery

200. Breast Surgery is one of several specialties where services are provided by Frimley Park, but activity is recorded in another specialty (in this case General Surgery). Other specialties where Frimley Park has not recorded activity include Anticoagulant Services, Colorectal Surgery, Diabetic Medicine, Gastroenterology and Upper Gastrointestinal Surgery.[26] This means that Frimley Park does not show up as a competitor in the GP referral analysis in these specialties, thus overstating the importance of all other competitors, including the importance of RSC relative to ASP.

201. Reviewing the number of first outpatient appointments in Breast Surgery at other NHS Acute Trusts in Tables 13 and 14 shows that most Trusts have around 4,000 to 6,000 first outpatient appointments per annum in this specialty. As a result, we have re-estimated the GP referral analysis results for Frimley Park assuming this range of first outpatient appointments in Breast Surgery, and a corresponding decrease in General Surgery referrals to Frimley Park.

202. The results of this re-estimation are that the Proportional Measure for RSC as a competitor to ASP drops from 57% to 34-39%, while the Proportional Measure for ASP as a competitor to RSC drops from 37% to 16-18%. On these revised figures, there is no basis for concluding that an SLC is likely to arise in Breast Surgery.

203. We investigated the impact on the Proportional Measure for General Surgery of reducing the number of General Surgery referrals to Frimley Park, and found that the Proportional Measure for RSC as a competitor to ASP in this specialty increased from 22% to 24-26%.

204. To carry out this analysis we allocated the assumed level of Breast Surgery referrals across those GP practices that made General Surgery referrals to Frimley Park Hospital NHS FT. This revised referrals data was then used to recalculate the Proportional Measures for Breast Surgery and General Surgery.

[26] Evidence of this lack of coding by Frimley Park can be seen in Table 13, which sets out the level of activity in each of the overlap specialties for ASP, RSC and other providers.

5.5.6 ENT

205. For ENT, using the Proportional Methodology for first outpatient appointments, approximately 50% of patients attending ASP for a first outpatient appointment are assumed to have RSC as their second preference if ASP was no longer offering services in this specialty. This conclusion is based on the restrictive set of assumptions that are applied to patient/GP switching behaviour in this analysis (see the third and fourth bullet points in paragraph 180).

206. We believe that the results of the GP referral analysis in ENT (and other specialties, such as Oral & Maxillo Facial Surgery) are likely to be distorted as a result of RSC being the regionally designated provider of elective inpatient services in this specialty.

207. While ASP and other Trusts offer outpatient and day case treatments in ENT, only RSC provides elective inpatient services. This is likely to mean that those patients that believe they are more likely to require an elective inpatient admission (regardless of whether such an admission eventuates in practice) are more likely to choose RSC as their provider.

208. This has the effect of inflating RSC's overall share of patient referrals, and because of the way the GP referral analysis works, this means that it a greater proportion of patients that are referred to ASP are assumed to have RSC as their preferred alternative provider. However, those patients that have chosen ASP in the first place may have quite a different second preference, which is a function of these patients believing that they are less likely to require the elective inpatient services that RSC offers. We believe that the patient survey should be able to usefully gather further evidence on this issue and its significance.

209. In any event, we do not believe that the GP referral analysis, on its own, is sufficient for the CMA to conclude that an SLC in ENT is more likely than not. We would note that ENT services are widely offered by other providers, including both Acute Trusts and private providers (see Table 13). As a result, there is no difference in market structure that indicates that an SLC is more likely in ENT than in other specialties.

210. Further, an analysis of catchment area overlaps (using the CMA's preferred methodology) indicates that of those GP practices that account for 80% of ENT referrals to the merged Trust, there would no increase in the number of GP practices that is in three or fewer catchment areas for ENT services following the merger (based

on data up to October 2012) – see Table 20. (Revised numbers based on the more recent GP referral dataset will be submitted shortly.)

Table 20: Catchment areas for GP practices that account for 80% of ENT referrals to the merged Trust

GP practices in catchment area for …	Pre-merger	Post-merger
5 or more Trusts	2	0
4 Trusts	0	2
3 Trusts	21	13
2 Trusts	36	27
1 Trust	32	49
Total	91	91

211. Moreover, there is nothing in the internal documents of either Trust that indicates that ENT is somehow different to the other specialties in which ASP, RSC and other providers of routine elective care compete for patients.

