

Anticipated merger between Derby Teaching Hospitals NHS Foundation Trust and Burton Hospitals NHS Foundation Trust

Decision on relevant merger situation and substantial lessening of competition

ME/6726-17

The CMA's decision on reference under section 33(1) of the Enterprise Act 2002 given on 15 March 2018. Full text of the decision published on 5 April 2018.

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SUMMARY

Background

1. Derby Teaching Hospitals NHS Foundation Trust (**DTHFT**) and Burton Hospitals NHS Foundation Trust (**BHFT**) plan to merge to form a single NHS Foundation Trust (the **Merger**). DTHFT and BHFT are together referred to as the **Parties**.
2. The Competition and Markets Authority (**CMA**) believes that it is or may be the case that the Parties will cease to be distinct as a result of the Merger, that the turnover test is met and that, accordingly, arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation.¹
3. DTHFT provides general and specialised services from two hospitals: the Royal Derby Hospital, which incorporates the Derbyshire Children’s Hospital, and the London Road Community Hospital. BHFT provides services predominantly from Queen’s Hospital Burton and the adjacent Outwoods site, both in Burton-upon-Trent. The Parties are located near to one another and overlap across a number of healthcare services provided to NHS patients, overseen by local commissioners and NHS England.

Competitive assessment

4. In its recent merger investigations between NHS hospitals in Manchester and Birmingham, the CMA found that NHS providers were facing significant growth in demand for services, while working under tight budgetary, capacity

¹ Section 79(1) of the Health and Social Care Act 2012 (**HSCA**) states 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.

and regulatory constraints.² The CMA also found that, although competition between NHS service providers was possible, it may be more limited than had previously been the case. The CMA has taken account of these findings in its investigation of the Merger.

5. In the present case, the CMA adopted a counterfactual in which DTHFT and BHFT would operate independently, but acknowledged the financial and clinical difficulties that both are facing.
6. In assessing the potential impact of the Merger on competition in the provision of healthcare services, the CMA found each specialty to constitute a separate product frame of reference and, within each specialty, it treated outpatient, inpatient and day case activities (as well as non-elective and elective services) as separate frames of reference. The CMA distinguished between the provision of community services and services which are provided in hospital settings. The CMA also distinguished between private services and NHS services,³ and assessed the Merger on the basis of its impact on competition both 'in' and 'for' the market.
7. The CMA did not identify competition concerns with regard to community services, a number of elective and non-elective acute services, specialised services, or private services. In each case there was either no overlap, limited scope for patients to choose which hospital to attend, or a sufficient number of alternative healthcare providers in Derbyshire and East Staffordshire. The CMA also did not identify competition concerns with regard to hospital-wide effects.
8. However, with regard to a number of NHS elective services and maternity services,⁴ the CMA found the Parties to be close alternatives for patients.
9. The Parties' submitted that a range of factors including: limited patient choice, capacity constraints, increased collaboration and differentiation meant that there would be no substantial lessening of competition (**SLC**) as a result of the Merger. However, the CMA did not find this evidence sufficient to exclude a realistic prospect of an SLC in 18 specialities (various elective specialties and maternity). The CMA therefore believes that the Merger gives rise to a

² For Manchester, see [Report on the anticipated merger between Central Manchester University Hospitals and University Hospital of South Manchester of 1 August 2017](#) (hereafter **CMFT/UHSM Report**). For Birmingham, see [Decision on the anticipated merger between University Hospitals Birmingham NHS Foundation Trust and Heart of England NHS Foundation Trust](#) of 30 August 2017 (hereafter **UHB /HEFT Decision**).

³ Within private services, each specialty constitutes a separate market and within each specialty, markets can be defined along inpatient, outpatient and day case lines (as with NHS services).

⁴ Such services are typically planned or scheduled in advance and usually require a referral from a GP or other primary care provider.

realistic prospect of an SLC as a result of horizontal unilateral effects in the supply of 18 specialties.⁵

Relevant Customer Benefits

10. Under section 33(2)(c) of the Act, the CMA may decide not to refer a case in which it has found a realistic prospect of an SLC if it believes that any relevant customer benefits (**RCBs**) related to the merger outweigh the effects of the SLC. The Parties submitted that the Merger has led, and will lead, to RCBs outweighing any adverse competitive effects.
11. For a merger involving one or more NHS Foundation Trusts, NHS Improvement (**NHSI**) is required to provide the CMA with advice on any benefits which may accrue from that merger for people who use health services provided by the NHS.⁶ NHSI advised the CMA that the Merger was likely to deliver improvements and higher quality care for patients of both DTHFT and BHFT.
12. Specifically, NHSI advised the CMA that the Merger would deliver the following RCBs:
 - Workforce improvements across the merged trust.
 - RCBs in the following clinical services: Cardiology, Trauma and Orthopaedics, Renal Medicine, Stroke, Radiology and Cancer.
13. NHSI advised the CMA that these improvements were Merger-specific because, prior to the involvement of DTHFT, BHFT had not demonstrated the leadership and ability needed to implement a strategy that delivered wide-scale improvements in quality. NHSI told the CMA that it was highly likely that the benefits yet to be implemented or embedded would be realised within a reasonable period following the Merger. The CMA has placed significant weight on this advice, given NHSI's role and expertise as sector regulator for the NHS. The CMA also had regard to the evidence and submissions from key stakeholders, supporting the findings in the NHSI advice.
14. In light of the Parties' submissions and NHSI's advice, the CMA believes that the Merger will give rise to the following RCBs: (i) Workforce improvements at

⁵ These specialties are Breast surgery, Dietetics, Endocrinology / Diabetics, ENT, Gastroenterology / Hepatology, General surgery, Geriatric medicine, Gynaecology, Maternity, Ophthalmology, Oral / Maxillofacial surgery, Orthodontics, Orthotics, Paediatrics, Physiotherapy, Rheumatology, Trauma & Orthopaedics and Urology. See Annex 1 for a detailed overview.

⁶ See [NHS Mergers Guidance \(CMA29\)](#), paragraph 7.5. NHSI is not required to provide such advice where the merger involves only NHS Trusts and not NHS Foundation Trusts.

BHFT; and (ii) in Cardiology, Trauma and Orthopaedics, Renal Medicine, Stroke, Radiology, and Cancer.

15. The CMA considered whether these RCBs would outweigh the competition concerns identified. In making this assessment the CMA had regard, on the one hand, to the magnitude of the RCBs and the probability of them occurring, and, on the other hand, to the scale of the SLCs and the probability of them occurring.⁷
16. NHSI advised the CMA that it was strongly supportive of the Merger. It said that the RCBs were likely and that they would benefit a large number of patients. In particular, NHSI said that the Merger would address some of the challenges in delivering high quality and sustainable care at BHFT.
17. The CMA believes that the RCBs are substantial and will have a positive impact on many BHFT patients and some DTHFT patients. The CMA also believes that there is a high probability of the RCBs occurring.
18. In contrast, whilst the CMA identified a number of competition concerns, they relate to a small percentage of services provided by the Parties (representing just 7.9% of the Parties' total activity and tariff revenues). Further, the CMA believes that the potential for BHFT to exert a strong competitive constraint on DTHFT in the foreseeable future is limited. In particular, the CMA has noted several factors that limit the likelihood, magnitude and scale of the SLC, such as the existing resource sharing between the Parties, the asymmetry of competition for patients, the capacity constraints that both Parties are facing, differentiation between the services that the Parties offer, and limitations on patient choice for some specialties.
19. For these reasons, the CMA believes that, in this case, the RCBs arising from the Merger outweigh the adverse effects of the SLCs identified. The CMA has therefore exercised its discretion not to refer the Merger for an in-depth Phase 2 investigation.
20. The Merger will therefore **not be referred** under section 33(1) of the Act.

ASSESSMENT

Parties

21. DTHFT provides general and specialised services in southern Derbyshire. It provides services from the Royal Derby Hospital (**RDH**) site, incorporating the

⁷ [NHS Mergers Guidance](#), paragraph 7.26.

Derbyshire Children's Hospital, which is an acute teaching hospital with 1,159 beds, and the London Road Community Hospital. The RDH site includes the Derby Medical School and the new School of Health Sciences. DTHFT also offers a number of private healthcare services via Derby Private Health at the RDH site. It also offers peripheral clinics at a variety of community hospitals. The turnover of DTHFT in the financial year ended 31 March 2017 was £537.4m, generated entirely in the UK.

22. BHFT provides general and (limited) specialised services in Staffordshire. It provides services predominantly from Queen's Hospital Burton (**QHB**) and the adjacent Outwoods site, both situated in Burton-upon-Trent. BHFT also provides maternity services, inpatient and outpatient services, surgery and Minor Injury Units from the Sir Robert Peel and Samuel Johnson Community Hospital facilities in, respectively, Tamworth and Lichfield. BHFT also offers a small number of private healthcare services via the Burton Clinic at its QHB site. Across its three hospitals sites it has a total of 496 beds. It also provides clinics in a number of other locations. The turnover of BHFT in 2016-17 was approximately £197m, generated entirely in the UK.

Transaction

23. The Merger will be structured as an acquisition of BHFT by DTHFT, but it is being treated by the Parties as a merger of two NHS Foundation Trusts (**FTs**) as partners, rather than as an acquisition.

Procedure

24. The Merger was considered at a Case Review Meeting.⁸

Jurisdiction

25. The Parties engage in activities which constitute 'enterprises' for the purposes of section 23 of the Act and these enterprises will cease to be distinct as a result of the Merger.⁹ The Parties submitted that the proposed arrangements between their FTs create a qualifying merger reviewable by the CMA under the merger control provisions of the Act.

⁸ See [Mergers: Guidance on the CMA's jurisdiction and procedure](#) (CMA2), January 2014, from paragraph 7.34.

⁹ Section 79(1) of the HSCA states that where the activities of two or more NHS FTs cease to be distinct activities, this is to be treated as a case in which two or more enterprises cease to be distinct enterprises for the purpose of Part 3 of the Act. The HSCA confirmed the CMA's role in assessing the competition aspects of mergers involving FTs.

26. The UK turnover of BHFT exceeds £70 million, so the turnover test in section 23(1)(b) of the Act is satisfied.
27. The CMA therefore believes that it is or may be the case that arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation.
28. The initial period for consideration of the Merger under section 34ZA(3) of the Act started on 19 January 2018 and the statutory 40 working day deadline for a decision is therefore 15 March 2018.

Background

Regulation in the NHS sector

29. This section provides a brief overview of the policy and regulatory bodies related to the Merger.
30. The Department of Health is responsible for the NHS, public health and social care in England. It develops policy, introduces legislation and allocates funding from HM Treasury to the NHS.
31. NHS England (**NHSE**) is responsible for setting the direction of the NHS and improving care. It is also the commissioner of primary healthcare services (ie medical services provided by general practitioners (**GPs**), dental practices, community pharmacies and high street optometrists) and specialised tertiary healthcare services (ie services provided in more specialised medical centres), and is responsible for overseeing the operation of Clinical Commissioning Groups (**CCGs**).
32. CCGs are clinically-led bodies responsible for the planning and commissioning of healthcare services for their local area. CCGs commission most secondary care services (ie medical services provided by specialists or consultants in a field of medicine, whether in a hospital or community setting).
33. NHSI authorises and regulates NHS FTs, sets prices for NHS services (the National Tariff) and supports commissioners. NHSI also oversees NHS trusts in England, and assists and supports NHS trusts to ensure continuous improvement in quality and the financial sustainability of NHS services.
34. The Care Quality Commission (**CQC**) is an independent regulator of standards in health and adult care. It monitors services to make sure that they are safe, effective, caring, responsive to patient needs and that providers are well led. It carries out unannounced inspections and gives ratings of acute hospitals.

35. In its competitive assessment of the Merger, the CMA has taken into account how each of these bodies provide safeguards on hospital quality.

