CMA
Competition & Markets Authority

Ashford and St Peter's and Royal Surrey County

A report on the anticipated merger of Ashford and St Peter's Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust

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Summary

1. The Competition and Markets Authority (CMA) has cleared the proposed merger between Ashford and St Peter's Hospitals NHS Foundation Trust (ASP) and Royal Surrey County Hospital NHS Foundation Trust (RSC) (together 'the Parties'). These hospitals provide clinical services from their sites in Ashford, Chertsey and Guildford.

2. On 26 February 2015, the CMA started an in-depth inquiry after an initial phase 1 review of the merger found that it may lead to a reduction of competition across a range of National Health Service (NHS) and private medical services in Surrey.

3. Competition in the NHS is one of a number of important drivers of the quality of services for patients, supplementing the role played by regulation, various regulatory bodies and commissioners as well as the professionalism of NHS staff. Patients have the right to choose which hospital to attend for a first consultant-led outpatient appointment. Patient choice creates an incentive for NHS service providers to improve the quality of their services in order to attract patients and funding.

4. Specifically, the aspects of quality which may be affected by a reduction in incentives to compete include clinical factors such as infection rates, mortality rates, ratio of nurses or doctors to patients, equipment and best practice and non-clinical factors such as waiting times, patient experience, cleanliness and parking facilities.

5. The CMA recognises the benefits that the exercise of patient choice and competition can deliver, as well as the potential benefits a merger can bring. The CMA investigated the potential impact of the proposed merger on the services provided by both ASP and RSC and whether it may be expected to result in a substantial lessening of competition. The purpose of this assessment is to ensure that, from a competition perspective, the merger would not be expected to lead to a reduction in quality of services for patients and/or commissioners in the local area.

6. The CMA's independent inquiry group examined evidence from ASP and RSC about the provision of healthcare services in their area, as well as evidence from a number of third parties including patients and GPs in the area, Monitor, NHS England, local Clinical Commissioning Groups and neighbouring hospitals.

7. The inquiry group concluded that the merger may not be expected to result in a substantial lessening of competition.

8. We are required to publish our final report by 7 October 2015, following an extension to the original deadline of 12 August 2015.

9. This is a summary of our detailed findings.

Background

10. The first part of our report sets out the analytical framework we use to assess how the merger might affect patients and the quality of NHS services in the local area. We looked at the wider industry background, the Parties' reasons for wanting to merge, how we should define the markets in which the Parties are active and how competition works in the NHS. We also satisfied ourselves that the proposed merger between the Parties will, if carried into effect, result in the creation of a relevant merger situation, thus giving us jurisdiction to consider the impact of the merger in the provision of healthcare in the local area.

The National Health Service

11. In our review we first considered the wider NHS context in which the Parties operate. In the report we set out the relevant regulations which determine the minimum quality levels required of NHS hospitals and the bodies involved in enforcing these standards, such as the Department of Health, Monitor and the Care Quality Commission (CQC).

12. We also looked at how hospitals are paid for the services they provide. NHS services are publicly funded and commissioned by local commissioning groups and NHS England. Monitor also plays a role in the setting of the tariffs for the services provided by NHS hospitals. We considered the specific contractual arrangements between each of the Parties and their main commissioners and how these arrangements might affect the Parties' incentives to attract additional patients.

Rationale for the merger

13. We looked at the Parties' reasons for wanting to merge and considered what would happen if the merger were not to go ahead. The Parties considered a merger to be the most effective way to ensure that they would be in the best position to continue to deliver high quality services to their patients. This initiative was prompted by the Parties' assessment of the financial and capacity related challenges faced by them and by the NHS in general. The Parties were concerned that, if the merger were not to go ahead, they would find it difficult to maintain current quality levels over time. We are not aware of any plans to consolidate services; any such steps would be likely to require public consultation and commissioner agreement.

Market definition

14. As part of our assessment of the merger, we identified the product and geographic markets in which the Parties are active. In keeping with our previous decisions in relation to NHS mergers, we found that each specialty, such as Breast Surgery, constitutes a separate product market and, in each specialty, outpatient, day-case and inpatient activity constitute distinct product markets. Community and hospital based care, non-elective care, and private and NHS-funded services were also considered separately. We found that the geographic market was local given the preference of patients to attend hospitals close by.

Nature of competition in the NHS

15. We note that competition among NHS providers of elective services is almost always in relation to quality, rather than price.

16. The quality of hospital services is the outcome of many different decisions taken by hospital clinicians and managers. In making such decisions, they trade off different factors, notably the benefit of deploying additional resources against the cost of doing so.

17. To the extent that there is a fixed price for each elective procedure, hospitals increase their revenues by treating more patients, so providers have an incentive to compete on quality in order to attract patient referrals and hence income. Research has broadly shown that, in the NHS, under the current system of largely fixed prices, greater competition is associated with higher levels of quality. The effect of competition is, in principle, that decisions affecting quality reflect factors that matter to patients and general practitioners (GPs). We have, however, also taken into account that competition among providers is just one of the factors driving quality and that normal incentives to compete that one sees in the commercial sector are diluted to some extent in the context of the NHS.

The specific services reviewed

18. The above factors provided the context for our assessment of how the merger might affect patient choice and the quality of services in the areas where the Parties are both active. These are:

    (a) acute elective services;

    (b) non-elective emergency services;

    (c) private patient services;

(d) specialised services; and

(e) community services.

19. To carry out our analysis, we assessed evidence provided by the Parties and a number of third parties including patients and GPs in the local area, Monitor, neighbouring hospitals and clinical commissioning groups (CCGs). We also considered two types of patient information. First, we carried out a local patient survey. Second, we looked at data about which hospitals patients in the local area chose to attend. This information helped us to understand whether and why patients might have preferences for specific hospitals in the local area. The survey confirmed that the quality of services and the proximity of the hospital are among the most important factors that patients (and their GPs) take into account when choosing which hospital to attend.

Elective services

20. We considered the effect of the merger on the elective specialties provided by both Parties. Our analysis identified four specific types of treatment – General Surgery, Breast Surgery, Maxillo-Facial Surgery, and ear, nose and throat (ENT) treatments – which required more detailed review. This was because our research showed that in relation to these specialties GP practices referring patients to one of the Parties, also refer a significant number of patients to the other party.

21. We also looked at a number of factors that might currently affect the degree of competition between the Parties. These factors include the high degree of regulation, the relatively limited degree to which the Parties make a profit on the elective services they provide and the pressures each of the Parties is experiencing in terms of capacity. We consider that these factors might reduce competition to some extent.

22. In addition, our investigation of each of these services showed that there are a number of other hospitals in the local area, apart from the merging Parties. This means that patients and GPs would be able to choose another hospital, if the quality of the services provided by the merged entity were to decline. Moreover, in respect of both ENT and Maxillo-Facial, the Parties currently work very closely together and operate with a high degree of clinical integration such that there is already limited competition between them. We have therefore concluded that the merger may not be expected to result in a substantial lessening of competition in respect of elective services.

Emergency services (non-elective care)

23. Patients who need emergency services often cannot choose which hospital they attend. This is because there are protocols that determine the hospital to which an ambulance should take a patient in need of emergency care and a large proportion of emergency patients are taken to hospital by ambulance. We also found that emergency services are generally not profitable which further reduces any incentive to compete for emergency patients. We also took into account the NHS policy to reduce attendances at accident and emergency (A&E) departments. On this basis, we have concluded that the merger may not be expected to result in a substantial lessening of competition in respect of emergency services.

Private patients

24. Both Parties provide services to private patients to a very limited extent. Because of the limited scope of the Parties' activities, the limited overlap between them, the number of other private patient healthcare providers nearby, and the potential for the Parties to compete with private providers for more private work in the future, we have concluded that the merger may not be expected to result in a substantial lessening of competition in respect of private patients.

Specialised services

25. Specialised services are treatments for rare and often more complex conditions that are commissioned at a national level by NHS England. Both Parties provide specialised services but in different specialties. Because of the limited nature of the overlap between the Parties in the provision of these services, we have concluded that the merger may not be expected to result in a substantial lessening of competition in respect of specialised services.

Community health services

26. Community health services are services provided by hospitals in residential and community settings, such as at home or in health centres, schools and small local hospitals. These services are often commissioned by way of a tender.

27. For both Parties, community health services account for a small proportion of their overall turnover. We also found that the Parties do not currently overlap in the provision of community health services and that even if the merger were to proceed there would be a number of alternative credible bidders for future community health service contracts. For these reasons we have concluded that

the merger may not be expected to result in a substantial lessening of competition in respect of community health services.

Conclusions

28. For the reasons given above, we conclude that the proposed merger between ASP and RSC may not be expected to result in a substantial lessening of competition in any market for the provision of healthcare in the local area.

Findings

1. The reference

1.1 On 26 February 2015, the CMA, in exercise of its duty under section 33(1) of the Act, referred the anticipated merger between ASP and RSC (together 'the Parties') for further investigation and report by a group of CMA panel members (inquiry group).

1.2 The CMA must decide:

(a) whether arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation; and

(b) if so, whether the creation of that situation may be expected to result in an substantial lessening of competition (SLC) within any market or markets in the UK for goods or services.

1.3 Our terms of reference are set out in Appendix A together with information on the conduct of the inquiry. We are required to publish our final report by 7 October 2015, following an extension to the original deadline, which was 12 August 2015.

1.4 This document, together with its appendices, constitutes our findings, published and notified to the Parties in line with the CMA's rules of procedure.[1] Further information relevant to this inquiry, including a non-confidential version of the submission received from the Parties, as well as summaries of evidence received in oral hearings, can be found on our webpages.

2. Industry background and the Parties

2.1 This section provides an overview of the Parties and the law, policy and competition relating to the commissioning and provision of NHS services.

2.2 The first part of this section, paragraphs 2.7 and 2.8, sets out a brief overview of the Parties.

2.3 The second part of this section, paragraphs 2.9 to 2.18, sets out the rules, regulations and the role of competition in the provision of NHS services as well as the role of the CMA and Monitor in NHS mergers.

2.4 The third part of this section, paragraphs 2.19 to 2.73, reviews the environment in which foundation trusts operate and describes the commissioning and

[1] *Rules of procedure for merger, market and special reference groups (CMA17)*, Rule 11.

funding of NHS services. It also sets out the financial pressures that affect the NHS, which are relevant to our consideration of the merger.

2.5 The fourth part of this section, paragraphs 2.74 to 2.104, reviews the role of patient choice, quality measures and how competition is more constrained in relation to healthcare services provided in the NHS than in conventional markets.

2.6 The latter part of this section, paragraphs 2.105 to 2.124, describes the Parties and their arrangements with their respective host commissioners.

Overview of the Parties

2.7 The Parties are medium-sized, Surrey-based NHS foundation trusts with a strong record of clinical and financial performance. The Parties operate district general hospitals (DGHs) located in Chertsey, Ashford and Guildford.

2.8 The Parties supply services typical of a DGH, including A&E, maternity and routine elective care services, whilst also providing a number of specialist services (primarily cardiology-related services at ASP and cancer-related services at RSC). Both Parties also supply community and private patient services to a very limited extent. In the financial year ended 31 March 2015, ASP had revenues of £260 million and RSC had revenues of £307 million.

Rules and regulations

2.9 Between 2009 and 2012, the NHS was subject to an explicit set of 'Principles and Rules for Cooperation and Competition' (the Principles and Rules) issued by the Department of Health, which provided guidance for system managers, commissioners and providers on the expected behaviours and rules governing cooperation and competition in the NHS.

2.10 From 1 April 2013, the Principles and Rules were replaced by the NHS provider licence and the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (the NHS Procurement Regulations) as discussed further in Appendix B, Annex 2.

Role of the CMA and Monitor in NHS mergers

2.11 Monitor is the sectoral regulator for the NHS[2] and also regulates NHS foundation trusts.[3] Monitor's main duty is to protect and promote the interests of people who use the NHS by promoting the provision of healthcare services. It must carry out that duty by having regard to likely future demand for NHS services.[4]

2.12 Monitor must exercise its functions with a view to preventing anti-competitive behaviour in the provision of NHS services which is against the interests of people who use such services.[5] The Health and Social Care Act 2012 (HSCA 2012) confirmed that the UK merger control regime applies to NHS foundation trusts and assigned to Monitor a role advising the CMA on relevant customer (patient) benefits.

2.13 The HSCA 2012 expressly gives the CMA exclusive jurisdiction over mergers between NHS foundation trusts. The role of the CMA in this context is to examine the impact that a merger between two such trusts could have on competition, and the consequences this may have for the quality of healthcare services provided.

2.14 The functions of the CMA and Monitor in respect of mergers involving foundation trusts are set out in more detail in Appendix B, Annex 3.

Competition in the provision of NHS services

2.15 Since the early 1990s, steps have been taken to facilitate competition in the NHS, including:

(a) splitting the responsibility for providing healthcare from the responsibility for purchasing it;

(b) allowing some NHS care to be provided by the independent sector;

(c) establishing the Any Qualified Provider (AQP) principle, under which qualified providers have contracts with NHS commissioners giving them the right to provide certain NHS services;

(d) introducing Payment by Results (PbR), the payment of fixed national tariff prices for treatments provided;

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[2] Monitor's duties are found at Chapter 1 of Part 3 of HSCA 2012.
[3] Section 2 of the 2003 Act.
[4] HSCA 2012, section 62(2).
[5] HSCA 2012, sections 62(1) and (3).

(e) introducing patient choice, which was enshrined in the NHS Constitution;

(f) establishing NHS foundation trusts as bespoke legal entities that are required to provide certain NHS services but also have a degree of operational autonomy; and

(g) developing new Standard Contract terms combining the accountability and incentives of PbR with the cost control and discipline of semi-fixed budgets.

2.16 There are two different models of competition in the provision of NHS services:

(a) competition in the market (ie competition for patient referrals), which occurs where patients have a choice among providers of the same services; and

(b) competition for the market, which occurs where the commissioning entity enters into contracts with providers under which the providers have the right to provide services to patients.

2.17 Competition for the market may occur in relation to community services and some non-elective services, but it is less likely to occur in relation to elective services that are subject to a national tariff. Competition for the market may also occur in relation to specialised services when they are competitively tendered by NHS England at a regional or national level. There are some services where both competition for the market and competition in the market are present.

2.18 A detailed description of the main categories of NHS services relevant to our consideration of the Parties and the merger is set out in Appendix B, Annex 1.

Foundation trusts

2.19 NHS trusts are bodies established by order of the Secretary of State for Health (Secretary of State) to provide goods and services for the purposes of the health service.[6] Under the NHS Act 2006, NHS trusts and other entities incorporated as public benefit corporations are able to apply to Monitor to become NHS foundation trusts.

2.20 Monitor authorises NHS trusts to become foundation trusts if it is satisfied in relation to a range of matters. In taking its decision as to whether or not to allow a trust to become a foundation trust, Monitor is also required to consider the financial position of the applicant.[7]

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[6] The National Health Service Act 2006 (the NHS Act 2006), section 25.
[7] The NHS Act 2006, section 35(3).

2.21 NHS foundation trusts are bespoke legal entities that provide NHS services but which have some operational autonomy, including the ability to sign contracts, employ staff, generate, retain and reinvest surpluses and to engage in significant levels of private patient work.

2.22 NHS foundation trusts are public benefit corporations that are authorised to provide goods and services for the purposes of the health service in England. Public benefit corporations are bespoke legal entities originally created by the Health and Social Care (Community Health and Standards) Act 2003[8] (the 2003 Act) and now governed by the NHS Act 2006, as amended by the HSCA 2012.[9] Further information on the governance of foundation trusts is set out in Appendix B, Annex 4.

2.23 Foundation trusts may provide goods and services for any purposes related to the supply of health services provided to individuals or in connection with the prevention, diagnosis or treatment of illness and the promotion and protection of public health. Foundation trusts may also carry on other activities for the purpose of generating additional income. However, the HSCA 2012 obliges foundation trusts to ensure that the income they receive from providing goods and services for the NHS is greater than the income they receive from other sources.

2.24 HSCA 2012 also obliges foundation trusts to publish information on their non-NHS work and to explain its impact on the delivery of goods and services for the NHS. In addition, any foundation trust that wishes to increase the share of its income from non-NHS sources (including private work) by more than five percentage points in any one year must obtain prior approval from its governors. Further detail on the funding arrangements for foundation trusts is set out in Appendix B, Annex 4.

Role of Monitor in relation to foundation trusts

2.25 Monitor supervises the governance and financial performance of foundation trusts.[10] If a foundation trust is found to be failing clinically or financially, Monitor has the power to appoint a trust special administrator (TSA).[11]

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[8] The 2003 Act, section 1(1) (repealed by the National Health Service (Consequential Provisions) Act 2006, section 6, Schedule 4).
[9] The NHS Act 2006, Chapter 5.
[10] Section 2 of the 2003 Act.
[11] The trust special administration provisions are set out in sections 65A–65O of the NHS Act 2006, as inserted by section 174 HSCA 2012 and amended by the Care Act 2014.

2.26 A TSA will be appointed if Monitor, or the CQC in respect of clinical issues, considers that a foundation trust is unlikely to be able to function as a going concern. TSAs are required to make recommendations to Monitor to resolve a situation of clinical or financial failure. The proposed solution is likely in most cases to involve merging all or part of the business of the failing trust with another foundation trust or NHS trust.[12]

2.27 Further detail on special measures applying to foundation trusts that are failing, clinically or financially, is set out in Appendix B, Annex 5.

Commissioning

2.28 Different NHS services are commissioned by different entities. The following sections describe how services are currently commissioned, following changes made pursuant to HSCA 2012.

NHS England

2.29 The NHS Commissioning Board (under the operational name of NHS England) is responsible for overseeing CCGs and for commissioning specialised services in respect of which a national strategic approach is required. It also directly commissions primary care services, out-of-hours services and other services provided through the GP contract, pharmaceutical services, primary ophthalmic services, dental services (primary, community and hospital), health services for people in prison and in the armed forces and various public health services such as immunisation and national screening programmes.

2.30 NHS England was established by the HSCA 2012[13] and became fully operational on 1 April 2013. It has a concurrent duty with the Secretary of State to promote a comprehensive health service. Ultimately, however, the Secretary of State is responsible to Parliament for the provision of the health service in England.

2.31 NHS England has a statutory duty to exercise its functions with a view to securing continuous improvement in the quality of services.[14] Continuous improvement in quality refers to either the prevention, diagnosis or treatment of illness or the protection or improvement of public health.[15] This statutory duty is

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[12] The Secretary of State has similar powers to appoint TSAs in relation to failing NHS trusts. The first such case was South London Healthcare NHS Trust. Subsequent to the TSA's report, the Secretary of State ordered its dissolution by October 2013.
[13] Section 1H(1) of the NHS Act 2006 (following amendment pursuant to section 9 of HSCA 2012).
[14] The NHS Act 2006 was amended by section 23(1) of the Health and Social Care Act 2012 to include this duty. The relevant provision (section 31A of HSCA 2012) came into force on 1 April 2013.
[15] NHS Act 2006, section 13E(1).

to be exercised in conjunction with statutory duties to promote autonomy, choice, reduction of inequality, effectiveness and efficiency, and various other duties.[16]

2.32 In seeking to secure the provision of higher quality services, NHS England is statutorily obliged to have reference to guidelines laid down by the National Institute for Health and Clinical Excellence (NICE).[17] NHS England works closely with NICE in order to establish a Commissioning Outcomes Framework that provides transparency and accountability in relation to the quality of services commissioned by CCGs and their contribution to improving performance in relation to the NHS Outcomes Framework.[18]

Role of NHS England in commissioning specialised services

2.33 NHS England directly commissions specialised services provided in a hospital setting and community services that are specified in Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

2.34 When commissioning specialised services, NHS England is guided by Clinical Reference Groups (CRGs). These are service-specific teams of professionals and patients who produce national specifications and policies in respect of different clinical areas, including, for example, guidance on the minimum number of procedures that have to be provided by a hospital to safeguard quality.

2.35 NHS England has regional teams responsible for commissioning specialised and primary healthcare services.

Role of NHS England in relation to Clinical Commissioning Groups

2.36 NHS England is responsible for ensuring that each provider of primary healthcare services is a member of a CCG and that the constitutions of CCGs cover the whole of England and do not overlap.[19]

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[16] NHS Act 2006, section13A–13Z4.
[17] The duty to have reference to NICE guidelines is a reference to NICE's power to issue guidelines under section 234 of the HSCA 2012, which came into force on 1 April 2013.
[18] The NHS Outcomes Framework provides a national overview of how well the NHS is performing, is the primary accountability mechanism between the Secretary of State for Health and NHS England and drives up quality throughout the NHS by encouraging a change in culture and behaviour focused on health outcomes not process, Source: Department of Health (November 2013), *The NHS Outcomes Framework 2014/15*.
[19] Section 14A(1) and 14A(2) of the NHS Act 2006 (as amended by section 25 of HSCA 2012).

Clinical Commissioning Groups

2.37 CCGs were created by the HSCA 2012.[20] There are 211 CCGs in England and all GP practices in England are represented in a CCG. CCGs became fully operational on 1 April 2013. NHS England monitors their financial performance and compliance with statutory obligations.

2.38 CCGs are responsible for commissioning urgent and emergency care, some out-of-hours primary medical services, elective hospital care, community health services, rehabilitation services, maternity and newborn services (excluding neonatal intensive care), learning disability services, mental health services and infertility services. NHS England is also working with CCGs to explore how to co-commission primary care services, and some CCGs started co-commissioning primary care services with effect from April 2015. Co-commissioning can involve greater input from CCGs in primary care decision-making, joint commissioning with NHS England or commissioning being delegated completely to a CCG.

2.39 North West Surrey CCG (NWSCCG) is the host commissioner for ASP and Guildford & Waverley CCG (GWCCG) is the host commissioner for RSC. Working with the respective trusts, both CCGs have recently developed commissioning intentions for 2015/16 based on the enhanced tariff option (ETO).[21] Further detail on the Parties and their arrangements with their respective host commissioners is given in paragraphs 2.105 to 2.124 below.

2.40 CCGs have statutory obligations towards NHS England, including improving the quality of services and complying with certain financial and auditing obligations.[22]

Role of Monitor in relation to commissioning

2.41 Monitor has powers to investigate complaints, but not to carry out investigations on its own initiative, about commissioners' compliance with their obligations in respect of patient choice and procurement.[23] Monitor also has the power to require explanations and information.[24]

2.42 Where there is a serious breach, Monitor is able to declare an NHS healthcare service arrangement to be ineffective, although this does not affect rights

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[20] HSCA 2012, section 10.
[21] Monitor and NHS England: Tariff arrangements for your 2015/16 NHS activity. The ETO is explained in paragraphs 2.69–2.72 below.
[22] Sections 14R, 223H-J and others of the NHS Act 2006.
[23] Monitor cannot investigate a complaint where the person making the complaint has brought a legal action under the Public Contracts Regulations 2006 or Public Contracts Regulations 2015 in relation to the same matter.
[24] The NHS Procurement Regulations, Regulation 13.

already acquired under the arrangement concerned. Monitor also has the power to give various types of directions to commissioners, for example to prevent failures to comply, to put in place measures to mitigate the effect of such failures, and to vary or withdraw arrangements and tender procedures. Monitor is not permitted to direct a commissioner to hold a competitive tender. Instead of giving directions, Monitor may accept undertakings from the relevant party.[25]

NHS funding

Five Year Forward View

2.43 Over the past five years, NHS spending has been protected, which has helped to sustain services. However, according to the *Five Year Forward View,*[26] funding pressures are increasing. In terms of future funding scenarios, flat real terms NHS spending overall would represent a continuation of current budget protection. Flat real terms NHS spending per person would take account of population growth. Flat NHS spending as a share of GDP would differ from the long-term trend in which health spending in industrialised countries has tended to increase as a share of national income (according to the aforementioned report).[27]

2.44 It has been calculated by Monitor, separately by NHS England, and also by independent analysts, that a combination of growing demand, no further annual efficiencies and flat real terms funding could, by 2020/21, result in a gap of nearly £30 billion between resources and the cost of meeting patients' needs.[28]

2.45 NHS England, in its *Five Year Forward View* plan, identified a number of ways to address this estimated budgetary gap. Depending on the combined efficiency and funding option pursued, NHS England's plan would be to close the £30 billion gap by one-third, one-half or in total.

(a) In scenario one, the NHS budget remains flat in real terms from 2015/16 to 2020/21 and the NHS delivers its long-run productivity gains of 0.8% a year. The combined effect is that the £30 billion gap in 2020/21 is cut by about a third, to £21 billion.

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[25] The NHS Procurement Regulations, Regulation 14 (Declaration of ineffectiveness) and Regulation 15 (Power to give Directions), Regulation 16 (Undertakings).
[26] NHS England (October 2014), *Five Year Forward View*.
[27] ibid, p37.
[28] ibid, p35.

(a) In scenario two, the NHS budget remains flat in real terms over the period but the NHS delivers stronger efficiencies, of 1.5% a year. The combined effect is that the £30 billion gap in 2020/21 is halved, to £16 billion.

(b) In scenario three, the NHS gets the funding needed to make the infrastructure and operating investment required to enable it to move rapidly to the new care models and ways of working described in the Forward View, which in turn enables demand and efficiency gains of 2 to 3% net each year to be achieved. Combined with staged funding increases close to 'flat real per person' the £30 billion gap is closed by 2020/21.[29]

2.46 Following a period of consultation, NHS England released an updated view of the future in its *The Forward View into Action: Planning for 2015/16* report, published in December 2014.[30] NHS England stated that, for 2015/16, NHS England was allocated an extra £1.83 billion, to which NHS England will reallocate a further £150 million of its own resources, bringing the total of new money for front-line services to £1.98 billion.[31]

2.47 NHS England also stated that the pace and scale of transformation over the next five years will depend partly on the scale of additional investment in, and uptake of, new care models. NHS England committed to invest £200 million in new care models in 2015/16, and a further £250 million in primary care.[32]

2.48 The significant financial pressures that the NHS faces form the backdrop to our assessment of the effects of this merger.

Pricing framework

2.49 NHS England and Monitor are jointly responsible for the NHS payment system under the pricing provisions of the HSCA 2012. The 'national tariff' regime was introduced in April 2014, following the entry into force of the applicable provisions of the HSCA 2012.[33]

2.50 The pricing provisions of the HSCA 2012 comprise a comprehensive payments system, including a set of specific currencies (units of healthcare for which payments are made), and associated prices, as well as a set of principles, rules

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[29] ibid, p36.
[30] NHS England (December 2014), *The Forward View into Action: Planning for 2015/16*.
[31] ibid, p3, paragraph 1.4.
[32] ibid, p3, paragraph 1.5.
[33] Chapter 4 of the HSCA 2012.The national tariff replaced the PbR system, under which (broadly speaking) commissioners paid healthcare providers for each patient seen or treated, taking into account the complexity of the patient's healthcare needs.

and methods to determine prices and govern modifications and variations to national tariffs.

2.51 Commissioners pay for the provision of NHS services a price stipulated in the national tariff (if available) or a price determined in accordance with the rules of the national tariff payment system.[34] The national tariffs are set each year. At present, the NHS is transitioning from using PbR to implementing the reforms introduced in the national tariffs to support the NHS's *Five Year Forward View*.[35]

National tariffs

2.52 The national tariffs apply to the majority of acute healthcare services provided in hospitals, including admitted patient care, outpatient attendances and A&E services. The number of services for which a tariff is in place has increased gradually, with a focus on establishing tariffs for routine elective services in respect of which patients have a choice of provider.

2.53 The two fundamental features of national tariffs are nationally determined currencies and tariffs. Currencies are the units of healthcare for which payments are made, and can take a number of forms and cover different time periods, from an outpatient attendance or a short stay in hospital to a year of care for a long term condition. Tariffs are the prices paid for each currency.

2.54 The tariff for each service (or unit of activity) is intended to cover the cost of providing that service. It is based on national average costs reported by NHS providers and a market forces factor (MFF) which takes account of local differences in costs, for example costs of land and labour. There may also be adjustments to tariffs for long or short stays, for specialised services or to support particular policy goals. Differences in the costs of providing elective and non-elective care are, to some extent, reflected in different tariffs for elective and non-elective care.

Variations to the national tariffs

- *National variations*

2.55 In some circumstances, it may be appropriate to make national adjustments to national prices (for example, to reflect certain features of cost that the formulation of national prices has not taken into account, or to share risk more

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[34] See section 115 HSCA 2012.
[35] *Five Year Forward View*.

appropriately among parties).[36] These are nationally determined adjustments to the national prices.

2.56 Each national variation aims to achieve one of the following:

(a) improve the extent to which actual prices paid reflect location-specific costs;

(b) improve the extent to which actual prices paid reflect the complexity of patient needs;

(c) provide incentives for sharing the responsibility for preventing avoidable unplanned hospital stays; or

(d) share financial risk appropriately following (or during) a move to new payment approaches.[37]

2.57 It is important to note that:

(a) national variations only apply to services with a national price;

(b) if a commissioner and a provider agree to bundle services that have a mix of national prices and locally determined prices, national variations need not be applied. In those cases, the rules on local modifications apply;

(c) in the case of an application or agreement for a local modification, the analysis of that application or agreement by Monitor and NHS England must reflect any national variations that might alter the price payable for a service; and

(d) where a new service is commissioned that does not have a national price, rules applicable to local price-setting apply.[38]

- *Local variations*

2.58 Local variations are adjustments to a national price or currency for a nationally priced service which are agreed by a commissioner and the provider(s) of that service. The intention is to allow commissioners and providers an opportunity to innovate in the design and provision of services for patients.[39] Sections 116(2) and (3) of the HSCA 2012 state that local variations must follow the rules set by NHS England and Monitor and that Monitor must have regard to the objectives

[36] Section 116(4)(a) HSCA 2012.
[37] 2015/16 National Tariff Payment System: A consultation notice, p155.
[38] ibid, p155.
[39] ibid, p175.

and requirements for the time being specified in the mandate published under section 13A of the NHS Act 2006.

- *Local modifications*

2.59 Local modifications (which are not the same as local variations) are changes to national prices for specific services and specific providers which have to be approved by Monitor. Local modifications are intended to ensure that services essential to patients' needs are sustained where national prices do not cover unavoidable exceptional costs.[40]

2.60 There are two types of local modifications:

(a) a provider and one or more commissioners agree a proposed increase to a nationally determined price for a specific service; or

(b) a provider is unable to agree an increase to a nationally determined price with one or more commissioners and instead applies to Monitor for authorisation of an increase to that price.[41]

- *Local prices*

2.61 Local prices apply to services that do not have national prices.

2.62 Commissioners and providers should apply the following principles when agreeing a local payment approach:

(a) the approach must be in the best interest of patients;

(b) the approach must promote transparency to improve accountability and encourage the sharing of best practice; and

(c) the provider and commissioner(s) must engage constructively with each other when seeking to agree local payment approaches.[42]

2.63 These principles for variation of national tariffs are in addition to other obligations on commissioners and providers, including the rules set out under section 75 of the NHS Regulations 2013 and Monitor's provider licence.

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[40] ibid, p175.
[41] The legal framework for local modifications is set out in sections 116(10(d) and 124–126 of the HSCA 2012.
[42] 2015/16 National Tariff Payment System: a consultation notice, p176.

Alternative tariff systems for 2015/16

2.64 In August 2014, NHS England and Monitor published proposals for the 2015/16 national tariff payment system. Commissioners, providers and other parties with an interest in the NHS payment system were invited to review the proposals and provide feedback, to help inform the development of final proposals to be put out for consultation. As the majority of providers rejected the proposals, providers were offered a choice of default tariff rollover (DTR) and ETO.[43] We explain these concepts below.

Default tariff rollover

2.65 If a provider has chosen to operate under DTR, the national prices, currencies and rules set out in the 2014/15 national tariff will continue to apply.

2.66 Under DTR, providers will have to use the 2014/15 agreed prices, subject to any local variations and modifications, until they are formally superseded. Any changes in the rollover 2014/15 tariff will not be backdated. [44]

2.67 Providers who opt for the ETO will do so for the full year 2015/16, with no ability to move from the ETO back to the DTR option and on the basis that it will be continued under any subsequent national tariff for 2015/16.

2.68 Providers that did not opt for ETO or opted to stay within the DTR will for the time being:

(a) continue to be paid a 30% marginal rate for emergency admissions, rather than the 70% rate payable pursuant to the ETO option;

(b) not benefit from prices that reflect additional funding;

(c) not benefit from the 2015/16 proposed service uplift for mental health; and

(d) not be eligible for CQUIN payments (up to 2.5% of contract value).[45]

Enhanced tariff option

2.69 The ETO is a package of local variations and local prices for the period from 1 April 2015 to 31 March 2016, in respect of which a provider agrees with the

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[43] Guide to the Enhanced Tariff Option for 2015/16 issued by Monitor and NHS England, 23 March 2015.
[44] Q&As on tariff arrangements for 2015/16.
[45] Commissioning for Quality and Innovation (CQUIN) is one of the NHS England national efforts, where there is a national framework which began in 2009/10, that provides a financial reward (or penalty) for the achievement (or failure to achieve) quality goals.

relevant commissioners to vary the 2014/15 prices to incorporate the changes proposed for the 2015/16 tariff.

2.70 Compared with the original 2015/16 tariff proposal, it is estimated that these enhancements will increase providers' revenues by approximately £500 million, if all providers choose this option.[46]

2.71 Under the ETO, providers will have the following benefits:

(a) the marginal rate paid for additional emergency admissions will increase from 30% to 70%;

(b) the marginal rate for additional specialised services will also increase, from the originally proposed 50% to 70%;

(c) the headline efficiency requirement will be 0.3 percentage points lower than originally proposed (3.5%); and

(d) the right to receive CQUIN payments up to 2.5% of the contract value.

2.72 The ETO incorporates an allowance for service developments in mental health and changes to trusts' clinical negligence premiums. Participating providers have joined an NHS-wide efficiency collaborative to help them track and manage cost pressures, including temporary staffing costs and procurement savings.

2.73 Both ASP and RSC have opted for the ETO arrangement.[47]

Patient choice

2.74 The underlying rationale for providing patients with the ability to choose among providers of routine elective care is that choice empowers patients to select the provider that best meets their needs. Additionally, the need to attract patients ensures that providers have an ongoing incentive to offer high-quality care. We focus here on patient choice of provider in respect of a first consultant-led outpatient appointment for routine elective care.