212. In conclusion, while the Proportional Measure indicates a high rate of diversion for ENT patients from ASP to RSC, the direction of this possible competitive constraint is asymmetric. Further, for the reasons set out in paragraph 180, the results of the GP referral analysis must be treated with caution. It embeds highly restrictive assumptions about patient switching for which there is no supporting evidence. Moreover, there is no other evidence in the internal documentation at either Trust or elsewhere to support an SLC finding in ENT.

5.5.7 Conclusions on GP referral analysis

213. In conclusion, the updated GP referral analysis using more recent data compared with Phase 1 shows potential competition concerns in only a few specialties (Medical Oncology, Anaesthetics, Audiology & Audiological Medicine, Breast Surgery and ENT).

214. In two of these five specialties, the application of the GP referral analysis is meaningless. In Medical Oncology and Anaesthetics, patients do not exercise choice of provider. Rather these are ancillary clinical services that are provided to patients that require them once the patient has been referred to a provider within another specialty.

215. In a further specialty, Breast Surgery, the results of the GP referral analysis is fundamentally flawed by the fact that Frimley Park does not code any activity in this specialty, but rather records all Breast Surgery activity under General Surgery. Applying very reasonable assumptions about the level of Breast Surgery activity at Frimley Park, we find that the Proportional Measure in this specialty is likely to be around 34% to 39% (ie below the 40% threshold used by the CMA in Phase 1 to assess whether there is a realistic prospect of an SLC in a specialty).

216. Finally, in ENT and Audiology/Audiological Medicine, while the Proportional Measure indicates a high rate of diversion for patients from ASP to RSC, the results of the GP referral analysis must be treated with caution. It embeds highly restrictive assumptions about patient switching for which there is no supporting evidence. An analysis of catchment area overlaps shows that GP practices would retain extensive choice of provider following the merger. Moreover, there is no other evidence in the internal documentation at either Trust or elsewhere to support an SLC finding in ENT or Audiology/Audiological Medicine.

5.6 Entry and expansion

217. The evidence from recent entry and expansion in routine elective care services demonstrates that barriers to entry and expansion in these services are low.

218. The proposed merger will have no impact on the size of these already low barriers to entry/expansion. An existing provider of routine elective care services need only have a contract with a commissioner to be able to compete for GP referrals. This is because all patients have the right to choose to be referred to any contracted provider of routine elective services to NHS patients (see Section 5.1.1).

219. Further, it is relatively easy to establish outpatient clinics in new locations. All that is needed is for the consultants to have access to suitable premises in which to meet with patients. This can include community hospitals, private hospitals and GP practices. As discussed in Section 5.1.3, opening outpatient clinics in more convenient locations is an important means of attracting patients.

220. It is less easy for a provider of routine elective care services to start offering inpatient services at a new location. This is because of the investment in facilities and equipment that is required. Moreover, services that require an overnight stay will involve higher start-up costs compared with day case services, given the need for

extra facilities and staffing for these services. But, as discussed in Section 5.1.1, all patients start their interaction with a provider through a first outpatient appointment, and this means all providers are able to compete for these referrals (as all providers offer outpatient services), and then refer onwards any patients that require more complex treatment than they are able to offer. Moreover, in some specialties, only outpatient services are required. This means that barriers to entry or expansion are low in the part of the care pathway that is critical to capturing patient referrals.

221. The evidence in this case is that entry/expansion is common (with a balancing amount of exit/contraction). That is, the overall market in routine elective care services appears quite dynamic. The experience of PIMS/EDICS (see Section 5.1.3) shows that entry does not have to be large scale to impact on established providers. Moreover, it also shows that entry can be focused simply on outpatient services. The experience of St George's Healthcare, and other providers that have significantly expanded their share of referrals in recent years (see paragraph 179), also supports the view that barriers to entry/expansion are limited.

222. Another way in which entry/expansion can occur in routine elective care is where commissioners sponsor entry through reconfiguring the patient pathway and then holding a tender for the newly redesigned service. For example, in dermatology, Guildford & Waverly CCG wanted to expand capacity and address quality and waiting time issues so established a new community based service that all patients are now referred to before accessing services at acute care providers. A tender was held and a private firm, Sussex Community Dermatology Service (using the brand Surrey Dermatology Service) were appointed. This new service includes outpatient services in this specialty that were previously provided by RSC. We discuss this example further below in relation to countervailing buyer power.