How competition works between NHS hospitals

36. There are two models of competition in the provision of NHS healthcare services.¹⁰ These are competition *for* the market to attract contracts to provide services to patients, and competition *in* the market to attract patients.
37. Competition for the market occurs as commissioners often use tenders to select providers that are best placed to offer services to patients. Providers therefore have an incentive to maintain their reputation for quality and value in order to demonstrate their credibility and to maximise their chance of winning a contract.
38. Competition in the market arises because NHS providers can raise income by attracting additional patients. Providers are commonly paid at nationally mandated prices for every consultation or treatment made (in most services), based on ‘payment-by-results’ (**PbR**) rules. Providers therefore have an incentive to improve quality to attract patient referrals, assuming that patients can exercise their choice effectively. Patient choice, PbR, and the freedom for providers to invest in quality improvements are together the fundamental components of competition in the market.¹¹

Competition in Derbyshire and East Staffordshire

39. DTHFT and BHFT are two NHS acute FTs in the Derbyshire and East Staffordshire area. The Parties identified nine other NHS acute trusts located in other parts of the West and East Midlands as their main competitors. These competitors are discussed in more detail in the competitive assessment section below.
40. East Staffordshire CCG and South Derbyshire CCG are the host commissioners of BHFT and DTHFT, respectively. Both CCGs [redacted]. They said that the Merger is [redacted].
41. The CMA has examined the context of the local healthcare economy (**LHE**)¹², including the challenges that the Parties are currently facing, and the approach taken by the CCGs and other NHS acute providers, as well as

¹⁰ [NHS Mergers Guidance](#), paragraph 6.5.

¹¹ See P8, Bournemouth/Poole Final Report, and paras. 4.3.8 and 4.3.9, Merger Notice.

¹² Local health economy refers to NHS organisations including GP practices, and voluntary and independent sector bodies involved in the commissioning, development and provision of health services for particular population groups.

the state of public health in Derbyshire and East Staffordshire. These considerations provide important background for understanding the role of competition and for assessing the potential impact of the Merger.

42. The proposed Merger arises during a period in which both Parties are facing significant challenges, including risks to the clinical and financial sustainability of their services. The Parties have been encouraged to work together by NHSI to address these sustainability issues. As a result, since early 2016, the Parties had a common Chair and a number of senior staff from DTHFT have been appointed at BHFT, including the CEO and the Chief Operating Officer. NHSI told the CMA that the Merger is the solution to longstanding and significant challenges in delivering high quality and sustainable healthcare at BHFT.
43. The Parties have faced general capacity pressures similar to other NHS trusts in recent years. The CMA recognises that the Parties (and, in particular, DTHFT) have failed some key national targets,¹³ and that their bed occupancy rates are currently above the recommended operational standard for some specialties (see paragraphs 107 and 196 to 199 below for a further discussion on capacity constraints).¹⁴
44. The CMA has taken these factors into account in its competitive assessment and when considering whether the claimed RCBs outweigh the adverse effects of the SLCs identified.

Counterfactual

45. The CMA assesses a merger's impact relative to the situation that would prevail absent the merger (ie the counterfactual).
46. The counterfactual is an analytical tool used in answering the question of whether the merger gives rise to a realistic prospect of an SLC.¹⁵ For anticipated mergers, the CMA generally adopts the prevailing conditions of competition as the counterfactual against which to assess the impact of the merger. However, the CMA will assess the merger against an alternative counterfactual where, based on the evidence available to it, it believes that, in the absence of the merger, the prospect of these conditions continuing is not

¹³ According to the Parties, DTHFT has recently failed to meet the 92% target for 18 weeks of referral in the following specialties: ENT, general surgery, [REDACTED], neurology, [REDACTED], orthopaedics, urology and [REDACTED].

¹⁴ The National Audit Office suggested that hospitals with average occupancy levels in excess of 85% could expect to have regular bed shortages, periodic bed crises and increased numbers of hospital-acquired infections, while the Department of Health also said that occupancy of greater than 85% was a cause for concern. The Parties said that, at DTHFT, as examples, the bed utilisation rate is at [REDACTED], and at [REDACTED].

¹⁵ See [Merger Assessment Guidelines](#), paragraphs 4.3.1.

realistic, or there is a realistic prospect of a counterfactual that is more competitive than these conditions.¹⁶

47. The Parties submitted that BHFT is facing clinical, financial and operational challenges. It ended the financial year 2016-17 with a deficit of £8.2m and it is currently in category 3 of the Single Oversight Framework (**SOF**).¹⁷ The Parties submitted that BHFT is also facing staff recruitment and retention issues, which are having an adverse impact on the clinical and financial sustainability of its services.
48. The Parties submitted that DTHFT ended the financial year 2016-17 with a deficit of £27.9m, and faces significant capacity constraints. The Parties submitted that, while DTHFT has a stronger recruitment capability than BHFT in many specialities, it is also facing staff recruitment and retention issues in those specialities where there is a national shortage of consultants and other staff.¹⁸
49. The Parties acknowledged that they could not provide evidence which would support an alternative counterfactual to the status quo for the purposes of a Phase 1 merger review. However, the Parties submitted that the Merger should be assessed with a recognition that the Parties will continue to operate against a background of a deteriorating financial and clinical situation that will affect the services they deliver.
50. The Parties submitted that, absent the Merger, they would not be able to continue operating as separate FTs in the long term and they would each be forced to consider entering into collaborative arrangements with and/or merge with other trusts in the East and West Midlands.
51. The CMA considered whether the prevailing conditions of competition constitute the most competitive conditions between the Parties. On the one hand, the clinical, financial and recruitment issues that both Parties are facing may continue and further reduce their ability to compete, while, on the other hand, collaborative agreements with and/or a merger with other trusts in the

¹⁶ *Merger Assessment Guidelines* (OFT1254/CC2), September 2010, from paragraph 4.3.5. The *Merger Assessment Guidelines* have been adopted by the CMA (see *Mergers: Guidance on the CMA's jurisdiction and procedure* (CMA2), January 2014, Annex D).

¹⁷ The SOF replaced Monitor's Risk Assessment Framework and the NHS Trust Development Authority's Accountability Framework in September 2016. NHSI uses the SOF framework to assess provider performance and identify the level of support each Trust and Foundation Trust needs. NHSI assigns each Trust and Foundation Trust to one of the following categories based on the level of support needed: 1. Providers with maximum autonomy; 2. Providers offered targeted support; 3. Providers receiving mandated support for significant concerns; 4. Special measures. More information is available at <https://improvement.nhs.uk/resources/single-oversight-framework/>

¹⁸ According to the Parties, these areas are Care of the Elderly, ENT and Neurology (Merger Notice, paragraph 6.4).

region may enhance BHFT's ability to compete, making BHFT a more credible alternative to DTHFT, and vice versa.

52. For the purposes of its assessment of the Merger, the CMA adopted a counterfactual in which BHFT would continue to operate independently from DTHFT, and therefore the Parties would continue to exert some competitive constraint on each other. However, the CMA recognised the financial and clinical difficulties faced by the Parties. The CMA has taken these issues into account in its competitive assessment and when considering whether the claimed RCBs outweigh the adverse effects of the SLCs identified.

Frame of reference

53. Market definition provides a framework for assessing the competitive effects of a merger and involves an element of judgement. The boundaries of the market do not determine the outcome of the analysis of the competitive effects of the merger, as it is recognised that there can be constraints on merging parties from outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others. The CMA will take these factors into account in its competitive assessment.¹⁹

Product scope

54. The Parties overlap across a significant number of healthcare services provided to patients, commissioned by local CCGs and NHSE. Their overlapping services can be broadly categorised as follows:
- (a) **Elective services:** Planned specialist medical care usually following referral from a primary or community health professional such as a GP;
 - (b) **Non-elective services:** Services that are not scheduled, arising when admission is unpredictable because of clinical need (eg following an A&E attendance);
 - (c) **Community services:** Services provided by care professionals in the community such as health visiting, district nursing, health promotion drop-in sessions, residential care home visits, school nursing activities and community dentistry.

¹⁹ [Merger Assessment Guidelines](#), paragraph 5.2.2.

(d) **Private patient services:** Care not funded by the NHS and instead paid for by patients or their insurers.

55. The Parties submitted that the CMA should follow its past approach to the assessment of healthcare mergers.
56. In line with past decisional practice, including the recent UHB / HEFT Decision and the CMFT /UHSM Report, and the CMA's guidance, the CMA has adopted the following approach for determining the relevant product frames of reference for the purposes of its assessment of the Merger:²⁰
- (a) Each specialty²¹ is a separate frame of reference and,
- (i) within each specialty:
- the provision of elective services²² is a separate frame of reference from the provision of non-elective services; and
 - and within each of elective and non-elective services, the provision of outpatient (**OP**) services, inpatient (**IP**) services, and day-cases (**DC**) are also separate frames of reference;
- (b) the provision of community services is a separate frame of reference from services which are provided in hospital settings, although there may be an asymmetric constraint from hospital-based to community-based services; and
- (c) the provision of private patient services is a separate frame of reference from services provided through the NHS.
57. The CMA also considered whether certain specialties should be aggregated (for example because quality and/or investment decisions are taken on a wider level than individual specialties) or whether there are narrower segmentations than those described above. The CMA did not conclude on the precise scope of the product frame of reference within and between

²⁰ CMA guidance on the review of NHS mergers (CMA29), paragraphs 6.37 to 6.39.

²¹ To account for differences in how the Parties record the same procedures into different treatment codes some specialties are referred to as "synthetic" and include multiple treatment codes.

²² Specialised services (commissioned nationally/regionally and directly by NHSE, see footnote 42 of the UHB / HEFT decision and chapter 11 of the CMFT/UHSM report) and routine services (commissioned locally by CCGs) can both be part of the elective specialty. Specialised services refer to services in respect of rare, cost-intensive, or complex conditions as specified in NHS England's 'Manual of Prescribed Specialised Services'. In previous cases, the CMA carried out a more in-depth competitive assessment for specialised services given that segment of the specialty is subject to more intense competition *for* the market and less intense competition *in* the market. In line with previous cases, and on a cautious basis, the CMA has assessed competition to provide specialised services separately.

specialties, but it considered possible aggregations or narrower segmentations where relevant in its competitive assessment.

Geographic scope

58. The CMA has previously found that location is important to patients and GPs when they choose a hospital and hospitals providing the same services in different locations are not perfect substitutes for one another. Hospitals that are near one another may be expected to exert a stronger competitive constraint than hospitals located further away.²³ The CMA has in the past used catchment area analysis to identify the local area over which the merging parties are likely to be important alternatives.²⁴

Parties' submissions

59. The Parties submitted that the relevant geographic market in this case should be based on a catchment area encompassing patients' willingness to travel for consultation or treatment. However, the Parties noted the limited benefit of catchment area maps since, although they are useful in demonstrating the asymmetry of the referral patterns, they do not capture all competitive constraints (ie the competitor trusts in the elective services referral analysis are not captured within the map catchment areas).

CMA's assessment

60. For non-elective services (and A&E, but excluding maternity), the CMA considers that the geographic frame of reference is informed by the willingness of patients to travel for consultation or treatment, taking into account travel distance and travel time. For specialised services and community services, the CMA has looked at the geographic scope of relevant contracts, and previous bidding contracts, where information was available. However, the CMA has not found it necessary to conclude on the appropriate geographic frame of reference for non-elective, specialised or community services as it has not found any competition concerns arising from the Merger with regard to these services (see paragraphs 85 and 86).
61. For elective and maternity services, the CMA considers that the geographic frame of reference is informed by GP patient referral information. This

²³ See for example the [Report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust \(Bournemouth and Poole Report\)](#), 17 October 2013, paragraph 5.56.

²⁴ See, for example, the *Bournemouth and Poole Report*, paragraphs 5.54 to 5.71.

includes all GPs that make referrals to the Parties and therefore, to the extent that these GPs refer patients to other competing trusts, will also capture the constraint from these competing trusts. The CMA believes this approach captures the most significant competitive alternatives available to the Parties' patients and includes the sources of competition to the Parties that are the immediate determinants of the effects of the Merger.²⁵

62. For private healthcare services, the CMA considers that the geographic frame of reference is likely to be at least as large as for elective services. In the Private Healthcare Market Investigation, the CMA found that the average travel time for private hospital patients was just over 30 minutes.²⁶ However, it has not been necessary for the CMA to conclude on the exact geographic frame of reference for private healthcare services since it has not found any competition concerns arising from the Merger with regard to these services (see paragraph 85).
63. Overall, and for the purposes of its assessment of the Merger, the CMA believes that the Parties compete and face their most relevant competitive constraints in Derbyshire and East Staffordshire. The CMA has therefore assessed the impact of the Merger in this broad geographic area.