2.75 Patients' ability to choose among providers of routine elective care is underpinned by a range of supporting infrastructure. Key elements include:

[46] Q&As on tariff arrangements for 2015/16.
[47] See Monitor and NHS England: Providers selecting the 'Enhanced Tariff Option' for 2015/16.

(a) the e-Referral system, which allows patients (and GPs acting on patients' behalf) to select their provider and book their first outpatient appointment with that provider;

(b) PbR, which remunerates providers for routine elective care according to patient treatment volumes based on a framework of fixed tariffs;[48] and

(c) NHS choices, which provides performance information on each provider to assist patients in selecting their preferred provider.

Summary of current provider and commissioner obligations

2.76 Statutory obligations on commissioners in respect of patient choice came into force on 1 February 2013. Regulation 39 of the NHS Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012 provides that CCGs and NHS England must, subject to limited exceptions, ensure that a person who requires an elective referral is given a choice in respect of a first outpatient appointment with a consultant or a member of a consultant's team of:

(a) any clinically appropriate health service provider with which any NHS commissioner has a commissioning contract for the service required; and

(b) any named consultant employed by that health service provider.[49]

2.77 CCGs and NHS England must ensure that the availability of choice is publicised and promoted.[50]

2.78 All licensed providers are subject to a licence condition that protects patients' rights to choose among providers by obliging providers to make information available and act fairly.[51]

2.79 The NHS Standard Contract, prepared by the NHS Standard Contracts Team on behalf of NHS England,[52] will normally be used by CCGs when entering into contracts for clinical services and by NHS England when entering into contracts for non-primary care clinical services.

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[48] The PbR system was replaced by the national tariff. Whilst some of the principles have been retained, it is also true that CCGs have greater flexibility to put limits on the amounts that trusts are able to earn (thus both conserving resources and incentivising efficiency).
[49] Responsibilities and Standing Rules Regulations 2012, Regulation 43.
[50] Responsibilities and Standing Rules Regulations 2012, Regulation 42.
[51] Condition C1:This condition applied to foundation trusts from 1 April 2013 and to other licensed providers from 1 April 2014.
[52] The 2013/14 NHS Standard Contract is available on the NHS Commissioning Board's website.

Quality regulation of acute service providers

2.80 This section summarises our understanding of various mechanisms designed to safeguard the quality of NHS services.

NHS Standard Contract

2.81 Technical Contract Guidance on the 2015/16 NHS Standard Contract states that the 'Standard Contract is a key lever for commissioners to ensure improvements in quality and cost effectiveness.'[53]

Monitor

- *Implementation and supervision of the licensing regime*

2.82 Pursuant to HSCA 2012, all foundation trusts have been required to have a licence since 1 April 2013. Other eligible NHS providers have been subject to the licensing regime from April 2014. All providers of NHS services are required to be licensed unless they are exempt by regulation.[54] Monitor has said that its provider licence is the main tool for regulating providers of NHS services. Monitor published standard licence conditions on 14 February 2013.

- *Monitoring foundation trusts from April 2013*

2.83 The following paragraphs explain how Monitor has, since 1 April 2013, monitored compliance with licence conditions.

2.84 Monitor is required by the HSCA 2012 to assess risks to the continued provision of NHS services and to oversee the governance of NHS foundation trusts. Since April 2013, all NHS foundation trusts have been required to hold a licence from Monitor stipulating specific conditions that they must meet, including financial sustainability and governance requirements. Monitor's Risk Assessment Framework sets out its approach to overseeing NHS foundation trusts.[55]

2.85 Monitor uses the Risk Assessment Framework to indicate where there is:

(a) a significant risk to the financial sustainability of a provider of key NHS services which endangers the continuity of those services; and/or

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[53] NHS Standard Contract 2014/15 Updated Technical Guidance, p6, paragraph 1.1.
[54] HSCA 2012, Part 3, Chapter 3.
[55] Monitor (March 2015), *Risk assessment framework*.

(b) poor governance at an NHS foundation trust.

2.86 Monitor assesses financial sustainability on the basis of liquidity and capital servicing capacity ratios, [56] having regard to annual plans, quarterly reviews and following significant in-year events such as the loss of a major contract. Monitor's regulatory tools range from discretionary requirements and licence amendments to the appointment of a TSA.[57]

2.87 Monitor rates foundation trusts on the basis of CQC inspection reports, organisational health indicators,[58] third party information and continuity of service provision. Trusts that achieve high standards in relation to these matters are given a green rating. If Monitor is concerned about governance of a trust, the green rating is replaced with a note that the trust is under review, together with a description of the issues causing concern. A red rating is published once regulatory action is recommended. Given the reputational impact of the traffic light system, a foundation trust under review is incentivised to alleviate governance concerns, even if no formal enforcement action is taken.

- *Compliance with licence obligations*

2.88 As noted above, the authorisations of foundation trusts were replaced by licences with effect from 1 April 2013. Thereafter, Monitor has also had powers to enforce licence conditions.[59]

2.89 In its Enforcement Guidance, Monitor explains that, if it finds that a provider is breaching or has breached a licence condition, it may impose one or more discretionary requirements:

(a) compliance requirements: a provider may have to take such steps as Monitor may specify to ensure that the breach in question does not continue or recur;

(b) restoration requirements: a provider may have to take such action as Monitor specifies to restore the situation to what it would have been if the breach had not occurred; and/or

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[56] In the 'Glossary for NHS finance and governance', the capital servicing capacity ratio is one of the metrics incorporated within the continuity of services risk rating. It is defined as the number of times the costs of a foundation trust's annual debt can be covered by the money available.
[57] ibid, pp24–34.
[58] Organisational health is about having the properties and qualities today that create the conditions for high performance tomorrow. Healthy organisations typically have a culture which promotes trust, openness and engagement and enables continuous learning and improvement.
[59] By operation of law, namely section 88 of HSCA 2012.

(c) monetary penalties, which may not exceed 10% of the provider's turnover in England.[60]

2.90 Where Monitor has reasonable grounds to suspect that a provider is breaching or has breached one or more of its licence conditions, it may accept enforcement undertakings. Monitor may also revoke a provider's licence if it is satisfied that the provider has failed to comply with a licence condition.

2.91 Further information on Monitor's enforcement powers and the means by which Monitor places a foundation trust in special measures and attempts to effect a recovery of clinical and governance standards are set out in Appendix B, Annex 5.

Care Quality Commission

2.92 The CQC monitors, inspects and regulates health and adult social care services in England. Monitor looks to the CQC to assure it that expected standards of quality and safety are being met.[61] The tools used by Monitor and the CQC overlap and are directed towards achieving similar goals. The two bodies communicate in relation to concerns and cooperate in deciding which of them is best placed to apply appropriate regulatory remedies.

2.93 Persons who provide health and social care services in England[62] are required to register with the CQC.[63] In addition to providing and monitoring minimum standards, the CQC also performs inspections of providers.[64]

2.94 Following an inspection, the CQC gives a hospital a rating on a four-point scale (different from the scale used by Monitor in respect of governance and financial sustainability). The ratings are 'Outstanding', 'Good', 'Requires Improvement' and 'Inadequate'.

2.95 If the CQC identifies a lack of compliance with its standards, registration conditions or statutory provisions, it can seek a requirement notice,[65] issue a warning notice[66] and, ultimately, propose that Monitor place the foundation trust into special administration under the Care Act 2014. Requirement notices are generally prompts to trusts that are not in a serious situation and which do not have a record of low standards. Warning notices are more serious and include

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[60] Monitor (2013), *Enforcement Guidance*, Chapter 3.
[61] CQC (2015), *How CQC regulates: NHS and independent acute hospitals, Provider handbook* (CQC's provider handbook).
[62] Some exceptions apply, particularly regarding the supply of care services to children. See section 8 of the Health and Social Care Act 2008 (HSCA 2008).
[63] Section10, HSCA 2008.
[64] Section 60, HSCA 2008.
[65] CQC enforcement policy, p18.
[66] Section 29 of the HSCA 2008 (as amended by Care Act 2014) Warning Notices.

a timescale for improvement, after which the CQC will take civil or criminal action. Warning notices under section 29A of the Care Act 2014 precede special administration, which is triggered by continued failure to comply with relevant regulation and standards.

2.96 In relation to the Parties, ASP was inspected by the CQC in March 2015 and received an overall rating of good (Ashford Hospital (AH) good, St Peter's Hospital (SPH) requires improvement).[67] RSC was inspected in December 2013 and received an overall rating of good.[68]

The National Institute for Clinical Excellence

2.97 NICE is a special health authority established in 1999.[69] As a special health authority, NICE deals at arm's length from the Department of Health and Monitor and is responsible for all of England and Wales rather than a specific geographical location.[70]

2.98 NICE's statutory duty is to 'perform such functions in connection with the promotion of clinical excellence in the health service as the Secretary of State may direct.' In practice, NICE's primary role is issuing national guidance to health professionals, NHS organisations and the public at large.

General Medical Council

2.99 The General Medical Council (GMC) is the independent regulator of doctors in the United Kingdom. Since 1858,[71] it has had statutory authority to oversee the practice of medicine in the United Kingdom. The GMC provides 'Good Practice Guidance' for doctors. Much of its published guidance concerns issues of professional ethics, such as protecting patient confidentiality, treating patients with respect and dealing properly with children. In addition, the GMC maintains a register of all practising doctors in the United Kingdom. If complaints are made about a doctor, they may be investigated by the GMC and doctors are removed from the register of practitioners if they are found to be unfit to practice.

2.100 The GMC also supervises medical education in the United Kingdom by regulating medical schools to ensure the quality of their graduates. The GMC determines which medical schools are entitled to issue medical degrees and

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[67] CQC inspection ratings and report: ASP.
[68] CQC inspection ratings and report: RSC.
[69] By SI N.220 (1999): The National Institute for Clinical Excellence (Establishment and Constitution) Order 1999. The HSCA 2012 establishes a new statutory framework for NICE (most of it not yet in force). The main change made by the HSCA 2012 is that NICE now can set standards for care services as well as health services.
[70] www.nice.org.uk/Guidance.
[71] Medical Act 1858. The Medical Act 1983 is now the contemporary statutory footing for the GMC.

what standard of proficiency is required. The GMC similarly regulates the Deaneries, which are responsible for postgraduate education, to ensure that medical graduates receive appropriate training. More recently, the GMC has assumed a role in assisting in maintaining standards through revalidation, which is an annual system of checks and appraisals that doctors must complete in order to continue to practise.

The Royal Medical Colleges

2.101 The Royal Medical Colleges are professional medical bodies incorporated by royal charter. Each college ministers to the practitioners of a particular medical specialty, such as Surgery, Anaesthetics or Paediatrics. Colleges promote research within their field, administer examinations to specialist practitioners, and offer continuing professional development and other training to specialist practitioners. In addition, colleges publish medical practice guidelines, including best practice information regarding their specialty.

2.102 The colleges also have an indirect impact on quality maintenance, as they make representations to the Department of Health and other professional bodies in relation to the development of their own standards and regulations.

Commissioners

2.103 The Parties emphasised the breadth and depth of qualitative regulation from a range of entities in relation to licences, obligations and the measurement of inputs and outputs. Much of the regulatory pressure is exerted through the soft (buyer) power of CCGs rather than use of direct enforcement measures.

2.104 The withdrawal by a commissioner of a contract to provide a service or additional competition from a new entrant would be likely to result in a provider losing (or risking losing) income, which would have an adverse effect on its financial position.

ASP

2.105 ASP was established as an NHS trust in 1998, as a result of a merger between AH and SPH, and achieved foundation trust status on 1 December 2010.[72] ASP serves a catchment area of approximately 410,000 people,[73] primarily in North

[72] Parties' phase 2 initial submission to the CMA, March 2015 ('Parties' initial submission').
[73] Parties' initial submission, p9, Table 3.

Surrey and West and South West London, from its sites in Chertsey (SPH) and Ashford (AH).[74]

2.106 Specialist services provided by ASP include Cardiology, Bariatric Surgery, Vascular Surgery, Limb Reconstruction and Neonatal Intensive Care. AH's focus of service is on planned care, including outpatient services and day-case surgery, whilst SPH provides more complex medical and surgical care and emergency services. Private patient services at ASP are restricted to providing some specialised care for patients admitted to the BMI Runnymede Hospital, which is co-located at SPH.[75]

2.107 A small number of services at ASP are commissioned by Hounslow CCG and other Surrey CCGs.[76]

2.108 In the financial year ended 31 March 2014, ASP had revenues of £246 million[77] and, in the financial year ended 31 March 2015, ASP had revenues of £260 million. It has 570 beds and approximately 3,300 full-time equivalent employees (FTEs). Monitor's rating of ASP is currently 'under review' for governance and 3 (out of 4) in respect of its financial position.

2.109 ASP's rating from the CQC, received at the most recent inspection dated 10 March 2015, is 'Good'.

North West Surrey Clinical Commissioning Group and ASP

2.110 ASP and NWSCCG have agreed Heads of terms (HoT) setting out the contractual overview and financial arrangements for 2015/16.[78] The HoT provide for a baseline contract value of £[✂] for 2015/16.[79] The remainder of the HoT breaks down this value, sets out how the contract will be managed and performance monitored and identifies savings required to limit costs to the targeted amount. Section 7 of the HoT provides for a series of cost reduction programmes at a hospital-wide and specialty level with reference to the previous year's activity plan and contract value.[80] NWSCCG has identified around £[✂] of Quality, Innovation, Productivity and Prevention (QIPP) savings for 2015/16.

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[74] Parties' initial submission, p6, Figure 1.
[75] Parties' initial submission, paragraph 26.
[76] Parties' initial submission, paragraph 27 and Table 1.
[77] Parties' initial submission, paragraph 23.
[78] HoT ASP 2015/16 Final.
[79] HoT ASP 2015/16 Final, section 5.
[80] HoT ASP 2015/16 Final. section 7.

2.111 ASP's share of these savings amounts to £[✂], of which approximately £[✂] relates to planned (elective) care.[81] Examples include savings from diabetes pathway redesign, an ear-syringing programme to deliver ENT service savings and savings in relation to the provision of Musculoskeletal (MSK) services. The remainder of the cost reduction is constituted by A&E expenditure savings for which ASP accepts the risk. NWSCCG is responsible for the remaining £[✂] of A&E savings; the contract value will be increased by up to this amount if emergency admissions exceed the contracted activity levels.[82] Any additional activity above the reassessed contract value will be subject to the national 70% marginal rate under the ETO.

2.112 [✂].[83] The parties are obliged to use their best endeavours to manage the contract in line with the agreed baseline value.[84]

2.113 Extensive monitoring and benchmarking arrangements are in place to ensure that NWSCCG is aware of diversions from agreed baselines. Increases in activity above forecast levels will result in discussions between the parties and, potentially, the implementation of activity management plans (AMPs) to restrict excess activity. If increased activity is the result of new referrals, representing an increase in ASP's share of the healthcare market, with patients undergoing clinically justified treatment, the monthly contractual payments receivable by ASP will be adjusted upwards.

2.114 The £[✂] figure is accordingly not a cap; it is an indication of expected activity based on previous baselines, demographic changes, local factors, anticipated health developments, tariff deflation and targeted savings. ASP will be paid for repatriated patients representing referral shares previously lost to neighbouring providers.

RSC

2.115 RSC was established as an NHS trust in 1991 and achieved foundation trust status on 1 December 2009. It serves a catchment area of approximately 320,000 people[85] in respect of emergency and DGH services, from its main hospital site in Guildford, and is the specialist centre for cancer patients in Surrey, West Sussex and Hampshire. Approximately 40% of RSC's

[81] HoT ASP 2015/16 Final, paragraph 5.2.
[82] HoT ASP 2015/16 Final, paragraph 7.2.1.
[83] HoT ASP 2015/16 Final, paragraph 6.3.
[84] HoT ASPH2015/16 Final, paragraph 5.4.
[85] CQC inspection ratings and report: ASP.

commissioned income is derived from its cancer services.[86]

2.116 RSC provides cancer services through the St Luke's Cancer Alliance.[87] RSC has also established an outreach radiotherapy treatment centre at East Surrey (the main site for SASH), which opened in July 2014. RSC has been selected as a partner for the delivery of cancer services with Western Sussex.[88]

2.117 Other specialist services provided by RSC include Maxillo-Facial Surgery and ENT Surgery. Private patient services at RSC are limited to cancer services, primarily radiotherapy and some complex cancer services,[89] in part because of an agreement with Nuffield Health Guildford Hospital, which is co-located at RSC.[90]

2.118 RSC's main commissioner of NHS services is GWCCG, whilst specialist acute services are primarily commissioned by NHS England through its Surrey and Sussex Area Team. Some specialist services at RSC are commissioned by other CCGs, including other Surrey and Hampshire CCGs.[91]

2.119 In the financial year ended 31 March 2014, RSC had revenues of £281 million[92] and, in the financial year ended 31 March 2015, RSC had revenues of £307 million. It has approximately 520 beds and 3,200 FTEs. Monitor's rating of RSC is green for governance and 4 (out of 4) in respect of its financial position.

2.120 RSC's rating from the CQC, received at the most recent inspection dated 18 December 2013, is 'Good'.[93]

Guildford & Waverley Clinical Commissioning Group and RSC

2.121 GWCCG and RSC have agreed terms for 2015/16. The contract value appears in the draft contract particulars and is £[✂]. The contract value variation arrangements are contained in a separate financial adjustment triggers document.[94] The limitation of RSC's income from GWCCG to this contract value depends on GWCCG's success in delivering reductions in non-elective admissions and outpatient appointments by promoting alternative primary and community care pathways. If these QIPP programmes are unsuccessful or are

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[86] Parties' initial submission, paragraph 29.
[87] The Alliance comprises RSC, ASP, Frimley Park Hospital (Frimley Park), SASH , and Basingstoke (Parties' initial submission, paragraph 30).
[88] Parties' initial submission, paragraphs 30 & 31.
[89] Parties' initial submission, paragraph 32.
[90] Operating Agreement between RSC and Nuffield Nursing Homes Trust relating to the Nuffield Guildford Hospital at the RSC dated 1 May 1997.
[91] Parties' initial submission, paragraph 33 and Table 2.
[92] Parties' initial submission, paragraph 28.
[93] CQC inspection ratings and report: RSC.
[94] NHS GWCCG and RSC financial adjustment triggers above 15/16 baseline financial value.

only partly delivered, resulting in levels of attendances and admissions between the 2014/15 values and the contract activity levels for 2015/16, the contract value will rise up to £[✂].[95]

2.122 The financial triggers document provides a mechanism for this. GWCCG aims to avoid [✂] non-elective admissions relative to 2014/15. RSC will be paid £[✂] for each such admission above the new baseline which GWCCG fails to avert. An additional payment of £[✂] per admission is available for a limited number of additional admissions constituting unforeseen and unavoidable emergency pathway growth. GWCCG and RSC are similarly targeting a 25% reduction in elective outpatient attendances. There are stepped contract value increases in increments of 5% of the previous attendance level for non-delivery of this target, rising to a potential additional payment of £[✂]. The cumulative effect of achieving none of the reductions identified in the financial triggers document would be to increase the potential value of the contract from the variable baseline of £[✂] to the £[✂] figure mentioned above.

2.123 RSC submitted that this constituted an upper limit to income from GWCCG and that it had no incentive to increase activity beyond this level. RSC has reaffirmed this following publication of the provisional findings in this inquiry. During discussions with the CMA, GWCCG indicated that £[✂] was not a hard cap. As was the case with NWSCCG/ASP, additional activity reflecting a greater share of referrals was eligible for additional payments which would be negotiated as part of a reconciliation process. RSC's income could also fall below the £[✂] contract value floor if its share of referrals fell significantly. This created an incentive not to lower standards, although it was likely that RSC and GWCCG would share the burden of any shortfall, following negotiation.

2.124 Adherence to the £[✂] target whilst maintaining a £[✂] deficit for the 2015/16 financial year would entail total efficiency and QIPP savings of £[✂].[96] If these savings were not made, there would be likely to be an increase in the contract value as well as an increased deficit (any contract value uplift is unlikely to match the savings shortfall).

[95] NHS GWCCG and RSC financial adjustment triggers above 15/16 baseline contract value.
[96] NHS GWCCG and RSC financial adjustment triggers above 15/16 baseline financial value.

3. The proposed merger and the relevant merger situation

Outline of the merger situation

3.1 In April 2014, the Parties decided to merge, which they announced publicly in a press release dated 2 May 2014. This would be a merger of two foundation trusts to create a single trust operating multiples sites.

Rationale for the merger

Background – national challenges

3.2 The Parties told us that the health and social care context within which they operated was undergoing significant change. The Parties believed that the changes which were taking place posed significant challenges to the viability of the traditional DGH model.

3.3 As set out in paragraphs 2.45 to 2.47 above, NHS England's *Five Year Forward View* plan describes the challenges that NHS England as a whole is facing, in particular a potential annual funding gap of £30 billion within five years.[97]

Parties' views

3.4 In order to meet the challenges referred to above and deliver services consistent with national policy objectives, for example implementing new models of care, putting in place an appropriately qualified workforce, harnessing technology and delivering innovation, the Parties carried out an in-depth analysis of various options for their future.

3.5 In October 2013, the Parties' boards of directors commissioned a report considering three possible next steps:

(a) status quo – the Partnership arrangements would remain as they currently are;

(b) extended Partnership – the Parties would remain independent foundation trusts but would increase their level of collaboration in order to maximise the synergies that can be delivered; or

(c) full merger – the Parties would merge to form a new single foundation trust.

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[97] See also the Monitor report (22 May 2015), NHS foundation trusts: quarterly performance report (quarter 4, 2014/15).

3.6 The Parties' boards of directors decided that maintaining the status quo would lead to a gradual degradation of services and this option was therefore ruled out in the outline business case (OBC) published in April 2014.

3.7 The appraisal outlined in the OBC found that, although some aspects of the Parties' clinical and operational visions might be delivered through partnership structures, the partnership options would not deliver the required degree of organisational alignment and momentum. Accordingly, this option was also ruled out.

3.8 In the OBC, it is stated that the Parties' boards of directors concluded that the only way to provide high-quality services for patients on a sustainable basis would be to merge. The Parties decided to take this step in April 2014.

3.9 Regarding the competitive situation that would prevail in the absence of the proposed transaction (also called the counterfactual, see Section 4), the Parties have concerns about the ongoing financial and clinical sustainability of their organisations given the financial challenges that they are now facing. The Parties told us that ASP had a deficit of £1 million in the financial year ended 31 March 2015, whilst RSC had a £1.1 million surplus in that financial year. Both Parties expect, however, to be in deficit on a stand-alone basis in each of the five financial years to March 2020.

3.10 In the full business case (FBC), the Parties stated that the drivers for the merger arise from:

(a) the external environment in which the Parties are operating; and

(b) the synergies and development opportunities that a merger will create for the merged trust.

External operating environment

3.11 As regards the external operating environment, the Parties stated that this is characterised by:

(a) tight funding allocations for commissioners combined with increasing demand for health services, circumstances that are common across the NHS;

(b) relatively close proximity to central London teaching hospitals, from which many specialised services for patients in Surrey have historically been delivered, combined with a push by commissioners towards greater centralisation of these services;

(c) rising quality expectations that are being reflected in tightening regulatory standards in areas such as providing seven-day services; and

(d) a highly competitive local environment, with increasing competitive pressure as a result of the merger between Frimley Park and Heatherwood and Wexham and the intended merger between West Middlesex and Chelsea & Westminster.[98]

3.12 The Parties believe that the effect of tightening budget allocations for the NHS would leave both Parties in deficit in the coming years. In their view, these forecast deficits did not take into account the possible loss of specialised services from the Parties or the full cost for each of them of independently delivering seven-day services.

3.13 Both Parties' boards of directors, in assessing the available options, have concluded that a merger will allow the external challenges set out above to be met more effectively, whilst enabling them to deliver their shared clinical vision. In contrast, they believe that a continued Partnership would deliver only some of the benefits set out above, and at a considerably slower pace.

Synergies and development opportunities that a merger will create

3.14 The Parties believe that a merger would allow them to address many of the issues which they currently face and would continue to face going forward as stand-alone entities. Among the potential merger benefits outlined in the FBC, the Parties focused on the points made below.

(a) The merger would facilitate the delivery of seven-day services, thereby improving the quality and safety of services for patients. In the Parties' view, the delivery of seven-day services in a number of core specialties (including stroke, gastro-intestinal services and interventional radiology) was only possible through the merger due to the financial and recruitment constraints that the Parties would face as stand-alone entities. The Parties submitted that in other specialties the merger would improve the quality and effectiveness of seven-day services compared with what could be achieved on a stand-alone basis.

(b) The merger would enable improvements and enhancements in cardio-vascular and cancer services, and support the repatriation of other specialist services over time, thereby improving patient experience and outcomes. In the Parties' view, the merger would strengthen and secure the

[98] Chelsea and Westminster and West Middlesex formally merged to become a single foundation trust on 1 September 2015.

existing cardiovascular and cancer services currently being offered by the Parties. The Parties told us that a merged trust would be able to extend and enhance its offerings in both of these service areas, thereby providing improved access to local patients and, in some cases, improving patient outcomes through reduced travel times. The merger would enhance the opportunity to invest in a Cancer Diagnostic and Treatment Centre at Ashford (subject to business case approval). It was anticipated that, over time, a merged trust would be better placed to repatriate other specialist services (such as renal services) to Surrey, thereby further improving patient access.

(c) The merger would support the delivery of integrated care, thereby improving patient outcomes and experience. The Parties believe that, by creating a strong and resilient provider, the merger would support and facilitate collaboration with commissioners to ensure that services were well integrated across the local health economy and weighted more to supporting patients in the community, thereby helping to improve patient outcomes and experience as well as maintaining the financial stability of the local health system.

(d) The merger would support the development of a modern workforce capable of delivering high-quality care for patients. In the Parties' view, an enlarged organisation would have the profile and critical mass to attract and retain outstanding staff, by providing educational opportunities and offering a broad array of opportunities for career development and progression. The Parties faced strong competition for the recruitment of medical staff from London hospitals, which typically offered higher pay, although living costs in London were not significantly higher than those in Surrey.

(e) The merger would help to create a stable financial foundation to support the delivery of high-quality care. The Parties believe that a merger would deliver recurrent financial synergies of approximately £8 million a year.

(f) The merger would help support the deployment of digital technology, thereby improving patient outcomes and experience. The Parties believed that the financial sustainability provided by a merger would enable investment in a 'digital hospital'. The Parties believed that effective deployment of digital technology, for example the implementation of electronic patient health records, was widely recognised to be essential to improving the effectiveness and consistency of care delivery both within hospitals and across the broader health system.

(g) The merger would enable patients to benefit from innovation and research. The Parties believe that the merger would result in an enhanced capability

in research, education and innovation. Over time, a practical benefit of this would be to increase patients' access to cutting-edge clinical trials and treatments.

3.15 The Parties' boards of directors' preference for a merger compared with a continued partnership is based on the experience of both organisations in terms of their existing Partnership, and the effort that has been required to date to deliver the limited benefits which have been achieved so far.

3.16 We have not heard any evidence that the rationale for the merger includes, or that the Parties intend to implement, any consolidation of services that currently take place at more than one site. We note that any such proposed consolidation of services would be likely to require public consultation and agreement by the relevant CCG(s).

Commissioners' views

3.17 NWSCCG told us that it supported the merger in principle because it accepted the case made by the Parties regarding seven-day working.[99]

3.18 NWSCCG told us, however, that it did have some concerns regarding the merger. First, it would like to see a more robust business case regarding the bringing together of clinical services by the Parties and that, in its experience, clinical alignment was the biggest challenge to achieving an effective merger. NWSCCG said that the Parties needed to demonstrate not only what was going to be delivered but how it was going to be delivered, and how this would be achieved without adversely affecting current activities. NWSCCG said that, if they could do this, it would be in favour of the merger.

3.19 Secondly, NWSCCG told us that there were a number of standards that ASP was not currently meeting and that NWSCCG was working actively with it to get delivery back on track. NWSCCG was concerned that, if ASP was going through a major organisational change, it might not focus on the things necessary to enable NWSCCG to deliver the best care for the population it served.

3.20 GWCCG told us that it supported the merger in principle and considered that the merger represented the best chance of securing healthcare stability in the local area. GWCCG told us that a merger would enable RSC and ASP to

[99] Hearing with NWSCCG on 29 April 2015.

become more financially secure and to take on some activity that was currently being carried out in London-based hospitals.[100]

3.21 GWCCG told us that the merger would also enable the trusts to reduce their spending on agency nursing through having a greater critical mass and, with greater credibility as an organisation, an enhanced ability to recruit good people. It said that a merged trust would potentially be able to pay a higher premium as a result of the cost savings in other areas and therefore not lose good staff who were attracted to the higher rates of pay arising from London weighting.

Jurisdiction

3.22 Under section 36 of the Act, and pursuant to the terms of reference (see Appendix A), we must, in our final report, answer:

(a) whether arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation; and

(b) if so, whether the creation of that situation may be expected to result in an SLC within any market or markets in the UK for goods or services.

3.23 A relevant merger situation is created if two or more enterprises cease to be distinct and either the share of supply or turnover test set out in the Act is met.

3.24 Section 79 of HSCA 2012 provides that, where the activities of two or more NHS foundation trusts cease to be distinct, this is to be treated as a case in which two or more enterprises cease to be distinct for the purpose of Part 3 of the Act. The Parties publicly announced their decision to merge by press release dated 2 May 2014. We therefore consider that arrangements are in progress or contemplation which, if carried into effect, will result in enterprises ceasing to be distinct.

3.25 As noted above, the Act requires that, for a relevant merger situation to be created, either the turnover test or the share of supply test must be met. The turnover test is met if the value of turnover in the UK of the business being taken over exceeds £70 million.[101] ASP had UK revenues of £246 million in the financial year ended 31 March 2014, whilst RSC had revenues of £281 million

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[100] Hearing with GWCCG on 22 April 2015.
[101] Pursuant to the CMA's *Merger Assessment Guidelines* (the Guidelines), paragraph 3.3.2, the CMA considers the turnover within the UK in the business year preceding the date of reference of the merger to be relevant for the jurisdictional assessment.

in that financial year.[102] Accordingly, the turnover test is satisfied so there is no need to consider separately the share of supply test.

3.26 For the reasons given above, we are satisfied that the proposed merger between the Parties will, if carried into effect, result in the creation of a relevant merger situation. We therefore have jurisdiction to consider whether the creation of that situation may be expected to result in an SLC within any market or markets in the UK for goods and services.

4. Counterfactual

Framework for our analysis

4.1 In order to assess whether the merger may be expected to result in an SLC, we considered the competitive situation without the merger. This situation is referred to as the counterfactual. The counterfactual is an analytical tool used in answering the question of whether the merger gives rise to an SLC.[103] The counterfactual is also relevant to an analysis of relevant customer (patient) benefits in the event that this is required.

4.2 At phase 2, we may examine several possible situations, one of which may be the continuation of the pre-merger situation, but only the most likely situation will be selected as the counterfactual.[104]

4.3 We incorporate only those aspects of scenarios that appear likely to occur on the basis of the facts available to us and our ability to foresee future developments.[105]

4.4 Against this framework and in light of the Parties' submissions, we considered the following:

(a) the expected financial performance of the Parties over the next five years and its implication for the likelihood of ASP or RSC exiting the market, wholly or partially, in the foreseeable future;

(b) the possible extension of the existing level of integration and cooperation between the Parties, but falling short of a merger; and

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[102] CMA phase 1 decision, paragraph 37, referring to the financial statements contained in ASP's Annual Report and Accounts 2013–2014 and RSC's Annual Report and Accounts 2013–2014.
[103] The Guidelines, paragraph 4.3.1.
[104] The Guidelines, paragraph 4.3.6 and the *CMA Guidance on the review of NHS mergers* (31 July 2014), CMA29 (NHS Merger Guidance), paragraph 6.13.
[105] The Guidelines, paragraph 4.3.6.

(c) other counterfactual scenarios, such as possible mergers with other providers.

Parties' views

4.5 The Parties submitted that, if the merger does not proceed, they have concerns about the ongoing financial and clinical sustainability of their organisations given the financial challenges they face (as is the case in the NHS more generally).[106]

4.6 The Parties believed that, without the merger, service quality would decline at both ASP and RSC as they remained in or entered into deficit. The Parties' ability to exert competitive pressures on each other and on neighbouring hospitals would also diminish. The Parties told us that they viewed this as the appropriate counterfactual and that this, rather than the current situation, should therefore be the benchmark against which the merger's effects were measured.

4.7 The Parties' concerns are based on the Parties' long-term financial model (LTFM), which predicted that both Parties would have deficits for the foreseeable future, assuming that the merger did not proceed. Such deficits would have a significant impact on the ability of each of the Parties to recruit and retain staff and to finance capital expenditure, and thus deliver high-quality services to patients.[107] In particular, the Parties told us that their reduced ability to recruit and pay for medical and nursing posts, given the high proportion of total costs that was represented by employment costs, was an important part of the link between being in deficit and declining service quality.

4.8 The Parties submitted that they would not be able to deliver seven-day services if the merger did not proceed. The Parties also believed that they would not be able to sustain safe levels of nursing over time, consistent with the latest national guidance. If national standards were to be rigorously enforced, the Parties would be required to make savings elsewhere, possibly in relation to capital expenditure. An inability to deliver seven-day services or maintain safe levels of nursing would have a significant adverse effect on the quality of services provided by the Parties and thus also on the competition they offered to each other and to other providers.[108]

4.9 Since submitting their LTFM to us, the Parties refined the forecasts of their financial positions on a stand-alone basis. They also told us that, since the work on the LTFM finished in February 2015, the financial outlook for both Parties

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[106] See paragraphs 2.43 to 2.48 above.
[107] Parties' initial submission, paragraphs 80 & 81.
[108] Parties' initial submission, paragraphs 82–84.

has continued to deteriorate. They had set out a number of 'material subsequent changes' based on high-level assumptions applied to their 2015/16 forecasts, including increases to QIPP requirements, changes to the national tariff and reductions in the Parties' expected delivery of cost improvement plans (CIPs), which in aggregate suggest that both Parties would be in small deficit over each of the next five years.