223. In conclusion, the evidence of entry, expansion, contraction and exit in routine elective care services in Surrey and the surrounding area shows a picture of dynamism, with new entrants offering services and existing providers gaining (and losing) patient referrals from local GP practices. It is clear that other providers would rapidly be able to take advantage of any deterioration in services at a merged ASP/RSC to start offering additional services to local patients through new outpatient clinics in the area.

5.7 Countervailing buyer power

224. In assessing the merger's effect on competition, ASP and RSC believe that the countervailing buyer power of CCGs needs to be taken into account. The rights of patient choice in routine elective care mean that it is not easy for commissioners to simply switch the provision of an entire routine elective care service, including outpatient and inpatient services, away from a provider where that provider is the local Acute Trust that may well be providing a significant volume of inpatient services.

225. Nevertheless, it is possible for a CCG that is unhappy with the quality of service that is being provided by a local Acute Trust to shift at least some part of a service and/or impose costs on that Trust as a means of incentivising it to provider higher quality services.

226. For example, a CCG can reconfigure part of the care pathway for a particular specialty and then hold a tender for the 'new' service, which may also incorporate significant elements of the previous routine elective care service. Examples of this type of reconfiguration are where a CCG decides to put in place a community-based service that takes referrals from GPs, and which may offer community-based health interventions as well as the equivalent of the outpatient service that was previously offered by an Acute Trust. Musculoskeletal programmes are a typical example of this type of shift, and in Surrey, the new community-based dermatology service is a further example.

227. In ASP's and RSC's experience, such actions by a commissioner might usually be expected in a service where the commissioner believes that the incumbent Acute Trust is underperforming on efficiency, and perhaps less commonly, on service quality. However, in principle, a commissioner could also take action in another service if the it wishes to impose costs on the Trust as a means of incentivising performance improvement.

228. Commissioners will generally seek to re-commission elements of routine elective care driven by:

- opportunity, particularly if there are available intermediate GP-led type providers or others in or around the market place;
- services where there are established models of care for intermediate outpatient or out of hospital provision, such as dermatology, sexual health,

ophthalmology, gynaecology and MSK. These are services where there is already quite a lot of this type of service provision nationally, and as a result, the service redesign effort by commissioners is minimised and there is likely to be a ready supply of alternative service suppliers; and

- a need to do so, such as an identified opportunity in a specialty to reduce the costs to commissioner or, perhaps less commonly, to improve the quality of the service perhaps by reducing the level of ultimate interventions or surgery requirements.

229. Often commissioners want to transfer control of gateway referrals and assessment away from the acute provider as they believe the incumbent will not challenge itself over the number of admissions for treatment (as inpatients). By introducing a third party, commissioners may often believe that they can reduce inpatient admission rates and reduce expenditure on more complex health interventions. The mere process of developing a new pathway of care and threatening to tender this will often result in a shift in behaviour at an Acute Trust. RSC radically redesigned the MSK pathway in 2014 specifically because the CCG threatened to shift work to another provider or go out to tender. Guildford & Waverly CCG had further similar meetings and discussions with RSC about cardiology service and ophthalmology service in 2014.

230. Another example of commissioners in Surrey exercising countervailing buyer power is in relation to dermatology services at RSC. In this particular case, Guildford & Waverly CCG were unhappy with the quality and waiting times of RSC's dermatology service. As a result, the CCG established a community based service, and appointed the newly established, privately-run Surrey Dermatology Service to supply this service. This had the effect of taking away most dermatology volumes from RSC, and limiting activity to RSC to those situations in which acute care is definitively required, such as where the dermatologist suspects cancer.

231. Following the merger, commissioners of services at the merged ASP/RSC would continue to be able to take similar actions to address any performance issues at the combined Trust. That is, the merger would not have any impact on the presence of this countervailing buyer power.

232. The presence of countervailing buyer power provides a further reason why the merger cannot be expected to result in an SLC. The merged Trust would face the threat of

services being redesigned and effectively taken away by their commissioners if the quality of service provision was to deteriorate.