Conclusion on frame of reference

64. For the reasons set out above, the CMA has considered the impact of the Merger in Derbyshire and East Staffordshire in the following frames of reference:
- (a) Each specialty separately and, within each specialty:
- the provision of elective services as a separate frame of reference from the provision of non-elective services;
 - within elective services, the provision of specialised services as a separate frame of reference; and
 - within each of elective and non-elective services, the provision of OP services, IP services, and DC as separate frames of reference;
- (b) the provision of community services as a separate frame of reference from services which are provided in hospital settings; and

²⁵ [Merger Assessment Guidelines](#), paragraph 5.2.1.

²⁶ [Private Healthcare Market Investigation](#), Final Report, 2 April 2014, footnote 52.

- (c) the provision of private patient services as a separate frame of reference from NHS-funded services.

Competitive assessment

65. Horizontal unilateral effects may arise when one firm merges with a competitor that previously provided a competitive constraint, allowing the merged firm profitably to raise prices or to degrade quality on its own and without needing to coordinate with its rivals.²⁷
66. The CMA assessed whether the Merger might lead to horizontal unilateral effects in the provision of healthcare services to patients in Derbyshire and East Staffordshire.
67. The CMA first assessed some cross-cutting considerations relating to the scope for and extent of competition in the NHS and, in particular with regard to the Parties' activities in the LHE. As noted below, the CMA did not find that these considerations precluded any SLC arising from the Merger. Therefore, the CMA then assessed competition by service type.

Cross-cutting considerations on the scope for and extent of competition

The role of patient choice and competition in the NHS

Parties' views

68. The Parties submitted that the NHS is under nationwide financial pressure, which has led to closer collaboration between commissioners and providers across the NHS and local government to make the best use of resources.²⁸

CMA's assessment

69. Competition between NHS providers may arise where NHS providers, such as the Parties, can raise income by attracting additional patients. As indicated in paragraph 38, providers are commonly paid at nationally mandated prices for most types of consultation or treatment made, based on PbR rules. Providers therefore have an incentive to improve quality to attract patient referrals, and

²⁷ [Merger Assessment Guidelines](#), from paragraph 5.4.1.

²⁸ The Parties supported the view that NHSE "has identified that patient choice has not worked in the way it was originally intended to in the NHS and that as a result it is increasingly turning to collaborative models rather than competition to manage the NHS at the local health economy level." CMFT/UHSM Report, paragraph 4.34.

hence raise income.²⁹ PbR rules generally apply to elective and non-elective services. In addition, NHS providers may compete for contracts to provide services (ie competition for the market), when commissioners such as CCGs and NHSE select providers to offer services to patients.³⁰

70. The incentive for hospitals to compete exists where patients can exercise some choice. Patients have the right to choose any provider in England that has been commissioned by a CCG or NHSE for their first OP appointment for NHS elective services. This is enshrined in the NHS Constitution (2009). Patients generally choose a provider in combination with their GP based on information and recommendations given by their GP.³¹ Moreover, patients are entitled to ask to change hospital if they must wait longer than the target waiting times.³²
71. The CMA recognises that NHS FTs, such as the Parties, are public service providers that operate in a heavily regulated environment, with numerous safeguards³³ overseen by the CQC and NHSI, as well as NHSE and local CCGs. This regulation limits the extent to which competition can affect the quality and range of healthcare services offered.
72. The CMA found in UHB/HEFT and CMFT/UHSM that current policies, such as the Five Year Forward View and Sustainability and Transformation Plans, had encouraged greater levels of collaboration and collective responsibility in the provision of NHS services within LHEs.³⁴ The CMA found in these cases that these policy developments, combined with increased financial and capacity constraints, had led to a reduced emphasis on competition. The CMA concluded that regulation and capacity might determine behaviour more than competition.³⁵
73. The CMA continues to believe that patient choice drives and creates scope for competition and improved outcomes in the NHS, and regulation and capacity

²⁹ For NHS services, competition does not occur on price as the people who receive care do not pay for their treatment at the point of delivery and therefore providers cannot use price as a way to ration demand. Unlike price or quantity, many aspects of quality cannot be set directly. The quality of a product or service is the outcome of many different decisions which will involve trading off different factors. For example, the decision not to fill a nursing vacancy is made by trading off the possible effect on quality of care and the impact on the cost of providing care. The priorities that determine how these decisions are made will affect individual aspects of the hospital's quality, such as the ratio of nurses to patients, as well as feeding into the hospital's overall reputation. See paragraph 4.7 of the [CMFT/UHSM Report](#).

³⁰ NHS Mergers Guidance, paragraphs 6.5-6.9.

³¹ For a more detailed discussion of patient choice, see paragraphs 4.2 to 4.5 of the CMFT/UHSM Report.

³² For example, the 18 weeks from referral to treatment (RTT) target or the target of 2 weeks for a patient to be seen by a cancer specialist. However, the right to choose does not normally extend to IP or DC treatments after a first OP appointment, or to non-elective services.

³³ Appendix B of the CMFT /UHSM Report provides a detailed industry background and regulation in the NHS.

³⁴ See, for example, paragraphs 36 and further of the UHB /HEFT decision and paragraphs 4.17-4.26 of the CMFT / UHSM Report.

³⁵ See, for example, paragraph 9.7 and further of the CMFT / UHSM Report.

constraints do not exclude the role of competition. However, the CMA recognises that these factors may limit the impact of competition across certain services. The CMA has taken these factors into account in its competitive assessment and when considering whether the claimed RCBs outweigh the adverse effects of the SLCs identified.

The role of competition in the Parties' activities

Parties' views

74. The Parties submitted that they both face increasing financial pressures and clinical sustainability challenges. They said that NHSI has been encouraging them to address these challenges through greater collaboration, limiting the scope for competition between them. The Parties also submitted that they both have capacity constraints, which limit their ability to compete with each other.
75. The Parties said that their operational plans do not focus on any competitor analysis but rather on their financial challenges, maintaining and improving the quality of care, and developing their collaboration with each other. They said this shows that competition is not a factor driving decision making.
76. The Parties submitted that the referral analysis data shows an asymmetry in competition, with DTHFT acting as a competitive constraint on BHFT, but not the other way around. The Parties submitted that the Merger would not change DTHFT's incentives substantially because the main constraints on DTHFT come from other providers in the surrounding area. The Parties added that, while the Merger may give rise to a loss of constraint on BHFT from DTHFT, it will not be possible for the combined trust to reduce the quality of service at BHFT sites only and this loss of constraint will not affect the quality of care across the trust overall.
77. The Parties highlighted a number of other features which they submitted indicate that the scope for and extent of competition between the Parties is limited, including significant service differentiation, and competitive constraints from other trusts, which they said were understated in the referral data.³⁶

Third parties' views

78. One private healthcare provider told the CMA that DTHFT and BHFT compete. However, the large majority of the healthcare providers that

³⁶ See Merger Notice, paragraph 8.15.

responded to the CMA's merger investigation, and [REDACTED], said that they do not see the Parties as being in competition.

79. NHSI said that DTHFT is facing significant difficulties to unlock capacity to compete for patients. It added that the rationale for the Merger is to improve quality of services. NHSI also said that, absent the Merger, BHFT would not on its own be able to act as an effective competitive constraint on DTHFT. In NHSI's opinion, the diminished role of competition and the Parties' capacity constraints mean that any loss of competition across the specialities arising from the Merger would be limited.³⁷

CMA's assessment

80. The GP referral analysis suggests that overall BHFT and DTHFT are competitors, and that BHFT is DTHFT's closest competitor for maternity and a significant number of elective services.
81. While the CMA accepts that the factors mentioned by the Parties may reduce the magnitude of any loss of competition, it does not believe that they remove the scope for competition. Moreover, while these factors apply generally, they are not necessarily relevant to every frame of reference affected by the Merger.
82. The CMA has taken these factors into account in its competitive assessment and when considering whether the claimed RCBs outweigh the adverse effects of the SLCs identified.

Competitive assessment – by service type

83. Competition in the NHS takes place where patients have a choice between NHS service providers, incentivising providers to improve quality. Mergers between providers of NHS acute services may dampen this incentive if they remove a significant alternative for patients, resulting in lower quality.³⁸
84. The CMA assessed the impact of the Merger in each frame of reference (see paragraph 64).

³⁷ NHSI's response to the CMA's Issues Paper, 23 February 2018.

³⁸ [CMA29](#), paragraph 1.5 and 6.48. Examples of clinical factors include infection rates, mortality rates, ratio of nurses or doctors to patients, equipment, best practice. Examples of non-clinical factors include cleanliness and parking facilities.

Non-elective, private patient, specialised and community services

85. For non-elective and private patient services, the CMA examined whether the Merger would be likely to remove an important alternative for patients.

(a) **Non-elective services:** The CMA found that the Parties did not materially compete such that any loss of competition would not be substantial. Most patients either attend via ambulance or attend their nearest A&E department, meaning that there is limited active patient choice. The CMA has also not seen evidence that the quality of non-elective services is a significant driver of any residual choice. In addition, the CMA notes that payments to trusts for non-elective services are subject to a ‘marginal rate tariff’, under which providers who go beyond a baseline level are paid 70% of the tariff rate for each additional patient treated.³⁹ This funding formula dampens trusts’ incentives to go beyond their baseline level, meaning that the Parties have less incentive to attract patients for non-elective services than they do for elective services.

(b) **Private patient services:** The Parties overlap in a small number of private patient specialties, each with relatively low activity.⁴⁰ Other providers in the relevant local area offer a greater volume of services in the specialties where the Parties overlap and these providers will continue to constrain the Parties post-Merger.⁴¹

For these reasons, the CMA has not found any competition concerns arising from the Merger in relation to non-elective or private patient services.

86. For specialised services and community services, the CMA examined whether the Merger would be likely to remove an important alternative for commissioners.

(a) **Specialised services:** NHSE told the CMA that [REDACTED]. BHFT provides only three specialised services, all of which are commonly provided by all or almost all trusts. NHSE also told the CMA that [REDACTED]. The CMA has previously found that barriers to entry into the provision of specialised services are high,⁴² and it does not expect BHFT to be a strong bidder in the foreseeable future for any specialised services that it does not currently provide.

³⁹ CMFT/UHSM Report, paragraph 12.21.

⁴⁰ For context, private services account for less than 1% of the Parties’ total activity by revenue.

⁴¹ These providers include Nuffield Health in Derby; BMI Park, Circle Health and NUH NHS Trust all in Nottingham; and Spire in Nottingham and in Little Ashton.

⁴² CMFT/UHSM Report, paragraph 11.58.

(b) **Community Services:** the CMA found that neither of the Parties currently provides community services, and they have not bid against each other to provide any community services in the recent past. The CMA also notes that there are a range of alternative providers available in the LHE who offer these services.

For these reasons, the CMA has not found any competition concerns arising from the Merger in relation to specialised or community services.

Elective services and Maternity

87. The CMA first identified those elective specialties offered by both Parties and conducted an initial filtering based on referral analysis to filter out those specialties where competition between the Parties is limited. The CMA then conducted a more detailed analysis of each of the specialties that ‘failed’ the filter.

Referral analysis

- *Approach*

88. In line with the CMA’s previous investigations relating to NHS mergers, the CMA applied a filtering methodology to identify specialties where the Parties are potentially close competitors,⁴³ and to remove from further analysis those specialties where there is no realistic prospect of significant competition concerns. This referral analysis provides a starting point for assessing the closeness of competition between the Parties.⁴⁴

89. The referral analysis is based on Hospital Episode Statistics (**HES**) data, which records referrals to hospitals made by medical practitioners (including GP practices and to a lesser extent dentists or optometrists).⁴⁵ Using Parties’ shares of referrals from each referrer to either DTHFT or BHFT (the ‘anchor hospital’), the CMA estimated the share of referrals which would go to the alternative provider if the anchor hospital became unavailable.⁴⁶ This gives an indicator of the main competitive constraints on the anchor hospital (but not

⁴³ [CMFT/UHSM Report](#), paragraph 10.47. [UHB / HEFT decision](#), paragraph 92.