4.10 Thus, whilst the Parties did not suggest that either of them would be at immediate risk of financial failure if the merger did not proceed, they considered that there was a likelihood of significant service degradation at both Parties in the absence of a merger and that competition offered by the Parties to each other and to neighbouring providers of acute services would become significantly weaker.[109]

4.11 The Parties told us that, whilst the Partnership had been beneficial to both Parties, the scale of the benefits achieved had been small and the pace of implementation had been slow.[110]

The likely financial performance of each Party absent the merger and the implications for the counterfactual

4.12 We analysed the Parties' LTFM and information made available to us subsequently and considered whether the Parties would be in deficit if the merger did not proceed. We also considered the possible consequences of this, including the risk of either or both Parties failing over the next five years and/or needing to change or cease providing some clinical services.

Potential consequences of NHS foundation trusts going into deficit

4.13 The paragraphs below describe the potential consequences of foundation trusts going into deficit.

4.14 We understand that there are certain mechanisms that enable commissioners to provide additional funding to trusts in the form of settlements; likewise, there are funds available to the Department of Health and Monitor to provide financial loans to foundation trusts in financial difficulties.

4.15 Generally, if Monitor suspects that a foundation trust has breached or is at risk of breaching its licence, it may start an investigation and then take regulatory action if needed. For example, if a foundation trust consistently fails to meet national standards of care or is at financial risk, Monitor requires the foundation

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[109] Parties' initial submission, paragraph 90.
[110] Parties' initial submission, paragraph 48.

trust to explain why this is the case and to develop a plan for addressing the problem(s). When financial problems become serious, Monitor can appoint a contingency planning team.

4.16 If the problem persists, Monitor may choose to put a foundation trust into 'Special Measures'. The Special Measures regime involves close scrutiny by Monitor combined with the appointment of an improvement director and, in most cases, linkage with a partner trust to assist in the areas where improvement is needed.[111] It may also involve changes being made at board level. In parallel and/or liaising with Monitor, the CQC takes action if a provider is in breach of the CQC regulations.[112]

4.17 In exceptional circumstances, where a foundation trust is likely to fail financially, Monitor has the power to appoint a TSA to take control of the foundation trust's affairs.[113] The TSA produces a report including proposed actions that can be adopted by the Secretary of State for Health if he or she agrees with the proposals. Further information on special measures, the powers of Monitor and the appointment of a TSA is set out in Appendix B, Annex 5.

The requirement for seven-day services

4.18 The following paragraphs discuss the requirement to provide seven-day services in the NHS in the future and the Parties' submission on expanding current services to accommodate this requirement.

4.19 In February 2013, the NHS Services, Seven Days a Week Forum, chaired by the NHS National Medical Director, was established to consider how NHS services can be improved to provide a more responsive and patient-centred service across the seven-day week.[114]

4.20 The Parties told Monitor that, in certain specialties, they both offered on-call consultants on a seven-day rota, currently at a ratio of 1:4, meaning that consultants were on duty every fourth weekend and every fourth evening, in addition to their Monday to Friday duties.[115] The Parties noted that the NHS Consultant Contract required hospitals to review annually and reduce the frequency of 1:4 or more frequent on-call rotas. A report from the Royal College

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[111] See Monitor, NHS Trust Development Authority and CQC, *A guide to special measures* (updated February 2015) and *Special measures: one year on* (August 2014).
[112] CQC: Special measures. See also more generally on CQC's enforcement actions.
[113] See the NHS Act 2006, section 65D and more generally sections 65A–65O. In broad outline, where TSAs are appointed, they are required to make recommendations to the Secretary of State to resolve the situation of clinical or financial failure: see section 65I. Following input from Monitor, the Secretary of State must decide whether to accept the recommendations: see section 65KB.
[114] Board Paper, NHS Services, Seven Days a Week, December 2013.
[115] Monitor Report on the Proposed Merger, January 2015, paragraph 39.

of Radiologists recommends that consultant radiologists should not be on an on-call rota more frequently than 1:6.[116]

4.21 In order to comply with these recommendations, the Parties will both need to employ additional consultants and clinical nurse specialists in the event that the merger does not go ahead, significantly increasing the Parties' costs on a stand-alone basis.

4.22 The Parties noted that, in response to an increase in costs, they would have to reconsider the range of services they offered and the level of investment made in staff. The Parties believed that, in this scenario, their ability to provide sustainable clinical services would be severely compromised.

4.23 The Parties submitted that, if the merger took place, the provision of seven-day services should enable them to achieve certain cost savings, such as quicker discharge of patients admitted over the weekend and fewer beds being occupied due to quicker discharge.[117]

ASP's likely financial performance over the next five years without the merger and its implication for the counterfactual

4.24 ASP's income from patient-related activity has grown over the last four years as a result of increased elective work, despite tariff deflation in each year.

4.25 ASP has a good track record of CIP, having delivered £48.2 million over the previous four years. Increasingly, ASP has had to consider more transformational schemes to produce efficiencies, as the traditional methods of achieving cost reductions are exhausted.

4.26 The Parties told us that the merged trust would make investments of approximately £[✂] over [✂] years on the ASP sites whereas, in the absence of a merger, ASP was planning to spend approximately £[✂] on its current sites. In addition, ASP submitted revised figures to reflect 'material changes' of which it has become aware since the LTFM was finalised in February 2015. These changes include:

(a) new cost pressures resulting from QIPP contract renegotiation;

(b) new cost pressures relating to national rules; and

(c) revised CIP targets.

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[116] Royal College of Radiologists (2008), *Standards for providing a 24-hour interventional radiology service*.
[117] Parties' initial submission, paragraphs 22 & 58.

4.27 On the basis of the revised figures, ASP is forecasting a deficit in each of the next five years. We have seen some data underpinning the 'material changes' and we consider that ASP's assumptions appear to be reasonable.

Monitor risk rating for ASP

4.28 ASP achieved a Monitor risk rating of 3 out of 4 ('good') in the last financial year. This rating is expected to remain the same over the next five years. ASP told us that it currently had a green (low risk) rating for its governance.[118]

Assessment of ASP's financial performance

4.29 Our assessment is that ASP would remain in the market if the merger did not proceed. Whilst we have not seen any evidence that ASP would fail in the short to medium term, we recognise that, in the absence of the merger, ASP would be under increasing financial pressure due to budgetary constraints and that it is predicted to run at a small deficit over the next five years. This would be likely to have an adverse impact on the range and quality of services it provides.

RSC's likely financial performance over the next five years without the merger and its implication for the counterfactual

4.30 RSC has shown year-on-year increases in patient activity, particularly in specialised cancer-related areas. It has been innovative in implementing outreach projects in both radiotherapy and chemotherapy at a number of neighbouring trusts. This innovation has been combined with further centralisation of highly specialised Cancer Surgery procedures (such as Urology and Oesophageal Surgery) that has increased activity.

4.31 RSC told us that it operated in a challenging commissioning environment, with its host commissioner, GWCCG, itself facing financial pressures.[119] RSC noted that there was an urgent need to find efficiencies across the whole local health economy to ensure its ongoing stability and sustainability, and it was working closely with other foundation trusts[120] to integrate patient pathways and reduce costs. GWCCG has an ambitious QIPP programme and, as a result, RSC is forecasting a reduction of approximately £12 million in patient-related income over the period 2015/16 to 2016/17.

4.32 RSC has had a good track record of delivering its CIP in recent years. However, RSC told us that, in 2014/15, delivery of the CIP programme came

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[118] Parties' initial submission, paragraph 25.
[119] Parties' initial submission, paragraph 41.
[120] Partners include ASP, Frimley Park, St George's and others.

under pressure and required the implementation of an in-year financial recovery plan.

4.33 RSC told us that it was becoming increasingly difficult to identify savings through the traditional methods of reducing posts or implementing small cost-cutting schemes. Some support services had already been outsourced, leaving little scope for further initiatives in this area. RSC noted that it had achieved productivity improvements in areas such as theatre efficiency and clinical support. This meant, however, that RSC now had to find more transformational schemes to deliver further efficiencies.

4.34 The Parties told us that the merged trust would be making investments of approximately £[✂] over [✂] years on the RSC site whereas, in the absence of a merger, RSC was planning to spend approximately £[✂] on its current site.[121] In addition, RSC submitted revised figures to reflect 'material changes' of which it had become aware since the LTFM was finalised in February 2015. These changes included:

(a) higher than expected overseas recruitment costs and other charges; and

(b) revised CIP targets.

4.35 On the basis of the revised figures, RSC is forecasting a small deficit in each of the next five years. We have seen some data underpinning these 'material changes' and, based on the information available to us at this stage, we consider that RSC's assumptions appear to be reasonable.

Monitor risk rating for RSC

4.36 RSC reported a surplus and achieved a Monitor risk rating of 4 out of 4 ('Good') in the most recent financial year. This rating is expected to remain the same over the next five years. RSC told us that it currently had a green (low risk) rating for governance.[122]

Assessment of RSC's financial performance

4.37 Our assessment of RSC is that it would remain in the market if the merger did not proceed. Whilst we have not seen any evidence that RSC would fail in the short to medium term, we recognise that, in the absence of the merger, RSC would be under increasing financial pressure due to budgetary constraints and that it is predicted to run at a small deficit over the next five years. This would

[121] Parties' initial submission, paragraph 85 and Table 9.
[122] Parties' initial submission, paragraph 28.

be likely to have an adverse impact on the range and quality of services it provides.

Current level of integration and cooperation

4.38 We also considered the extent to which, without the merger, the Parties might seek to extend their current Partnership. To the extent that this is a likely outcome, it might enable the Parties to realise some of the expected benefits of the merger.

4.39 At present, the Parties cooperate in some areas, for example, procurement and overseas nursing staff recruitment campaigns. This has been brought about by a number of factors, including:

(a) their duty of cooperation under the NHS Constitution and the requirement to provide an integrated clinical service in accordance with Monitor's integrated care requirements and improve patient care;

(b) the history and geographical locations of the Parties: the three hospitals are located within a short driving distance of each other; and

(c) the need to achieve operating efficiencies, as both Parties are under pressure to achieve annual cost reductions, which has led to some sharing of their respective cost bases, especially in relation to staff recruitment and the procurement of supplies.

4.40 The Parties reviewed the potential benefits of extending their partnership as part of the work leading to the OBC. However, the Parties do not believe that an extended partnership would allow them to achieve the same benefits and cost savings as a merger, as their analysis indicated that:

(a) the clinical benefits of providing complex seven-day services at scale could not be delivered or sustained through a partnership model;

(b) specialist service growth and enhancement would be less likely to occur without a merger, given competing trust priorities and the complexity of delivering this without a single overarching organisational structure;

(c) financial synergies and opportunities would be (at most) one-third of those of the merged trust and the outcome would remain that neither party would be financially sustainable; and

(d) other key potential merger benefits would either not be delivered at all or would be far harder, and take far longer, to realise in any partnership model.

4.41 In view of the limited extent to which the Parties have developed the Partnership since agreeing the HoT, and in the absence of any further evidence, our view is that an extended partnership is unlikely to be the appropriate counterfactual.

Other counterfactual scenarios

4.42 We also considered the extent to which, without the merger, the Parties have other options.

4.43 In terms of other horizontal mergers, the Parties told us that there were no other suitable merger candidates for either organisation. In the Parties' opinion, their complementary clinical services, and the similar culture and values of their respective clinical and managerial leaders, made the merger of these two organisations the preferred choice.

4.44 In the absence of further information, we believe that a merger with another party is not an appropriate counterfactual to the merger.

Conclusion on the counterfactual

4.45 We consider that, if the merger were not to proceed, neither ASP nor RSC would exit the market in the near future. However, the Parties would come under financial pressure, mainly due to continued tariff deflation and increasing requirements to deliver quality and efficiency improvements compounded by the increasing difficulty and cost of sourcing skilled staff. We consider that, as is the case for other NHS providers of acute services, this may have an adverse impact on their ability to provide the same or a better range and quality of services as is the case currently, and to make capital investments.

5. Market definition

5.1 The Guidelines state that the purpose of market definition in a merger inquiry is to provide a framework for the analysis of the competitive effects of a merger. Market definition is a useful analytical tool, but not an end in itself, and identifying the relevant market involves an element of judgement.[123]

5.2 The boundaries of the market do not determine the outcome of our analysis of the competitive effects of a merger in a mechanistic way. In assessing whether a merger may give rise to an SLC, we may take into account constraints

[123] The Guidelines, paragraphs 5.2.1 & 5.2.2.

outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others.[124]

5.3 The Guidelines also note that, in practice, the analysis underpinning the identification of the market or markets and the assessment of the competitive effects of a merger overlap, with many of the factors affecting market definition being relevant to the assessment of competitive effects and vice versa. Therefore, market definition and the assessment of competitive effects should not be viewed as distinct analyses.[125]

5.4 In the remainder of this section, we address the relevant markets in which the effects of the merger should be assessed. First, we address the appropriate product and geographic markets and, second, we present our conclusion on market definition.

Product market

NHS Merger Guidance

5.5 The NHS Merger Guidance states that the product market definition is specific to each case but that, in relation to mergers of NHS hospitals and providers of clinical services, we may adopt the following product market definitions:[126]

(a) each specialty is considered a separate product market;

(b) within each specialty, the following are considered as separate markets:

(i) outpatient and inpatient activities; (with day-cases treated as part of inpatient activity);

(ii) community and hospital-based care; and

(iii) elective and non-elective care; and

(c) private and NHS-funded services are also considered separately from each other, with the delineations at (a) and (b) being applicable to both private and NHS-funded services.

5.6 The Parties submitted that the product market definition as outlined above was a useful starting point for considering the constraints which the providers of different services may impose on each other. The Parties submitted that it was

[124] The Guidelines, paragraph 5.2.2.
[125] The Guidelines, paragraph 5.1.1.
[126] NHS Merger Guidance, paragraph 6.38.

necessary to assess the evidence at the specialty level on a case-by-case basis to reach a conclusion on the constraints that would be faced by a merged trust in each of the specialties in which it provided services.

5.7 We did not receive any evidence or submissions to suggest that we should take a different approach to that taken in the NHS Mergers Guidance. The Parties did, however, raise concerns about the approach taken regarding outpatient and inpatient activity, which we address below. We also address the constraints at sub-specialty level below.[127]

Outpatient, day-case and inpatient activity

5.8 Outpatient care includes first and follow-up consultant appointments, as well as diagnostic treatments that do not require admission.

5.9 Admitted patients may be day-case or inpatient. A day-case is where a patient is admitted electively during the course of a day with the intention of receiving care, but does not require the use of a hospital bed overnight and returns home as scheduled.[128] Inpatient treatments require patients to be admitted to hospital and involve an overnight stay.

5.10 Most specialties have both an outpatient and an admitted element, although there are some specialties that include only, or predominantly, outpatient treatments (for example, Audiology).

5.11 With respect to admitted activity for the Parties, inpatient activity constitutes a small proportion of admitted activity and day-cases comprise the remainder.

Parties' views

5.12 The Parties raised concerns about how outpatient and inpatient markets are defined and assessed. The Parties submitted that there was a complex interaction between the quality of inpatient and outpatient services, and how this influenced patient choice. They submitted that patients (and/or GPs) took the quality of inpatient services into account when choosing a provider.[129]

5.13 The issues raised by the Parties with respect to the determinants of patient choice are discussed in detail in Section 6 (elective acute and maternity services) below, drawing on information from the patient survey which we

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[127] NHS Merger Guidance, paragraph 6.38, notes that where there are limits to supply-side substitution within specialties, we may take into account constraints at sub-specialty level in our competitive assessment.
[128] Health & Social Care Information Centre: A coded classification of patients who have been admitted to a Hospital Provider Spell.
[129] Parties' initial submission, paragraph 141.

commissioned, including the extent to which patients and/or GPs choose particular providers based on inpatient and outpatient services.

5.14 In addition, the Parties submitted that, 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 offered outpatient services. This was because patients took into account the combined quality of inpatient and outpatient services when selecting their provider. The provider to which a patient switched would depend on the relative weighting that the patient/GP attached 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.[130]

5.15 The Parties submitted that a provider of elective inpatient services in a specialty was readily able to supply the less complex treatments that were typically undertaken as day-case procedures, as such a provider could be expected to have the necessary personnel, skills and equipment.

5.16 The Parties submitted that a provider of day-case procedures would not always be readily able to provide elective services to inpatients in the same specialty, for at least two reasons:

(a) First, locally defined clinical pathways might require that elective inpatient services in a particular specialty were carried out by only one provider. As a result, other providers that carried out day-case procedures in that specialty might be unable to start supplying elective inpatient services in response to tariff or other changes in market conditions.

(b) Secondly, a provider that offered day-case procedures in a specialty might not have the facilities or staff necessary for the provision of elective inpatient services. For example, a provider might be unable to recruit (or it might not be profitable to recruit) sufficient additional consultants to provide the level of consultant cover necessary to supply an inpatient elective service. Further, a provider specialising in day-case surgery may not have the facilities to allow patients to stay overnight.

5.17 The Parties submitted that providers of outpatient services could not readily start to offer day-case and elective inpatient services. They submitted that, in both cases, substantial investments in new facilities and in recruiting staff were

[130] Parties' initial submission, paragraph 142.

likely to be required, and that this pointed to separate product markets with the asymmetric constraint that is identified in the NHS Merger Guidance.[131]

Our assessment

5.18 We consider that, from a demand-side perspective, outpatient and either day-case or inpatient services are not substitutable, because of the different services offered in each setting, and because the setting in which it is most appropriate for a patient to be treated can depend on that patient's condition. However, day-case and inpatient services may have some similarities in some specialties and it may be the acuity of the patient's condition that determines which service is received.

5.19 We consider that, from a supply-side perspective, inpatient providers are readily capable of providing both day-case and outpatient services. Day-case-only providers are readily capable of providing outpatient services, but not inpatient services, because of the facilities and expertise required. Similarly, outpatient-only providers are not readily able to provide day-case or inpatient services.

5.20 In summary, consistent with the decision at phase 1, we consider there to be asymmetric constraints among different providers of inpatient, day-case and outpatient care for each specialty. We therefore consider that these treatments settings are distinct product markets.[132]

5.21 Providers of inpatient care generally compete with a wider set of providers, including day-case-only and outpatient-only providers, in the provision of day-case and/or outpatient care. However, this is unlikely to be the case across the full range of day-case and outpatient treatments, where day-case-only and outpatient-only providers cannot provide certain services. This may be because some day-case activity may have to take place at inpatient providers because of the equipment or capability required, and patients attend outpatient appointments at the provider at which their inpatient or day-case treatment has taken or will take place.

5.22 In our analysis, we distinguish between outpatient, day-case and inpatient services where this is possible and take into account the extent of competition that the Parties face from each other and other providers.

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[131] Parties' initial submission, paragraph 143.
[132] CMA phase 1 decision (February 2015), paragraph 65.

Speciality and sub-specialty level

5.23 Each specialty is considered to be a separate product market since:

(a) on the demand side, patients and referring GPs will only choose treatments that are relevant to the diagnosed condition or symptoms; and

(b) on the supply side, different sub-specialty services can generally be aggregated into a broader product market at the specialty level: providers have the ability and incentive quickly (generally within a year) to shift capacity between these different services depending on demand for each, and the same providers compete to supply these services.[133]

5.24 Where the conditions of competition are the same, certain specialties may be grouped together.

5.25 The NHS Mergers Guidance notes that, where there are limits to supply-side substitution within specialties, the CMA may take into account constraints at sub-specialty level in its competitive effects assessment.[134]

5.26 We note that there may be limits to supply-side substitution within specialties, because providers may not have the ability or incentive to provide certain sub-specialty treatments. Providers may not have the ability to undertake all complex treatments, for example because of the equipment or capability needed, or because of the pricing structure, whereby the same tariff applies to treatments with differing costs.

5.27 Commissioning arrangements may also limit the extent to which providers can offer certain sub-specialty level treatments. In this regard, specialised services (some of which are provided by the Parties and third parties nearby) are a subset of more complex treatments within a specialty, which providers can only offer if they are commissioned to do so by NHS England. Accordingly, the commissioning of these services places limits on supply-side substitution within a specialty.

5.28 Since not all providers have the ability or incentive to offer all treatments within a specialty, for the reasons set out above, the extent to which providers compete with each other for these treatments differs. We take this into account in the competitive assessment.

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[133] The Guidelines, paragraph 5.2.17.
[134] NHS Merger Guidance, paragraph 6.38.

Geographic market

NHS Merger Guidance

5.29 The NHS Merger Guidance states that, in publicly funded healthcare services, the relevant geographic market may be based on the locations of providers and will be informed by an assessment of the willingness of patients to travel for consultation or treatment, the 'catchment area'.[135]

5.30 Both Parties are located in Surrey. ASP has two sites, SPH in Chertsey and AH in Ashford, Middlesex. RSC's main site is in Guildford. In addition to their main hospital sites, both Parties also hold outpatient clinics at different locations. ASP holds 47 different outpatient clinics at 14 other locations across Surrey and South West London. RSC holds 79 different outpatient clinics at 26 other locations across Surrey and further afield.[136]

Parties' views

5.31 The Parties submitted that the rationale for opening outpatient clinics in locations other than a provider's main hospital site was that patients valued having access to services as close to home as possible. As a result, providing outpatient clinics at places other than the main hospital site met the overarching public service requirements of NHS providers to offer the best possible service to patients. The Parties submitted that there was, 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 needed to be provided at the main hospital site).[137]

5.32 The Parties submitted that the catchment area overlap analysis was relevant to our consideration of whether an SLC arose from this merger because they considered that the assumptions in the GP referral analysis about how GPs/patients might switch among providers were restrictive.[138]

Catchment area

5.33 We used a catchment area analysis to identify the extent of the areas (in terms of travel distance from the hospital) from which a large proportion of patients originate. This provides an indication of the area in relation to which the Parties are likely to be important alternatives to each other for patients/GPs. Where

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[135] NHS Merger Guidance, paragraph 6.40.
[136] Parties' initial submission, paragraph 119.
[137] Parties' initial submission, paragraph 118.
[138] Parties' initial submission, paragraph 164.

catchment area analysis is used, the CMA generally considers the area from which 80% of patients travel (calculated from their GP practice).

5.34 We used catchment areas as a starting point of reference. In our competitive assessment in Section 6 (elective acute and maternity services), we examine the constraints on the Parties from other providers by reference to GP referral analysis, which allows us to infer the strength of each hospital as an alternative choice at the GP practice level, including those outside the catchment area.

- *Data and methodology*

5.35 We used data[139] containing details on the referring GP practice postcode for each period of care for a patient under a consultant (an episode). We used the GP practice postcode as a proxy for patients' locations. We used MapInfo software to estimate the drive-time between the sites of the Parties and the locations of the GP practices from which they drew patients. We then calculated the drive-times that captured 80% of the patients treated by each merging hospital.

- *CMA analysis*

5.36 Table 1 shows the drive-times of patients that were treated at AH, SPH and RSC across treatment settings and averaged across specialties over four years.

Table 1: Drive-time for 80% catchment area over time, across specialties

minutes

Hospital	*Service*	*2010/11*	*2011/12*	*2012/13*	*2013/14*	*2010/11 to 2013/14*
RSCH	Elective day-case	24	24	24	24	24
RSCH	Elective inpatient	24	24	24	24	24
RSCH	Elective outpatient	21	21	22	23	22
RSCH	Non-elective day case	23	24	23	24	23
RSCH	Non-elective inpatient	24	24	24	24	24
SPH	Elective day-case	15	15	15	15	15
SPH	Elective Inpatient	15	15	15	15	15
SPH	Elective outpatient	15	15	14	14	15
SPH	Non-elective day case	14	15	14	14	14
SPH	Non-elective inpatient	14	14	14	14	14
AH	Elective day-case	18	21	20	21	20
AH	Elective inpatient	21	21	21	21	21
AH	Elective outpatient	14	14	15	15	14
AH	Non-elective inpatient	18	21	21	21	21

Source: Hospital Episode Statistics (HES) data, CMA analysis.

[139] HES data set covering admitted patients during the period 2010–2014.

5.37 We found that the average drive-time associated with the 80% catchment area of SPH was smaller than that of AH or RSC. It was around 14 to 15 minutes for SPH and between 20 and 25 minutes for AH and RSC, with the exception of outpatient services at AH, which had an average drive-time of 14 minutes.

5.38 This suggests that outpatients at AH came from areas closer to the hospital site, in terms of drive-time, than was the case for patients of other services.

5.39 We found that the drive-times remained stable over the four years.

5.40 We considered the drive-times associated with the 80% catchment areas for each specialty, at each of the Parties' main sites (see Tables 2, 3 and 4). We found there to be little variation in the drive-time associated with the 80% catchment across the majority of specialties for each site. We found that the catchment areas remained stable over the four years, when averaged across specialties. When averaged across specialties, we consider these drive-times to be representative of the typical drive-times of the Parties' patients and we therefore used these to map the catchment areas.

Table 2: Drive-time within which AH draws 80% catchment area over time, across specialties

minutes

	Elective			*Non-elective*		
Specialty	*Outpatient*	*Inpatient*	*Day-cases*	*Inpatient*	*Day-cases*	*Total number of patients*
Accident & Emergency			20			[400–500]
Anaesthetics	16					[0–100]
Audiology/Audiological Medicine	13					[9000–10,000]
Breast Surgery	17	21	21			[10,000–15,000]
Cardiac Rehabilitation	13					[0–100]
Cardiology	14	15	21			[6,000–7,000]
Clinical Haematology	13					[900–1,000]
Clinical Oncology (Previously Radiotherapy)	5		13			[400–500]
Colorectal Surgery	16		17	22		[3,000–4,000]
Dermatology	17					[9,000–10,000]
Diabetic Medicine	11					[600–700]
Dietetics	11					[1,000–2,000]
ENT	14	11	18			[9,000–10,000]
Endocrinology	17		23			[2,000–3,000]
Gastroenterology	13	11	14	21		[5,000–6,000]
General Medicine	20	21	21	21	25	[1,000–2,000]
General Surgery	21	21	20	16	5	[5,000–6,000]
Geriatric Medicine	17			20		[1,000–2,000]
Gynaecology	17	21	22			[8,000–9,000]
Maxillo-Facial Surgery	15	13	20	14		[9,000–10,000]
Midwifery Service	11					[2,000–3,000]
Nephrology	12					[400–500]
Neurology	16					[3,000–4,000]
Obstetrics		15				[0–100]
Occupational Therapy	13					[600–700]
Ophthalmology	15	17	18	18	23	[25,000–30,000]
Oral Surgery		20	21	11		[1,000–2,000]
Orthodontics	17					[1,000–2,000]
Orthoptics	15					[1,000–2,000]
Paediatric Ophthalmology	17					[3,000–4,000]
Paediatrics	13					[2,000–3,000]
Pain Management	14	20	18			[5,000–6,000]
Physiotherapy	11					[7,000–8,000]
Rehabilitation Service		11		21		[500–600]
Respiratory Medicine	15					[2,000–3,000]
Rheumatology	13					[3,000–4,000]
Speech And Language Therapy	22					[0–100]
Trauma & Orthopaedics	14	21	21	22		[25,000–30,000]
Upper Gastrointestinal Surgery	16	15	20	22		[1,000–2,000]
Urology	14	22	21	21		[10,000–15,000]
Vascular Surgery	13	37	21			[2,000–3,000]
Average across specialties	**14**	**21**	**20**	**21**	**24**	**[100,000–200,000]**

Source: HES data, CMA analysis.

Table 3: Drive-time within which SPH draws 80% catchment area over time, across specialties

minutes

	Elective			*Non-elective*		
Specialty	*Outpatient*	*Inpatient*	*Day-cases*	*Inpatient*	*Day-cases*	*Total number of patients*
Accident & Emergency	14	16	16	14	14	[10,000–15,000]
Adult Mental Illness				13	16	[0–100]
Anaesthetics	15			21		[0–100]
Anticoagulant Service	14					[1,000–2,000]
Audiology/Audiological Medicine	15					[9,000–10,000]
Breast Surgery	14	14	15	16	14	[4,000–5,000]
Cardiac Rehabilitation	13					[0–100]
Cardiology	15	19	18	16	19	[20,000–25,000]
Cardiothoracic Surgery	13					[0–100]
Chemical Pathology			10			[0–100]
Clinical Haematology	14	15	15	15	14	[10,000–15,000]
Clinical Oncology (Previously Radiotherapy)		14	14	16		[300–400]
Clinical Psychology	30					[0–100]
Colorectal Surgery	14	15	14	15	14	[10,000–15,000]
Critical Care Medicine		15	14	15	16	[100–200]
Dermatology	14		16	16	14	[15,000–20,000]
Diabetic Medicine	15			13		[1,000–2,000]
Dietetics	13					[2,000–3,000]
ENT	15	14	14	13	16	[10,000–15,000]
Endocrinology	15	16	16	16	18	[1,000–2,000]
Gastroenterology	15	14	14	14	15	[20,000–25,000]
General Medicine	14	15	15	14	14	[35,000–40,000]
General Surgery	15	15	14	14	15	[25,000–30,000]
Geriatric Medicine	13	13	14	14	14	[2,000–3,000]
Gynaecological Oncology			16	8		[0-100]
Gynaecology	15	15	15	14	15	[25,000–30,000]
Learning Disability			13			[0–100]
Maxillo-Facial Surgery	15	15	16	16	11	[15,000–20,000]
Medical Oncology	14	12	13	13		[500–600]
Medical Ophthalmology						-
Midwifery Service	14	14	14	20	18	[40,000–45,000]
Neonatology		15	16	25	15	[2,000–3,000]
Nephrology	16		9	5		[0–100]
Neurology	15		14	16		[5,000–6,000]
Obstetrics	14	14	14	36	13	[25,000–30,000]
Occupational Therapy	13					[300–400]
Ophthalmology	15	14	16	16	14	[25,000–30,000]
Oral Surgery			20			[600–700]
Orthodontics	20					[400–500]
Orthoptics	16			7		[200–300]
Paediatric Cardiology	14					[0–100]
Paediatric Clinical Haematology	12					[0–100]
Paediatric Clinical Immunology And Allergy Service	14					[300–400]
Paediatric Diabetic Medicine	16					[0–100]
Paediatric Endocrinology	15					[0–100]
Paediatric Ophthalmology	16					[800–900]
Paediatric Respiratory Medicine	14					[0–100]
Paediatric Rheumatology						-
Paediatric Surgery	15					[100–200]
Paediatric Trauma And Orthopaedics	15					[500–600]
Paediatric Urology	13					[0–100]
Paediatrics	14	14	13	14	14	[25,000–30,000]
Pain Management	16	14	14	4		[5,000–6,000]
Physiotherapy	11					[5,000–6,000]
Rehabilitation Service				14	10	[0–100]
Respiratory Medicine	15	15	15	14	14	[7,000–8,000]
Rheumatology	14	16	16	15	14	[6,000–7,000]
Speech And Language Therapy	13					[0–100]
Transient Ischaemic Attack	7					[0–100]
Trauma & Orthopaedics	14	16	16	15	15	[45,000–50,000]
Upper Gastrointestinal Surgery	14	21	16	14	16	[5,000–6,000]
Urology	15	16	15	14	14	[10,000–15,000]
Vascular Surgery	15	18	16	18	19	[6,000–7,000]
Well Babies		14	14	14	14	[10,000–15,000]
Average across specialties	**15**	**15**	**15**	**14**	**14**	**[400,000–500,000]**

Source: HES data, CMA analysis.

Table 4: Drive-time within which RSC draws 80% catchment area over time, across specialties

minutes

	Elective			*Non-elective*		
Specialty	*Outpatient*	*Inpatient*	*Day-cases*	*Inpatient*	*Day-cases*	*Total number of patients*
Accident & Emergency				23	23	[3,000–4,000]
Adult Mental Illness						-
Anaesthetics	17	24		11		[0–100]
Anticoagulant Service	18					[100–200]
Audiology/Audiological Medicine	21		26		26	[4,000–5,000]
Breast Surgery	24	24	24	31	35	[10,000–15,000]
Cardiac Rehabilitation						-
Cardiology	18	21	18	21	24	[15,000–20,000]
Cardiothoracic Surgery	21		12		10	[0–100]
Chemical Pathology	18		31	13		[700–800]
Clinical Haematology	18	23	23	23	21	[7,000–8,000]
Clinical Immunology and Allergy Service	36	25	28	18	18	[5,000–6,000]
Clinical Microbiology				18		[0–100]
Clinical Oncology (previously Radiotherapy)	36			37		[200–300]
Clinical Psychology						-
Colorectal Surgery	23	24	24	24	23	[700–800]
Dermatology	18	39	19	18		[15,000–20,000]
Diabetic Medicine	21	2	20	24	23	[1,000–2,000]
Dietetics						-
ENT	22	29	24	29	29	[25,000–30,000]
Endocrinology	23	6	6	24	18	[2,000–3,000]
Gastroenterology	20	24	23	23	23	[25,000–30,000]
General Medicine	23	21	24	23	18	[3,000–4,000]
General Surgery	23	35	24	24	24	[55,000–60,000]
Geriatric Medicine	18	24	24	23	23	[15,000–20,000]
Gynaecological Oncology	23	36	34	28	28	[1,000–2,000]
Gynaecology	18	24	23	20	20	[30,000–35,000]
Haemophilia Service			12			[0–100]
Hepatobiliary & Pancreatic Surgery	28	41	28	44	24	[500–600]
Hepatology	24	11	18	23	16	[1,000–2,000]
Interventional Radiology		39	29	29	43	[100–200]
Learning Disability						-
Maxillo-Facial Surgery	23	30	23	30	28	[40,000–45,000]
Medical Oncology	31	36	37	30	30	[30,000–35,000]
Medical Ophthalmology	20					[3,000–4,000]
Midwifery Service	30	24	17	17	18	[100–200]
Neonatology		20	24	19	20	[2,000–3,000]
Nephrology	24					[0–100]
Neurology	23	29	24	24	17	[7,000–8,000]
Obstetrics	18	20	18	18	24	[20,000–25,000]
Occupational Therapy						-
Ophthalmology	20	24	23	29	29	[30,000–35,000]
Optometry	18					[600–700]
Oral Surgery	24	24	24	31	25	[10,000–15,000]
Orthodontics	21	32	21	18		[2,000–3,000]
Orthoptics	18					[2,000–3,000]
Paediatric Cardiology	18					[500–600]
Paediatric Clinical Immunology and Allergy Service	18		4			[100–200]
Paediatric Diabetic Medicine	18					[0–100]
Paediatric Endocrinology	24					[300–400]
Paediatric Medical Oncology		15	18			[0–100]
Paediatric Nephrology	21					[100–200]
Paediatric Neuro-Disability	18					[900–1,000]
Paediatric Neurology	23			11		[0–100]
Paediatric Ophthalmology						-
Paediatric Respiratory Medicine	24			24		[100–200]
Paediatric Rheumatology	23					[0–100]
Paediatric Surgery	19	41	19	18		[700–800]
Paediatric Trauma And Orthopaedics	17					[0–100]
Paediatrics	18	19	20	23	20	[15,000–20,000]
Pain Management	23	24	24		35	[6,000–7,000]
Palliative Medicine	24			18		[0-100]
Physiotherapy						-
Plastic Surgery	20	17		38		[2,000–3,000]
Rehabilitation Service				30		[0–100]
Respiratory Medicine	21	18	20	23	24	[9,000–10,000]

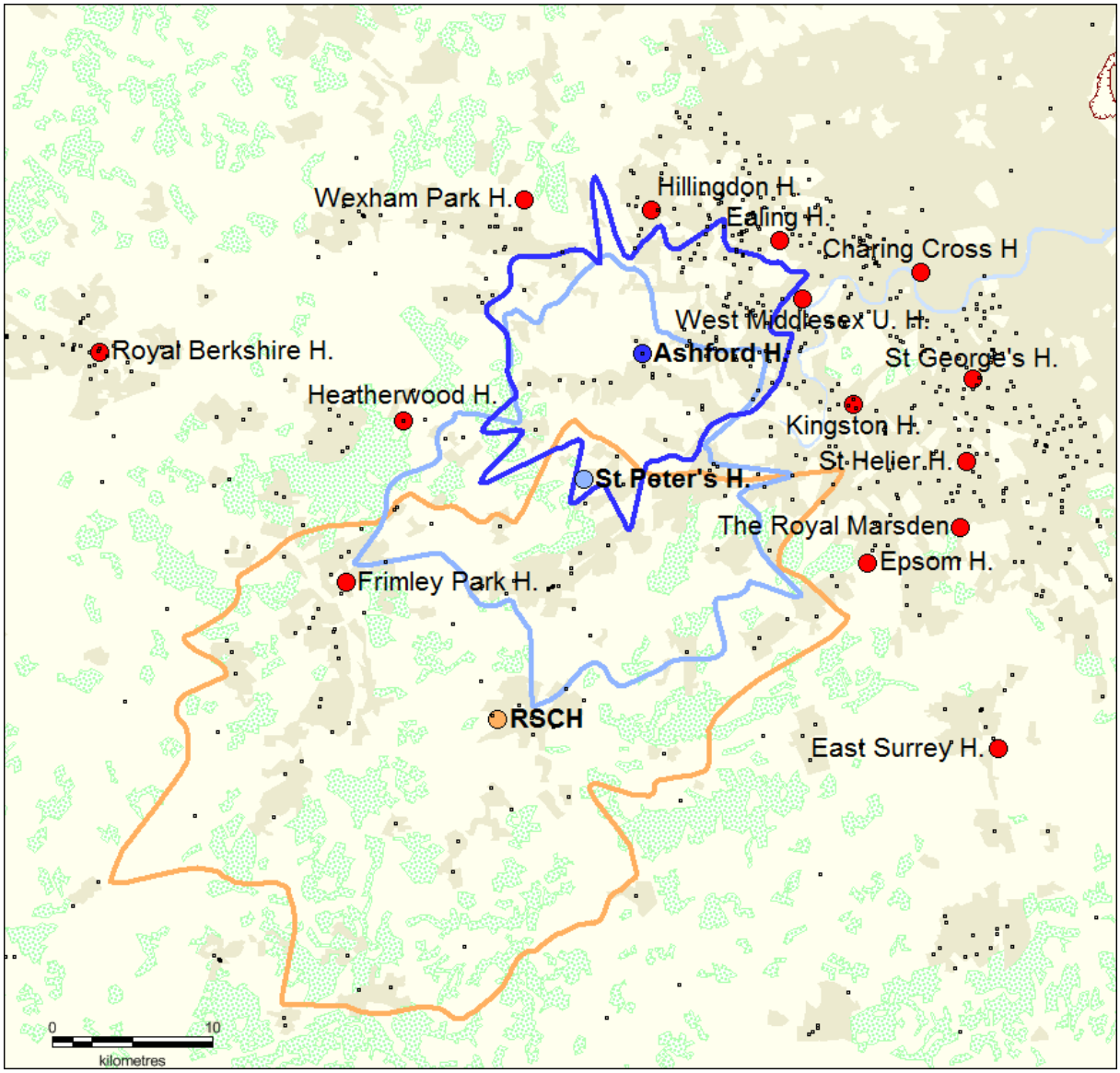
						minutes
	Elective			Non-elective		
Specialty	*Outpatient*	*Inpatient*	*Day-cases*	*Inpatient*	*Day-cases*	*Total number of patients*
Respiratory Physiology	24					[1,000–2,000]
Rheumatology	23	24	18	23	23	[10,000–15,000]
Transient Ischaemic Attack	23					[600–700]
Trauma & Orthopaedics	23	23	23	24	24	[50,000–55,000]
Upper Gastrointestinal Surgery	6	28	26	41	2	[0–100]
Urology	18	30	23	23	24	[25,000–30,000]
Vascular Surgery	18	12	18	12	35	[1,000–2,000]
Well Babies		18	18	18	4	[7,000–8,000]
Average across specialties	**22**	**24**	**24**	**24**	**23**	**[500,000–600,000]**

Source: HES data, CMA analysis.

5.41 We mapped the catchment areas by drawing isochrones around the sites of the Parties using the drive-time data provided in the above tables. Figures 1, 2 and 3 below show the 80% catchment areas of AH, SPH and RSC for elective outpatient, elective inpatient and elective day-cases. The locations of the GP practices of the patients who attended the Parties are shown in the maps as small black dots.

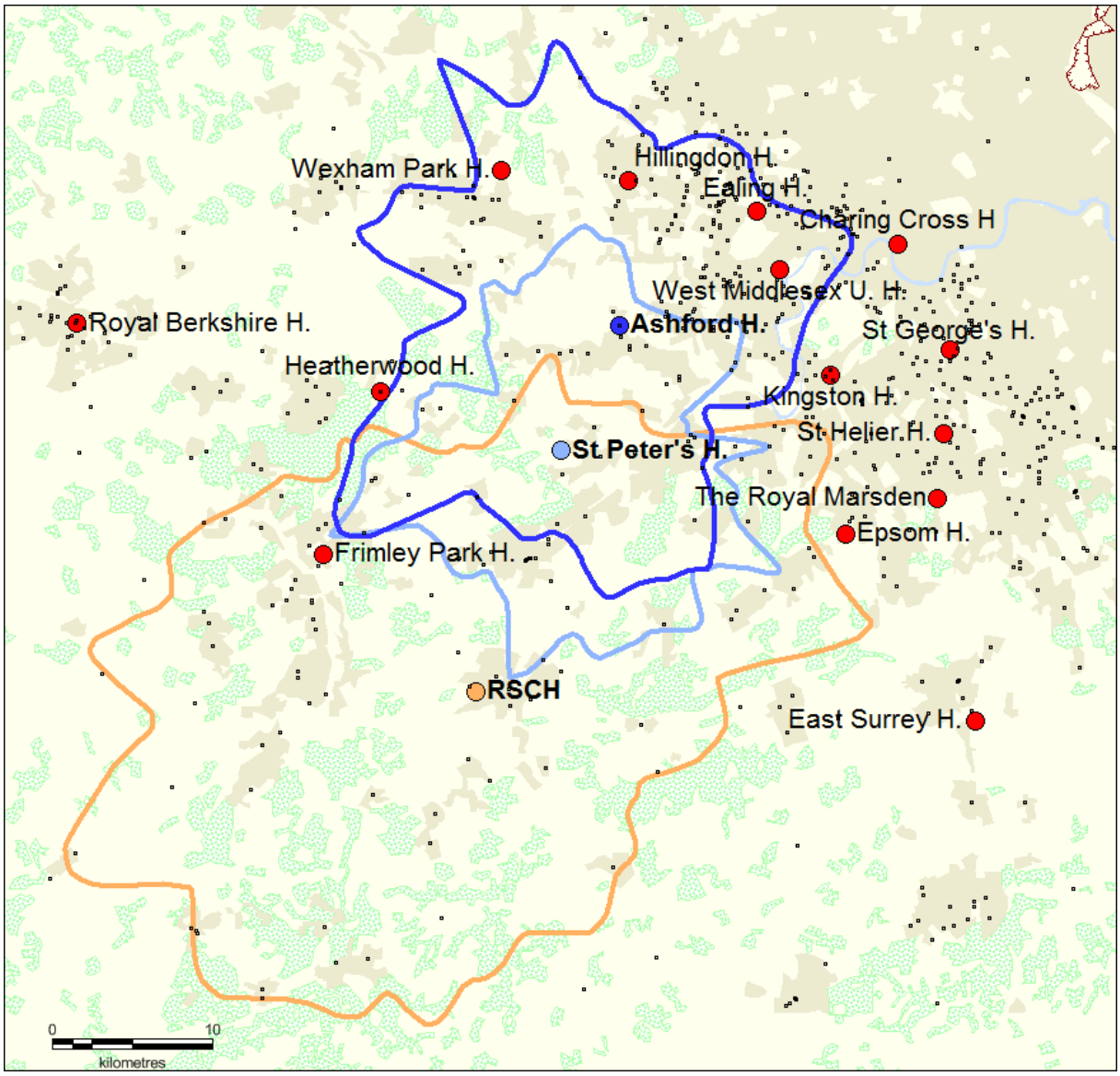
5.42 Figures 1, 2 and 3 show that the catchment area of RSC overlaps with the southern half of the catchment area of SPH, across each of the three elective treatment settings. RSC's catchment area also overlaps with much of AH's catchment area in relation to elective inpatient and elective day-case services, but the overlap is relatively small in relation to elective outpatient services.

Figure 1: Outpatient catchment areas



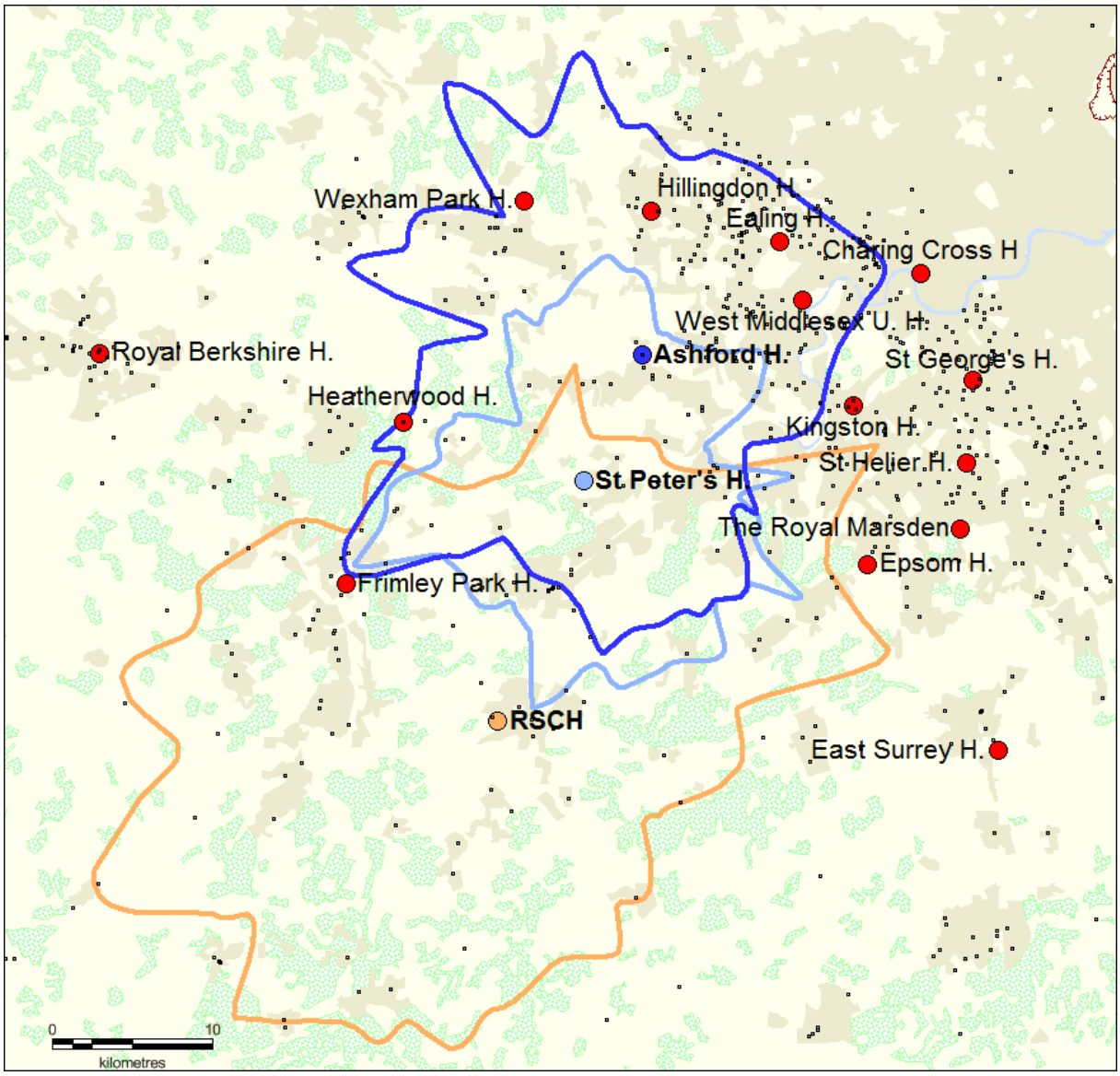
Source: HES data, CMA analysis.

Figure 2: Day-case catchment areas



Source: HES data, CMA analysis.

Figure 3: Inpatient catchment areas



Source: HES data, CMA analysis.

GP practices in overlapping catchment areas

5.43 We examined the number of GP practices that lie in the overlap of the catchment areas of AH, SPH and RSC and of nearby hospitals. We considered this in relation to elective services across treatment settings. Our results are summarised in Table 5.

Table 5: Number of GP practices and patients within overlap of catchment areas of Parties' hospitals and of other hospitals

	Overlap of Parties' hospitals' catchment areas GP practices (Number of patients)	*Overlap of Parties' and of other hospitals' catchment areas GP practices (Number of patients)*		
		Parties plus one or more	*Parties plus two or more*	*Parties plus three or more*
Elective day-case	33 (110.848)	8 (34,854)	3 (14,615)	1 (2,870)
Elective inpatient	36 (49,758)	10 (16,416)	6 (8,816)	0 (0)
Elective outpatient	22 (192,048)	2 (26,351)	2 (26,351)	0 (0)

Source: HES data, CMA analysis.

5.44 Table 5 shows the number of GP practices that are within the overlap of the catchment area of RSC and of either AH or SPH, and of the catchment area of one or more, two or more or three or more other hospitals. The table shows that, in relation to elective day-cases for example, there are 33 GP practices that are in the overlap of the catchment areas of the Parties. Of these, eight are also in the catchment area of one or more other hospital sites, and three are in the catchment area of two or more other hospitals. Only one of those 33 practices is also within the catchment area of three or more other hospitals.

5.45 Table 5 shows that, of the GP practices that are within the overlap of the catchment areas of the Parties' hospitals, a small share, no greater than a third, are also within the catchment area of one or more other hospitals. The share is particularly small for elective outpatient services in relation to which, of the 22 practices that are within the overlap of the Parties' catchment areas, only two are also within the catchment areas of two or more other hospitals, and none are within the catchment areas of three or more other hospitals. For elective day-cases and elective inpatients, slightly more than a quarter of the GP practices that are in the overlap of the Parties' catchment areas are also within the catchment area of one other hospital. Of these, only one in the case of day-cases and none in the case of outpatients is also within the catchment area of three or more other hospitals.

5.46 Overall, this evidence appears to suggest that relatively few GP practices which are within the catchment area overlaps of the Parties are also in the catchment area of another trust. This indicates that, for these practices at least, the Parties may be the closest competitors for patient referrals.

5.47 We examined which was the hospital nearest to those patients that attended RSCH, SPH or AH. We considered outpatients, elective day-cases, elective inpatients, non-elective day-cases and non-elective inpatients separately. We

considered that the nearest hospital to a patient would be the one with the shortest drive-time from the GP practice at which the patient was registered.[140]

5.48 We found that 10 to 14% of the patients who attended RSC lived in areas for which SPH is the closest hospital. Around 1% of patients who attended RSC lived in areas for which AH or SPH is the closest hospital. This suggests that more patients closest to SPH choose RSC than patients closest to RSC viewed either AH or SPH as an alternative.

Conclusions on the relevant markets

5.49 Regarding the product market, we conclude the following:[141]

(a) Each specialty is a separate product market. Where not all providers have the ability or incentive to offer all treatments within a specialty, the extent to which providers compete with each other in respect of these treatments differs. We take this into account in the competitive assessment.

(b) Within each specialty, the following were considered as separate markets:

(i) outpatient, day-case and inpatient activity. Given the existence of asymmetric constraints among different providers, for each specialty, inpatient, day-case and outpatient care are considered to be distinct product markets;

(ii) community and hospital-based care; and

(iii) elective and non-elective care.

(c) Private and NHS-funded services were also considered separately from each other, with the delineations at *(a)* and *(b)* being applicable to both private and NHS-funded services.

5.50 Regarding the geographic market, the evidence from our catchment area analysis indicated that the Parties attracted most of their patients from within a drive-time of 14 to 15 minutes for SPH and 20 to 25 minutes for AH and RSC (with the exception of outpatients attending AH, which had an average drive-

[140] In our analysis we restricted the set of hospital sites which could be considered to be the ones nearest to a patient. In particular, we wished to exclude hospital sites (eg community hospitals) which we considered would not be reasonable alternatives for many of the patients that attended RSCH, SPH or AH because of the limited services offered. We chose as the set of candidate hospital sites nearest to patients those that were identified by the Parties as acute trust hospitals near RSCH, SPH and AH.
[141] NHS Merger Guidance, paragraph 6.38.

time of 14 minutes). There is no significant variation in drive-times associated with different specialties.

5.51 We note that the catchment area is typically narrower than the geographic market identified using the hypothetical monopolist test.[142] We take this into account in our competitive assessment in Section 6 where we look at other providers and the competitive pressures they place on Parties.

5.52 We conclude that the Parties compete locally in Surrey and the surrounding area.

6. Elective acute and maternity services to patients

6.1 As set out in our issues statement, we have investigated the services that both Parties offer for inpatients, day-cases and outpatients. These are:

(b) Elective acute services: services that are planned and typically require a referral from a GP or an allied healthcare professional.

(c) Non-elective acute services: services that are unplanned or provided in urgent circumstances, such as A&E as well as supporting services such as emergency surgery and critical care services. Patients may be treated across a range of specialties.

(d) Services to private patients: services to private (fee-paying) patients.

(e) Specialised services: these services are often low-volume, and tend to have few providers in a region. These services can be elective or non-elective.

(f) Community services: services provided in residential and community settings.

6.2 We set out our findings for each of these services in turn in the following sections. This section focuses on elective acute and maternity services.

6.3 Elective services are services that are planned in advance, as opposed to emergency (non-elective) services, and are provided by medical specialists in a hospital or other secondary care setting. Maternity services, whilst categorised as non-elective, are planned services; on this basis, we have included maternity services as part of our assessment of elective acute services.

[142] The Guidelines, paragraph 5.2.25.

6.4 We considered whether the merger may be expected to give rise to unilateral effects in the provision of elective acute and maternity services. Unilateral effects may arise in horizontal mergers where the merger involves two competing entities and removes the rivalry between them. In this case, we considered whether the merger might result in the elimination of rivalry which would remove the incentive of the merged trust to maintain or improve quality.

6.5 First, we set out our views on the nature of competition in elective services.

6.6 In the next sections, we set out the building blocks of our competitive assessment. We first discuss evidence on the how patients/GPs choose providers of elective services.

6.7 We next consider specific factors that may influence the Parties' incentives to compete to maintain current patient referral levels or to increase patient referrals, namely the commissioning arrangements, the profitability of services and the Parties' capacities.

6.8 We discuss the role that competition plays in the Parties' decision-making through our assessment of the Parties' internal documents.

6.9 We then provide information on elective service providers in the Surrey area, outlining aspects of geographic and service differentiation by providers.

6.10 Finally, we provide our competitive assessment, in which we consider the extent to which the Parties compete with each other and other hospitals in and around the Surrey area.

The nature of competition in elective services

6.11 We note that competition among NHS providers of elective services is almost always in relation to quality, rather than price. This is because the majority of prices for services are determined centrally in accordance with set tariffs.[143]

6.12 The quality of a product or service is the outcome of many different decisions that are made at different levels across an organisation. In the case of hospital services, these decisions are taken by clinicians and managers. We understand that, when making such decisions, they trade off different factors. For example, a decision not to fill a nursing vacancy is likely to involve trading off the possible effect on quality of care against the impact on the cost of providing that care,

[143] We note that the prices that NHS commissioners pay providers for healthcare services can be determined locally rather than nationally in a range of circumstances (see Monitor and NHS England guidance: NHS providers and commissioners: submit locally determined prices to Monitor).

even though the NHS clinical and other staff who make that decision are personally and professionally committed to providing quality care for patients.

6.13 To the extent that there is a fixed price for each elective procedure, hospitals will increase their revenues by treating more patients. Providers are motivated to compete on quality in order to attract patient referrals and hence income. Research has broadly shown that, in the NHS, under the current system of largely fixed prices, greater competition is associated with higher levels of quality. The effect of competition is, in principle, that decisions affecting quality reflect factors that matter to patients and GPs. Further information on the nature of competition in the NHS is set out in Appendix H.

The role of regulation

6.14 The Parties submitted that quality regulation and professional diligence are critical in determining how healthcare services are delivered. In their view, competition considerations do not have a significant influence on the attitudes and objectives of the management and staff of providers of healthcare services (their primary concerns are to meet regulatory standards and achieve the best outcomes for patients) and market incentives, whilst playing a role, are significantly less important for providers operating predominantly in the NHS than for private sector entities operating in a normal commercial environment. In support of this, the Parties submitted a survey of board meeting minutes over a period of two years which indicated that issues relating to standards, quality and governance were discussed much more frequently than competition with third parties.

6.15 The Parties also submitted that there are financial consequences to a failure to maintain quality, including potential fines and penalties where governance, infection, access and outcome standards are not met. In addition, insurance premiums are a significant cost item and poor claims records lead to material increases in such premiums.

6.16 In our view, whilst regulation plays an important role in ensuring minimum standards of quality in the provision of elective services, it does not lead to all providers providing the same levels of quality and does not remove the incentive for providers to compete to offer higher quality care than is mandated by regulatory standards. That said, we recognise that financial constraints may limit the scope for improving quality levels substantially above the prescribed standards.

Theory of harm

6.17 The concern that we investigated is whether the merger may be expected to lead to a reduction in competition in the Surrey area, which would reduce the incentive on the merged trust to improve or maintain quality, and as a result lead to lower quality services for patients than in the counterfactual.

6.18 In analysing the likely effects of the merger, we consider there are many different aspects of quality. Aspects of quality which may be affected by a reduction in competition include clinical factors, such as infection rates, mortality rates, ratio of nurses or doctors to patients, equipment and best practice; and non-clinical factors, such as waiting times, access, cleanliness and parking facilities. Accessibility of services may also be viewed as an aspect of quality if a provider offers, or could offer, a choice of locations at which particular services are made available. Some of these aspects of quality relate to specialties (such as departmental standards) while others relate to hospital-wide quality (such as facilities).

6.19 We have also investigated whether there are linkages between services, such that there are aspects of quality which are set in a common way across those services. Examples of reasons for such linkages include the following:

(a) The delivery of care and patient pathways are inter-linked.

(b) The organisation of specialties within providers, for example because patients across specialties are on the same ward.

(c) Decision-making processes are consistent across specialties.

(d) Quality is considered to be linked by patients/GPs when they make decisions about choice of hospital. Examples of aspects of quality that may be common across specialties include (i) cleanliness of wards; (ii) nurse ratios for specialties on the same ward; and (iii) expertise and equipment for specialties that are clinically linked.

6.20 Linkages between services are important to how we conduct and interpret the analysis and also in determining if and where harm may arise as a result of the merger.

6.21 We set out our summary of our linkages analysis in Appendix E. We discuss linkages in relation to particular specialties in paragraphs 6.167 to 6.170, 6.187 and 6.203 to 6.205 below.

Patient/GP choice

6.22 In order for the Parties to have an incentive to compete, they must expect that the decisions they make which affect the quality of their services will affect the choices made by GPs and patients. In this section, we consider how patients and GPs make choices of elective service providers.

6.23 We commissioned a patient survey and GP research to help us understand how patient choice in relation to elective treatment might be affected by the merger. One of the objectives of this research was to improve our understanding of patients' choice of hospitals and the reasons they chose the hospital they attended. The survey report is published on our case page.[144]

6.24 Four hundred and seventy-nine telephone interviews were conducted with patients who had been referred by a GP to one of the two hospitals within the previous six months for treatment of a condition involving one of the overlap specialties (we discuss overlaps between the Parties in paragraphs 6.113 to 6.120); there were 251 interviews with SPH patients and 228 with RSC patients.

6.25 Seventeen qualitative telephone interviews were conducted with GPs who had made a referral to either of the hospitals in one of the overlap specialties in the previous three months.

Role of the GP

6.26 We found that GPs and patients both contribute to the choice of provider. From the patient survey, we found that one in four of patients who were aware that they had a choice discussed with their GP the hospital to which they might go. Just over a quarter of patients said their GP gave a recommendation of a hospital, and in the large majority of these cases the recommended hospital was the hospital that the patient actually attended.

[144] We note that patients at AH and SPH may have different preferences and choice sets, and so, taking a cautious approach, we interpret the results of the survey with respect to SPH. We have chosen to conduct the survey at RSC and SPH as we consider that patients attending these hospitals are most likely to be impacted by the merger due to their locations and we note that that RSC and SPH are more similar in service offering than AH, which only offers planned care (including outpatient services and day case surgery). Moreover, given the substantially fewer outpatients seen at AH, as compared with SPH and RSC, it would be challenging to achieve a sufficient sample size and coverage within the time constraints of the merger review for survey results at AH to be meaningful. We have therefore chosen to prioritise our resources on SPH and RSC, given the time and budget constraints. We note that evidence from the survey is only one source of evidence that we considered as part of this merger investigation.

6.27 This indicates the important role of GPs in providing information to patients about their choices and in making recommendations to patients of a provider, which are usually followed.

Patient awareness of choice

6.28 Approximately half of the patients interviewed were aware before they visited their GP that they could choose which hospital to attend, and only a small minority said that they were unaware in advance but were informed by the GP that they had a choice. Most (about three in four) of those who were aware they had a choice before they went to their GP also knew which hospital they wanted to go to if they needed to be referred. The academic research was echoed in the GP research (see below).

Factors important to choice

6.29 We note that academic research indicates that location is an important factor influencing the choice of hospital, as well as measures of quality (see Appendix H, paragraphs 34 onwards).

6.30 The results of our patient survey were in line with these findings:

(a) When asked unprompted why they had decided to go to the hospital they attended, the overwhelming reason for SPH patients was that it was close to their home: 62% said that this was the case, compared with 45% of RSC patients. This is consistent with our catchment area drive-time analysis discussed in paragraphs 5.36 to 5.42.

(b) When patients were asked to rate the importance of features after prompting with a list of different features, the factor considered most important was the expertise of the consultants and other healthcare professionals, and the next most important factors were the quality of nursing care, good previous experience at the hospital, the availability of specialist medical equipment and treatment outcomes.

6.31 The GP research suggests that, for GPs, expertise of a consultant or unit was often the priority, and that feedback from patients on the following aspects also affected their referral decisions: long waiting times; bounce-back referrals (where referrals are returned to the GP); staffing capacity (with particular concerns regarding the availability of staff to provide aftercare for patients following treatment); and poor consultant attitude.

Hospital versus specialty quality in patient/GP decision-making

6.32 The Parties submitted that, in making a choice of provider at the point of referral and not knowing what treatment would ultimately be required, patients would take into account the quality of both outpatient and inpatient services because of the possibility that the patient might ultimately be a user of inpatient services.

6.33 The results of the patient survey showed that half of the patients in the survey who were aware they had a choice said that the quality of their particular specialty was a more important factor in their choice of hospital than the quality of the hospital overall, and there was no difference in this regard between SPH and RSC patients. A significant minority said the overall quality of the hospital was more important (31% at SPH and 26% at RSC), and the remainder said both were equally important.

6.34 We also note that the GP research suggests that the expertise of a consultant or unit was often the most important factor for the GP, and GPs would consider changing the provider to which they referred patients if they had concerns about specialty level quality.

6.35 We therefore consider that specialty level concerns are important to large numbers of patients and GPs. We also recognise that a patient's choice of hospital may also reflect factors other than the quality of a particular specialty, such as the wider reputation of the hospital as a whole.

Choice along the patient pathway

6.36 The Parties submitted that patients chose a provider of routine elective care services without knowing their treatment requirements. They submitted that this meant that a patient's choice of provider would be based on all aspects of a hospital's offering that the patient might use, such that all patients in specialties that offered inpatient services would have taken the quality of these services into account when selecting a provider.

6.37 Patients have the right to exercise choice of provider at their first outpatient appointment. In choosing a provider, there is scope for patients to exercise choice based on the quality of outpatient, day-case and/or inpatient services. However, the extent to which patients/GPs choose a provider based on future treatment is likely to vary by specialty. Some specialties are outpatient only, admission as a day-case or inpatient may be less likely for certain specialties and, in relation to some GPs may not be well placed to advise the patients as to the likelihood of future treatment.

6.38 With respect to patients' knowledge of their pathway, the evidence from the patient survey shows that patients were evenly split as to whether or not they

had expected at the time of their initial referral that they would subsequently need treatment or surgery, with approximately half saying they thought it was not likely (50% RSC and 48% SPH), and slightly fewer saying they thought it was very or quite likely (there was no difference in the pattern by hospital).

6.39 When it came to assessing the relative importance of considerations about the initial appointment or possible future treatment in making the choice of hospital, 37% of SPH patients said the initial appointment was more important, 39% said future treatment considerations were more important and 16% said they were equally important. At RSC, 25% of patients said that the initial appointment was more important, whilst 43% said subsequent treatment considerations were more important and 25% said both were equally important.

6.40 In summary, the evidence from the patient survey suggests that the quality of outpatient services is more important than the quality of future treatment to some patients in choosing a provider, whilst the quality of day-case and inpatient services is more important for other patients. Whilst there is no right to patient choice in relation to day-case or inpatient treatment, the quality of the services a hospital provides in relation to day-case and inpatient elective activity (including the scope and quality of that activity) may influence the choice of hospital for the first outpatient referral (although the extent to which this is the case may vary by specialty as discussed above). This choice will affect outpatient, day-case and inpatient parts of the pathway, and the exercise of this choice generates scope for hospitals to compete against one another in relation to outpatient, day-case and inpatient services.

Assessment of factors affecting the Parties' incentives to compete for patients

6.41 In paragraphs 6.11 to 6.40 above, we consider the industry-wide features that determine the impact of competition between NHS service providers. In the following section, we consider how features specific to each of the Parties have an impact on their incentives to attract patients. The specific features we have considered are:

(a) commissioning arrangements;

(b) profitability; and

(c) capacity.

6.42 In considering the features specific to the Parties, we have also had regard to the wider financial context, including the financial pressures experienced by the Parties and generally in the NHS (as discussed in Section 2). In particular, we have had regard to our conclusion on the counterfactual in paragraph 4.45 above, where we note our view that, if the merger were not to proceed the

Parties would come under financial pressure, mainly due to continued tariff deflation and increasing requirements to deliver quality and efficiency improvements compounded by the increasing difficulty and cost of sourcing skilled staff. We consider that, as is the case for other NHS providers of acute services, this may have an adverse impact on their ability to provide the same or a better range and quality of services as is the case currently, and to make capital investments.

Commissioning arrangements

6.43 We assessed the impact of commissioning arrangements on the Parties' incentives to compete in relation to elective services and whether the payment structures which form part of those arrangements might reduce the Parties' incentives to compete with one another. Such commissioning arrangements might have an adverse impact on the Parties' incentives to retain and/or attract additional patients for those services.

6.44 In our assessment, we had regard to the role of NHS England as the commissioning body for specialised services, as well as the role of CCGs in commissioning elective acute care for patients.[145]

6.45 We considered the payment structures that apply to each of the Parties. We note that CCGs use local variations to the national tariff as a means of achieving their QIPP programme savings by targeting specific reductions in non-elective and elective hospital attendance and admissions.

6.46 We have therefore reviewed the contract information provided by the Parties and discussed the arrangements with both NWSCCG and GWSCCG, as well as Monitor. Our assessment of these contractual arrangements is set out in Section 2 above.

6.47 We recognise that there is some uncertainty as to the revenues the Parties will generate from each of the relevant CCGs. For example, we note that ASP's revenues depend to some degree on the successful delivery of certain efficiency gains agreed with NWSCCG. The revenues of both Parties will depend on the outcomes of year-end revenue adjustment discussions with individual CCGs. The ultimate outcome of these and other factors will have an impact in turn on the overall profitability of elective services provided by the Parties.

[145] See Section 2 above for a summary of the role and functions of CCGs and NHS England in relation to the commissioning of NHS services.

6.48 We consider that the structure of the payment arrangements between the Parties and the CCGs does not, itself, remove the Parties' incentives to retain and/or attract additional patients for elective services where it is profitable to do so, as to do so his would increase revenue or prevent it from falling. That said, we nevertheless recognise that the risk attached to the size of the final payments received from commissioners may reduce these incentives. We discuss the impact of the revenues the Parties generate through these arrangements on the profitability of elective services in the next section.

Profitability

6.49 We analysed the costs and revenues of ASP and RSC by groups of service, and by service line.[146] Our analysis was based on service line reporting data provided by the Parties. We note that ASP maintains detailed service line revenue records and that ASP takes such revenue and profitability information into account, for example when considering major investments. [✂].

6.50 The analysis informed our view of the financial incentive of the Parties to compete to attract additional patients, or to retain present levels of activity. We consider that there would be no such incentive to attract more patients unless additional revenue at least covered variable costs. For further details of the analysis, see Appendix I.

6.51 We calculated two measures of profit margin: a variable margin that takes account of variable costs alone, and a semi-variable margin that takes account of variable costs and of semi-fixed costs[147]. We understand that variable costs cover items such as materials, drugs and agency staff, and that semi-fixed costs include salaries of senior managers, and of medical, nursing and support staff.