⁴⁴ A detailed explanation of the referral analysis can be found in Appendix C of the [CMFT/UHSM Report](#).

⁴⁵ Unless otherwise stated, the CMA has used the term ‘GP’ to refer to GP practices and other medical practitioners that can make referrals to hospitals, including dentists and optometrists.

⁴⁶ To give a numerical example, if a particular GP practice refers patients to four hospitals (A, B, C and D) and it sent 60 referrals to A, 30 to B, 15 to C, and five to D, then the referral analysis anchored on hospital A would reallocate 36 (or 60%) of A’s referrals to B, 18 (30%) to C, and 6 (10%) to D. This would suggest that B and C are likely to be important alternatives to A for patients at that GP practice.

vice versa). The analysis is run separately for each of DTHFT and BHFT as the anchor hospital.

90. In line with previous cases,⁴⁷ the CMA applied filters to the HES data and ruled out concerns in specialty/setting combinations⁴⁸ where any of the following apply:

- (a) the share of reallocated referrals to the other party is less than 40%;⁴⁹
- (b) either Party had limited activity (fewer than 100 episodes a year in OP and/or fewer than 50 episodes in IP/DC); or
- (c) the Merger would give rise to a small increment (if one of the Parties accounts for less than 5% of their combined referrals).

- *Results*

91. The Parties submitted their referral analysis following the framework used by the CMA in previous cases. The Parties identified 19 specialties where the reallocated share of referrals fails the above filters in either an OP, DC or IP setting.⁵⁰ All of these were with BHFT as the anchor trust.

92. These 19 specialties include “synthetic specialties”, which have been created by combining specialties where “cross-coding” is common between DTHFT and BHFT. The purpose of these synthetic specialties is to account for potential differences in how the Parties code activity despite the treatment received being similar.⁵¹

93. The CMA’s referral analysis used two years of data (FY 2014/15 and FY 2015/16). In addition to the 19 specialties identified by the Parties, the CMA found a further five specialties which failed the 40% filter threshold for at least one setting.⁵² Two of these, Orthodontics and Paediatrics, are specialties for

⁴⁷ See paragraph 10.48 and Appendix C of the [CMFT/UHSM Report for further explanation of these filters](#) and paragraph 93 of the [UHB / HEFT Decision](#).

⁴⁸ Where the setting is OP, DC or IP.

⁴⁹ In some previous cases the CMA has applied an initial filtering threshold of 30%. However, recent policy developments have encouraged greater levels of collaboration in the provision of NHS acute services which have reduced the emphasis on the role of competition within the NHS. Also, previous CMA cases have not identified an SLC with regard to clinical specialties in which reallocated referrals are below 40% to the other merger party. See footnote 168 of the CMFT/UHSM Final Report.

⁵⁰ These specialties are Breast surgery; Clinical haematology; Endocrinology / Diabetics; ENT; Gastroenterology / Hepatology; General Surgery; Gynaecology; Maternity; Medical Oncology; Nephrology; Occupational Therapy; Ophthalmology; Oral /Maxillofacial Surgery; Orthotics; Physiotherapy; Rheumatology; Stroke /TIA; Trauma & Orthopaedics; Urology.

⁵¹ The referral analysis identified potential issues in all of these synthetic specialties, and therefore the CMA can be confident that combining them in this way is not missing competition concerns.

⁵² These specialties are Chemical Pathology, Dietetics, Geriatric Medicine, Orthodontics and Paediatrics.

patients aged under 18 and, as such, were not considered by the Parties' analysis.⁵³ The CMA's results included five specialities which failed the filters with DTHFT as the anchor trust.⁵⁴

94. The CMA worked with the Parties' to identify the source of the discrepancies in the results. The CMA noted that the two sets of data are from different providers, although based on the same underlying data. Furthermore, the time periods are slightly different, although mostly overlapping. The CMA also noted that most of the specialties with significant discrepancies are relatively small, meaning that differences in the results could arise from small differences in patient numbers.
95. Given the different results, and on a cautious basis, the CMA considered any specialty and setting that failed the filters in either the Parties' or the CMA's analysis. Therefore, the CMA identified 24 specialties requiring further analysis, as listed in Table 1.⁵⁵ Annex 1 provides further detail on the specialties and settings (ie OP, IP and DC) concerned.

Table 1: Specialties failing filters

1) Breast surgery	13) Nephrology
2) Chemical pathology	14) Occupational therapy
3) Clinical haematology	15) Ophthalmology
4) Dietetics	16) Oral/Maxillofacial surgery
5) Endocrinology/Diabetics	17) Orthodontics
6) ENT	18) Orthotics
7) Gastroenterology/Hepatology	19) Paediatrics
8) General surgery	20) Physiotherapy
9) Geriatric medicine	21) Rheumatology
10) Gynaecology	22) Stroke/TIA
11) Maternity	23) Trauma & Orthopaedics
12) Medical oncology	24) Urology

⁵³ Under-18 patients generally have a different choice of provider, and including them in referral analysis for these specialties could distort the results. The number of under-18 patients in other specialties is sufficiently low at one or both Parties that the CMA does not have competition concerns about them.

⁵⁴ These specialties are Chemical pathology, Medical oncology, Dietetics, Physiotherapy and Rheumatology.

⁵⁵ Applying the filters stated in paragraph 90, in addition to the 19 specialties identified by the Parties, the CMA found a further five specialties which failed the 40% filter threshold for at least one setting. Therefore, the CMA identified 24 specialties requiring further analysis.

- *Assessment*

96. The Parties submitted that there are significant limitations with this analysis and the weight given to the results of this analysis should be considered in light of the following:
- (a) The referral analysis is based on historical data that does not accurately reflect forward-looking dynamics;
 - (b) The referral analysis does not capture the full competitive constraints that DTHFT faces from other FTs;
 - (c) The referral analysis does not reflect when patients choose an FT solely on the basis of considerations related to the quality of OP services, or also taking into account the quality of IP and DC services, if the patient or the GP expect follow-on treatment;
 - (d) The referral analysis relies on the assumption that each patient's registered GP practice was also the referring organisation, however (i) not all first OP appointments result from a referral by a GP, and some of these referrals might not involve patient choice; and (ii) referrals after the first appointment consultation do not involve any further patient choice.
97. The CMA notes that it acknowledged these issues in past cases, ie in the CMFT/UHSM Report and the UHB/HEFT Decision. In particular, the CMA recognises that the referral analysis may not fully capture competitive dynamics between providers in IP or DC activity.⁵⁶ This is because whilst patients are entitled to choose their first OP appointment under NHS regulations,⁵⁷ they cannot exercise a direct choice for IP and DC treatments as they are typically admitted following an OP appointment. However, the CMA notes that some patients (or their GPs) may expect IP or DC treatments when they make their first OP appointment,⁵⁸ and these patients may take the hospital's quality for IP and DC services into account when exercising choice. As such, the referral analysis for OPs will partially encompass patients' preferences for IP and DC treatments, though it does not distinguish between patients who choose solely on the basis of OP services and patients who consider IP and DC quality. The CMA acknowledges that referral analyses that focus on IP and DC specifically could provide additional insight into the closeness of competition between the Parties in those settings.

⁵⁶ See paragraphs 10.49-10.54 of the [CMFT/UHSM Report](#) and paragraph 96 of the [UHB / HEFT Decision](#).

⁵⁷ See paragraph 70 above.

⁵⁸ See paragraph 10.51 of the [CMFT/UHSM Report](#) and paragraph 97 of the [UHB / HEFT Decision](#).

98. Overall, the CMA continues to believe that referral analysis provides a useful screening tool to identify specialties where trusts are potentially close competitors. However, the CMA took the Parties' comments into account when interpreting the results and when attempting to gauge the strength and scope of any potential SLC and its impact on patient outcomes.

Alternative providers

99. Unilateral effects are more likely where customers have little choice of alternative supplier. The CMA considered whether there are alternative suppliers which would provide a competitive constraint on the combined entity in the specialties identified.
100. BHFT identified the following trusts and hospitals as key competitors: DTHFT, HEFT, University Hospitals of Leicester NHS Trust (**UHL**), University Hospitals of North Midlands NHS Trust (**UHNM**), Royal Wolverhampton Trust, Royal Orthopaedic Hospital, Staffordshire and Stoke-on-Trent Partnership, and the private provider Spire at Little Aston.⁵⁹
101. DTHFT did not identify BHFT as a key competitor. It identified the following as its main competitors: Nottingham University Hospitals NHS Trust (**NUH**), Nuffield Health in Derby, UHL, Chesterfield Royal Hospital, Sheffield Teaching Hospitals, and the private providers Spire at Tollerton and Circle Health in Nottingham.⁶⁰
102. The CMA believes that the closeness of competition between the Parties and these rivals is already captured to a certain extent in the referral analysis set out above. This analysis indicates that in some specialties the Parties are significant competitors to each other and the constraint from other competitors is limited, while, in other specialties, where the filters are passed, there is prima facie evidence of a strong remaining constraint from rivals.
103. In line with previous cases, the CMA notes that location is the most important factor to patients.⁶¹ From the perspective of DTHFT, NUH is a similar distance to BHFT, it offers a wide range of services and is likely to be a significant competitive constraint. This is reflected in the referral analysis where DTHFT is the anchor. From the perspective of BHFT, most of the trusts and hospitals identified by the Parties, except the private provider Nuffield Health in Derby, are located significantly further away and, given the importance to patients of

⁵⁹ Merger Notice, paragraph 8.2 (a).

⁶⁰ Merger Notice, paragraph 8.2 (b).

⁶¹ See [CMFT/UHSM Report](#), paragraph 10.8.

proximity, they are likely to be regarded as weaker alternatives by patients. This is also reflected in the referral analysis where BHFT is the anchor.

104. The CMA also notes that many of these rivals also face capacity and financial pressure of the types described above, which may to some extent limit their ability and/or incentive to compete with the Parties.
105. The CMA therefore believes that the extent to which alternative providers will impose a competitive constraint on the merged entity is reflected in the referral analysis. The CMA has not, therefore, evaluated these alternative providers when assessing individual specialties.

Specialty assessments

106. For each specialty which did not pass the filters set out in paragraph 90, the Parties put forward the following additional reasons why the Merger does not give rise to a realistic prospect of an SLC:
 - (a) Limited patient choice: For many specialties, the Parties provided evidence of specific limitations in the role of competition due to lack of patient choice in some aspects of the specialty;
 - (b) The impact of capacity constraints: The Parties submitted that DTHFT is significantly capacity constrained in both physical space and equipment and due to high consultant vacancies across several specialties; and BHFT is significantly capacity constrained due to staff vacancies, using a large number of locums following persistent failures to recruit to some specialties – in part due to the national shortage of consultants but in part also due to BHFT’s size and catchment area limiting the number and complexity of patients that are treated there, making it less attractive;
 - (c) Existing cross-working and collaboration between the Parties: The Parties submitted that they already share a high proportion of consultants in some specialties.⁶² According to the Parties, this sharing of resources has reduced BHFT’s ability to differentiate itself and its ability to compete with DTHFT, in particular since DTHFT could withdraw these consultants; and
 - (d) Differentiation in sub-specialisation between the Parties: For many specialties, the Parties provided evidence of specific limitations on the role of competition, due to the Parties undertaking different activities within the specialty.

⁶² Notably Oral and Maxillofacial Surgery and Nephrology, where BHFT has no consultants of its own and relies entirely or largely on DTHFT consultants.