6.52 For both ASP and RSC, we found that elective outpatient and day-case services had positive margins, regardless of the cost measure considered. We also found that elective inpatient services at ASP had positive margins, regardless of the cost measure considered. The case was less clear for elective inpatients at RSC, where the margin was positive when variable costs alone were considered but negative when semi-fixed costs were also taken into account.[148]

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[146] Our analysis drew on 2013/2014 data for ASP and on 2012/2013 data for RSC.
[147] Unless otherwise stated, where we refer to margin this takes account of both variable and semi-variable costs.
[148] As regards non-elective services, margins depend on the tariff arrangements that are in place with regard to emergency admissions. In a scenario where the Parties are paid the full tariff for such services, the margins are positive. In scenarios where the Parties are paid 30 or 70% of the tariff for a marginal patient – scenarios which

6.53 We consider that our analysis of the profitability of elective services shows that the Parties have a financial incentive to prevent a decline in referrals and to attract patients across their elective services. That said, we also recognise the limited extent to which meaningful profitability information at service level is available and relied upon (particularly by RSC).

Capacity

6.54 Whether the Parties have an incentive to compete will also depend on whether they have sufficient capacity to treat additional patients.

6.55 We note that capacity constraints can be the result of inefficiency as well as absolute shortages of bed or staff. We note that capacity is variable to some extent, rather than rigidly fixed. In general, a hospital can unlock potential capacity by innovating, reducing length of stay and managing beds more effectively. If paid for additional activity, providers have an incentive to achieve such efficiencies. This section addresses the Parties' existing capacity constraints as well as their means of increasing capacity through efficiencies or investment.

6.56 Regarding capacity constraints at RSC, the Parties submitted that they reviewed several indicators of capacity and usage, including bed and theatre utilisation rates and RSC's performance in relation to NHS Referral to Treatment (RTT) standards.

6.57 The Parties submitted that their capacity to carry out additional activity is low in most specialties.

6.58 As regards RSC, the Parties submitted that the hospital is managing to meet RTT 18 week targets, but that this is at the cost of running a significant number of extended weekday and weekend theatre sessions. The most frequent users of extended weekday and weekend theatre sessions were General Surgery, Maxillo-Facial Surgery, Orthopaedics, ENT and Breast Surgery. RSC therefore has limited incentive to attract additional volumes of patients from ASP or any other providers, in particular in General Surgery, Breast Surgery and Maxillo-Facial Surgery, as to do so would require RSC to incur additional costs for out of hours and weekend activity in order to keep within its 18 week RTT target.

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reflect the arrangement under the current ETO for 2015/2016, and the arrangement that was in place for 2013/2014 – we estimate that for both ASP and RSC the revenue earned on the marginal patient would cover variable costs but not variable and semi-variable costs.

6.59 We also note that the Parties considered business cases supporting expansion of capacity in particular specialties. Examples include additional breast and colorectal surgeons at ASP.

6.60 However, we also note that the data for RSC regarding theatre utilisation rates and other efficiency benchmarks, compared to equivalent NHS benchmarks,[149] suggests that there may be additional scope for RSC to increase the utilisation of its assets, including in relation to patient admission and discharge procedures.

6.61 We consider that ASP and RSC will be able to increase capacity for elective care if they deliver savings in conjunction with NWSCCG and GWCCG, respectively. If the latter redesign pathways, alter GP behaviour and deliver a transfer of patients from hospitals to community settings, the Parties will potentially be able to expand their provision of elective care.

6.62 We acknowledge that the Parties, and in particular RSC, may be experiencing some capacity pressures. However, we consider that the evidence provided shows that the Parties can accommodate additional patients and in certain areas seek to expand their activities and this may be able to be enhanced through efficiency gains. Against this background, we consider that the Parties continue to have an incentive to attract additional patient referrals in elective services. That said, the capacity pressures experienced by the Parties may dilute these incentives to some extent.

Conclusion on incentives to compete

6.63 On the basis of our assessment of the structure of the Parties' commissioning arrangements, profitability and capacity levels, we consider that currently (ie pre-merger) the Parties have an incentive to maintain current levels of patient referrals and attract additional patient referrals for elective services. That said, the risks attached to the payments, the uncertainty regarding profitability, and the capacity pressures experienced by the Parties, may weaken these incentives to some extent.

The role of competition in the Parties' decision-making – the role of Commissioners and analysis of the Parties' internal documents

6.64 The Parties' investment decisions and internal documents illustrate the extent to which competition is a driver of improvements to the quality of services. NHS providers operate in a regulated environment and commissioners play an

[149] NHS Better Care, Better Value Indicators.

important role in protecting the quality of services. Furthermore, NHS hospitals are required to provide high-quality care to their patients and have a duty to cooperate with other providers of NHS services for the purposes of the NHS. Therefore, competition is only one of the factors that might help to maintain or improve the quality of services and must be viewed in light of these other factors.

6.65 We have identified examples of investments in services that were primarily or wholly on the basis of considerations other than competition. These investments were typically aimed at addressing issues concerning service quality and were triggered by commissioner or regulator concerns about service standards. We found examples of the important role played by commissioners in driving quality improvements.

6.66 We also identified examples of responses which appear consistent with competitive responses, including investment in outpatient clinics, monitoring and responding to referral activity at other trusts, market research and communication efforts aimed at improving GP, patient and commissioner awareness of the Parties' services.

6.67 Further details are provided in Appendix G.

The role of commissioners

6.68 Both GWCCG and NWSCCG were of the view that they could intervene in the event of deteriorations in the quality of services.

6.69 In relation to orthopaedics services, GWCCG told us that:

> Last year, we very much were heavy-handed with the Trust about saying if you do not change, we will encourage our patients to choose an alternative provider. That could have been one of the local private providers, which could provide NHS services, or to actually steer patients towards Frimley Park because we do not believe if you do not change the way you are treating our patients is in their and our best interests.[150]

6.70 In relation to ophthalmology services, GWCCG told us that patient choice would have been unlikely to constrain RSC and ensure that it provided a high quality service: 'With ophthalmology, would it have changed? Probably not, not without us putting that leverage on them.'[151]

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[150] GWCCG hearing, 22 April 2015.
[151] GWCCG hearing, 22 April 2015.

6.71 In relation to trauma and orthopaedics:

> Ultimately, the lever is the stick within the standard NHS contracts and there are significant quality levers within that that are deemed centrally. We do have, as with the transfer of activity to trauma and orthopaedics from Royal Surrey to Ashford that we saw this year, the ability for our GPs and our population to go elsewhere and impact on the Trust to a level.[152]

6.72 In relation to endoscopy services at ASP, NWSCCG told us the following:

> […] Reputation counts for a lot and where quality or capacity is an issue GPs may send their patients elsewhere and patients will choose to go elsewhere. This is currently happening in, for example, endoscopy where we have problems with waiting times at the Trust. We are working with the Trust to commission alternative providers because actually they are struggling to find the capacity required to meet demand.[153]

6.73 The above suggests that commissioners have an important role in responding to falling service quality, for example by redesigning services or patient pathways. Commissioner submissions suggest that, following intervention, the threat of financial penalties or service removal acts as a significant motivator for trusts to improve their offerings to patients.

6.74 However, such interventions may be limited in practice where alternative providers are limited. This could be in relation to complex services, whereby only full-service providers (as opposed to community providers, for example) can realistically offer an alternative to the incumbent provider. Furthermore, regulatory or commissioner interventions act to maintain prescribed standards in a given specialty and there may be scope for competition to incentivise providers to improve the quality of services beyond these standards.

6.75 Below, we set out examples of actions taken by commissioners in response to falls in service quality.

Ophthalmology services at RSC

6.76 We considered ophthalmology services at RSC as an example of changes to services aimed at improving the quality of services. Evidence from internal documents highlights the role of commissioners and regulation in maintaining

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[152] GWCCG hearing, 22 April 2015.
[153] NWSCCG hearing, 29 April 2015.

the quality of services. The CMA considers RSC's investment in its ophthalmology services as likely to have been driven largely by regulatory and commissioner intervention, with competition unlikely to have been an important consideration.

6.77 RSC told us that, following an inspection by the CQC in October 2013, it was awarded a 'Good' rating overall. However, a number of concerns were raised relating to its ophthalmology service, particularly in relation to physical infrastructure, appointment bookings and waiting times.

6.78 GWCCG told us that it initially raised concerns about the quality of ophthalmology services at RSC in November 2013, at its monthly clinical quality review meeting with RSC. The new ophthalmology building was completed by RSC in February 2015 and a new consultant appointed.

6.79 Internal RSC documents identified pressures in the ophthalmology services prior to the intervention by GWCCG and suggested that the changes to ophthalmology services were largely driven by regulatory and commissioner intervention. However, we note that RSC referred to the benefits of increases in referral volumes in order to support the business case for the investments which it made.

Dermatology services at RSC

6.80 GWCCG told us that dermatology services were an area where the RSC had struggled historically:

> […] dermatology three years ago had been considered poorly performing by our GPs and action was taken both by the GPs but patients not choosing to stay with those specialties, which led to us, as commissioners, re-commissioning or changing the pathways for those departments. For example, dermatology, we procured a community service as a result of that and the majority of referrals have left the Royal Surrey.

6.81 The above suggests that patients, GPs and commissioners responded to the falling quality in dermatology services at RSC by seeking alternative options.

Large-scale investments

6.82 We also considered further examples of the Parties undertaking large-scale investments aimed at improving the quality of services. We consider the investments described below to be examples of where ASP or RSC identified issues in relation to their services and addressed the risk of regulatory and

commissioner intervention. While these investments seem primarily to have been driven by regulatory and commissioner concerns, the beneficial impact of such investments on activity volumes was also included as a consideration.

(a) Vascular services at ASP: Vascular services are an example of the interplay between regulatory standards and incentives to attract additional referrals. Internal documents suggest that ASP's service, while being successful in attracting referrals, required investment to meet best practice guidelines. ASP documents show the rationale for increasing investment into vascular services at both ASP sites to in order (i) to attract additional patient referrals; and (ii) to meet national clinical and regulatory standards. This has led to improved vascular services for patients at ASP.

(b) Maternity services at ASP: ASP documents from 2012 noted plans for a new unit, the Abbey Birth Centre, which opened in May 2014. ASP's investment in its maternity services is an example of the trust responding to a perceived lower quality service by improving its offering to patients. The investment was accompanied by marketing efforts and internal documents, and commissioner submissions show that the trust has subsequently seen increases in activity levels.

Monitoring referral activity and other trusts

6.83 We also found examples of the Parties monitoring referral activity, quality of services and financial performance compared with other trusts.

6.84 For example, ASP's Quarterly Marketing Reports were presented at board meetings between January 2011 and March 2013. These reports monitored its market share in Surrey and benchmarked its performance against other Surrey hospital trusts.

6.85 Such monitoring is sometimes accompanied by follow-on actions. For example:

> ASP operates […] 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.
>
> […] there are a wide number of projects across the Trust that are expected to have a positive impact [on ASP services] either ensuring that we maintain our facilities and services at a level comparable with competitors or in some cases where we are aiming to provide a superior offering.

6.86 We note, however, that this appears to be more important for ASP (which regularly prepared 'marketing reports') than RSC.

Investments in outpatient clinics

6.87 Improving access to services for patients can take the form of having outpatient clinics in more convenient locations. We consider that it is possible that, without competitive pressure, trusts' priorities would likely have been to reduce financial costs. Such reductions might result in the closure of certain services and consolidation onto fewer sites, thereby affecting overall patient access to services.

6.88 Internal documents, the Parties' submissions and third party responses suggest that, in addition to patient benefits in the form of more convenient access, such responses are aimed at extending the geographic footprint of trusts and gaining additional referrals. Examples of references to investments in outpatient clinics are set out in Appendix G.

Market research and communication efforts aimed at improving GP, patient and commissioner awareness of the trusts' services

6.89 Competitive pressures may result in trusts considering and implementing investments in improving integration or cooperation in order to produce additional referrals and improve financial performance. The internal documents and responses by the Parties illustrate this point:

(a) ASP opened a new maternity ward, the Abbey Birth Centre, in May 2014, which was advertised on its website.[154] This was supported with marketing and communications activities, including open day events for patients. [✂]

(b) ASP Operational Plan Document for 2014–2016:

[✂]

Conclusion on internal documents

6.90 The evidence which we considered suggests that competition is one of the drivers for improving services, although its importance varies with the context. Regulatory and commissioner considerations appear to be more important in relation to major clinical investments, while competition considerations appear to be more important in relation to the introduction of services in new geographic areas, such as through outpatient clinics.

[154] ASP news release (2 May 2014): 'New Midwifery Led Unit opens for local mums to be at St Peter's Hospital'.

Elective service providers in the Surrey area

6.91 This section provides an overview of other elective services providers in the area in which the Parties operate in Surrey. This is relevant to our later consideration of competition between the Parties and other providers in the area.

6.92 We considered which other providers of elective services operate in Surrey and the surrounding areas. We looked at how close other acute elective providers are to the Parties (geographically and by drive-time), and in terms of the services that they provide.

Parties' views

6.93 The Parties submitted that, following the merger, patients and GPs will still have a significant number of other providers of acute services from which to choose. The Parties also submitted that, looking at the 271 GP practices in the combined 80% catchment area for the merged trust, the average GP practice is in 3.9 catchment areas and that, after the merger, the average GP practice will be in 3.7 catchment areas.

6.94 In relation to particular providers, the Parties consider Frimley and West Middlesex to be in a significantly better financial position than either of them, having merged or planning to merge with other providers, Heatherwood and Wexham Park and Chelsea and Westminster, respectively.[155] The Parties referred to funding worth £328 million to be made available to Frimley and explained that the Parties expect both providers to compete more strongly in future, given their significantly enhanced financial situation.

CMA assessment

6.95 We note that location is an important factor when patients and/or GPs choose a hospital for treatment and this was confirmed by our patient survey and GP research. We note that SPH and AH are within 13 minutes' drive-time of each other. RSC is to the south-west. The drive-time from AH to RSC is 29 minutes, and from SPH to RSC it is 20 minutes.

6.96 Our patient survey found that the great majority of patients lived within 30 minutes' drive-time of the hospital they attended. We noted that there are nine

[155] Chelsea and Westminster and West Middlesex formally merged on 1 September 2015.

acute hospitals located within 30 minutes' drive of at least one of the Parties' main sites. We set out the results of our drive-time analysis in Table 6.

Table 6: Drive-time from main sites of Parties to nearby acute hospitals (minutes)[156]

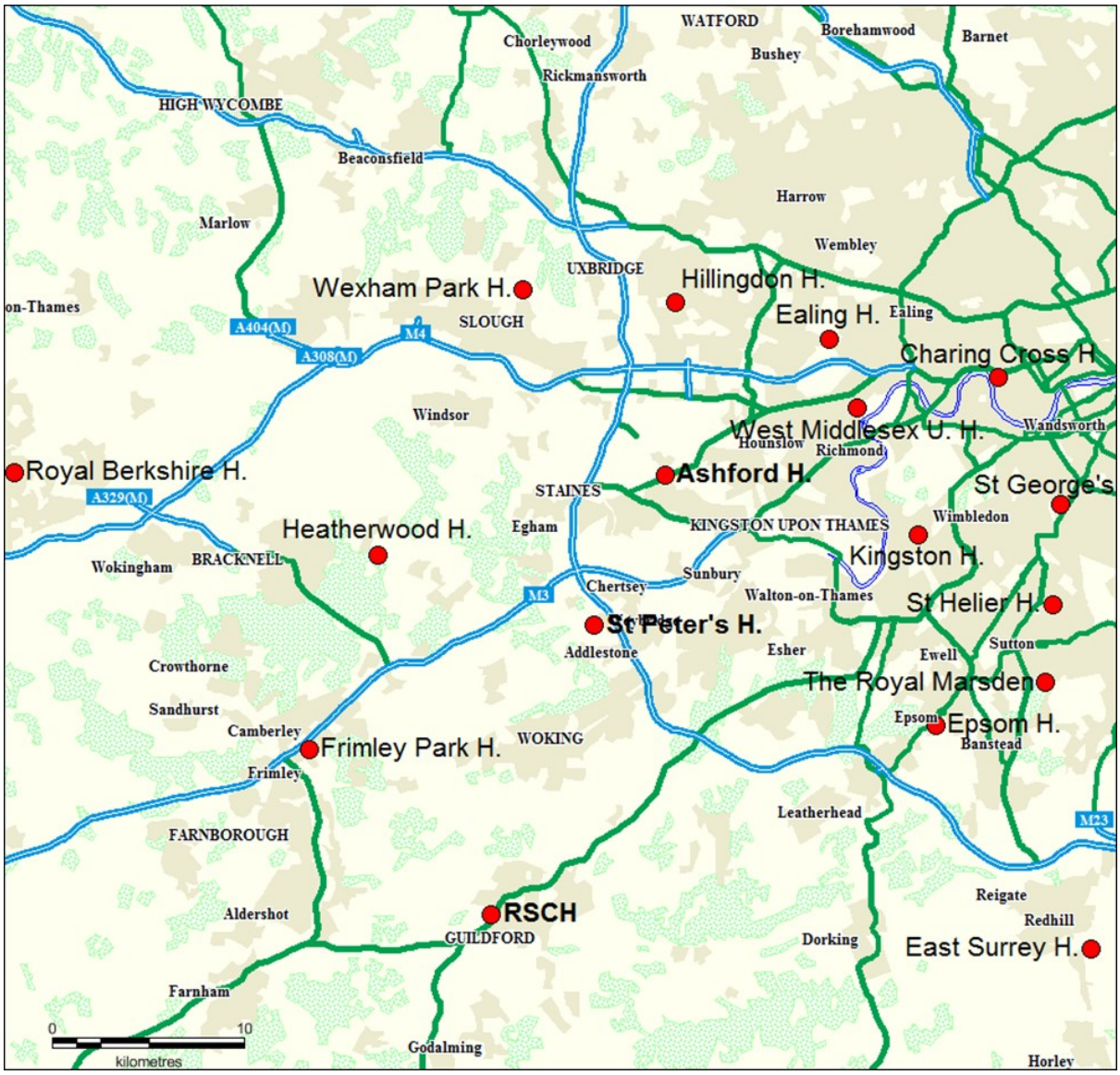
Hospital site	*Drive-time from (minutes)*		
	AH	*SPH*	*RSC*
AH	-	20	29
SPH	13	-	20
RSCH	29	13	-
West Middlesex	16	22	39
Hillingdon	16	21	37
Ealing	18	29	46
Frimley Park	21	17	19
Heatherwood	22	18	27
Wexham Park	22	26	43
Charing Cross	24	32	43
Kingston	26	25	31
Epsom	32	23	28
St Helier	41	32	37
Royal Berkshire	35	34	42
St George's	42	33	38

Source: CMA analysis using HES data covering the period 2010–2014, using the software MapInfo, specifying 'off-peak' driving conditions.

6.97 The map in Figure 4 below shows the locations of the Parties' main hospital sites and those of the other nearby hospitals included in our drive-time analysis above.

[156] The Parties' figures are broadly in line with our figures, other than for drive-times from RSC. For that hospital, the figures in Table 6 are around 10% higher than those submitted by the Parties with the exception of drive-time to Frimley Park – for which our estimated drive-time is close to that of the Parties – and of the drive-times to Hillingdon and to Ealing for which our estimated drive-time is 5 and 7 minutes respectively higher than that submitted by the Parties.

Figure 4: Locations of Parties' main hospital sites and other nearby hospitals



Source: CMA analysis.

6.98 We have considered the services provided by each of the hospitals and trusts in Table 6 and Figure 4. We set about below information with respect to providers located close to the Parties. We start with Frimley and West Middlesex, which have both been involved in completed mergers.

Frimley

6.99 Frimley provides NHS hospital services for 900,000 people across Berkshire, Hampshire Surrey and South Buckinghamshire. It came into being in October 2014, following the amalgamation of two neighbouring trusts. Services are delivered from three main hospital sites, at Frimley Park, near Camberley, Heatherwood at Ascot and Wexham Park, Slough, along with a number of satellite centres. As well as delivering DGH services to its population, the trust

provides specialist heart attack, vascular, stroke, spinal, cystic fibrosis and plastic surgery services to patients in a wide catchment.

6.100 In the context of Frimley's acquisition of Heatherwood and Wexham Park, Frimley obtained approval for additional funding through a loan application for £[✂] and Public Dividend Capital application for £[✂] – part of an overall funding package of £[✂] to fund improvements to the Frimley, Heatherwood and Wexham Park sites. Of this amount, a substantial sum was earmarked in the loan application for the Heatherwood site. The application explains that part of this funding is intended to increase the provision of General Surgery services at Heatherwood. Frimley told us that it is still considering the specific improvement plans for both sites which will need to be put to the board for approval and that the loan has not yet been drawn down.

6.101 We note that Frimley has already invested in management and clinical staff in order to improve services at Heatherwood and Wexham Park with the objective of achieving top ratings across all three sites: Frimley Park, Heatherwood and Wexham Park. Frimley's plan is that Heatherwood and Wexham's CQC rating will increase following the CQC inspection due next year. We noted that the CQC has given Frimely an 'outstanding' rating for the quality of clinical services, one of only two hospitals in the country to hold this rating. We also note Frimley's rating by Monitor as 'green' for governance and 4 (out of 4) in respect of its financial position.

West Middlesex

6.102 West Middlesex is a DGH based in Hounslow. West Middlesex has annual income of about £150–£160 million a year. West Middlesex was formally acquired by Chelsea & Westminster on 1 September 2015 to become a single foundation trust. We understand that, under the North West London Collaboration of CCGs' *Shaping a healthier future* vision for the future of healthcare in North West London boroughs, West Middlesex, under the management of Chelsea and Westminster, will remain a major hospital with all the services of a local hospital plus a 24/7 A&E and associated emergency surgery. It will also deliver complex medicine and surgery and have intensive care beds. It will have inpatient paediatric services and consultant-led and midwife-led maternity units, as well as a 24/7 urgent care centre and outpatient and diagnostic services.

Other local providers

6.103 Below is an overview of other alternative providers in the local area surrounding the Parties:[157]

(a) Epsom and St Helier is a medium-sized acute trust with a combined annual turnover of over £360 million. It was formed in 1999 as the result of a merger between the Epsom and St Helier trusts. It has two principal sites: St Helier Hospital in Carshalton, in the London Borough of Sutton, and Epsom Hospital in the Borough of Epsom and Ewell in Surrey. The trust provides a full range of DGH services. While both sites have an A&E as well as an obstetrics department and a number of other services, there is a degree of specialisation. The Epsom site does not carry out acute emergency surgery, which is focused on the St Helier site. Epsom has a focus on inpatient elective care. Epsom and St Helier broke even in 2014/15 and the TDA has now given it permission to work towards foundation trust status.

(b) St George's is the largest healthcare provider and main regional centre for specialised services in south-west London, with an annual turnover in excess of £700 million. Apart from specialist burns treatment it provides a comprehensive range of services, including hyper-acute stroke services. It is also a major trauma centre serving south-west London and parts of Surrey. As well as acute and specialist services, it provides a range of community services. St George's was authorised by Monitor to become a foundation trust in February 2015.

(c) Kingston is a DGH approximately 12 miles from central London, serving around 320,000 people in the surrounding area including Kingston, Richmond, Roehampton, Putney and East Elmbridge.

(d) Hillingdon provides services at the Hillingdon Hospital and Mount Vernon Hospital, serving a local population of around 350,000 people in the surrounding areas of Ealing, Harrow, Buckinghamshire and Hertfordshire. The trust has annual turnover of around £222 million. Hillingdon provides the services of a local hospital and 24/7 A&E and associated emergency surgery. It also carries out complex medical and surgical activity and has intensive care beds. We understand that, under the North West London Collaboration of CCGs' *Shaping a healthier future* vision for the future of healthcare in North West London boroughs, Hillingdon Hospital is to undergo a £12 million redevelopment, with improvements to A&E,

[157] Information has been sourced from publicly available information or from direct conversations with these providers.

paediatric emergency department, acute medical admission unit and endoscopy unit. Hillingdon will have inpatient paediatric services and consultant-led and midwife-led maternity units, as well as a 24/7 urgent care centre and outpatient and diagnostic services. Capital funding for the project across north-west London has yet to be agreed but we understand it is likely to be upwards of £[✂].

(e) The Royal Marsden is a leading cancer centre specialising in diagnosis, treatment, care, education and research. It has two hospitals: one in Chelsea in London, and the other in Sutton, Surrey, as well as a chemotherapy day-care unit at Kingston Hospital. It also provides community services in the London boroughs of Sutton and Merton. Its commissioner is NHS England.

(f) Ealing is part of London North West, which was established in October 2014 following the merger of Ealing and The North West London trusts. It serves a local population of around 850,000 people, with a budget of more than £640 million a year.

(g) Charing Cross is an acute hospital and part of the Imperial College trust, providing a full range of adult clinical specialties. It is also a key site for the teaching of medical students from Imperial College London.

(h) Royal Berkshire provides acute medical and surgical services to patients in Reading, Wokingham and West Berkshire and specialist services such as cancer, dialysis and eye surgery to a wider population in Berkshire and bordering areas.

6.104 In summary, there are a number of hospitals providing electives services which are located within, or close to, 30 minutes' drive of the Parties.

6.105 In our competitive assessment below, we have considered the extent to which these other providers are credible alternative providers to the Parties of elective services to patients following the merger.

Competitive assessment

6.106 In this section, we first set out the data used in the following analysis. We then set out our assessment of the volumes and values of the overlapping services that the Parties provide. We assess the degree of competition between the Parties, considering the extent to which the Parties compete with each other and other hospitals in and around the Surrey area.

Data used in CMA analysis

6.107 The data used in the CMA's competitive assessment is an extract of HES data. This is a set of individual records for every NHS admitted acute, community or psychiatric hospital admission, outpatient appointment and A&E attendance in England. HES data is provided by the Health and Social Care Information Centre. One of the purposes of the data is to enable providers to be paid for the care they deliver, as well as for CCGs to monitor providers' services.

6.108 The CMA received an extract of this HES data for outpatients, admitted patients and A&E patients covering the period 1 April 2010 to 31 March 2014.[158]

6.109 One concern raised by the Parties with HES data was that local trusts had different specialty coding practices, despite the existence of guidelines.[159] To address this issue, the CMA used the treatment level information available in HES data to reassign the specialties of some activity we could identify as cross-coded.

6.110 Our methodology looked for treatments that most providers coded consistently under one specialty and, if the Parties had identified that specialty as part of a group of specialties that was frequently cross-coded, we moved any instances of these treatments found in other specialties into the consistently coded specialty.[160]

6.111 The reallocation did not move all cross-coded activity given the extent of variation in coding practices, the limitations of outpatient data[161] and the need to avoid moving any more activity than necessary. In order to address this issue qualitatively in the competitive assessment, we used information on volumes of patients at specialty level provided directly by Frimley Park for 2014/15[162]

6.112 In line with previous CMA investigations,[163] we used Treatment Function Codes (TFCs) as proxies for specialties when defining overlaps and running our analysis. We understand that this classification is the basis for the NHS e-

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[158] The data set contains among other information the treatments given to the patient, the specialty of their care, the dates the care occurred, the location of treatment and the GP practice of the patient. These variables allowed us to approximate patient locations and identify actual patient flows to providers at specialty level across the period of interest. This formed the basis of the GP referral analysis and the contestable GP analysis.
[159] For example, Frimley Health told us that the Main Specialty Code classification was used for specialty information during the period covered by our data. This is more general than the Treatment Function Classification used by the Parties, and meant for example that prior to our reallocation no information was reported in Breast Surgery between 2010 and 2014, even though the trust confirmed that it was providing this specialty.
[160] See Appendix C for details of how this reallocation was implemented.
[161] Full diagnosis and procedure level information is not available in outpatient data.
[162] We focused on Frimley as the changes in volume as a result of the reallocation were relatively more significant, because the Parties' comments on our reallocation methodology focused around Frimley Park and because it frequently appeared to be an important alternative to the Parties.
[163] See for example CMA phase 1 decision (February 2015), Appendix A, GP referral analysis.

Referral Service (formerly the Choose and Book system) and that, in general, where hospitals monitor their services, they often use TFCs.

Overlaps between the Parties

6.113 The extent to which each specialty might be affected by the merger is influenced by the degree of overlap between the Parties. We have, therefore, assessed the services in which the Parties overlap and the extent of that overlap in terms of volume and value of treatments undertaken.[164]

6.114 As a starting point for the identification of overlaps, we used the HES data covering the four financial years from April 2010 to April 2014. We considered the Parties to overlap in all specialties where both trusts provided at least ten periods of care during this period.[165] Where the Parties told us that they did not consider themselves to be providers of services identified using this methodology, we assessed the evidence they provided and took this into account. To avoid missing any potential competition concerns, we also included additional specialties which both Parties told us they considered themselves to be providing, where this was not reflected in the HES data.

6.115 We found that the Parties overlap in at least one treatment setting for the 58 specialties shown in Table 7 below.

[164] The Parties identified overlaps between ASP and RSC in those specialties where both Parties were recorded as performing at least a minimum amount of activity in HES data over the 2012/14 period. The Parties also submitted that HES data was subject to coding inaccuracies, and submitted for each specialty whether each trust believed itself to be a meaningful provider of that service. They further submitted that the extent of the overlap in each specialty varied according to whether one or the other provided specialist treatments or other services in that specialty, and that in some specialties patients could not meaningfully exercise choice. Given the uncertainty around these measures, we defined overlaps in a broad way and considered these issues in full in the competitive assessment. See Appendix F for further details.

[165] We calculated overlaps using Finished Consultant Episodes, which represent units of care given to patients by the same consultant during one stay in hospital.

Table 7: Summary of specialty level overlaps as calculated by the CMA[166]

Specialty	*Outpatient appointments*	*Day-case spells*	*Inpatient spells*	*Non-elective spells*
Accident & Emergency	Y			Y
Anaesthetics	Y			
Anticoagulant Service	Y			
Audiology & Audiological Medicine	Y			
Breast Surgery	Y	Y	Y	Y
Cardiac Rehabilitation	Y			
Cardiology	Y	Y	Y	Y
Cardiothoracic Surgery	Y			
Clinical Haematology	Y	Y	Y	Y
Clinical Neurophysiology	Y			
Clinical Oncology	Y			
Clinical Psychology	Y			
Colorectal Surgery	Y	Y	Y	Y
Critical Care Medicine			Y	Y
Dermatology	Y	Y		Y
Diabetic Medicine	Y			Y
Dietetics	Y			
Endocrinology	Y	Y	Y	Y
Ent	Y	Y	Y	Y
Gastroenterology	Y	Y	Y	Y
General Medicine	Y	Y		Y
General Surgery	Y	Y	Y	Y
Geriatric Medicine	Y		Y	Y
Gynaecology	Y	Y	Y	Y
Interventional Radiology		Y	Y	Y
Maxillo-Facial Surgery	Y	Y	Y	Y
Medical Oncology	Y	Y		Y
Midwife Episode	Y			Y
Neonatology		Y	Y	Y
Neurology	Y	Y		
Obstetrics	Y	Y	Y	Y
Occupational Therapy	Y			
Ophthalmology	Y	Y	Y	Y
Oral Surgery	Y	Y		
Orthodontics	Y			
Orthoptics	Y			
Paediatric Cardiology	Y			
Paediatric Clinical Immunology And Allergy	Y			
Paediatric Diabetic Medicine	Y			
Paediatric Endocrinology	Y			
Paediatric Respiratory Medicine	Y			
Paediatric Surgery	Y			
Paediatric Trauma And Orthopaedics	Y			
Paediatric Urology	Y			
Paediatrics	Y	Y	Y	Y
Pain Management	Y	Y	Y	Y
Physiotherapy	Y			
Respiratory Medicine	Y	Y	Y	Y
Rheumatology	Y	Y	Y	Y
Speech And Language Therapy	Y			
Transient Ischaemic Attack	Y			
Trauma & Orthopaedics	Y	Y	Y	Y
Upper Gastrointestinal Surgery	Y		Y	Y
Urology	Y	Y	Y	Y
Vascular Surgery	Y	Y		
Well Babies		Y	Y	Y

Source: CMA analysis.

6.116 In order to measure the significance of the overlap specialties to the Parties, we identified the volumes and values of treatments within the overlap specialties in the most recent year covered by HES data (2013/14).

[166] The table shows only TFCs where an overlap was found in at least one treatment setting.

6.117 The Parties submitted that, within some specialties that the both of them provide, there were significant differences in the sub-specialty level offerings. For example, the Parties submitted that there were significant areas within Maxillo-Facial Surgery where RSC provided services that were not offered by ASP (and to a lesser extent vice versa).

6.118 To measure the extent to which the Parties actually provide the same services in each overlap specialty for day-case and inpatient services,[167] we calculated the percentage of the overlap volumes and values relating to treatments common to both Parties.[168] Since this analysis does not account for the possibility that different treatments may be substitutable either from a demand or a supply-side perspective, we believe this measure to be indicative of the minimum extent of sub-specialty level overlaps.

6.119 Tables 8, 9 and 10 below summarise the aggregated overlaps values and volumes between the Parties by treatment setting (outpatient, day-case and inpatient). This is shown both including all treatments and for only those treatments common to both Parties. We consider that these show that almost all of the Parties' elective activity and revenue relates to overlap specialties, and that a large majority relates to treatments offered by both Parties. We note that overlaps do not necessarily indicate a competition issue.

[167] Due to limitations in outpatient data, and the more homogenous nature of these services, we were only able to calculate this measure for day-case and inpatient services.
[168] We calculated the overlapping treatment measure using either the dominant procedure or primary diagnosis, depending on which formed the basis for payment. For a fuller explanation, see Appendix F.

Table 8: Overlaps as a proportion of outpatient services, 2013/14

Outpatient overlaps	*Volume*			*Value*		
Specialty	*AH*	*SPH*	*RSC*	*AH*	*SPH*	*RSC*
Total overlap volume, all treatments	[100,000–200,000]	[300,000–400,000]	[300,000–400,000]	[10,000,000–15,000,000]	[25,000,000–30,000,000]	[30,000,000–35,000,000]
Total volume, all treatments	[100,000–200,000]	[300,000–400,000]	[300,000–400,000]	[10,000,000–15,000,000]	[25,000,000–30,000,000]	[30,000,000–35,000,000]
Percent overlap, common treatments	[91–100]	[91–100]	[91–100]	[91–100]	[91–100]	[91–100]

Source: CMA analysis.

Table 9: Overlaps as a proportion of day-case services, 2013/14

Day-case overlaps	*Volume*			*Value*		
Specialty	*AH*	*SPH*	*RSC*	*AH*	*SPH*	*RSC*
Overlap volume , common treatments	[10,000–15,000]	[20,000–25,000]	[25,000–30,000]	[9,000,000–10,000,000]	[10,000,000–15,000,000]	[15,000,000–20,000,000]
Overlap volume, all treatments	[10,000–15,000]	[20,000–25,000]	[35,000–40,000]	[10,000,000–15,000,000]	[15,000,000–20,000,000]	[20,000,000–25,000,000]
Total volume, all treatments	[10,000–15,000]	[20,000–25,000]	[35,000–40,000]	[10,000,000–15,000,000]	[15,000,000–20,000,000]	[20,000,000–25,000,000]
Percent overlap, common treatments	[71–80]	[81–90]	[61–70]	[81–90]	[71–80]	[71–80]
Percent overlap, all treatments	[91–100]	[91–100]	[91–100]	[91–100]	[91–100]	[91–100]

Source: CMA analysis.

Table 10: Overlaps as a proportion of inpatient services, 2013/14

Inpatient overlaps	*Volume*			*Value*		
Specialty	*AH*	*SPH*	*RSC*	*AH*	*SPH*	*RSC*
Overlap volume , common treatments	[1,000–2,000]	[8,000–9,000]	[9,000–10,000]	[6,000,000–7,000,000]	[10,000,000–15,000,000]	[15,000,000–20,000,000]
Overlap volume, all treatments	[1,000–2,000]	[10,000–15,000]	[10,000–15,000]	[6,000,000–7,000,000]	[15,000,000–20,000,000]	[20,000,000–25,000,000]
Total volume, all treatments	[1,000–2,000]	[10,000–15,000]	[10,000–15,000]	[6,000,000–7,000,000]	[15,000,000–20,000,000]	[25,000,000–30,000,000]
Percent overlap, common treatments	[91–100]	[71–80]	[61-70]	[91–100]	[71–80]	[61–70]
Percent overlap, all treatments	[91–100]	[91–100]	[91–100]	[91–100]	[91–100]	[91–100]

Source: CMA analysis.

6.120 In order to understand the significance of each specialty within these treatment settings, we also calculated values and volumes for each overlap specialty. These are shown in Tables 11 to 13 below.

Table 11: Outpatient overlap specialties by volume and value, 2013/14

Outpatient overlaps	*Volume (number of episodes)*			*Value (£)*		
Specialty	*AH*	*SPH*	*RSC*	*AH*	*SPH*	*RSC*
Accident & Emergency	-	[1,000–2,000]	[500–600]	-	-	-
Anaesthetics	[5,000–6,000]	[10,000–15,000]	[500-600]	[100,000–200,000]	[600,000–700,000]	[80,000–85,000]
Anticoagulant Service	-	[1,000–2,000]	[1,000–2,000]	-	-	-
Audiology & Audiological Medicine	[6,000–7,000]	[7,000–8,000]	[2,000–3,000]	[100,000–200,000]	[100,000–200,000]	[100,000–200,000]
Breast Surgery	[6,000–7,000]	[6,000–7,000]	[8,000–9,000]	[700,000–800,000]	[800,000–900,000]	[1,000,000–2,000,000]
Cardiac Rehabilitation	[2,000–3,000]	[2,000–3,000]	-	-	-	-
Cardiology	[4,000–5,000]	[10,000–15,000]	[8,000–9,000]	[500,000–600,000]	[1,000,000–2,000,000]	[1,000,000–2,000,000]
Cardiothoracic Surgery	-	[200–300]	[100–200]	-	[40,000–45,000]	[30,000–35,000]
Clinical Haematology	[900–1,000]	[7,000–8,000]	[4,000–5,000]	[100,000–200,000]	[900,000–1,000,000]	[500,000–600,000]
Clinical Neurophysiology	-	[1,000–2,000]	-	-	[200,000–300,000]	-
Clinical Oncology (previously Radiotherapy)	[0–100]	-	[70,000–80,000]	[9,000–10,000]	-	[3,000,000–4,000,000]
Clinical Psychology	[100–200]	[600–700]	-	-	[300–400]	-
Colorectal Surgery	[1,000–2,000]	[7,000–8,000]	[0–100]	[200,000–300,000]	[900,000–1,000,000]	[5,000–6,000]
Dermatology	[6,000–7,000]	[20,000–25,000]	[10,000–15,000]	[500,000–600,000]	[1,000,000–2,000.,000]	[1,000,000–2,000,000]
Diabetic Medicine	[1,000–2,000]	[2,000–3,000]	[2,000–3,000]	[100,000–200,000]	[300,000–400,000]	[300,000–400,000]
Dietetics	[1,000–2,000]	[3,000–4,000]	-	[100–200]	-	-
Endocrinology	[3,000–4,000]	[3,000–4,000]	[2,000–3,000]	[300,000–400,000]	[300,000–400,000]	[300,000–400,000]
ENT	[6,000–7,000]	[8,000–9,000]	[15,000–20,000]	[500,000–600,000]	[700,000–800,000]	[1,000,000–2,000,000]
Gastroenterology	[2,000–3,000]	[5,000–6,000]	[5,000–6,000]	[300,000–400,000]	[700,000–800,000]	[700,000–800,000]
General Medicine	[100–200]	[1,000–2,000]	[300–400]	[20,000–25,000]	[300,000–400,000]	[40,000–50,000]
General Surgery	[900–1,000]	[200–300]	[15,000–20,000]	[80,000–90,000]	[15,000–20,000]	[1,000,000–2,000,000]
Geriatric Medicine	[1,000–2,000]	[1,000–2,000]	[1,000–2,000]	[200,000–300,000]	[100,000–200,000]	[300,000–400,000]
Gynaecology	[3,000–4,000]	[15,000–20,000]	[15,000–20,000]	[300,000–400,000]	[1,000,000–2,000,000]	[1,000,000–2,000,000]
Maxillo-Facial Surgery	[7,000–8,000]	[9,000–10,000]	[15,000–20,000]	[700,000–800,000]	[900,000–1,000,000]	[1,000,000–2,000,000]
Medical Oncology	[0–100]	[3,000–4,000]	[35,000–40,000]	[1,000–2,000]	[400,000–500,000]	[2,000,000–3,000,000]
Midwife Episode	[2,000–3,000]	[10,000–15,000]	[4,000-5,000]	[10,000–15,000]	[100,000–200,000]	[15,000–20,000]
Neurology	[2,000–3,000]	[2,000–3,000]	[3000–4,000]	[100-200]	[300-400]	-
Obstetrics	-	[7,000–8,000]	[8,000–9,000]	-	[700,000–800,000]	[700,000–800,000]
Occupational Therapy	[4,000–5,000]	[3,000–4,000]	-	-	-	-
Ophthalmology	[20,000–25,000]	[15,000–20,000]	[20,000–25,000]	[2,000,000–3,000,000]	[1,000,000–2,000,000]	[1,000,000–2,000,000]
Orthodontics	[7,000–8,000]	[2,000–3,000]	[8,000–9,000]	[900,000–1,000,000]	[300,000–400,000]	[1,000,000–2,000,000]
Orthoptics	[4,000–5,000]	[3,000–4,000]	[6,000–7,000]	[50,000–55,000]	[30,000–35,000]	-
Paediatric Cardiology	-	[400–500]	[300–400]	-	[70,000–80,000]	[60,000–70,000]
Paediatric Clinical Immunology and Allergy	-	[1,000–2,000]	[0–100]	-	[1,000–2,000]	[200–300]
Paediatric Diabetic Medicine	[100–200]	[400–500]	[100–200]	[20,000–25,000]	[50,000–55,000]	[15,000–20,000]

Paediatric Endocrinology	-	[700–800]	[400–500]	-	[100,000–200,000]	[100,000–200,000]
Paediatric Respiratory Medicine	-	[300–400]	[100–200]	-	[30,000–35,000]	[20,000–25,000]
Paediatric Surgery	-	[100–200]	[300-400]	-	[30,000–35,000]	[45,000–50,000]
Paediatric Trauma and Orthopaedics	-	[3,000–4,000	[0–100]	-	[300,000–400,000]	[2,000–3,000]
Paediatric Urology	-	[200–300]	[0–100]	-	[35,000–40,000]	[1,000–2,000]
Paediatrics	[3,000–4,000]	[15,000–20,000]	[6,000–7,000]	[400,000–500,000]	[2,000,000–3,000,000]	[1,000,000–2,000,000]
Pain Management	[2,000–3,000]	[5,000–6,000]	[3,000–4,000]	[200,000–300,000]	[600,000–700,000]	[300,000–400,000]
Physiotherapy	[20,000–25,000]	[25,000–30,000]	-	[1,000–2,000]	[25,000–30,000]	-
Respiratory Medicine	[2,000–3,000]	[10,000–15,000]	[5,000–6,000]	[300,000–400,000]	[1,000,000–2,000,000]	[200,000–300,000]
Rheumatology	[4,000–5,000]	[7,000–8,000]	[4,000–5,000]	[500,000–600,000]	[900,000–1,000,000]	[600,000–700,000]
Speech and Language Therapy	[0–100]	[500–600]	-	-	-	-
Transient Ischaemic Attack	-	[100–200]	[300–400]	-	[50,000–55,000]	[95,000–100,000]
Trauma & Orthopaedics	[10,000–15,000]	[50,000–55,000]	[40,000–45,000]	[1,000,000–2,000,000]	[4,000,000–5,000,000]	[3,000,000–4,000,000]
Upper Gastrointestinal Surgery	[2,000–3,000]	[3,000–4,000]	[100–200]	[200,000–300,000]	[300,000–400,000]	[10,000–15,000]
Urology	[7,000–8,000]	[7,000–8,000]	[15,000–20,000]	[1,000,000–2,000,000]	[900,000–1,000,000]	[2,000,000–3,000,000]
Vascular Surgery	[2,000–3,000]	[5,000–6,000]	[0–100]	[200,000–300,000]	[500,000–600,000]	[2,000–3,000]
Total	**[100,000–200,000]**	**[300,000–400,000]**	**[300,000–400,000]**	**[10,000,000–15,000,000]**	**[25,000,000–30,000,000]**	**[30,000,000–35,000,000]**

Source: CMA analysis.
Note: Volume is calculated on the basis of episodes. Value is calculated at the spell level.

Table 12: Day-case overlap specialties (including all treatments) by volume and value, 2013/14

Day-case overlaps	*Volume (number of episodes)*			*Value (£)*		
Specialty	*AH*	*SPH*	*RSC*	*AH*	*SPH*	*RSC*
Breast Surgery	[300–400]	[0–100]	[300–400]	[500,000–600,000]	[80,000–90,000]	[500,000–600,000]
Cardiology	[0–100]	[1,000–2,000]	[700–800]	[700–800]	[3,000,000–4,000,000]	[1,000,000–2,000,000]
Clinical Haematology	-	[3,000–4,000]	[1,000–2,000]	-	[900,000–1,000,000]	[300,000–400,000]
Colorectal Surgery	[0–100]	[500–600]	[0–100]	[90,000–100,000]	[200,000–300,000]	[15,000–20,000]
Dermatology	-	[0–100]	[0–100]	-	[6,000–7,000]	[25,000–30,000]
Endocrinology	[0-100]	[0–100]	[0–100]	[2,000–3,000]	[1,000–2,000]	[900–1,000]
ENT	[100–200]	[800–900]	[1,000–2,000]	[100,000–200,000]	[800,000–900,000]	[1,000,000–2,000,000]
Gastroenterology	-	[4,000–5,000]	[3,000–4,000]	-	[2,000,000–3,000,000]	[1,000,000–2,000,000]
General Medicine	[1,000–2,000]	[200–300]	[0–100]	[500,000–600,000]	[100,000–200,000]	[9,000–10,000]
General Surgery	[800–900]	[3,000–4,000]	[5,000–6,000]	[900,000–1,000,000]	[2,000,000–3,000,000]	[3,000,000–4,000,000]
Gynaecology	[900–1,000]	[400–500]	[1,000–2,000]	[700,000–800,000]	[400,000–500,000]	[900,000–1,000,000]
Interventional Radiology	-	-	[0–100]	-	-	[20,000–25,000]
Maxillo-Facial Surgery	[500–600]	[900–1,000]	[3,000–4,000]	[300,000–400,000]	[600,000–700,000]	[2,000,000–3,000,000]
Medical Oncology	-	[100–200]	[7,000-8,000]	-	-	[700,000–800,000]
Neonatology	-	[0–100]	[0–100]	-	[3,000–4,000]	[15,000–20,000]
Neurology	-	[0–100]	[200–300]	-	[3,000–4,000]	[200,000–300,000]
Obstetrics	-	[3,000–4,000]	[800–900]	-	[1,000,000–2,000,000]	[700,000–800,000]
Ophthalmology	[3,000–4,000]	[200–300]	[2,000–3,000]	[2,000,000–3,000,000]	[100,000–200,000]	[1,000,000–2,000,000]
Oral Surgery	[300–400]	[200–300]	[1,000–2,000]	[200,000–300,000]	[100,000–200,000]	[900,000–1,000,000]
Paediatrics	-	[600–700]	[100–200]	-	[400,000–500,000]	[80,000–90,000]
Pain Management	[1,000–2,000]	[500–600]	[1,000–2,000]	[600,000–700,000]	[300,000–400,000]	[700,000–800,000]
Respiratory Medicine	-	[0–100]	[100–200]	-	[20,000–25,000]	[100,000–200,000]
Rheumatology	-	[0–100]	[300–400]	-	[1,000–2,000]	[200,000–300,000]
Trauma & Orthopaedics	[2,000–3,000]	[900–1,000]	[2,000–3,000]	[3,000,000–4,000,000]	[1,000,000–2,000,000]	[3,000,000–4,000,000]
Urology	[400–500]	[900–1,000]	[2,000–3,000]	[100,000–200,000]	[400,000–500,000]	[900,000–1,000,000]
Vascular Surgery	[100–200]	[100–200]	-	[100,000–200,000]	[100,000–200,000]	-
Well Babies	-	[400–500]	[500–600]	-	[60,000–70,000]	[45,000–50,000]
Total	[10,000–15,000]	[20,000–25,000]	[35,000–40,000]	[10,000,000–15,000,000]	[15,000,000–20,000,000]	[20,000,000–25,000,000]

Source: CMA analysis.

Table 13: Inpatient overlap specialties (including all treatments) by volume and value, 2013/14

Inpatient overlaps	*Volume*			*Value*		
Specialty	*AH*	*SPH*	*RSC*	*AH*	*SPH*	*RSC*
Breast Surgery	[0–100]	[0–100]	[300–400]	[300,000–400,000]	[100,000–200,000]	[900,000–1,000,000]
Cardiology	-	[200–300]	[0–100]	-	[400,000–500,000]	[200,000–300,000]
Clinical Haematology	-	[0–100]	[0–100]	-	[85,000–90,000]	[200,000–300,000]
Colorectal Surgery	-	[100–200]	[0–100]	-	[700,000–800,000]	[100,000–200,000]
Critical Care Medicine	-	[100–200]	-	-	[20,000–25,000]	-
Endocrinology	-	[0–100]	-	-	[5,000–6,000]	-
ENT	-	[0–100]	[700–800]	-	[35,000–40,000]	[1,000,000–2,000,000]
Gastroenterology	[0–100]	[100–200]	[0–100]	[400–500]	[100,000–200,000]	[95,000–100,000]
General Surgery	[0–100]	[600–700]	[1,000–2,000]	[75,000–80,000]	[1,000,000–2,000,000]	[4,000,000–5,000,000]
Geriatric Medicine	-	[0–100]	[0–100]	-	[15,000–20,000]	[4,000–5,000]
Gynaecology	[0–100]	[300–400]	[500–600]	[30,000–35,000]	[900,000–1,000,000]	[1,000,000–2,000,000]
Interventional Radiology	-	-	[0–100]	-	-	[50,000–55,000]
Maxillo-Facial Surgery	[0–100]	[0–100]	[400–500]	[2,000–3,000]	[3,000–4,000]	[1,000,000–2,000,000]
Neonatology	-	[600–700]	[500–600]	-	[2,000,000–3,000,000]	[600,000–700,000]
Obstetrics	-	[3,000–4,000]	[3,000–4,000]	-	[5,000,000–6,000,000]	[5,000,000–6,000,000]
Ophthalmology	[0–100]	[0–100]	[100–200]	[15,000–20,000]	[20,000–25,000]	[100,000–200,000]
Paediatrics	-	[100–200]	[0–100]	-	[200,000–300,000]	[15,000–20,000]
Pain Management	[0–100]	[0–100]	[0–100]	[4,000–5,000]	[3,000–4,000]	[1000–2,000]
Respiratory Medicine	-	[0–100]	[0–100]	-	[30,000–35,000]	[40,000–45,000]
Rheumatology	-	[0–100]	[0–100]	-	[1,000–2,000]	[2,000–3,000]
Trauma & Orthopaedics	[1,000–2,000]	[500–600]	[1,000–2,000]	[6,000,000–7,000,000]	[2,000,000–3,000,000]	[5,000,000–6,000,000]
Upper Gastrointestinal Surgery	[0–100]	[100–200]	[0–100]	[3,000–4,000]	[500,000–600,000]	[20,000–25,000]
Urology	[0–100]	[600–700]	[900–1,000]	[1,000–2,000]	[1,000,000–2,000,000]	[1,000,000–2,000,000]
Well Babies	-	[2,000–3,000]	[2,000–3,000]	-	[400,000–500,000]	[400,000–500,000]
Total	[1,000–2,000]	[10,000–15,000]	[10,000–15,000]	[6,000,000–7,000,000]	[15,000,000–20,000,000]	[25,000,000–30,000,000]

Source: CMA analysis.

Closeness of competition

6.121 Having identified the elective services currently provided by both Parties in paragraphs 6.113 to 6.120 above, in this section, we consider the extent to which the Parties compete with each other and with other hospitals in and around the Surrey area. First, we consider the relevant results from our patient survey, where we asked patients about what they would have done if the hospital they were attending did not offer the treatment they required or provided lowered quality services. We then consider GP referral patterns.

Patient survey

6.122 Patients were asked about which hospital they would have attended had they not been able to go to the hospital at which they had had an appointment. In interpreting the evidence from the patient survey, we are mindful that the patient survey was conducted at SPH and RSC, and so does not provide evidence in relation to ASP at a trust level. We also note that, as regards specific specialties, the patient sample size was too small to be able to consider the results at the specialty level.

6.123 Among RSC patients, one in four patients (27%) said they would have gone to Frimley Park, whilst 16% of patients would have gone to SPH. Among SPH patients, the most popular alternative was RSC (22%), followed by Frimley Park (9%) and West Middlesex (6%). However, the most common answer for patients of both hospitals was that they did not know which other hospital they would have attended (41% for SPH and 31% for RSC).

6.124 In line with standard CMA practice, in calculating the diversion ratios, those who 'did not know' or 'would have asked GP/consultant' should not be included in the denominator as we have no useful information about their diversion behaviour for the purpose of the calculation. Note that this is equivalent to those patients being distributed pro rata to the distribution between mentions of the Parties and third parties. Nevertheless, in deciding how much weight to attach to the results, we have taken into account the relatively high number (over 50%) of such responses.

6.125 On this basis, the diversion ratio was significantly higher among SPH patients, at 41%, than it was among RSC patients, where it was 25%. RSC patients named Frimley Park more often as the alternative choice.

6.126 Our patient survey suggests that, when we consider competition at a hospital, there is an asymmetric constraint between SPH and RSC, with RSC appearing to be a stronger competitive constraint on SPH than SPH is on RSC.

Contestable GP practice analysis

6.127 We carried out an analysis to understand the extent to which the Parties pre-merger and the combined entity post-merger might compete for patients and are or would be exposed to competition. We did this by identifying 'contestable' GP practices as those GP practices and patients that were likely to have alternatives to one of the Parties pre-merger, and to the combined entity post-merger, because they referred to other providers historically.[169]

6.128 We found that pre-merger ASP and RSC derived around 13% and 16% of outpatient revenues from contestable GP practices.[170] The merged entity would have around 4% of outpatient revenues from contestable GP practices. We interpret this as suggesting that the merger may lead to an internalisation of competition, and motivated our specialty level assessment.

Patient/GP referral analysis

6.129 We undertook patient/GP referral analysis to provide an insight into the strength of each provider as an alternative choice to the Parties. This analysis has been used in previous merger cases by the CMA's predecessor, the Competition Commission (CC) and Monitor's predecessor, the Co-operation and Competition Panel (CCP).

6.130 We looked at the share of patients referred to each provider from GP practices that referred at least one patient to either one of the Parties over four years starting in 2010. As a proxy for assessing to which hospital patients/GPs of the Parties might switch their choice in response to a reduction in quality at the relevant Party, we assumed that patients/GPs would switch providers in accordance with the share of patient/GP referrals received by the other providers at the GP practice concerned.[171] The output of the GP referral analysis is a list of providers by the numbers of patients that, we assume, would switch to each hospital.

6.131 We undertook GP referral analysis for each specialty and treatment setting in which the Parties overlap. As we noted above in paragraph 6.40, whilst there is no right to patient choice in relation to day-case and inpatient treatment, the

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[169] Contestable GP practices are in contrast to a situation where all patients at a given GP practice are referred to one Party. We tested various thresholds for the share of referrals to the Party/combined entity at the GP practice, and interpreted the results from these analyses as broadly consistent across treatment settings. We show below the results for outpatients for the threshold set at a GP practice sending between 10 and 70% of referrals to the Party.
[170] We considered the value of referrals, rather than volume, as we consider that this is the most informative measure of how competition for referrals influences the Parties'/combined entities' incentives.
[171] We call this 'proportional analysis'. An alternative version (ordinal analysis) assumes that patients of the anchor will all switch to the most referred-to non-anchor provider. Given the intuitiveness of the proportional methodology and the strong switching assumption in the ordinal methodology, we have adopted the former throughout.

quality of services that a hospital provides in relation to day-case and inpatient elective activity is likely to influence the choice of hospital for the first outpatient referral and this generates scope for hospitals to compete against one another in relation to outpatient, day-case and inpatient services.

6.132 Patient/GP referral analysis is based on the actual choices of provider (at outpatient level, and inferred choices for day-cases and inpatients), which allows us to determine historical patient/GP preferences. We use this information to infer the providers to which patients/GPs might switch in the event of a decline in quality at one of the Parties, making the assumption that historical patient/GP preferences of provider provide good predictions of future patient/GP provider choices under this scenario. We consider this to be a reasonable assumption to apply in the healthcare setting, since one distinguishing feature of healthcare markets is that patients cannot perfectly observe the quality of the service that they will receive before they experience the service. There is, therefore, an important role for GPs in making recommendations to patients, which are often subsequently acted upon (from our patient survey, over a quarter said that their GP gave a recommendation of a hospital, and in the large majority of these cases this recommendation was for the provider that the patient actually attended). Moreover, results from the academic literature suggest that the higher the proportion of patients a GP refers to a particular provider, the more likely it is that future patients will be referred by that GP to that provider.[172]

6.133 We are, however, mindful of the limitations of such analysis, both with respect to the data used and the assumptions underpinning the interpretation of the analysis.

6.134 As with all types of analysis, the quality of this analysis is dependent on the quality of the data set used. We had regard to the Parties' argument that the same treatment that a patient receives can be coded under different specialties at different providers. This could cause the analysis to misstate the extent to which providers provide the same services, and how closely they compete. Whilst we developed a methodology that reallocated inconsistently coded treatments,[173] we acknowledge that this reallocation did not identify all miscoded data.[174] This presents a limitation to the analysis of which we are mindful in interpreting its results. In particular, where relevant, we asked third

[172] See Beckert, W, Christensen, M and Collyer, K (2012), 'Choice of NHS-funded hospital services in England', *The Economic Journal*, Vol 122, Issue 560, pp400–417.
[173] See Appendix C.
[174] The methodology relies on a minimum number of trusts coding activity consistently, and cannot reallocate small volumes.

party providers to provide information on volumes of activity in a given specialty under consideration and took this into account in interpreting the results.

6.135 With respect to our assumption that the choices of past providers by patients and GPs provide an indication of the providers to which patients and GPs might switch in the future, the past choices of provider made by patients/GPs are unlikely to have good predictive power where there have been changes to the competitive landscape in the recent past or such changes take place in the future. We consider that the proposed investment at Frimley and Heatherwood, as discussed above (see paragraph 6.100 above), may result in patient/GP choices in the future being different from past choices. We have taken this into account in interpreting the results of the patient/GP referral analysis.

6.136 A further factor in our analysis is that we use GP practice level data rather than GP level data. This is based on the assumption that an individual GP's willingness to switch patients to other providers is in line with the behaviour of other GPs in the same practice. This approach allows locations of GP practices to be treated as proxies for patient locations, whilst not suffering to the same extent from the defects associated with small numbers of referrals, as would be the case in an analysis based on individual GP referrals. We note that this assumption is supported to some degree by the GP research, which suggests that GPs share information with each other during practice meetings.[175] However, we note that this assumption may be a further limitation to the analysis.

6.137 In summary, while we believe the methodology and assumptions used in the GP referral analysis are appropriate to provide an insight into the strength of each provider as an alternative choice, we acknowledge there are weaknesses in the data and assumptions, and we have been mindful of these in interpreting the results of the analysis.

- *CMA analysis*

6.138 We have undertaken the following variants of GP referral analysis:

(a) Specialty, linked groups of specialties, trust level.

(b) Outpatient, day-case and inpatient.[176]

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[175] See Survey Report (GfK research report), paragraph 123.
[176] For outpatient referrals, we are able to identify the source of referrals to a provider. We consider that patient choice may be limited in respect of referrals from A&E or consultants. In the outpatient analysis, we ran two versions of the GP referral analysis: one including all sources of referral, and one excluding referrals from the following sources: Other (code 8), Other,not consultant initiated (code 97), Unknown (coded 99), Following an

(c) All GP practices, except those that only referred to one of the Parties.[177]

6.139 The output of the GP referral analysis is ranked lists of providers, with the referrals from the anchor hospital[178] reallocated across providers. In interpreting the results, we view the ranking of providers as showing the preferences of patients and GPs for the providers – that is, we interpret the provider ranked first as being the next best alternative for patients and GPs. We also take into account the number of patients and GPs that the analysis suggested would switch to each provider, as an indication of the strength of that provider as an alternative.

6.140 We used the results at a specialty and specialty group level, to focus on specialties for which patients and GPs may view the relevant party as a close alternative option. This means that, for ASP we considered the specialties for which the first or second ranked provider was RSC and/or that RSC received a substantial number of patients switching from ASP. We did the same for RSC.

6.141 We consider that the GP referral data provides a useful starting point for identifying areas which warrant a more detailed assessment. We consider it important to take into account the referral analysis for outpatient, day-case and inpatient. This is because, although there is no right to patient choice in relation to day-case or inpatient treatment, these services influence the choice of hospital for the first outpatient referral for many patients and this generates scope for hospitals to compete with one another in relation to outpatient, day-case and inpatient services. However, we note that the extent to which patients/GPs choose a provider based on future treatment is likely to vary by specialty. In particular, some specialties are outpatient only and, for conditions relating to some specialties, a GP may not be well-placed to advise a patient as to the likelihood of future treatment. We have taken this into account in our assessment of each specialty.

6.142 We conducted a two-step filtering process to identify which of the 58 services, in which the Parties overlap, merited closer scrutiny. The outcome of this filtering process was the result of a finely balanced weighing up of different factors and required a degree of judgement.

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emergency admission, Following domiciliary visit, Following an A&E Attendance, Other (coded 11). We found that the results of both pieces of analysis were broadly the same. In this report, the results of the latter analysis are presented.

[177] It is not possible to conduct the analysis on the GP practices that only referred to an anchor hospital as the methodology relies on reallocating referrals in proportion to the referrals historically received by other providers. The interpretation is that these are inframarginal GPs/patients, who would be very unlikely to choose another provider following a reduction in quality of services provided by the anchor hospital.

[178] The anchor is the trust from which we have reallocated referrals. For the purposes of this investigation we have run analysis setting ASP as the anchor (allowing reallocation to RSC), and RSC as the anchor (allowing reallocation to ASP).

6.143 In the first step of our analysis we included for further review those specialties where the results of the GP referral analysis indicated in one or more treatment setting (ie outpatient, day-case or inpatient):

(a) RSC (with ASP as anchor) or ASP (with RSC as anchor) was the next closest alternative; and/or

(b) The referral percentages for either RSC (with ASP as anchor) or ASP (with RSC as anchor) were around 30% or greater; and/or

(c) There were no other providers with an equivalent or a greater level of referral percentage[179].

6.144 We excluded however specialities where our investigation showed that patients exercise little or no patient choice in relation to their first consultant-led outpatient appointment.[180]

6.145 Of the 58 overlap specialties, we also excluded 10 specialties where we considered that the referral analysis was not sufficiently robust, and there was no corroborating evidence, eg in internal documents, or other factors to suggest a competitive concern.[181] For example, as regards Upper Gastrointestinal Surgery, we considered that the number of referrals on which the analysis was based, was too small to yield robust results.

6.146 As a result of this filtering process we identified 19 specialties which required further analysis. The 19 specialties were: Audiology & Audiological Medicine, Breast Surgery, Colorectal Surgery, Dermatology, Diabetic Medicine, Endocrinology, ENT, Gastroenterology, General Surgery, Geriatric Medicine, Gynaecology, Maxillo-Facial Surgery, Obstetrics, Ophthalmology, Orthoptics, Paediatrics, Respiratory Medicine, Trauma & Orthopaedics and Urology.

6.147 For these 19 specialties, we note that there are at least 10 other hospitals in the local area surrounding the Parties which a number of patients regard as alternatives to the Parties for several specialties. Of these, Frimley is already a

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[179] In some cases, we nevertheless included a speciality even where there were third party providers with equivalent or greater referral percentages, where we had a *prima facie* concern that the other provider in question (eg Moorfields in the case of ophthalmology, or the Royal Marsden in the case of cancer-related treatments) may provide specialist services that may not compete as closely with the anchor Trust as the referral analysis might otherwise suggest.

[180] The most obvious example of this is Anaesthetics. While this is recorded as a "first consultant-led outpatient appointment" in the HES data, patients are directed towards an anaesthetist according to a well-defined clinical pathway and it is also clear that the choice of anaesthetist plays little or no role in their choice of provider for their initial outpatient appointment for the speciality concerned.

[181] These 10 specialties were: Clinical Oncology, Medical Oncology, Midwifery Service, Paediatric Cardiology, Paediatric Diabetic Medicine, Paediatric Endocrinology, Paediatric Respiratory Medicine, Paediatric Trauma And Orthopaedics, Paediatric Urology and Upper Gastrointestinal Surgery

strong alternative provider, with a CQC rating of Outstanding. Frimley's recent acquisition of Heatherwood and Wexham is expected to result in significant investment in the facilities and clinical services at these two sites.[182] Moreover, we note that the recent acquisition by Chelsea & Westminster of West Middlesex may also be expected to improve further the services provided by West Middlesex.

6.148 We then assessed a number of additional factors for those 19 specialities, which capture the differences in the competitive dynamics at a specialty level. The relevant factors we considered were:

(a) Whether there were high referral figures from one of the Parties to the other in one or more treatment settings;

(b) Whether the referral analysis indicated that there are credible alternatives to the Parties such that there would be sufficient patient choice post-merger;

(c) The strength of the reputation and market position, and investment plans, of certain alternative providers who we considered were likely to become increasingly strong alternatives in the near term;[183]

(d) Evidence as to the scope for competition between the Parties in the absence of the merger given their existing cooperation in some specialties;

(e) Evidence that local CCGs have previously intervened or would in the future intervene to prevent deteriorations in quality or to take initiatives, often in line with national strategic priorities, to alter clinical pathways and introduce new models of care to the benefit of patients.

6.149 In applying these factors, we also considered:

(a) that, in the specific context of healthcare markets, competition is only one of a number of factors that determine the Parties' incentives to maintain and improve the quality of their elective services;

(b) that the Parties' commissioning arrangements, profitability and capacity levels mean that the Parties have an incentive to maintain current levels of patient referrals and attract additional patient referrals for elective services but, at the same time, we recognise that risks attached to payment,

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[182] Independent Trust Financing Facility Application The Acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust by the Frimley Park Hospital NHS Foundation Trust.
[183] See discussion of Frimley and West Middlesex above.

uncertainty regarding profitability and capacity pressures may weaken these incentives to some extent; and

(c) that commissioners play an important role in driving quality improvements, as demonstrated in the Parties' internal documents and evidence provided by the commissioners themselves.

6.150 In assessing any given speciality, we took into account the cumulative effect of the above factors in assessing the competitive effect of the merger. This, again, meant that our assessment required a finely balanced weighing of the relevant factors and an exercise of judgement.

6.151 In our analysis, we considered that specialty-specific evidence of the intervention or threat of intervention of CCGs in a given specialty would act as an incentive on a hospital to maintain or improve the quality of that speciality. Such evidence would therefore be a relevant factor in reducing the likelihood of the merger giving rise to an SLC in that specialty. For example, as regards Dermatology services, GWCCG took action to re-tender Dermatology services to a community provider away from acute hospital care in response to a deterioration in the quality of Dermatology services provided by RSC.

6.152 Similarly, as regards cooperation between the Parties, we note that there are a number of specialties where the Parties were already in close cooperation. We consider that in certain circumstances incentives to compete in such services may be reduced due to such cooperation and/or clinical integration and that, as a result, a given merger between the relevant hospitals is unlikely to lead to an SLC. Audiology is an example of such a service since Audiology services at ASP are provided by RSC.

6.153 In our assessment, we also had regard to any relevant specialty-specific evidence contained in the internal documents. For example, the internal documents provided evidence which confirmed the roll-out of new models of care for Diabetic and Geriatric Medicine, with a view to shift these treatments out of acute hospitals and into the community.

6.154 On the basis of this assessment, we considered that the merger would not be expected to give rise to an SLC as regards the markets for 15 of the 19 specialties. We also considered that the following four specialties particularly stood out when compared to the others, and therefore required more detailed consideration to determine the likelihood of the merger leading to an SLC:

(a) General Surgery.

(b) Breast Surgery.