107. The CMA notes that, while these factors may reduce the scope for competition in a speciality, they would not necessarily remove it. In particular:
- (a) In relation to the scope of patient choice, the CMA recognises that, in principle, the scope for providers to compete for patients may be limited in specialties that do not offer material patient choice. However, the CMA would generally expect that for elective activity which is, by definition, scheduled and non-urgent, this is less likely to be the case.
 - (b) In relation to capacity constraints, it is possible that these capacity constraints weaken competition between the Parties in the short term. However, although small by comparison to most NHS FTs, the CMA notes that BHFT is not small relative to many hospitals in other countries, which are able to recruit required staff. In the longer term, dependent on sufficient resources being made available, all of the capacity constraints identified could be overcome.
 - (c) In relation to the impact of cross-working and collaboration, the CMA recognises that, in general, increased collaboration could reduce the set of parameters over which competition takes place and thus could reduce the magnitude of the competition concerns arising from the Merger. However, the CMA notes that cross-working or collaborative arrangements are often not intended to be permanent.
 - (d) In relation to differentiation, the CMA notes that, while general differentiation within a specialty where the Parties offer some of the same services may reduce the magnitude of an SLC, this is difficult to quantify. The commonality in the specialties identified by the referral analysis indicates that the Parties could be close competitors.
108. For these reasons, and on a cautious basis, in order to accept that these factors could reduce the scope for competition between the Parties to a sufficient extent that any lessening in competition would not be substantial, the CMA sought compelling evidence by speciality type. In particular:
- (a) In relation to lack of patient choice, the CMA sought evidence that the number of patients able to exercise choice as a proportion of the number of patients potentially affected in a given specialty was very small, such that it was unlikely to drive incentives for quality improvement;⁶³

⁶³ This is in line with the CMA's approach in UHB/HEFT and CMFT/UHSM to exclude from further analysis those specialties for which the vast majority of the parties' OP referrals are derived from sources that do not involve patient choice of provider (such as referrals from another consultant, or referrals from an A&E department).

- (b) In relation to capacity constraints, the CMA sought evidence that such constraints could not realistically be overcome in the foreseeable future;
- (c) In relation to existing cross-working and collaboration, the CMA sought evidence that it would not be realistic to assume that the service in question could be provided absent this collaboration;
- (d) In specialties where the Parties focus on differentiated sub-specialisations, the CMA sought evidence on the degree of such differentiation (eg explaining why the Parties' offerings within the specialty are not demand- or supply-side substitutes, and a quantification of the proportion of patients or revenues relating to these sub-specialisations within a specialty).

109. The CMA assessed each of these factors for each of the specialties listed in paragraph 95.

- *No SLC specialties*

110. The CMA found that the Merger will not result in a realistic prospect of an SLC in six of these 24 elective specialties, as set out below:

- Chemical pathology: the CMA concluded in CMFT/UHSM that there is little competition for patients in chemical pathology services as the majority of pathology is done 'behind the scenes' in support of other specialties and is unlikely to be the basis on which patients would make their decision about the hospital to attend for their main elective treatment.⁶⁴ The CMA found the same reasoning to apply in the present case.⁶⁵
- Clinical haematology: Choice will only be present where this speciality is delivered as a standalone service and not as part of a cancer pathway or another pathway. Around half of patients at BHFT across settings are part of a cancer pathway or from a non-choice source. Of the remainder, NHSI advised the CMA that these services (both IP and OP) are generally part of a different pathway and any choice will be reflected in a patient's choice for their underlying condition. Therefore, few if any patients will exercise choice based on this speciality.

⁶⁴ See CMFT/UHSM Report, paragraph 10.61.

⁶⁵ Some patients may be coded in this speciality because some consultants in Chemical Pathology run OP clinics in other specialties, which may be coded based on the consultant rather than the speciality.

- Medical oncology: In this specialty, treatment generally does not originate from a first OP appointment, but is an onward referral from a consultant in some other specialty; therefore, patient choice will not relate to a Trust's quality in this specialty.
- Occupational therapy: Only a small proportion of patients (9%) at BHFT came from sources with choice. The CMA believes it is unlikely that this small proportion of patients would be a significant driver of decisions relating to quality in this specialty.
- Stroke / TIA: This specialty is primarily non-elective. 64% of patients at BHFT came from sources without patient choice. Of the remainder, the CMA understands that the large majority relate to follow-up activity to emergency treatment, and that in these circumstances the GP referral would usually return to the source of the original treatment. In addition, the CMA notes that BHFT has had clinical issues in Stroke and was temporarily placed in regulatory special measures. The Parties said that East Staffordshire CCG has been pursuing the redesign of hyper acute stroke services, as BHFT has been found unable to meet the minimum requirements to maintain clinical competency within the available finances. This indicates that BHFT is not currently constrained by DTHFT for this service, and that it is unlikely the role of competition will increase in the foreseeable future.
- Nephrology: BHFT's activities in this specialty are limited. It has no renal consultants of its own. It operates two renal OP clinics per week, which are led and run by DTHFT's renal consultants, and a satellite renal dialysis service at Lichfield which is run by HEFT clinicians (and given its location between Burton and Birmingham, patients attending it are unlikely to consider DTHFT as a close alternative). NHSI advised the CMA that BHFT's clinics are largely follow-up services for patients that were initially treated within a different specialty or in an emergency context, rather than initial appointments that would feature choice. Given the limited role of patient choice and the difficulties for BHFT in expanding activities in a service provided by DTHFT consultants, the CMA believes that competition concerns will not arise in this case.

- *SLC specialties*

111. The CMA found that the Merger raises competition concerns in one or more settings (IP, OP and/or DC) in 18 of the 24 elective specialties in paragraph 95.⁶⁶ Please see Annex 1 for more information.
112. To reach this conclusion, the CMA took into account technical advice from NHSI, and considered, in particular, that both Parties provide these services at a sufficient scale to drive incentives, that referral analysis suggests that the Parties are close competitors (above 40% in all these cases), and that patient choice exists for a significant proportion of patients in each specialty.
113. In relation to these specialties, the Parties were unable to submit sufficient evidence on patient choice, capacity constraints, and collaboration or differentiation to remove the competition concerns identified. However, where the evidence indicated that there are some limitations on the extent of competition between the Parties, the CMA took this into account in its assessment of the adverse effects of the SLCs (as discussed in paragraphs 186 to 206 below).
114. The CMA would expect any adverse effects of the Merger to be felt principally at BHFT, resulting from the loss of constraint of DTHFT on BHFT.

Conclusion on horizontal unilateral effects

115. For the reasons set out above, the CMA found that the Merger raises competition concerns as a result of horizontal unilateral effects in the supply of the following specialties in the Derbyshire and East Staffordshire area: Breast surgery, Dietetics, Endocrinology / Diabetics, ENT, Gastroenterology / Hepatology, General surgery, Geriatric medicine, Gynaecology, Maternity, Ophthalmology, Oral / Maxillofacial surgery, Orthodontics, Orthotics, Paediatrics, Physiotherapy, Rheumatology, Trauma & Orthopaedics and Urology.

Barriers to entry and expansion

116. Entry, or the expansion of existing firms, can mitigate the initial effect of a merger on competition, and in some cases may mean that there is no SLC. In assessing whether entry or expansion might prevent an SLC, the CMA

⁶⁶ These specialties are Breast surgery, Dietetics, Endocrinology / Diabetics, ENT, Gastroenterology / Hepatology, General surgery, Geriatric medicine, Gynaecology, Maternity, Ophthalmology, Oral / Maxillofacial surgery, Orthodontics, Orthotics, Paediatrics, Physiotherapy, Rheumatology, Trauma & Orthopaedics and Urology.

considers whether such entry or expansion would be timely, likely and sufficient.⁶⁷

117. The Parties have not submitted that entry or expansion will mitigate the effect of the Merger on competition, and no other evidence has been provided to the CMA to indicate that sufficient entry or expansion is likely in the near future.
118. Based on the CMA's experience in previous NHS merger cases, and in the absence of evidence indicating entry or expansion in the present case, the CMA currently believes that entry or expansion would not prevent a realistic prospect of an SLC as a result of the Merger.

Third party views

119. The CMA contacted patient representatives, competitors, CCGs, NHSE and NHSI. The large majority of the third parties who responded had no concerns about the Merger, and most of them were very supportive of the Merger, citing its benefits to patients.
120. Two third parties raised concerns regarding the potential negative impact on patient care and quality as a result of the Merger. One of these third parties indicated that the Merger will have an impact on patient care and choice in the LHE, as patients can choose where they would like to receive certain types of services at the moment and post-Merger that choice would reduce. The CMA has considered patient choice in its competitive assessment. The other third party indicated that the Merger will impact negatively on patient services and care. The CMA tried to follow-up with this third party to understand fully the concerns but did not receive a response.

Conclusion on substantial lessening of competition

121. Based on the evidence set out above, the CMA believes that it is or may be the case that the Merger may be expected to result in an SLC in as a result of horizontal unilateral effects in relation to the 18 specialties set out in Annex 1 in the Derbyshire and East Staffordshire area.

Exceptions to the duty to refer

122. Where the CMA's duty to refer is engaged, the CMA may, pursuant to section 33(2)(c) of the Act, decide not to refer the merger under investigation for a Phase 2 investigation on the basis that RCBs in relation to the creation of the

⁶⁷ [Merger Assessment Guidelines](#), from paragraph 5.8.1.

relevant merger situation concerned outweigh the SLC concerned and any adverse effects arising from it (the **RCB exception**). The CMA has considered whether it is appropriate to apply the RCB exception to the present case.

123. The Parties submitted a full benefits case and, on 7 February 2018, NHSI gave its advice on these proposed benefits to the CMA, pursuant to section 79(5) of the HSCA.

Legal Framework

124. The CMA will examine the evidence put forward by the merger parties, together with NHSI's advice, on the benefits accruing to patients as a result of the merger. If the evidence received is sufficient for the CMA to establish that there are RCBs, it will then consider if these outweigh the likely adverse effects of the merger.⁶⁸
125. Weighing up the benefits against the adverse effects on patients involves consideration of the facts and circumstances of the case. In exercising its discretion to decide whether the claimed RCBs are such as to outweigh the SLC concerned and any adverse effects of the SLC, the CMA has regard both to the magnitude of the benefits and the probability of them occurring, and sets this against the scale of the identified anticompetitive effects of the merger and the probability of them occurring.⁶⁹ The RCBs do not need to be in the same market(s) or specialty as the CMA's SLC finding.
126. Only a benefit that meets the three conditions set out in section 30 of the Act can be considered an RCB:
- (a) The benefit must be a **benefit to relevant customers**⁷⁰ in the form of:
- (i) lower prices, higher quality or greater choice of goods or services in any market in the UK ... or
 - (ii) greater innovation in relation to such goods or services'.⁷¹

⁶⁸ CMA29, paragraph 7.24.

⁶⁹ CMA29, paragraph 7.26.

⁷⁰ In the context of the health sector and NHS mergers, 'relevant customers' include patients and/or commissioners (section 30(4) of the Act and CMA29, paragraph 7.3.

⁷¹ Section 30(1)(a) of the Act and see also CC8, paragraph 1.14.

- (b) The benefit must be expected to accrue to relevant customers within the UK within a **reasonable period** as a result of the creation of the relevant merger situation.⁷²
- (c) The benefit must be **unlikely to accrue without the creation of that situation** or a similar lessening of competition'.⁷³

Types of benefits that may represent RCBs

- 127. The assessment of whether benefits claimed by merger parties constitute RCBs must be assessed on a case-by-case basis.⁷⁴
- 128. The types of benefits that NHS providers have previously submitted as arising from a merger (either to NHSI or to the CMA) include higher quality services through implementing a particular model of care, service reconfiguration, increased consultant or staff cover, and improved access to equipment. They have also included greater innovation through research and development, a greater ability to attract funding for research and development, and financial savings.⁷⁵
- 129. NHSI has previously found that improvements in clinical service delivery and financial savings can be achieved through mergers between NHS providers.⁷⁶

Role of NHSI in the CMA's assessment of RCBs

- 130. Section 79 of the HSCA requires NHSI to provide advice on RCBs to the CMA in Phase 1 as soon as reasonably practicable after receiving notification that the CMA is investigating a merger involving an NHS foundation trust.⁷⁷
- 131. NHSI's advice is not binding on the CMA. However, the CMA will place significant weight on NHSI's advice, given NHSI's role and expertise as the sectoral regulator.⁷⁸

⁷² Section 30(1)(b)(ii) of the Act.

⁷³ Section 30(3) of the Act and see also [CC8](#), paragraph 1.16.