(c) ENT.

(d) Maxillo-Facial.

6.155 We considered that for these four specialties, based on the results of the GP referral analysis and the evidence available, there were particular concerns in respect of the availability of sufficient alternative providers whom patients / GPs could and would choose for treatment in the event of a reduction of quality in this service at the merged trust. To assess the validity of these concerns we sought further evidence from the Parties and relevant third parties. Our assessment of each of these services based on the evidence provided is set out below.

6.156 The following sections set out our analysis for each of these four specialties in turn. The evidence relevant to each of these four specialities is mixed. We have assessed the specialty-specific evidence alongside the factors set out in paragraphs 6.148 to 6.153 above. Our overall conclusions for each of the four specialities have been finely balanced.

General Surgery

Parties' views

6.157 The Parties argued that General Surgery services were standard services provided by all DGHs in the area surrounding the Parties.

6.158 The Parties noted that there were material differences in coding practices between the two Parties and between the Parties and Frimley, which might affect the reliability of the CMA reallocation methodology and the GP referral analysis (see paragraphs 6.162 to 6.165 below).

6.159 The Parties also noted that, as regards General Surgery services provided at RSC, there were three specialties of particular relevance to the competitive assessment, namely Colorectal, Upper Gastrointestinal Surgery, or Oesophageo-Gastric Surgery, and Hepato-Pancreatic-Biliary Surgery. This means that the Parties do not overlap in all General Surgery services because RSC, in contrast to ASP, operates clinical centres for pancreatic, bile duct, liver, stomach and oesophageal cancer, with specialist surgical teams. In the Parties' view, these specialisms-bias referrals to RSC for patients with certain conditions, including cancer and non-cancer related conditions.

6.160 The Parties also submitted that RSC was managing to keep within RTT 18-week targets in General Surgery only at the cost of running large numbers of extended weekday and weekend theatre sessions.

Competitive assessment

6.161 Our GP referral analysis (set out in Tables 14 to 16) shows that, where ASP was the anchor hospital, RSC received the highest number of referrals for General Surgery services in relation to outpatients, day-cases and inpatients.

Table 14: GP referral analysis for General Surgery for outpatients with ASP as the anchor hospital

General Surgery	*Volume*	*%*
RSC	[1,000–2,000]	41.1
Frimley Park*	**[500–600]**	**17**
West Middlesex	[300–400]	11.2
Heatherwood and Wexham Park*	**[100–200]**	**5.1**
Imperial College	[100–200]	3.5
St George's	[0–100]	3.2
Chelsea and Westminster	[0–100]	3.2
Hillingdon	[0–100]	3
Epsom and St Helier	[0–100]	2.2
Kingston	[0–100]	1.6

*To be combined as Frimley.

Table 15: GP referral analysis for General Surgery for day-cases with ASP as the anchor hospital

General Surgery	*Volume*	*%*
RSC	[6,000–7,000]	42.3
Frimley Park*	**[5,000–6,000]**	**34.7**
West Middlesex	[1,000–2,000]	7.7
Heatherwood and Wexham Park*	**[400–500]**	**2.6**
Kingston	[300–400]	2.1
Epsom and St Helier	[300–400]	2
Royal Marsden	[300–400]	1.9
Imperial College	[100–200]	0.9
Guy's and St Thomas'	[0–100]	0.6
North West London	[0–100]	0.6

*To be combined as Frimley.

Table 16: GP referral analysis for General Surgery for inpatients with ASP as the anchor hospital

General Surgery	*Volume*	*%*
RSC	[1,000–2,000]	44.7
Frimley Park*	**[300–400]**	**12.1**
Epsom and St Helier	[300–400]	10.9
West Middlesex	[200–300]	7
St George's	[100–200]	5.8
Royal Marsden	[100–200]	4.4
Chelsea and Westminster	[0–100]	2.7
Heatherwood and Wexham Park*	**[0–100]**	**2.7**
Imperial College	[0–100]	2.7
University College London	[0–100]	1

*To be combined as Frimley.
Source: HES data, CMA analysis.[184]

6.162 In response to our analysis, the Parties queried whether differences in the basis on which the hospitals recorded specific services might affect the robustness of

[184] Frimley Park volumes are reported for the 2014/15 period and stem from a different set of data to CMA numbers, being directly provided by Frimley.

our analysis. Specifically, the Parties queried whether the HES data correctly reflected Frimley Park's position in relation to General Surgery services.

6.163 To investigate this issue, we obtained additional volume information directly from Frimley Park, which allowed us to conduct a further sensitivity check on our analysis.

6.164 We compared the volumes of activity of the Parties and of Frimley Park. These volumes are shown below

Table 17: Volumes in General Surgery and Colorectal Surgery for the Parties and Frimley Park

General Surgery	*ASP*	*RSC*	*FPH*
Outpatients[185]	[0–100]	[5,000–6,000]	[2,000–3,000]
Day-cases	[3,000–4,000]	[5,000–6,000]	[300–400]
Inpatients	[600–700]	[1,000–2,000]	[1,000–2,000]

Source: HES data, CMA analysis, Frimley data.

6.165 On the basis of this further information, we found that the analysis based on the HES data materially overstated Frimley Park's volume.[186] We took this into account when considering the HES data.

6.166 As described above, linkages between specialties and treatment settings are important both to how we conduct the analysis and interpret the results and in determining whether and where harm might arise as a result of the merger.

6.167 The Parties submitted that, because of clinical linkages, we should consider General Surgery together with Colorectal Surgery. In General Surgery, there is a difference in clinical coding practices between Frimley Park and each of the Parties that affects the recording of activity in these specialties as well as in Colorectal Surgery and Upper Gastrointestinal Surgery.

6.168 On the basis of the coding practices of the Parties and also of Frimley Park, we conducted a sensitivity check by considering activities in General Surgery and Colorectal Surgery together.

[185] We note that ASP coded very few episodes of General Surgery in 2012–14, which we understand to be as a result of a drive to code activity in more specific specialties. Prior to this, they coded substantial volumes in this specialty.

[186] On the basis of this further information, we found that our reallocated HES data overstates Frimley Park's position as follows: for outpatients: the volume in our data is around three times larger than its reported 2014/15 volume; for day-cases, the volume in our data is around six times larger than its reported 2014/15 volume and for inpatients the volume in our data is around three times larger than its reported 2014/15 volume. Some variation between the volumes of patients treated under day-case and inpatients can be attributed to differences in the variables used by Frimley Park and the CMA to distinguish between these types of care spells.

Table 18: GP referral analysis for General Surgery combined with Colorectal Surgery for outpatients with ASP as the anchor hospital

General Surgery – Colorectal Surgery	*Volume*	*%*
RSC	[5,000–6,000]	34.7
West Middlesex	[2,000–3,000]	17.1
Frimley Park*	**[2,000–3,000]**	**15.3**
Heatherwood and Wexham Park*	**[700–800]**	**4.7**
Imperial College	[500–600]	3.5
Kingston	[500–600]	3.4
Hillingdon	[500–600]	3
St George's	[400–500]	2.8
Chelsea and Westminster	[400–500]	2.5
North West London	[300–400]	2.1

*To be combined as Frimley.

Table 19: GP referral analysis for General Surgery combined with Colorectal Surgery for day-cases with ASP as the anchor hospital

General Surgery – Colorectal Surgery	*Volume*	*%*
RSC	[7,000–8,000]	41.7
Frimley Park*	**[5,000–6,000]**	**34.5**
West Middlesex	[1,000–2,000]	7.7
Heatherwood and Wexham Park*	**[400–500]**	**2.6**
Kingston	[300–400]	2.3
Epsom and St Helier	[300–400]	1.9
Royal Marsden	[300–400]	1.9
North West London	[100–200]	0.9
Imperial College	[100–200]	0.9
Guy's And St Thomas'	[100–200]	0.7

*To be combined as Frimley.

Table 20: GP referral analysis for General Surgery combined with Colorectal Surgery for inpatients with ASP as the anchor hospital

General Surgery – Colorectal Surgery	*Volume*	*%*
RSC	[1,000–2,000]	43.1
Frimley Park*	**[400–500]**	**12.6**
Epsom and St Helier	[300–400]	10.3
West Middlesex	[200–300]	6.7
St George's	[100–200]	5.5
Royal Marsden	[100–200]	4.4
Heatherwood and Wexham Park*	**[0–100]**	**2.7**
Chelsea and Westminster	[0–100]	2.6
Imperial College	[0–100]	2.6
University College London	[0–100]	1.9

*To be combined as Frimley.
Source: HES data, CMA analysis.

6.169 Taking account of the additional volume information provided by Frimley Park, we found that its position had been materially overstated in our analysis based on the HES data. As a result, the data in the tables above should be adjusted downwards for Frimley and upwards for other providers, including the Parties.

6.170 With regard to linkages, we also tested how the referral analysis would change based on other combinations of surgical specialties. For example, when Upper Gastrointestinal Surgery was included, the referral share of RSC fell further relative to other hospitals across all treatment settings. We note that when we grouped General Surgery, Colorectal Surgery, Upper Gastrointestinal Surgery and Breast Surgery (to make up the complete set of surgical specialties the

Parties had identified to us as being linked) the numbers were closer to those relating to General Surgery alone.

6.171 We also considered the extent to which the outpatient activity in General Surgery consisted of referrals from GPs and the proportion which came from consultants, A&E departments and other sources. Our analysis shows that 45% of ASP's and 28% of RSC's outpatient referrals across the relevant period came from non-GP sources. We consider that these figures suggest that, in this specialty, patients are likely to have had a relatively limited ability to anticipate the clinical pathway that would ultimately result. This causes us to place greater weight on the outpatient figures and less weight on the figures relating to day-cases and inpatients.

6.172 The evidence relating to the potential impact of the merger on General Surgery is mixed. We have had particular regard to:

(a) the coding issues affecting the HES data, including the effect of including related surgical specialties (eg Colorectal Surgery) in the analysis;

(b) the significant proportion of outpatient referrals from consultants, A&E departments and other sources (ie not through GPs) that reduces the choices available to these patients; and

(c) the number of alternative providers of General Surgery services in the local area surrounding the Parties and, in particular, Frimley.

6.173 We note that on the basis of the HES data set out in Tables 18 to 20 above where ASP is the anchor hospital, RSC has the highest number of referrals for outpatients, day-cases and inpatients. Frimley Park also had a significant number of referrals for day-cases and also for outpatients and inpatients.

6.174 Moreover, the HES data provides only historical information. In terms of future developments, we consider it likely that the recent acquisition by Frimley of Heatherwood and Wexham Park can be expected to enhance the quality of the services provided by Frimley and its competitive position relative to ASP in the foreseeable future. Its position is likely to be further strengthened by the substantial investment Frimley is planning to make in the Heatherwood site, which is intended to help increase the provision of General Surgery services (among others) at Heatherwood. This is of particular significance, given the proximity of the Heatherwood and SPH sites. We also consider that in future Frimley is likely to have an increased incentive and ability to attract patients in general, including patients requiring General Surgery.

6.175 The analysis based on HES data also shows that, in addition to Frimley Park, other providers, such as West Middlesex, are credible alternatives to ASP within the Parties' area, albeit with lesser shares of referrals than Frimley Park.

Conclusion on General Surgery

6.176 We consider that the merged entity would face sufficient competition from a number of alternative providers that already attract a significant number of patients in the Parties' existing catchment area. The key competitor in this regard is Frimley. We expect Frimley to be an even stronger competitor in future, for the reasons set out above. Furthermore, the merged entity would also face competitive pressures from West Middlesex.

6.177 The differences in coding practices in this specialty by each of the Parties and other hospitals mean that we place less weight on the HES analysis on the basis of General Surgery alone. Also, we consider that the potential lack of knowledge of a patient as to whether he or she might ultimately require General Surgery as a day-case or an inpatient means that we place more weight on the outpatient figures.

6.178 We have therefore assessed the inclusion of other, linked surgical specialties, with particular emphasis on the outpatient data. This analysis provides evidence that, while the Parties are each other's closest competitors in this specialty, there are a material number of other hospitals in the local area that patients can and do choose to attend.

6.179 On this basis, we consider that the merged entity would not have an incentive to reduce quality in General Surgery at any of its sites. We therefore consider that the merger may not be expected to result in an SLC in the outpatient, day-case and inpatient markets for General Surgery services.

Breast Surgery

Parties' views

6.180 The Parties note that there are material differences in coding practices between the Parties and between the Parties and Frimley Park, which might affect the reliability of the CMA's re-allocation methodology and the GP referral analysis. Specifically, the Parties queried whether the HES data correctly reflected Frimley Park's position in respect of Breast Surgery services.

6.181 The Parties have also submitted that RSC's incentives and ability to increase its Breast Surgery activity are reduced due to profitability and capacity constraints.

Competitive assessment

6.182 Our GP referral analysis (set out in Tables 21 to 24 below) shows that, where ASP is the anchor hospital, RSC had the highest number of referrals for Breast Surgery services in relation to outpatients, day-cases and inpatients and that, where RSC is the anchor hospital, ASP had the highest adjusted number of outpatient referrals.

Table 21: GP Referral Analysis for Breast Surgery for outpatients with ASP as the anchor hospital

Breast Surgery	*Volume*	*%*
RSC	[5,000–6,000]	46.3
West Middlesex	[2,000–3,000]	20.6
Royal Marsden	[900–1,000]	7.3
Kingston	[800–900]	6.5
Heatherwood and Wexham Park	[800–900]	6.3
St George's	[400–500]	3.8
Imperial College	[200–300]	2
Guy's and St Thomas'	[100–200]	1.4
Barts	[100–200]	0.9
Hillingdon	[100–200]	0.8

Table 22: GP referral analysis for Breast Surgery for day-cases with ASP as the anchor hospital

Breast Surgery	*Volume*	*%*
RSC	[400–500]	55.9
Royal Marsden	[100–200]	17.8
West Middlesex	[0–100]	7.7
Imperial College	[0–100]	6.5
Frimley Park*	**[0–100]**	**6.1**
Kingston	[0–100]	4.4
Heatherwood and Wexham Park*	**[0–100]**	**0.7**
St George's	[0–100]	[✂]
Royal Berkshire	[0–100]	[✂]
Hillingdon	[0–100]	[✂]

*To be combined as Frimley.

Table 23: GP referral analysis for Breast Surgery for inpatients with ASP as the anchor hospital

Breast Surgery	*Volume*	*%*
RSC	[300–400]	63.2
Imperial College	[0–100]	7
Royal Marsden	[0–100]	6.3
Frimley Park*	**[0–100]**	**3.6**
West Middlesex	[0–100]	3.4
Heatherwood and Wexham Park*	**[0–100]**	**3**
St George's	[0–100]	2.9
Kingston	[0–100]	2.6
Royal Cornwall	[0–100]	1.3
Maidstone and Tunbridge Wells	[0–100]	1.3

*To be combined as Frimley.

Table 24: GP Referral Analysis for Breast Surgery for outpatients with RSC as the anchor hospital

Breast Surgery	*Volume*	*%*
ASP	[2,000–3,000]	32.7
Royal Marsden	[1,000–2,000]	18
Hampshire	[400–500]	6.1
Surrey and Sussex	[300–400]	5.4
St George's	[300–400]	4.8
Western Sussex	[300–400]	4.2
Kingston	[200–300]	3.2
King's College	[200–300]	3.1
Guy's and St Thomas'	[200–300]	3.1
University College London	[100–200]	2.7

Source: HES data, CMA analysis.

6.183 When interpreting these figures, we noted that ASP treated around seven times as many outpatients as admitted patients across the four-year period. This is important given that costs comprised a roughly similar proportion of revenues across treatment settings. Taken together, these factors imply that the trust has greater incentives to attract outpatients than inpatients.

6.184 In response to our analysis, the Parties queried whether differences in the basis on which the hospitals recorded specific services might affect the robustness of our analysis. Specifically, the Parties queried whether the HES data correctly reflected Frimley Park's position in respect of Breast Surgery services. We note that the HES outpatient figures exclude Frimley Park entirely as a result of coding issues, and therefore the tables overstate the referral numbers in respect of RSC and other providers.

6.185 To investigate this issue, we obtained additional volume information directly from Frimley Park. We compared the volumes of activity at the Parties and Frimley Park. These volumes are shown below.

Table 25: Volumes in Breast Surgery for the Parties and Frimley Park

General Surgery	*ASP*	*RSC*	*FPH*
Outpatients	[3,000–4,000]	[2,000–3,000]	[1,000–2,000]
Day-cases	[400–500]	[300–400]	[100–200]
Inpatients	[100–200]	[300–400]	[300–400]

Source: HES data, CMA analysis, Frimley data.[187]

6.186 On the basis of this further information, we found that in respect of Frimley Park, the HES data significantly understated its volumes.[188] We have taken this into account when considering the HES data.

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[187] Frimley Park volumes are reported for the 2014/15 period and stem from a different set of data to CMA numbers, being directly provided by Frimley Health.
[188] For outpatients, our data understates its actual volumes as there were no spells reported; for day-cases, our data understates its activity at about half of the reported 2014/15 volume; and for inpatients, our data understates its volumes slightly, but is within 12% of the reported 2014/15 volume.

6.187 We also note that, as discussed above under General Surgery, Breast Surgery can also be grouped with General Surgery, Colorectal Surgery and Upper Gastrointestinal Surgery to make up the complete set of surgical specialties the Parties had identified to us as being linked.

6.188 The evidence relating to the potential impact of the merger on Breast Surgery is mixed. We have had particular regard to:

(a) the coding issues affecting the HES data, in particular the fact that the HES data does not show Frimley as a provider of outpatient services in Breast Surgery in the HES data;

(b) the importance of outpatients in Breast Surgery; and

(c) the significant number of providers of Breast Surgery services in the local area and within a 25- to 40-minute drive-time of the Parties.

6.189 We note that, on the basis of the HES data set out in Tables 21 to 23 above, where ASP is the anchor hospital RSC had the highest number of referrals for outpatients (46.3%), day-cases (55.9%) and inpatients (63.2%). West Middlesex also had a significant number of referrals for outpatients (20.6%). Royal Marsden accounted for 17.8% of day-cases and 6.3% of inpatients.[189]

6.190 The HES data analysis also shows that other providers, such as St George's and Kingston, are also credible alternatives to ASP and RSC.

6.191 We consider, taking account of the additional information on Frimley that, Frimley appears to be a sufficiently strong alternative in relation to ASP for outpatients, day-cases and inpatients. We consider that the significant funding available to Frimley following its acquisition of Heatherwood and Wexham Park, is likely to lead to an increase in the quality of the services offered at Heatherwood and Wexham Park. This means that these hospitals will have an increased ability to attract patients in general, including patients requiring Breast Surgery. As regards Breast Surgery in particular, Frimley has told us that it is currently raising £1.5 million for equipment to improve its Breast Surgery centre further.[190] As we noted in connection with General Surgery, the planned improvement in the quality of services provided by Heatherwood is likely to increase the competitive constraint from this hospital.

6.192 We note that on the basis of the HES data set out in Tables 24 above, where RSC is the anchor hospital, ASP had the highest number of referrals for

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[189] We note that these percentages should be slightly lower in light of our sensitivity check regarding Frimley.
[190] www.fphcharity.org/bca.

outpatients (32.7%). Royal Marsden was a strong alternative in relation to RSC for outpatients (18%).

Conclusion on Breast Surgery

6.193 We consider that the merged entity would face sufficient competition from a number of alternative providers. In particular, West Middlesex and Frimley appear to be credible and sufficient alternative providers in relation to outpatients.

6.194 On this basis, we believe that the merged entity would not have an incentive to reduce quality in Breast Surgery at any of its sites. We therefore consider that the merger may not be expected to result in an SLC in the outpatient, day-case and inpatient markets for Breast Surgery services.

Maxillo-Facial – Oral Surgery

Parties' views

6.195 The Parties noted that Maxillo-Facial Surgery should be broken down into its four major constituent parts, namely:

(a) dental services;

(b) skin services;

(c) head and neck cancer services; and

(d) facial deformity services.

6.196 The Parties submitted that RSC was carrying out significantly more activity within this speciality than ASP.

6.197 The Parties broke dental services into three tiers, with tier one services being provided by all dentists, tier two services being provided by contracted dentists as well as some acute trusts and tier three services being provided only by acute trusts. Tier two and three services are commissioned by NHS England. ASP has an agreement with NHS England to provide tier two and three services, whilst RSC only provides tier three services.

6.198 The Parties submitted that, although they both provide skin services, RSC provides specialist services that are not provided by ASP, which reduces the degree of overlap between the Parties. RSC provides specialist services for ASP, SASH and Frimley Park. The Parties submitted that these specialist

services account for about 20% of skin services provided by RSC, which they submitted should be taken into account when considering the referral figures.

6.199 The Parties also submitted that, with regard to coding, skin services could fall within different specialties, such as Maxillo-Facial Surgery, Dermatology, ENT and/or Plastic Surgery TFCs.

6.200 In respect of head and neck cancer services, the Parties submitted that the consultants for these services are already clinically integrated and that services are always provided at RSC, under the supervision of a consultant from either ASP or RSC, so patients do not in effect have a choice as to which hospital will provide the service.

6.201 The Parties submitted that facial deformity services are provided in close cooperation with orthodontists and that RSC is the regional centre for the provision of these services, with other providers including St George's and Queen Victoria.

Competitive assessment of the overlaps between the Parties

6.202 We have considered the Parties' argument that there are specific types of Maxillo-Facial procedures provided by RSC that are not provided by ASP. We accept that there are some procedures provided to patients at RSC that are not provided by ASP. These included the specialist skin services provided by RSC for ASP (and SASH and Frimley Park). However, our analysis of the overlap between the Parties indicates that around 96% of the Maxillo-Facial volumes at ASP are accounted for by treatments that RSC provides, and 80% of RSC's volumes are accounted for by treatments that ASP provides.[191] This suggests that there is a high degree of overlap in the sub-specialty level services provided by the Parties. That said, we acknowledge that RSC is a specialist provider of Maxillo-Facial services and, ASP is not and that, it is likely therefore, that patients requiring more specialist procedures will be referred to RSC, even though ASP also carries out these procedures to a limited extent.

6.203 We have also considered the Parties' argument that Maxillo-Facial Surgery should be assessed in combination with Oral Surgery. Our assessment shows that there is a material degree of overlap between the specialties, with Oral Surgery being a dental specialty that is often coded in the same way as Maxillo-Facial. We have therefore combined these services in our referral analysis.

[191] This calculation was based on 2013/14 volumes at episode level for day-case activity. The revenue associated with these overlapping procedures comprised a similar percentage of each trusts' total day-case elective revenue from this specialty.

6.204 To arrive at this conclusion, we conducted an analysis of treatment and diagnosis codes to understand the extent to which spells with the same codes are coded in different specialties, either within the same trust or across different trusts. This analysis indicated that a significant volume of several trusts' Oral Surgery comprised procedures that the Parties code as Maxillo-Facial Surgery. The same was true for Kingston and, to a lesser extent, St George's.

6.205 Additional data obtained from Monitor allowed us to identify which treatments within specialties could validly be recoded. We found that a substantial proportion of Maxillo Facial Surgery volumes at these local trusts could be coded under Oral Surgery and that almost all Oral Surgery could be coded under Maxillo-Facial Surgery, but in neither specialty were substantial volumes of treatments valid in any other overlap specialty.

Table 26: GP referral analysis for Maxillo-Facial – Oral Surgery for outpatients with ASP as the anchor hospital

Maxillo-Facial – Oral Surgery	*Volume*	*%*
RSC	[6,000–7,000]	29.1
Kingston	[4,000–5,000]	21.2
West Middlesex	[4,000–5,000]	20.9
Guy's and St Thomas'	[1,000–2,000]	5.2
St George's	[1,000–2,000]	4.9
Heatherwood and Wexham Park*	**[800–900]**	**4**
Hillingdon	[400–500]	1.9
King's College	[300–400]	1.8
Epsom and St Helier	[300–400]	1.6
Frimley Park*	**[300–400]**	**1.3**

*To be combined as Frimley.

Table 27: GP Referral Analysis for Maxillo-Facial – Oral Surgery for day-cases with ASP as the anchor hospital

Maxillo-Facial – Oral Surgery	*Volume*	*%*
RSC	[3,000–4,000]	44.9
West Middlesex	[1,000–2,000]	20.2
Kingston	[600–700]	9.1
Frimley Park*	**[300–400]**	**4.7**
Heatherwood and Wexham Park*	**[200–300]**	**4**
Guy's and St Thomas'	[100–200]	2.3
University College London	[100–200]	2.1
St George's	[100–200]	1.5
Imperial College	[0–100]	1.4
King's College	[0–100]	1.4

*To be combined as Frimley.

Table 28: GP Referral Analysis for Maxillo-Facial – Oral Surgery for outpatients with RSC as the anchor hospital

Maxillo-Facial – Oral Surgery	*Volume*	*%*
Frimley Park*	**[9,000–10,000]**	**35.2**
ASP	[7,000–8,000]	27.1
Hampshire	[2,000–3,000]	7.9
St George's	[900–1,000]	3.6
Guy's and St Thomas'	[900–1,000]	3.4
Epsom and St Helier	[700–800]	2.7
Kingston	[600–700]	2.5
Heatherwood and Wexham Park*	**[600–700]**	**2.2**
Portsmouth	[500–600]	2
Surrey and Sussex	[400–500]	1.8

*To be combined as Frimley.

Table 29: GP Referral Analysis for Maxillo-Facial – Oral Surgery for day-cases with RSC as the anchor hospital

Maxillo-Facial – Oral Surgery	*Volume*	*%*
Frimley Park*	**[10,000–15,000]**	**57.1**
ASP	[3,000–4,000]	15.7
Hampshire	[1,000–2,000]	6
Portsmouth	[600–700]	3.1
Heatherwood and Wexham Park*	**[600–700]**	**3**
Epsom and St Helier	[400–500]	2
Western Sussex	[300–400]	1.8
Surrey and Sussex	[300–400]	1.7
Royal Berkshire	[200–300]	1.3
University College London	[200–300]	1

*To be combined as Frimley.
Source: HES data, CMA analysis.

6.206 We note that, on the basis of the HES data set out in Tables 26 to 27above where ASP is the anchor hospital, RSC had the highest number of referrals, most significantly in relation to outpatients (29.1%) and day-cases (44.9%). Kingston and West Middlesex had significant numbers of referrals for outpatients (21.2% and 20.9% respectively) and West Middlesex was significant in relation to day-cases (20.2%). Kingston had a lesser share of referrals (9.1%).

6.207 We note that on the basis of the HES data set out in Tables 28 to 29 above, where RSC is the anchor hospital, ASP had a significant number of referrals for outpatients (27.1%) and day-cases (15.7%). Frimley Park had the highest number of referrals for outpatients (35.2%) and day-cases (57.1%), and Hampshire was also an alternative within the Parties' catchment area, albeit with lesser shares for outpatients (7.9%) and day-cases (6%).

Conclusion on Maxillo-Facial – Oral Surgery

6.208 We consider that the merged entity would face strong competition from a number of credible, alternative providers which currently attract patients in the Parties' catchment areas. The key competitors in this regard are Kingston, West Middlesex and Frimley. We note that at Frimley Park, acute Oral and Maxillo-Facial Surgery services are provided by RSC consultants who are

supported by Frimley staff and equipment. We note that RSC shares the revenues generated by these services with Frimley (to cover the cost of using its staff and facilities). We further note that Frimley already employs consultants providing these services at the Heatherwood and Wexham Park sites, and that Frimley sells their staff's time to Northwick Park Hospital where they provide Maxillo-Facial and cancer services.

6.209 The fact that RSC is a specialist provider of Maxillo-Facial procedures, while ASP is not, limits the extent of competition between them for a sub-section of referrals.

6.210 Therefore, we consider that the merged entity would not have an incentive to reduce quality in Maxillo-Facial – Oral Surgery at any of its sites. We conclude that the merger may not be expected to result in an SLC in the outpatient, day-case and inpatient markets for Maxillo-Facial – Oral Surgery services.

Ear nose and throat

Parties' views

6.211 The Parties submitted that RSC is the network centre for inpatient services in ENT for RSC, ASP and Epsom and St Helier, pursuant to an arrangement which has been in place for over 20 years. The arrangement results in all elective inpatients being treated at RSC.[192] The Parties submitted that, to ensure effective delivery of elective and non-elective inpatients services at RSC, there is a high level of clinical integration between the ENT consultant teams at ASP and RSC. There is also a single set of clinical governance arrangements and the ENT consultants from ASP and RSC meet regularly to discuss clinical matters.

6.212 The high level of clinical integration also applies to outpatient and day-case appointments. The Parties have entered into reciprocal agreements for the mutual sharing of ENT consultants across both trusts to provide not only inpatient, but also out-patient and day-case services.

6.213 Due to the close cooperation between the Parties across all three treatment settings, they submitted that:

(a) they do not compete for elective inpatients, as all elective inpatient activity is carried out at RSC; and

[192] All non-elective inpatients are also treated at RSC.

(b) in relation to outpatients and day-cases, there is a high degree of clinical integration between the Parties which limits the incentives between the Parties to compete for patients.

Competitive assessment of the overlaps between the Parties

6.214 Our GP referral analysis (set out in Tables 30 to 32 below) shows that, where ASP is the anchor hospital, RSC received the highest number of referrals for ENT services in relation to outpatients, day-cases and inpatients and that, where RSC is the anchor hospital, ASP received the highest number of referrals for ENT services in relation to day-cases.

Table 30: GP referral analysis for ENT for outpatients with ASP as the anchor hospital

ENT	*Volume*	*%*
RSC	[10,000–15,000]	48.1
West Middlesex	[5,000–6,000]	20.2
Frimley Park*	**[1,000–2,000]**	**7.3**
Kingston	[1,000–2,000]	5.8
Heatherwood and Wexham Park*	**[1,000–2,000]**	**4.9**
Epsom and St Helier	[600–700]	2.6
Royal Free London	[600–700]	2.6
Imperial College	[600–700]	2.4
University College London	[300–400]	1.3
St George's	[300–400]	1.2

*To be combined as Frimley.

Table 31 GP Referral Analysis for ENT for day-cases with ASP as the anchor hospital

ENT	*Volume*	*%*
RSC	[2,000–3,000]	60.3
West Middlesex	[400–500]	11.4
Frimley Park*	**[100–200]**	**5**
Imperial College	[100–200]	3.6
Royal Free London	[100–200]	3.4
Epsom and St Helier	[100–200]	3.4
Kingston	[100–200]	2.9
University College London	[100–200]	2.9
Heatherwood and Wexham Park*	**[0–100]**	**2.2**
Royal Marsden	[0–100]	1

*To be combined as Frimley.
Source: HES data, CMA analysis.

6.215 Because ASP does not provide ENT services for inpatients (as these are provided by RSC), we have not included any referral figures for this activity.

Table 32 GP Referral Analysis for ENT for day-cases with RSC as the anchor hospital

ENT	*Volume*	*%*
ASP	[1,000–2,000]	29.4
Frimley Park	[900–1,000]	24.7
Epsom And St Helier	[400–500]	10.6
University College London	[200–300]	6.9
Royal Free London	[100–200]	3.6
Imperial College	[100–200]	3.2
Surrey And Sussex	[100–200]	2.6
Nottingham University	[0–100]	2.4
St George's	[0–100]	2.3
Portsmouth	[0–100]	2.1

Source: HES data, CMA analysis

6.216 With additional volume information obtained from Frimley Park, we found that Frimley Park's position had been materially understated.[193] As a result, the data in the table above should be adjusted upward for Frimley and downward for other providers, including the Parties.

6.217 In addition, we compared the volumes of activity at the Parties and Frimley Park and West Middlesex. These volumes are presented below.

Table 33: Volumes in ENT for the Parties and Frimley Park and West Middlesex

ENT	*ASP*	*RSC*	*FPH*	*WMUH*
Outpatients	[5,000–6,000]	[7,000–8,000]	[5,000–6,000]	[1,000–2,000]
Day-cases	[2,000–3,000]	[5,000–6,000]	[400–500]	[700–800]

Source: CMA analysis, Frimley Health analysis.[194]

6.218 We consider that this analysis shows that West Middlesex and Frimley Park both treat a significant number of patients in the Surrey area, alongside the Parties.

6.219 The evidence relating to the potential impact of the merger on ENT is mixed. In our assessment we have had particular regard to:

(a) the close degree of cooperation and integration between the Parties in all three treatment settings for ENT services, which means there is no competition between the Parties for inpatient ENT services and limited competition between the Parties for outpatient and day-case services; and

[193] Based on the additional information we obtained from Frimley Park, we conducted a further sensitivity check on our analysis. On the basis of this further information, we found that the position in respect of Frimley Park was as follows: (a) for outpatients: our data understates Frimley Park slightly, but is within 15% of its reported 2014/15 volume; (b) for day-cases: our data overstates Frimley Park slightly, as it is around 20% lower than its reported 2014/15 volume; and (c) for inpatients: our data estimates Frimley Park's activity correctly.
[194] Frimley Park volumes are reported for the 2014/15 period and stem from a different set of data to CMA numbers, being directly provided by Frimley.

(b) the number of alternative providers of ENT services in the local area and within a 25- to 40-minute drive-time of the Parties, in particular West Middlesex and Frimley.

6.220 We note that, on the basis of the HES data set out in Tables 30 to 31 above, RSC was the strongest referral alternative to ASP for outpatients (48.1%) and day-cases (60.3%). West Middlesex was a strong referral alternative in relation to ASP for outpatients (20.2%) and for day-cases (11.4%) and Frimley Park, combined with Heatherwood and Wexham Park, was also a significant alternative in relation to ASP for outpatients (12.2%) and day-cases (7.2%).

6.221 We note that, on the basis of the HES data set out in Table 32 above, ASP was the closest referral alternative to RSC for day-cases (29.4%). Frimley Park was a strong alternative in relation to RSC for day-cases (24.7%) and Epsom and St Helier was also an alternative within the Parties' catchment area, albeit with a lesser share of referrals (10.6%).

6.222 Our analysis of the HES data for elective inpatients shows very high referral figures. We note that ASP does not provide ENT inpatient services as these are provided solely by RSC. We therefore assessed the clinical integration between the Parties arising from the existing network arrangement. On this basis, we found that inpatients had limited choice between the services provided by the Parties.

Conclusion on ENT

6.223 In our assessment of the potential impact of the merger on ENT services, we have had particular regard to the close cooperation and degree of clinical integration between the Parties in ENT services across all three treatment settings. We have also had regard to the number of alternative providers of ENT services in the local area.