⁷⁴ [CMA29](#), paragraph 7.14.

⁷⁵ [CMA29](#), paragraph 7.13.

⁷⁶ See NHSI (May 2016), Improvements NHS providers have achieved through mergers and Aldwych Partners (May 2016), Benefits from mergers: lessons from recent NHS transactions.

⁷⁷ [CMA29](#), paragraph 7.5.

⁷⁸ [CMA29](#), paragraph 7.6.

Potential benefits arising from the Merger

132. The Parties submitted that the Merger will give rise to a wide range of benefits, not all of which it submitted as RCBs.⁷⁹ .
133. For the purposes of its assessment, the CMA focussed on those benefits which the Parties submitted as potential RCBs within the meaning of the Act and did not seek to determine whether additional benefits might arise from the Merger. For this reason, the CMA's assessment of RCBs may understate the overall magnitude of benefits arising from the Merger.

Assessment of whether there could be RCBs

134. In this section, the CMA outlines the RCBs proposed by the Parties and NHSI's advice on those proposed RCBs. The CMA then considers whether the proposed RCBs are RCBs within the meaning of Section 30 of the Act, drawing both on NHSI's advice and a number of general considerations relating to the implementation and merger specificity of the proposed RCBs.

RCBs proposed by the Parties

135. The Parties submitted that the Merger will give rise to workforce improvements, a cross-cutting RCB affecting many of the services to be provided by the merged trust, as well as further RCBs in specific clinical services.
136. The Parties submitted that the Merger would result in improved staff recruitment and retention, as the larger organisation would be able to offer consultants greater opportunity to sub-specialise and medical staff greater scheduling flexibility. Further, the parties claimed that DTHFT's teaching hospital status, offering staff the opportunity to participate in research trials and provide more cutting-edge services to patients, further enhanced the merged trust's attractiveness to existing and prospective staff.
137. The Parties developed a number of case studies to demonstrate the proposed RCBs arising from the Merger. The Parties submitted these as examples of the kind of benefits they expected to arise from the Merger. The case studies were in the following specific clinical services:

(a) Cardiology

⁷⁹ The Parties submitted that the Merger will also bring other benefits typically associated with a merger between two large NHS Trusts.

(b) Trauma and Orthopaedics

(c) Renal Medicine

(d) Stroke

(e) Radiology

(f) Cancer

138. The Parties submitted that the reconfiguration of these services, following the Merger, would bring a number of benefits, including:

(a) reduced travel and waiting times, as patients would be able to access services closer to their home;

(b) reduced multiple visits for treatment;

(c) reduced lengths of stay, as procedures could be offered onsite and in a more timely fashion;

(d) reduced anxiety for patients and their families due to an improved patient experience (described above);

(e) improved use of community sites; and

(f) improved long-term condition management, thus supporting GPs to keep people out of acute care settings where appropriate.

NHSI's advice on the proposed RCBs

139. NHSI advised the CMA that BHFT could not continue to provide high quality, safe services in its current form and that the Merger was an opportunity to create a larger organisation that would provide more robust and resilient services for patients across East Staffordshire and South Derbyshire.

140. NHSI's analysis found that there would be trust-wide patient benefits flowing from the merged trust's ability to strengthen its workforce, and that improved staff recruitment and retention, as well as less reliance on agency staff and locums, had the potential to benefit many patients through strengthened out-of-hours care and access to subspecialist consultants.

141. NHSI found that the Merger would result in relevant patient benefits in the six specialist areas proposed by the Parties (see paragraph 137), where some patients would experience reduced mortality, improved clinical outcomes, shorter stays in hospital and reduced waiting times for treatment.

142. NHSI advised the CMA that the Parties were likely to deliver the proposed improvements during the first three years after the Merger, because:
- (a) the Parties had already achieved improvements in organisational structure and clinical leadership at BHFT since the appointment of DTHFT's Chair at BHFT in 2016;⁸⁰
 - (b) DTHFT had proven experience in delivering high quality services; and
 - (c) there had been significant staff and clinical engagement and planning since 2016.
143. NHSI advised the CMA that the improvements were unlikely to be achieved without the Merger, as BHFT did not have the patient volumes or staff to deliver clinically sustainable services, and, prior to the involvement of DTHFT in 2016, BHFT had not demonstrated the leadership and ability needed to implement a strategy that delivered wide-scale improvements in quality.
144. Further, NHSI advised the CMA that BHFT's existing series of collaborative arrangements with multiple providers, including DTHFT, was complex to administer and was not a viable long-term solution to clinical sustainability, and that only the Merger would achieve the level of clinical engagement, accountability and incentives needed to develop a culture of continuous learning, improvements in quality of care, and efficient service delivery for patients.

General considerations relating to the implementation and merger specificity of the proposed RCBs and other potential benefits of the Merger

145. Before assessing whether each of the proposed RCBs is an RCB within the meaning of the Act, the CMA sets out a number of general considerations that are relevant to the Merger, the proposed RCBs and other potential benefits of the Merger. These considerations relate to the risks relating to the implementation of benefits (and how the Parties and NHSI will mitigate these risks) and the need for the Merger (rather than any other form of collaboration between the Parties) to deliver the benefits.

⁸⁰ Since 2011, NHSI has undertaken a series of regulatory actions to address problems at BHFT. In November 2011, NHSI took enforcement action against BHFT in relation to financial and governance concerns. In April 2013, NHSI agreed undertakings with BHFT intended to address these concerns. In July 2013, NHSI placed BHFT in special measures in response to the findings of the Keogh review, which found a number of issues with the safety and quality of patient care at BHFT. BHFT exited special measures in October 2016. In March 2016, following ongoing concerns with the clinical and financial sustainability of services at the trust, BHFT ([X]) appointed the Chair of DTHFT as the Chair of BHFT.

Implementation

146. The CMA is aware that NHS mergers are complex transactions and that the parties involved face heightened operational challenges and significant regulatory and clinical pressures to maintain quality and service levels. NHS mergers can therefore raise significant implementation risks to the prompt realisation of benefits.⁸¹
147. In this case, the CMA notes that there are a number of factors that support the Parties' ability to realise benefits within a reasonable period of the Merger:
- (a) The Parties have significant capability in and experience of delivering high quality services;
 - (b) The Parties have undertaken a significant amount of planning work in relation to the implementation and delivery of the proposed RCBs;
 - (c) The Parties have engaged with many stakeholders, which may be expected to assist in the delivery of the proposed RCBs;
 - (d) the Merger is widely supported by key stakeholders; and
 - (e) the Merger is subject to NHSI's merger assurance regime.
148. These factors are discussed further below.

Capability and experience

149. Based on the evidence set out below, the CMA believes that, given the experience and reputation of DTHFT's senior leadership team in delivering high quality services, the merged trust should be well placed to execute the Merger and achieve benefits for patients from it.
150. DTHFT has a strong track record of delivering high quality services. For example, DTHFT:
- (a) is one of fewer than 20 NHS trusts with a fully Imaging Services Accreditation Scheme (ISAS) accredited Radiology service;
 - (b) has an Emergency Department that was named as Clinical Team of the Year by the Royal College of Emergency Medicine in October 2017;

⁸¹ See NHSI, Literature review: the experiences of healthcare providers in delivering merger objectives, May 2016.

- (c) is one of few NHS trusts to have a pathology service that is fully accredited in all disciplines by the United Kingdom Accreditation Service (UKAS); and
 - (d) is the first NHS trust to be fully accredited as part of the Scan 4 Safety initiative (ie using bar coding technology to increase efficiency, reduce unwarranted clinical variation and improve patient safety).
151. Following the appointment of senior executives from DTFHT at BHFT in 2016, BHFT has also improved the quality of its services. For example, a recent mock CQC visit indicated that BHFT had improved its performance in the 'well-led' domain, and BHFT has also improved its performance in relation to compliance with core guidelines on sepsis.
152. The CMA understands that the proposed Chief Executive of the merged trust has nearly 30 years' NHS experience, including 10 years as a FT Chief Executive. Further, the proposed Chair of the merged trust has substantial executive and non-executive experience, and has been Chair of both trusts since 2016.
153. NHSI advised the CMA that DTHFT's track-record of delivering high quality care was evidence of its ability to deliver the improvements proposed in the Parties' benefits submission. NHSI advised the CMA that DTHFT had a number of high-performing services and, with respect to some services, operated more efficiently than hospital national averages.⁸²

Planning work undertaken to date

154. Based on the evidence set out below, the CMA believes that the planning work undertaken by the Parties means that they are well-placed to deliver the proposals set out in their benefits submission.
155. The Parties have developed an organisational structure for the merged trust and planned leadership changes to ensure appropriate governance:
- (a) The Parties have already identified the CEO and Executive Team for the merged trust and, in preparation for the Merger, the CEO and the Executive Team have developed leadership teams across the merged trust, which should ensure a smooth transition, with key personnel acquiring leadership posts.

⁸² According to NHSI Model Hospital data, DTHFT is in the highest performing quartile of trusts for operating theatre utilisation and for amount of potential additional activity.

- (b) A Strategic Collaboration Board is in place and is responsible for the development of implementation plans. The delivery of the transaction is managed and undertaken by a Project Group, composed of both CEOs, an executive lead for each of the various workstreams necessary for delivery and representatives for each trust across the key workstreams. The Project Group and the executive leads are supported by a dedicated Project Management Office.
- (c) A Transformation team will deliver quality of services, financial improvement, operational efficiency and improve the merged trust's transformation and change capability; and an Integration team will lead on the implementation of the post-transaction implementation plan.
156. NHSI advised the CMA that the Parties' merger proposal was the result of more than two years of work in which the leadership of both trusts, with the support of NHSI, worked with clinical teams to identify opportunities and develop plans to improve services for patients. NHSI advised the CMA that, while there was more work to do, the Parties had laid a strong foundation for building on their existing relationship.
157. NHSI advised the CMA that it had already seen improvements from the collaboration between the Parties, such as the recruitment of Renal consultants to provide greater consultant cover at BHFT.

Stakeholder engagement and support

158. Based on the evidence set out below, the CMA believes that the high levels of engagement activity undertaken by the Parties across management and clinical workforces, as well as wider stakeholders, increases the likelihood that the proposed RCBs will be delivered.
159. The Parties told the CMA that there had been a continuous process of engagement with staff and key stakeholders and that the trusts had undertaken an extensive programme of clinical engagement and planning to scope out and plan for the clinical changes that will be delivered through the Merger:
- (a) Nine clinical specialties were prioritised for an initial 'deep dive', which was undertaken between January and March 2017. These specialties were prioritised as the areas where the Merger was likely to be most critical in delivering change, and where the trusts identified the change to be prioritised after completion of the Merger. For each of these specialties, clinical teams from both trusts collaborated to identify the right clinical model for delivering the service post-Merger.

- (b) Following the initial deep dive, further in-depth reviews of seven clinical areas were undertaken. These clinical areas overlapped with the original deep-dives, though some refinements and additions were also made following the review of the output of the first process. This process focussed on developing in more detail the model of care, identifying any required investment or cost savings, and agreeing timelines for delivery.
- (c) The Parties held 'confirm and challenge' sessions, where clinical teams were challenged on the delivery of their plans, the scale of their ambition and the associated patient benefits. Plans were then refined accordingly. These sessions were well attended by staff, and members of the Council of Governors of both trusts have also participated.
- (d) Healthwatch in Staffordshire, Derbyshire and Derby City also arranged for a public meeting to allow local people to discuss the proposals directly with partner clinicians from both organisations.

Regulatory oversight

160. In addition to the CMA's merger assessment, the Merger is subject to NHSI's merger assurance process. NHSI told the CMA that its assurance process, which it expected to complete by 1 April 2018, would test the financial case for the Merger, as well as assessing other potential benefits and risks of the Merger.