6.224 We consider that the Parties currently have reduced incentives to compete for ENT outpatients and day-cases. We also consider that there is currently no competition between the Parties for inpatients. As a result of the clinical integration between the Parties and the presence of alternative providers in the surrounding area, including West Middlesex and Frimley, we consider it unlikely that the merged entity would have an incentive to reduce quality in ENT services at any of its sites.

6.225 On this basis we conclude that the merger may not be expected to give rise to an SLC in the outpatient, day-case and inpatient markets for ENT services.

7. Non-elective (emergency) acute services to patients

Background – non-elective services

7.1 In this section, we consider competition in the markets for patients, in particular unilateral effects in the provision of non-elective (emergency) acute services.

7.2 Non-elective services are services not scheduled in advance, but arise at short notice due to clinical need and admission is unpredictable.

7.3 Both Parties have A&E departments on their sites and provide services to non-elective patients. ASP's A&E department is located at SPH but there is no A&E department at AH. In the financial year ended 31 March 2014, 92,000 patients attended ASP's A&E department and 71,000 patients attended RSC's A&E department.[195]

7.4 Between 2011 and 2014, 29% of patients who attended ASP's A&E department were subsequently admitted to ASP.[196] The percentage of patients who attended RSC's A&E department who were subsequently admitted to RSC was slightly lower, at 25%.

7.5 In terms of patients attending A&E who were discharged without follow-up treatment, there was a significant difference between the Parties. The proportion was 61% at ASP and 19% at RSC. Conversely, the proportion of A&E attendees who were discharged with the need for follow-up treatment (to be provided by a GP) was significantly higher at RSC, at 34% compared with 4% at ASP.[197]

7.6 The Parties provide services to non-elective patients across a range of specialties. The range of specialties where the Parties overlap accounted in 2013/14 for around 98% of each Party's revenues in respect of non-elective patients across all specialties and for around 20% of each Party's revenues across all patient services.[198]

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[195] Parties' initial submission, Table 3.
[196] Figures based on the CMA's analysis of the HES data.
[197] There are no significant variations in the proportions over time, either for ASP or for RSC. The numbers do not add up to a 100% because there are other 'disposal routes' for A&E attendees including, for example, being transferred to another healthcare provider, being referred to another healthcare professional or dying at the A&E department. See definition of the variable AEATTENDDISP in the HES A&E Data Dictionary.
[198] Values were calculated by matching the HRG codes in the 2013/14 data with 2013/14 national tariffs, adjusted for length of stay, bundling and (for outpatients) procedure/attendance based variation. To account for the fact that hospitals are paid on spells rather than episodes, we allocated the spell payment to the dominant episode within the spell, which we determined to be the episode generating the highest-value procedure or diagnosis (depending on which generated the payment for the spell). Discussions with the Health and Social Care Information Centre indicated that this would be a reasonable approach to take when approximating PbR data, which the CMA did not have access to during this inquiry. We did not consider it necessary to adjust revenues by the MFF given that this

Parties' views

7.7 The Parties told us that non-elective services, involving admission of a patient who had attended A&E, did not involve patient choice, given the urgent and unplanned nature of the care required. Patients normally attended the nearest A&E department.

7.8 The Parties told us that, for certain patients, primarily those requiring Primary Percutaneous Coronary Intervention (PPCI) or emergency Vascular Surgery, there were ambulance protocols which required patients to be taken to designated sites (eg SPH, Frimley or St George's for Vascular Surgery and Frimley or St George's Hospital for PPCI). The Parties also noted that there were local arrangements for the transfer of emergency patients, including for ENT and Ophthalmology.

7.9 The Parties noted that there was no experience in the NHS of providers competing for contracts to supply A&E services, or the non-elective services that were provided as a result of a hospital having an A&E department.

Third party views

7.10 North East Hampshire & Farnham CCG, which mainly commissions services from Frimley, told us that distance appeared to be a significant factor in a patient's choice of which A&E department to attend. It told us that RSC had a greater market share for localities in the South East of the area which it covered.

Competitive assessment

7.11 In many cases, patients may not be able to exercise choice over non-elective services and they may have available to them less information on quality factors than is the case in respect of elective services, given the urgent and unplanned nature of the service. In the following section we consider:

(a) how a provider may influence a patient's choice for non-elective services;

(b) the extent of patient choice for non-elective acute services;

(c) the profitability of increasing, or retaining, activity, given the prevailing tariff and cost structures; and

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would apply uniformly, and would have been almost exactly the same at both Parties for the period considered. The revenues derived from this process will not be exact, but we consider them to be a reasonable approximation and informative for our analysis of the financial incentives on the Parties at the time the referrals were made.

(d) the extent of any capacity constraints on the Parties and other providers in the local area, which may limit providers' incentives to compete to attract additional patients.

Patient choice

7.12 We consider that patients are unlikely to exercise choice over which A&E department to attend when they are taken to an A&E department by ambulance. In those circumstances, the patient will be taken to the A&E department designated by the protocols of the ambulance service.

7.13 Of those patients who attended the A&E department at ASP, 30% arrived by ambulance and at RSC this proportion was 26%.[199]

7.14 Patients who did not arrive by ambulance, that is patients who self-referred or were referred by a GP, may have been able to exercise choice. For ASP, the share of such attendances was 41% whilst, for RSC, the share was around 50%.

7.15 The share of patients who were taken to A&E by ambulance is higher when we consider those patients who were admitted to hospital after having attended A&E rather than all patients who attended A&E. At ASP, around 60% of admitted non-elective patients had been taken to A&E by ambulance, and at RSC the share was around 50%.[200]

7.16 Admitted non-elective patients who arrived by means other than by ambulance and were self-referrals or were referred by a GP represented around 25% of admitted non-elective patients at ASP and around 40% at RSC.

7.17 The Parties told us that patients normally attended the nearest A&E department. We analysed whether patients were choosing their closest provider, considering first patients who attended A&E and then the subset of these patients which were admitted. We used the location of a patient's GP practice as a proxy for the location of the patient (as data on patients' addresses is not available) and, for each patient, identified the nearest provider by drive-time. Patients who arrived at the A&E department by ambulance or who had been referred by an emergency service were excluded in order to restrict the analysis to those patients who may have had an opportunity to exercise choice. We found that 89% of those patients who attended the A&E department at ASP and 75% of those who attended the A&E department at RSC had visited their nearest A&E department. We found the percentages to

[199] A&E attendance at ASP and RSC, CMA analysis of HES data for 2011–2014.
[200] A&E admission at ASP and RSC, CMA analysis of HES data for 2011–2014.

be similar when considering only those patients who were subsequently admitted at the hospital; 88% at ASP and 77% at RSC.[201]

7.18 For both Parties, we found that the percentages of admitted non-elective patients who had been admitted to their nearest provider did not vary substantially with the source of referral, except referrals to RSC from other healthcare providers (not including GPs, dental practitioners or community dental providers). For non-elective referrals to RSC that came from other healthcare providers, the percentage of admitted patients who lived closest to RSC was 54%.

How providers may seek to influence patient choice

7.19 A provider could seek to influence the choice of patients with a view to increasing its provision of non-elective services by improving the quality of the service offered. We consider it could do this through three broad routes:

(a) it could improve the quality of services at its A&E department;

(b) it could improve the quality of the hospital more generally, clinically and, for example, in terms of access, parking facilities or other amenities; and

(c) it could improve the quality of particular non-elective specialties, which may be linked to the quality of provision of services in the same specialty to elective patients, where the patient pathways of elective and non-elective patients overlap.

Parties' incentives to compete

Profitability of non-elective services

7.20 We examined the extent to which it might be profitable for a hospital to attract additional A&E attendees and non-elective patients. We analysed profitability by considering whether the payment received for treating an additional patient exceeded the incremental cost of treating that patient. The analysis drew on service line reporting data provided by the Parties.

7.21 In the last two years, the Parties exceeded the baseline for emergency admissions with their main commissioners so that the revenue earned on marginal non-elective admissions was 30% of the full tariff. In respect of these admissions, our analysis suggests that the margin for most service lines, taking

[201] Hospital nearest to admitted A&E patients, CMA analysis of HES data for 2011–2014.

account of semi-fixed and variable costs,[202] was [✂].[203] As a result, we consider that there is little or no financial incentive to attract additional non-elective referrals.

7.22 While some non-elective services may be profitable in some scenarios, there is uncertainty around precise cost allocation, applicable tariffs and margin analysis. This uncertainty may weaken the financial incentive of the Parties to compete to attract non-elective patients even in these scenarios.

Capacity

7.23 We considered whether the Parties have capacity to provide services to additional non-elective patients. There are two elements to this.

(a) Do the Parties have capacity to treat additional patients at their A&E departments?

(b) Do the Parties have capacity to provide services to additional patients that, subsequent to their attendance at A&E, would be admitted?

7.24 RSC's *Five Year Strategic Plan 2014–2019* notes that RSC's A&E department is working at or near capacity, especially at peak times during the winter and during early evening. It also comments that RSC will continue to look at ways to improve response times by changes to workforce structure and staffing, and it will also work with CCGs to reduce demand.

7.25 ASP made available to us a planning document that suggested that the A&E department at SPH faced some bed pressure for 2015. The paper also identified measures that could be implemented to relieve that problem.

7.26 As part of the business case in respect of the merger, the Parties envisage that SPH would become a Specialist Emergency Centre, providing high-quality secondary and tertiary emergency services, maternity and paediatric services and an enhanced A&E service.

7.27 In considering the Parties' capacity to provide non-elective services, we note that, in many specialties, capacity is shared with that used for elective services.

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[202] See Appendix I – Profitability, paragraph 10.
[203] We estimated ASP's average semi-variable margin for non-elective inpatients to be minus [100–200]%; with all service lines having a [✂] margin other than 'Critical care'. We estimated RSC's average semi-variable margin for non-elective inpatients to be minus [200–300]%, with [✂] of the [✂] relevant service lines having [✂] margins. Of the [✂] RSC service lines with [✂] margins, [✂] relate to ones for which no costs were set against in RSC's SLR data (these refer to the service lines labelled 'Therapies', 'Trust', 'Pharmacy' and 'Outpatients'). The other [✂] service lines with [✂] semi-variable margins for non-elective inpatients at RSC were 'Pathology', 'Acute Medicine and W&C Management' and 'Radiology'.

7.28 In light of these considerations, we conclude that the Parties' capacity to provide additional non-elective services is at least as constrained as it is for elective services, with an even higher level of constraint at times of peak demand.

Conclusion on the impact of the merger on non-elective services

7.29 We found that a significant share of the Parties' non-elective patients did not have a choice of which A&E department to attend because they were taken by ambulance.

7.30 We would expect that patients who self-refer to an A&E department, or who are referred by a GP to an A&E department, may be able to exercise choice of provider. However, our analysis showed that a very high percentage of these patients had attended the A&E department nearest to them.

7.31 We also assessed the Parties' incentives to compete. The NHS's policy is to reduce attendances at A&E departments. We sought to assess the profitability of providing non-elective services and found that the Parties' margins on non-elective services were negative when we took account of variable and semi-fixed costs and assumed that less than the full emergency admissions tariff would be paid in respect of admissions above a defined baseline. Both Parties also reported capacity pressures on their respective A&E departments.

7.32 Taking account of the evidence set out above, we conclude that the merger may not be expected to result in an SLC in the market for the provision of non-elective services.

8. Services to private patients

Background

8.1 In this section, we consider competition in the market for the provision of services paid for by patients or insurers (private patient services), as opposed to services funded by the NHS. Private healthcare providers, or NHS providers of private work, have flexibility in choosing the services and specialties which they offer and in setting tariffs for these services.

8.2 Given that the Parties provide services to private patients, we assessed whether the merger may give rise to an SLC as a result of the merged entity reducing the quality of private patient services and/or increasing the price of those services following the removal of a competitive constraint. We considered the extent to which:

(a) the Parties currently compete with one another to provide services to private patients;

(b) the Parties will provide a significant constraint on one another in relation to the provision of services to private patients in the future; and

(c) other providers represent a competitive constraint in the provision of services to private patients.

Parties' views

8.3 The Parties told us that they both provide private patient services to a small extent. Much of the private patient service provision is due to the co-location of a private hospital on the Parties' main sites [✂].

8.4 At ASP, much of the private patient income comes from services provided to BMI Runnymede Hospital, which is co-located at SPH, in addition to rent and other contractual income received from MBI Runnymede and not directly related to the provision of services by ASP staff.[204] At RSC, private patient services are limited to cancer services, primarily radiotherapy and some complex cancer services.[205] In addition, there are many other competing providers in the Parties' locality.

8.5 In the financial year ended 31 March 2015, ASP's revenues from services to private patients were approximately £[✂], accounting for approximately [✂]% of ASP's revenues for the year. The vast majority of ASP's private patient income was earned through its agreement with BMI Runnymede Hospital.

8.6 RSC entered into an agreement with Nuffield Health Guildford Hospital, whose Guildford Hospital is co-located at RSC. The agreement relates to the provision of a private hospital, as a result of which Nuffield Health Guildford Hospital pays RSC a ground rent.

8.7 In the financial year ended 31 March 2015, RSC's revenues from private patient services were approximately £[✂], accounting for approximately [✂]% of RSC's revenues for the year. Only a small proportion of RSC's private patient income was earned through the agreement with Nuffield Health Guildford Hospital. The majority was earned through services that RSC itself provided to private patients.

8.8 [✂]

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[204] Parties' initial submission, paragraph 26.
[205] Parties' initial submission, paragraph 32.

Competitive assessment

8.9 The overlap between the Parties in relation to the supply of services to private patients is limited. The services where there was an overlap represented only a very small proportion of the total income that the Parties earned from services provided directly to private patients (ie outside the agreements with the private providers). RSC earned [✂]% of private income from overlapping services and ASP earned [✂]% of income from such services.[206]

8.10 We consider that, in the Parties' local area, there are a number of both private and NHS providers that offer a range of services to private patients. In particular, BMI Runnymede Hospital and Nuffield Health Guildford Hospital, which are co-located with ASP and RSC respectively, are owned by national groups with a number of private hospitals across the UK and which offer a wide range of services to private patients.

8.11 We also note that the agreements that each Party has in place with the co-located private providers [✂]. [✂], we consider that they are likely to change going forward in a way that would potentially enable ASP and RSC to compete for more private work. [✂] The main competitive dynamic in the future will be between RSC and third party private healthcare providers, rather than between RSC and ASP. For these reasons, we consider that it is unlikely that the Parties would compete more strongly with one another in the absence of the merger.

8.12 We consider that, even if the Parties did start competing more strongly to provide private services, other providers, including BMI and Nuffield, would be likely to constrain the Parties.

Conclusion on the impact of the merger on services to private patients

8.13 We conclude that, due to the limited overlap of provision of the Parties and the presence of numerous alternative providers of services to private patients, the merger may not be expected to result in an SLC in the market for the provision of services to private patients.

9. Specialised services

Background

9.1 In this section, we consider the theory of harm related to the impact of the merger on competition to provide specialised services, in particular on the process used to determine which providers will have the right to supply

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[206] CMA analysis on the basis of data provided by the Parties.

specialised services. The process may or may not involve a formal tender with provider bidding.

9.2 Specialised services refer to services in respect of rare conditions as specified in Schedule 4 of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012. These services are commissioned directly by NHS England.[207]

9.3 Competition to provide a particular specialised service can take the form of a competitive tendering process, through some other procurement route or a commissioner-led designation process. Competition may also take the form of rival trusts developing the expertise of their staff and investing in equipment in anticipation of a possible reconfiguration in a given specialised service.

Parties' views

9.4 The Parties provide a range of specialised services under contracts they have in place with NHS England. In the financial year ended 31 March 2014, ASP's revenues from these services were approximately £27 million, accounting for 12% of revenues for that financial year.[208] RSC's revenues from specialised services in that year were approximately £71 million, 29% of its revenues for the year.[209]

9.5 The Parties noted that NHS England's commissioning plans in relation to specialised services, including the more specific plans of the Surrey and Sussex Local Area Team, included an intention to concentrate specialised services among fewer providers. The Parties stated, however, that there was nothing which referred to specific competitive processes in the near future.

9.6 The Parties submitted that, given the tenders that could be expected for different services in the foreseeable future, there was no reason to conclude that the merger would give rise to a realistic prospect of an SLC in relation to the provision of specialised services.

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[207] See paragraphs 2.33–2.35 above.
[208] The figure for ASP's revenue from specialised services is based on an extract from its Service Line Reporting (SLR) data. The percentage is calculated on the basis of revenues of £227.3 million reported in ASP's SLR data for 2013/14.
[209] The figure for RSC's revenue from specialised services is based on an extract from the SLAM accounting system used to invoice commissioners for activity. The percentage is calculated on the basis of revenues of £245.9 million for patient care activity as recorded in RSC's 2013/14 annual report.

NHS England's commissioning obligation

9.7 We considered NHS England's commissioning obligations in respect of:

(a) proposals to reconfigure services; and

(b) the commissioning and procuring of services.

9.8 In 2013, NHS England published guidance outlining a 'good practice framework' for commissioners to follow when developing plans for major service changes and reconfigurations.[210] The NHS England Commissioner Guidance stresses that such changes 'must put patients and the public first, by leading to higher quality and more sustainable services.'[211] It also notes that major service changes and reconfigurations should demonstrate the following:

(a) strong public and patient engagement;

(b) consistency with the current and prospective need for patient choice;

(c) a clear clinical evidence base; and

(d) support for proposals from clinical commissioners.

9.9 The NHS England Commissioner Guidance also reflects the requirements set out in the NHS Procurement Regulations. The NHS Procurement Regulations impose various requirements on NHS England, and on CCGs, to ensure good practice in relation to the procurement of healthcare services. See Appendix B, Annex 2 for further information. In particular, the NHS Procurement Regulations require that, when procuring services, commissioners do so with a view to securing the needs of the people who use the services, to improving the quality of services and to improving efficiency in the provision of services.[212] The NHS Procurement Regulations require NHS England to procure services from one or more providers that are capable of delivering services to the required standards and on a basis which meets these objectives and which provides best value for money in doing so.

NHS England's intentions in relation to reconfiguring services

9.10 We sought to identify specialised services in respect of which there may be opportunities to compete in the foreseeable future, due to planned

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[210] NHS England (20 December 2013), *Planning and delivering service changes for patients — A good practice guide for commissioners on the development of proposals for major service changes and reconfiguration*, (NHS England Commissioner Guidance).
[211] NHS England Commissioner Guidance, page 8.
[212] The NHS Procurement Regulations, Regulation 2.

reconfigurations, reconfigurations of services triggered by providers not meeting minimum requirements, and NHS England's intention to reduce the number of providers of certain services.

Planned reconfigurations

9.11 NHS England (South) told us that the only possible retendering of services that it was considering in the foreseeable future was that of HIV services.[213] As HIV services are currently supplied by ASP, but not by RSC, we consider it unlikely that RSC would be a strong competitor in relation to the provision of these services.

Reconfigurations of services triggered by providers

9.12 We considered whether there were services in which reconfiguration was likely as a result of a provider not meeting the minimum standards set out in the national service specifications, for example volumes of patients treated or financial viability. Other types of derogation may also prompt reconfiguration, although we note that, if one of the Parties was subject to a derogation, that Party might not be in a strong position to compete in any subsequent competitive process.

9.13 NHS England (South) told us that it had no serious concerns about the clinical safety of currently derogated services in respect of either Party and that it had no plans to institute a tendering process in relation to these services in 2015/16.

9.14 We consider that the existing derogations are not likely to give rise to any reconfiguration of services and opportunities for the Parties to compete to provide them.

NHS England's intention to reduce the number of providers for certain services

9.15 NHS England (South) told us that it was likely to reconfigure some specialised services, but that it was uncertain as to which services would be affected. It would be unlikely that any significant changes would be made until 2016/17 or 2017/18.[214] In any event, NHS England (South) would first consult with CRGs and ensure that the minimum national standards would be met and that patients would continue to have convenient access to the services concerned.[215]

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[213] NHS England (South) hearing with the CMA, 7 May 2015.
[214] NHS England (South) hearing with the CMA, 7 May 2015.
[215] NHS England (South) hearing with the CMA, 7 May 2015.

9.16 With regard to access, we considered whether NHS England (South) would take account of the Parties' locations in the event that it reconfigured services that are currently commissioned from the Parties and whether the Parties' location would place them at an advantage when a contract was awarded.

9.17 NHS England (South) told us that the Parties' hospitals were relatively close, but that there were other relevant factors to consider: *(a)* that the density of the population in the area is such that it may justify continuing to provide a specialised service at both Parties' sites; *(b)* that the M25 was congested at times, which could increase driving times for patients if a particular service was available at only one of the two hospitals; and *(c)* that there could be a need for both hospitals to have capabilities to deal with potential incidents at Heathrow Airport.[216]

9.18 We consider that there is no likely prospective reconfiguration of specialised services where the Parties overlap or where the Parties are close competitors, and that it is uncertain which process NHS England (South) would use for a reconfiguration. NHS England (South) also told us that it had no concerns about there being one fewer provider from which to commission specialised services, should the merger proceed.[217]

Conclusion on the impact of the merger on specialised services

9.19 We conclude that the merger may not be expected to result in an SLC in the market for the provision of specialised services.

10. Community services

Background

10.1 In this section, we consider the impact of the merger on competition in the provision of community health services. Community health services are services provided in residential and community settings. They may be provided to patients in their homes, in health centres, schools, community buildings or in small local hospitals.[218]

216 NHS England (South) hearing with the CMA, 7 May 2015.
[217] NHS England (South) hearing with CMA, 7 May 2015.
[218] Community health services cover a diverse range of services, including health visiting, school nursing, community nursing, mental health services, nutrition and dietetics, occupational therapy, speech and language therapy and diabetes care.

10.2 We consider both competition in the market (ie competition among providers for patients) and competition for the market (ie competition to be a provider of services).

Parties' views

10.3 For both Parties, community services account for a small proportion of revenue. In the financial year ended 31 March 2015, ASP's revenues from these services were approximately £3.5 million, accounting for less than 1.5% of its revenues for that financial year, and RSC's revenues were approximately £32,000, compared with RSC's revenue for that financial year of £307 million.

10.4 The community services provided by the Parties are set out in Table 34.

Table 34: Community services provided by the Parties, 2014/15

Trust	*Services*	*Commissioner*	*Hospital/community based*	*Date of tender*	*Basis of payment for service*	*Revenue 2014/15 (£)*
ASP	Community ophthalmology	Hounslow PCT	Community	2012	Block contract	[300,000–400,000]
ASP	Direct access echo and holter	Hounslow CCG	Hospital	2011	Local tariff	[100,000–200,000]
ASP	Ultrasound	NW Surrey CCG	Hospital	2013	National PBR	[1,000,000–2,000,000]
ASP	Ambulatory blood pressure monitoring	NW Surrey CCG	Hospital	2013	Local tariff	[900–1,000]
ASP	Sexual health services (GUM) clinic	Surrey County Council	Hospital and Community	No tender	National PBR	[1,000–2,000]
ASP	Community paediatrics	NW Surrey CCG	Community	No tender	Block contract	[200,000–300,000]
RSC	Physiotherapy, back and neck services	NE Hampshire and Farnham CCG	Community	2013	Local tariff	[3,000–4,000]
RSC	General physiotherapy services	Hampshire CCG	Community	2013	Local tariff	[7,000–8,000]
RSC	Direct access adult hearing services for age-related hearing loss	Berkshire East and Berkshire West CCG	Community	2013	Local tariff	[15,000–20,000]

Source: Parties.

10.5 The Parties submitted that they considered all services listed in Table 34 to be community services, as they were capable of being provided from community-based locations. The Parties told us that there was no overlap between them in the provision of community services.

Competitive assessment for competition in the market for patients

10.6 With respect to competition in the market for patients of community services, we assessed whether the merger would remove an important current or potential competitor, resulting in a reduced incentive for the merged trust to

maintain and provide better quality services to patients. The starting point for this assessment was to examine the extent to which the Parties overlap in relation to the community services which they provide under contracts they currently hold.

10.7 Given that there is currently no overlap between the Parties in the provision of community services, we conclude that the merger may not be expected to result in an SLC in the market for the provision of community services.

Competitive assessment for competition for the market as provider of community services

10.8 With respect to competition for the market as provider of community services, we considered whether the merger might have the following impacts:

(a) whether, in the event of a competitive tender, the merger would be expected to lead to worse outcomes because there would be fewer bidders (which might be reflected in commissioners receiving reduced value for money, including lower-quality services or higher prices where services are not subject to a national price); and

(b) whether providers under existing contracts might provide lower quality services, knowing that commissioners have fewer alternative possible providers of those services, and therefore commissioners would be less likely to switch away from the existing provider.

Competition for contracts

10.9 In relation to its assessment of competition for contracts, we considered:

(a) competition to provide Surrey-wide community services, as covered by the current Virgin Care contract; and

(b) competition to provide other discrete community services contracts.

10.10 We considered these types of contract separately because, in the markets for the services concerned, we believe that there are important differences in the nature of competition and in the type of potential bidders involved in tendering. The Virgin Care contract covers the provision of a wide range of community services, some covering all of Surrey; the award of the contract to another party would involve the transfer of staff, buildings, IT systems and other infrastructure, assuming that Virgin Care itself did not win the contract. Discrete sets of community services are narrower in scope in respect of services and geographical coverage, and might not involve the transfer of staff or assets.

10.11 In our assessment of the likely effects of the merger on competition to provide community services, we considered the history of tenders for community services in the area, commissioners' plans for tenders in Surrey in the future and whether the Parties would be likely to compete in relation to such tenders.

Competition to provide Surrey-wide community services, as covered by the current Virgin Care contract

- *Background*

10.12 In March 2012, Virgin Care entered into a five-year contract ('Virgin Care Contract') to provide a range of community services in South West and North West Surrey. The contract value was approximately £500 million.[219] The contract was awarded following a tendering process and is currently hosted by NWSCCG. Other local CCGs are signatories to it. Neither of the Parties bid to provide the services covered by the Virgin Care Contract.

10.13 Virgin Care told us that, following the award of the contract, it inherited some contracts with each of the Parties, which it has since reviewed and renegotiated.

- *Future contract(s)*

10.14 NWSCCG and GWCCG told us that work was being undertaken to decide how the services would be provided when the Virgin Care Contract expired in 2017. We were told that the CCGs would consider whether all services would be tendered as a block in line with the existing arrangement, or whether some elements of the service would be separated out, possibly across geographical or patient cohorts.

10.15 We have also been told of the drive to relocate services from acute providers into the community. This may lead to the definition of new patient pathways and could affect the scope of services covered by providers of community services.

- *Third party views*

10.16 Neither of the Parties bid to provide the services covered by the Surrey-wide contract that was awarded to Virgin Care. North East Hampshire and Farnham CCG told us that RSC had previously expressed an interest in providing these

[219] Virgin Care press release (30 March 2012): 'Virgin Care signs contract for community services in Surrey', accessed on 15 May 2014. We understand that the bid was awarded to Assura Medical, part of the Virgin Group, and that Assura Medical changed its name to Virgin Care in March 2012.

services and GWCCG said that it would expect both providers to be potential bidders.

10.17 Another CCG told us that it did not see acute trusts as natural providers of community services but noted that the Parties could be potential competitors in tenders for services currently covered by the Virgin Care Contract.[220]

10.18 NHS England is responsible for the provision of a number of services currently covered by the contract held by Virgin Care including immunisation, national breast screening, diabetic retinopathy and health visiting for under-fives.[221] It told us that it did not envisage continuing with a single contract through NWSCCG for those services.

10.19 Surrey County Council, which is responsible for providing Sexual Health services in Surrey, told us that it was at the start of a commissioning process for an integrated Sexual Health service. Virgin Care is the main community provider of these services. Surrey County Council told us that it had no concerns about the merger reducing the number of possible providers as it considered that there were a number of NHS trusts and private providers that provided these services in the South East region.[222]

10.20 Virgin Care's view was that the merger would not affect competition among bidders for the contract or contracts that would replace the Virgin Care Contract. Virgin Care intended to bid to remain the provider of community services after March 2017 and it considered that there were many other parties that would also bid, including Central Surrey Health, Capita, United Health, Southern Health NHS Trust and Solent NHS Trust.

10.21 Virgin Care told us that it would not be necessary for bidders already to have a presence in providing health services in Surrey, as infrastructure, staff and other assets would be transferred to the winning bidder or bidders. Virgin Care noted that it had had a minimal footprint in Surrey prior to winning the current contract. Therefore, we consider that having a footprint in the local health economy does not necessarily give the Parties a significant advantage over other bidders.

10.22 Regarding the contracts it had with each of the Parties, Virgin Care told us that the merger would not raise concerns in relation to competition between

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[220] [✂]
[221] NHS England told us that the responsibility for the provision of health visiting for under-fives would transfer to local authorities from 1 October 2015. NHS England also told us that it had a Personal Dental Services Agreement with Virgin Care covering special care, emergency care, prison dental services and minor Oral surgery (Dento-Alveolar Surgery) which was separate from Virgin Care's community services contract. Emails from NHS England (South) to CMA, 17 July.
[222] Surrey County Council response to CMA follow-up questions, 22 May 2015, question 3.

potential providers for the services which Virgin Care bought, as it believed that there was a sufficient number of other providers of these services.

Other discrete community services contracts

10.23 The Parties submitted that there was no reason to believe that the merger would give rise to concerns regarding the number of potential bidders given the wide range of potential providers of these services.

- *Closeness of competition between the Parties – past tenders*

10.24 To provide an indication of the closeness of competition between the Parties in bidding for other discrete community services contracts, we considered past tenders for such services between 2009 and 2014. From 2009 to 2014, ASP was involved in seven tenders and RSC in three. There was no tender in which the Parties competed against one another.

10.25 In contrast with the services covered by the Virgin Care Contract, other community service contracts cover a set of discrete services, typically with a tighter geographical scope.

10.26 The Parties submitted information on the contract value of the various tenders for community services in which they have participated. The annual values varied from £1,000 to £1.5 million.

10.27 Some of the tenders for community services in which the Parties participated were awarded on the basis of AQP. Under AQP, the commissioner selects bidders that provide evidence of having the necessary competence, quality and safety standards. We consider that the merger would not reduce competition in the bidding process for the services tendered on this model because commissioners would not be seeking to restrict the number of providers.

10.28 CCGs submitted additional information on those tenders in which either of the Parties participated. For each of these tenders, there were three or more bidders, and in none of them did the Parties compete against one another.

- *Closeness of competition between the Parties – future tenders*

10.29 The Parties told us that, given the tenders expected in the foreseeable future, there was no reason to conclude that the merger would give rise to a realistic prospect of an SLC in relation to the provision of community services.

10.30 CCGs provided us with the information about discrete community services that they had firm plans to procure or were in the process of procuring and whether the Parties would be likely to participate in these:

(a) NWSCCG told us that it was tendering for MSK services and was evaluating the bids [✂].[223]

(b) North East Hampshire and Farnham CCG told us that it was conducting a PACS Vanguard tendering process and that neither of the Parties was likely to be considered a strong contender in the process.

(c) Windsor, Ascot and Maidenhead CCG told us that it was planning tenders relating to NHS 111 services, to patient transport and to provision of out of hours primary care in East Berkshire. It considered that it would be unlikely, though not impossible, that the Parties would bid for the contracts to supply those services.

10.31 CCGs told us that they did not have any concerns about the merger in relation to the provision of community services as there were a number of potential bidders other than the Parties.

10.32 In relation to tenders for these services, we consider that the Parties are unlikely to be at an advantage compared with other potential bidders and that they would be likely to face competition from a number of other bidders. Further, the commissioning bodies planning to institute tender processes were not concerned about the possible reduction in the numbers of potential bidders.

- *Closeness of competition between the Parties – transfer of services into community-based settings*

10.33 The Parties noted GWCCG's plans to transfer a number of services into community based settings as part of their QIPP programme. These include Gynaecology, ENT, Ophthalmology, MSK, Cardiology and Dermatology.

10.34 We considered whether the Parties were at an advantage compared with other bidders to provide these services due to their respective local footprints. Three of the services provided by ASP are based at ASP's hospitals. In relation to ASP's remaining contract and in relation to RSC's three contracts, the services are provided from a number of sites, including local hospitals, health centres and local surgeries. We understand that these sites are not owned or run by the Parties themselves.

10.35 We consider that it is not necessary for a bidder to own or run a network of sites across the region to be successful in bidding for contracts to provide community services.

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[223] North West Surrey CCG, hearing with the CMA 29 April 2015.

10.36 Given the above, it does not seem likely that the Parties would have a significant advantage in bidding for these services due to their local footprint and there are likely to be several potential bidders for these services.

Conclusion on the impact of the merger on community services

10.37 In respect of the Surrey-wide community services currently covered by the Virgin Care Contract, third parties considered that the Parties may be bidders for the future contract or contracts to provide these services. However, third parties also appear to believe that having a local footprint does not give the Parties a significant advantage over other potential bidders and that there are likely to be a number of parties interested in bidding for the contract or contracts.

10.38 Several of the past tenders for discrete community services have been awarded on the basis of AQP. To the extent that the AQP principle applies, commissioners would not be seeking to restrict the number of providers, and so the Parties would not be bidding against one another. For those services that are tendered on that model, we consider that the merger would not reduce competition in the bidding process.

10.39 In relation to future tenders for discrete community services, we conclude that the Parties are unlikely to be at an advantage compared with other bidders and that there would be likely to be competition from a number of other bidders. Further, the commissioners planning tenders were not concerned about a potential reduction in numbers of bidders.

10.40 We also note that it is not necessary for a bidder to own or run a network of sites across the region to be successful in bidding to provide community services so it does not seem likely that the Parties would have a significant advantage in bidding for these services due to their local footprint. We also note that there are likely to be several potential bidders for these services.

10.41 For the reasons set out above, we conclude that the merger may not be expected to result in an SLC in the market for the provision of community services.

11. Conclusions

11.1 For the reasons set out in Section 3 above, we are satisfied that the proposed merger between the Parties will, if carried into effect, result in the creation of a relevant merger situation. We therefore have jurisdiction to consider whether the creation of that situation may be expected to result in an SLC within any market or markets in the UK for goods and services.

11.2 For the reasons set out in Section 6 to 10 above, we conclude that the merger may not be expected to result in an SLC in the markets for the supply of elective services, non-elective services, services to private patients, specialised services or community health services in the local area surrounding the Parties.