Merger specificity

161. The CMA has identified several reasons why, in general, it is unlikely that the proposed RCBs would accrue absent the Merger.
- *Role of DTHFT absent the Merger*
162. Based on the evidence set out below, the CMA believes that the continued presence of DTHFT's senior leadership, predicated on the Merger, is essential for the long-term stability of BHFT and the delivery and sustainability of the proposed RCBs.
163. Since being placed in special measures in 2013, BHFT has worked closely with DTHFT to address the clinical and financial sustainability of its services. For example:
- (a) the trusts have the same Chair;
 - (b) the Chief Executive of BHFT was previously Chief Operating Officer of DTHFT;

- (c) A Divisional Director of DTHFT is currently seconded to BHFT as Chief Operating Officer; and
- (d) the trusts have the same Head of Information Management and Technology and Head of Facilities.
164. The Parties told the CMA that the support provided to BHFT by DTHFT had been significant, and not without risk to the performance of DTHFT. They said that it was unlikely that this level of continued support could be justified if the Merger were not to proceed. The Parties told the CMA that, in the absence of the Merger, BHFT may not have the leadership needed to instigate tangible change, including maintaining and increasing quality improvements.
165. NHSI advised the CMA that, since 2011, NHSI and CQC had taken numerous regulatory actions to address concerns about the governance, finances and quality of care at BHFT, but that BHFT could not provide high quality, safe services without further support.ⁱ NHSI advised the CMA that the improvements set out in the Parties' benefits submission were unlikely to be achieved without the Merger as, prior to the involvement of DTHFT, BHFT had not demonstrated the leadership and ability needed to implement a strategy that delivered wide-scale improvements in quality.
166. NHSI advised the CMA that, if the Merger did not take place, DTHFT would have little incentive to continue to provide support to BHFT and, consequently, BHFT may have to be 'reimagined' as a different provider with different service provision, which would reduce the range of local services available to patients, or BHFT would have to find another merger partner. NHSI advised the CMA that there was not another provider with the ability to merge with BHFT to address its challenges.
167. In February 2018, NHSI agreed undertakings with BHFT to continue to work with DTHFT to develop a business case to support a transaction between the Parties in order to secure BHFT's long term sustainability.
- *Scale and complexity of change*
168. Based on the evidence set out below, the CMA believes that the nature and scale of the proposed RCBs, and the operational challenge of implementation, are so significant that the only way to realistically deliver on the full potential of the benefits is through the Merger. In the absence of the Merger, the CMA does not believe that change of the type and scale of the proposed RCBs is likely, given the time needed and the complexity of putting in place multiple cooperative agreements or similar arrangements.

169. The Parties told the CMA that the scale of the integration proposed was substantial and could not be achieved through bilateral service level agreements (**SLAs**) agreed for individual specialties, as this would not only be inefficient but also unlikely to succeed. The Parties said that SLAs did not ensure the clinical leadership, unity of purpose and governance necessary for a significant transformation of services.
170. NHSI advised the CMA that BHFT was already heavily dependent on collaboration with other trusts to provide many of its services, and that this current patchwork of collaboration with multiple providers was complex to administer and was not a viable long-term solution to sustain services at BHFT.
171. NHSI advised the CMA that a lesser form of partnership or collaboration (as an alternative to the Merger) was unlikely to achieve the level of clinical engagement, accountability and incentives needed to develop a culture of continuous learning, improvements in quality of care, and efficient service delivery for patients.
- *Barriers to working together*
172. Based on the evidence set out below, the CMA believes that the Merger is likely to remove many of the barriers to achieving change at BHFT by establishing a single accountable board and governance structure.
173. The Parties told the CMA that although BHFT had a number of clinical services provided by nearby NHS Trusts under SLAs, developing partnerships to address BHFT's challenges at pace had been difficult due to barriers, such as asymmetric incentives, lack of clinical support, extended governance, contractual complexities and clinical interdependencies with other key services. The Parties also told the CMA that SLAs did not provide the structures or incentives for clinical and medical leadership for the specialties involved.
174. The Parties told the CMA that the merged trust would have a single clinical strategy, a unified governance system, a single leadership team and an integrated culture. As a single organisation, it could also be more responsive to identified challenges across the LHE.

Summary of assessment of proposed RCBs

175. Table 2 presents a summary of the CMA's assessment of each of the proposed RCBs. A more detailed assessment can be found in Annex 3.

Table 2: Summary of assessment of proposed RCBs

<i>Proposed RCB</i>	<i>Is the proposed RCB likely to improve patient and/or commissioner outcomes?</i>	<i>Can the proposed RCB be expected to accrue within a reasonable period from the Merger?</i>	<i>Is the proposed RCB unlikely to accrue without the Merger?</i>	<i>Is the proposed RCB an RCB within the meaning of the Act?</i>
<i>Cross-cutting RCBs</i>				
Workforce improvements	<p>Yes</p> <p>Merger will improve staff recruitment and retention at BHFT, resulting in improved patient access to services and improved outcomes.</p> <p>However, the CMA believes the benefits to DTHFT patients are less clearly identifiable, as DTHFT, as a larger trust, does not currently face the scale of workforce issues experienced by BHFT.</p>	<p>Yes</p> <p>The Parties have relevant plans in place and the steps already taken towards integration suggest that they are on track to deliver the proposed improvements</p>	<p>Yes</p> <p>BHFT recruitment and retention challenges are longstanding and there have been repeated attempts to address them without success</p> <p>In the absence of the merger, BHFT will continue to provide limited opportunities for sub-specialisation and flexibility in rotas, and joint posts with other trusts is not a viable long-term solution</p>	Yes
<i>Clinical services RCBs</i>				
Cardiology	<p>Yes</p> <p>Merger will benefit Cardiology patients in the form of improved diagnosis, a reduction in patients receiving invasive</p>	<p>Yes</p> <p>Improvements likely to be delivered within a reasonable timescale based on the planning and implementation work carried out to date</p>	<p>Yes</p> <p>BHFT unlikely to be able to offer Computer Tomography Coronary Angiograms (CTCAs) or Percutaneous</p>	Yes

	procedures, improved patience experience and access to services		Coronary Intervention (PCI) in the absence of the merger Merger will make it easier to change current pathways so that BHFT patients are able to receive complex pacing devices at DTHFT	
Trauma and Orthopaedics	Yes Merger will benefit Trauma and Orthopaedics patients in the form of improved outcomes, reduced waiting times and reduced cancellations	Yes The Parties have developed sufficient plans at this stage to demonstrate how they will address the capacity challenges caused by the reconfiguration of Trauma and Orthopaedics services and deliver the improvements within a reasonable time	Yes BHFT unlikely to be able to offer the proposed improved outcomes for its Trauma and Orthopaedics patients without the merger The multiple service, staff and estate changes required to implement the proposals would likely be too complex to successfully deliver without a merger and a looser form of collaboration would be less likely to achieve the accountability and single leadership necessary to set the strategic direction and improve efficiencies and patient outcomes	Yes
Renal Medicine	Yes Merger will benefit Renal patients in the form of reduced mortality, reduced morbidity, reduced length of stay and improved quality of life	Yes The Parties have already started to implement the plans to provide an on-site consultant presence at BHFT	Yes BHFT unlikely to implement critical IT system changes and without the support of DTHFT specialist renal consultants	Yes

		<p>IT changes have been scoped, costed and planned, and a detailed implementation plan has been developed</p> <p>The Parties are well placed to implement key steps for the proposed changes to dialysis services</p>	<p>The Parties have previously failed to agree formal collaboration on dialysis services due to an inability to reach agreement on ownership of activity</p>	
Stroke	<p>Yes</p> <p>Merger will benefit Stroke patients in the form of reduced mortality, reduced risk of complications, improved outcomes and reduced risk of stroke</p>	<p>Yes</p> <p>The Parties have developed sufficient plans and timescales at this stage to demonstrate that the changes are likely to be delivered within a reasonable time</p>	<p>Yes</p> <p>The Parties have tried in the past to arrange for BHFT patients to be treated at the DTHFT HASU, but no plan has been taken forward to date</p> <p>BHFT does not have sufficient patient volumes to develop its own clinically and financially stable HASU</p>	Yes
Radiology	<p>Yes</p> <p>Merger will benefit those patients accessing BHFT's Radiology services in the form of higher quality, more reliable imaging reports (leading to more accurate and timely diagnosis), reduced waiting times for scans and results and more convenient appointment times</p>	<p>Yes</p> <p>Given the planning undertaking to date, the strong clinical engagement and DTHFT's strong track record of running a high performing Radiology service, the improvements should be delivered in a reasonable timescale</p>	<p>Yes</p> <p>Many of BHFT's problems in Radiology arise from its severe shortage of substantive consultant radiologists, which it has tried and failed to address for several years</p> <p>Potential candidates will be more attracted to work as part of a larger, high performing Radiology service following the merger</p>	Yes

Cancer	<p>Yes</p> <p>Merger to create smoother and more efficient pathways for patients needing complex cancer care, resulting in reduced referral to treatment times</p>	<p>Yes</p> <p>The Parties have developed sufficient plans at this stage to demonstrate that the improvements to cancer pathways are likely to be delivered within a reasonable time</p> <p>Upper GI Cancer services are subject to evaluation by NHSE and therefore, it is too early to assess whether the proposed improvements are likely to be delivered in a reasonable time</p>	<p>Yes</p> <p>Although the trusts could potentially achieve some aspects of their proposals as independent organisations, longstanding pathways arrangements are difficult to change without a common governance structure and the buy-in of clinicians to drive through change</p>	<p>Yes</p>
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Source: CMA analysis, Parties' benefits submission, NHSI's advice on benefits submission.

Conclusion on assessment of whether there could be RCBs

176. For the reasons set out above, the CMA believes that the Merger may give rise to the following RCBs:

- (a) Workforce improvements at BHFT.
- (b) RCBs in the following clinical services:
 - (i) Cardiology;
 - (ii) Trauma and Orthopaedics;
 - (iii) Renal Medicine;
 - (iv) Stroke;
 - (v) Radiology; and
 - (vi) Cancer.

Weighing RCBs against SLCs and adverse effects

177. In deciding whether the claimed RCBs are such as to outweigh the SLC concerned and any adverse effects of the SLC, the CMA has regard both to the magnitude of the RCBs and the probability of them occurring, and sets this against the scale of the identified anti-competitive effects and the probability of them occurring.⁸³

178. The CMA considered the broad timeframe within which each of the patient benefits comprising the RCBs could be expected to be implemented, noting that some benefits are likely to be implemented more quickly than others (eg the CMA would expect patient benefits involving the consolidation of sites to be slower to implement than patient benefits involving the reconfiguration of rotas).⁸⁴

Nature and magnitude of the RCBs

179. The Parties provided the CMA with a detailed analysis of the nature and magnitude of the RCBs that would arise from the Merger. NHSI interrogated this analysis and supported the conclusions. The CMA then analysed the proposed RCBs. Table 3 summarises the results of the CMA's analysis.

⁸³ CMA29, para 7.26.

⁸⁴ CMA29, footnote 94.

Table 3: Summary of nature and magnitude of RCBs

<i>RCB</i>	<i>Nature of benefit</i>	<i>Magnitude of benefit (patient numbers per year)</i>
<i>Cross-cutting RCBs</i>		
Workforce improvements	Improved staff recruitment and retention at BHFT, resulting in improved patient access to services and improved outcomes	Positive impact on many of the services provided by BHFT and many of the patients receiving those services
<i>Clinical services RCBs</i>		
Cardiology	<p>Introduction of CTCA to replace exercise tolerance tests for patients with stable chest pain will result in more accurate diagnosis and fewer invasive angiographies</p> <p>Introduction of CTCA to replace invasive coronary angiography for patients with chest pain or suspected coronary artery disease</p> <p>PCI to be provided at BHFT, eliminating need for two separate invasive procedures and reduced time to treatment</p> <p>BHFT patients requiring complex pacing devices to be treated at DTHFT, reducing travel times</p>	<p>790 patients</p> <p>220 to 260 patients</p> <p>Majority of the 80 to 90 urgent PCI patients and 270 planned PCI patients</p> <p>Subset of 30 to 40 patients currently travelling to other providers</p>
Trauma and Orthopaedics	<p>Centralisation of emergency Trauma services at DTHFT Trauma unit, resulting in improved access to a designated Trauma unit and subspecialist surgeons and improved outcomes</p> <p>Centralisation of elective IP surgery at DTHFT, resulting in reduced waiting times and improved outcomes</p> <p>Centralisation of DC surgery at BHFT, resulting in reduced waiting times, cancellations and risk of infection and improved patient recovery</p>	<p>1,000 patients</p> <p>700 patients</p> <p>3,225 patients</p>
Renal Medicine	DTHFT to provide Renal Medicine services at BHFT, resulting in reduced	2,000 patients

	<p>mortality, improved morbidity and lessened progression of AKI and reduced length of stay</p> <p>DTHFT to run BHFT's haemodialysis service and promote uptake of home haemodialysis, resulting in reduced mortality, improved self-management, better quality of life, reduced travel time and reduced risk of infection and need for an invasive procedure for dialysis</p>	5 patients (and more patients in the long term)
Stroke	<p>Centralisation of hyper-acute Stroke services at DTHFT HASU to cause reduced mortality, reduced complications and improved outcomes</p> <p>Combined Stroke service to enable seven-day consultant-led ward rounds, and improved access to consultant-led out-of-hours care for patients and improved access to therapists, resulting in reduced complications and improved outcomes</p> <p>Combined Stroke service to provide BHFT patients with weekend access to DTHFT Stroke clinic, resulting in reduced risk of stroke</p>	<p>400 patients</p> <p>At least two thirds of 400 hyper-acute patients and an unspecified number of BHFT and DTFHT patients</p> <p>70 to 80 patients</p>
Radiology	<p>Stabilisation of Radiology services at BHFT leading to reduced waiting times for diagnostics and improved quality of service</p> <p>Implementation of DTHFT Radiology processes at BHFT, resulting in improved access to and reduced waiting times for diagnostics and improved quality of service</p>	<p>170,000 patient spells</p> <p>6,868 patients</p>
Cancer	<p>Merger to create smoother and more efficient pathways for patients needing complex cancer care, resulting in reduced referral to treatment times</p>	184 patients

Source: CMA analysis on the basis of the Parties' benefits submission and NHSI's advice on benefits submission.

180. The Parties told the CMA that the Merger would result in the creation of a new trust that would provide high quality services across a patient population

spanning two counties. The Parties told the CMA that the expected patient benefits would impact a substantial proportion of patients at the merged trust, in particular at BHFT, and that the clinical services RCBs were examples of the patient benefits that would be delivered by the merged trust in the longer term.

181. NHSI advised the CMA that the RCBs arising from the Merger would affect many patients and were likely to result in improvements in reduced mortality, improved clinical outcomes, reduced length of stay in hospital and reduced time to treatment.
182. The CMA believes that the Merger is likely to give rise to substantial benefits to patients in the form of improved access to clinical services, particularly in relation to out of hours care, care close to home and access to sub-specialists, and improved safety and quality of care. The CMA considers that these benefits are likely to result in improved patient experience and improved patient outcomes, notably reduced time to treatment and reduced mortality and morbidity rates. The CMA therefore believes that the magnitude of the RCBs is significant.
183. The CMA also believes that there is a high probability of the RCBs occurring, having regard to the expertise of the merged trust's management, the track-record of DTHFT in the provision of high quality services, and NHSI's advice. In addition, the CMA considers that the continuing regulatory oversight by NHSI and others will ensure that the RCBs will be realised within a reasonable period of the Merger.

Nature of the SLC and adverse effects

184. For the purposes of assessing the adverse effects of the SLC, the CMA considered evidence on: (i) the scale of the SLC in terms of the number of patients and revenues associated with each of the specialties affected, both in absolute terms and relative to the Parties' overall activities; (ii) other indicators of the extent of competition lost by the Merger (ie magnitude of the SLC); and (iii) the likelihood that the SLC will occur.

Number of patients and revenues associated with the SLC specialties

185. The CMA has found that there is a realistic prospect that the Merger may give rise to an SLC in the 18 elective and maternity specialties listed in paragraph 111 above. These services represent less than 8% of the Parties' total activity and tariff revenues, and less than 12% of their patients (see Annex 2 for further detail). This evidence indicates that the scale of the SLC and any consequent adverse effects is likely to be limited.

Other factors relevant to the magnitude and likelihood of the SLC

186. The CMA believes that any adverse effects resulting from the SLC are likely to be constrained by the following factors concerning the nature of competition between NHS FTs in general:
- (a) The role of competition in the LHE and regulation (see paragraphs 69 to 73 above); and
 - (b) Increased collaboration between NHS service providers (see paragraph 72 above).
187. In addition to these general factors, the CMA believes that there are additional factors specific to DTHFT and BHFT which limit the magnitude and likelihood of the SLC, and therefore the extent of the adverse effects resulting from the SLC. These factors are:
- (a) resource sharing between the Parties;
 - (b) asymmetry of competition for patients;
 - (c) capacity constraints;
 - (d) differentiation between the Parties;
 - (e) limitations on patient choice; and
 - (f) ability and incentive to respond to an SLC at an individual speciality level.

The CMA discusses each of these factors below.

Resource sharing between the Parties

188. The Parties submitted that BHFT is dependent on consultants from DTHFT in some specialties,⁸⁵ which reduces BHFT's ability to differentiate itself and its ability to compete with DTHFT, in particular as DTHFT could withdraw these consultants.
189. The CMA notes that factors other than consultants affect the quality of a service. In addition, BHFT could, if necessary, seek to collaborate with other trusts, as they do in some specialties already.

⁸⁵ Notably Oral and Maxillofacial Surgery and Nephrology, where BHFT has no consultants of its own and relies entirely or largely on DTHFT consultants.

190. However, the CMA believes that, while these factors do not remove competition, they may reduce the magnitude of the SLC and therefore any adverse effects arising from it.

Asymmetry of competition for patients

191. All except three of the SLCs identified arise in specialties where the constraint between the Parties' is asymmetric, ie the concern only arises as a result of patient referral numbers where BHFT is the anchor.⁸⁶ Moreover, these three SLCs are all only slightly above the 40% threshold where prima facie concerns arise.
192. According to the Parties, this result demonstrates that BHFT is not a competitive constraint on DTHFT and, therefore, the Merger would not change DTHFT's incentives substantially. The Parties submitted that it would not be plausible for the combined trust to offer a worse service at BHFT sites only and there would be no incentive for it to reduce its quality overall as a result of the loss of constraint on BHFT.
193. The CMA believes that asymmetry alone does not remove the incentive to maintain or increase quality across combined trust. The CMA acknowledges that DTHFT is the larger of the Parties and its overall competitive constraints may not be significantly altered by the Merger. However, the CMA notes that the Merger represents a reduction in the overall level of competition faced by BHFT and thus may reduce the Parties' incentives to maintain or increase quality across the combined trust.
194. Furthermore, while some determinants of quality will be set across the whole trust, the CMA notes that other determinants of quality will be set at site level. Post-Merger, the Parties would be able to reduce investment in services or infrastructure at BHFT sites.
195. However, notwithstanding that the asymmetry between the Parties does not remove competition, the CMA accepts that it can reduce the Parties' incentives and ability to respond to a reduction in competition post-Merger and, therefore, it does reduce the magnitude of the SLC and any adverse effects arising from it.

⁸⁶ As noted above in paragraph 91, the Parties found in their referral analysis that there are no concerns where DTHFT is the anchor.

Capacity constraints

196. The Parties submitted that both trusts are capacity constrained.
197. The CMA believes that capacity constraints have somewhat limited DTHFT's ability to treat more patients. For example, as indicated in paragraph 43, DTHFT has failed some key national targets, DTHFT's bed occupancy rates are consistently above the level that is deemed appropriate for some specialties, and DTHFT has paid for private providers to treat some elective patients in order to meet its targets.⁸⁷ The CMA also notes that, according to Model Hospital Data, DTHFT ranks highly for efficiency, limiting its ability to increase capacity.
198. However, whilst capacity constraints may weaken DTHFT's ability to compete in some specialties, the CMA believes that this does not necessarily apply across all specialties. The CMA also notes that a hospital can switch capacity between specialties and treatment settings.
199. As noted in paragraph 107, the CMA believes that the Parties' capacity constraints may significantly weaken competition in a speciality, particularly in the short term, but they do not remove it. Nevertheless, they do indicate that the Parties' ability to respond to changed incentives to maintain and improved quality may be limited. Therefore, while these factors do not remove competition, they may reduce the magnitude of the SLC and any adverse effects arising from it.

Differentiation between the Parties

200. Differentiation between the Parties within a specialty may reduce the magnitude and scale of the SLC resulting from the Merger, either because incentives are affected to a lesser degree by the Merger or because a smaller number of patients are affected.
201. As noted in paragraph 106, the Parties are significantly differentiated in many specialties. DTHFT offers a much wider range of specialties than BHFT, and referrals are made to DTHFT from BHFT in some sub-specialty services which are not available at BHFT within specialties such as ENT, Ophthalmology and Trauma and Orthopaedics. However, the Parties still overlap in these specialties to a significant extent, as indicated by the referral data, which suggests that they are competing. Therefore, the CMA believes

⁸⁷ According to the Parties, DTHFT has failed to meet the 92% target for 18 weeks of referral in the following specialties: ENT, general surgery, [REDACTED], neurology, [REDACTED], orthopaedics, urology and [REDACTED]. The specialties failing the bed-occupancy rates are [REDACTED].

that while these factors do not remove competition, this differentiation may reduce the magnitude of the SLC and any adverse effects arising from it.

Limitations on patient choice

202. For a number of the specialties where the CMA found competition concerns, the Parties submitted that a significant part of the specialty is not amenable to patient choice, either because choice is limited in general or because the Parties do not offer the same services. In most specialties, the CMA found that the SLC does not extend across all settings (IP, DC and OP) – see Annex 1. In some specialties, the CMA also found that, even within a setting, choice is not relevant to a substantial proportion of patients, including in Breast Surgery, Dietetics, Endocrinology / Diabetics, Geriatric Medicine, Orthodontics, Orthotics, Paediatrics and Physiotherapy.
203. The CMA believes that the lack of patient choice in some specialties limits the scale of the adverse effects arising from the SLC as either incentives are affected to a lesser degree or the number of patients affected is smaller. Therefore, when considering how many patients and how much revenue are associated with an SLC, to include all patients and revenue from those specialties would overstate the scale of its adverse effects.

Ability and incentive to respond to an SLC at an individual specialty level

204. Some determinants of quality are set at a wider than elective speciality setting. The Parties' incentives to change the determinants of quality that are set at a wider than elective specialty setting will depend on the importance of the services with SLCs relative to those areas where the competitive constraints have not significantly changed.
205. The Parties submitted that 1% and 26% of tariff revenues at DTHFT and BHFT, respectively, are from the specialties and settings where the CMA found an SLC (although this will overstate the scale of the SLC due to the factors explained in paragraph 202). The CMA believes that these relative volumes indicate a limited impact on the Parties' incentives to not improve aspects of quality set at a wider level as a result of the SLC, and therefore suggest that the magnitude of the SLC and any adverse effects arising from it will be limited.

Conclusion on the nature of the SLC and its adverse effects

206. The CMA believes that the scale of any adverse effects arising from the SLCs identified is likely to be small as the specialties concerned represent only a small proportion of the combined trust's patient numbers and revenues. In

addition, the scale of the adverse effects is limited by a number of factors, including: (i) the nature of competition between NHS FTs and regulation in general, and (ii) factors specific to the Parties, including in particular the asymmetric constraint, their significant capacity constraints, differentiation between the Parties and limitations on patient choice.

Conclusion on the weighing up of the SLC and the RCBs

207. The CMA has found a realistic prospect that the Merger may be expected to result in an SLC in 18 elective specialties. However, the CMA believes that any adverse effects resulting from this SLC are likely to be limited.
208. The CMA has found substantial RCBs relating to the health and wellbeing of patients that are likely arise from the Merger. The CMA believes that these benefits will deliver a substantial improvement in patient care in the LHE.

Conclusion on the application of the RCB exception

209. Taking all the above factors into consideration, the CMA believes that the RCBs in relation to the creation of the relevant merger situation outweigh the SLC and any adverse effects of the SLC. As such, the CMA believes that it is appropriate for it to exercise its discretion to apply the RCB exception.

Decision

210. Consequently, the CMA believes that it is or may be the case that (i) arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation; and (ii) the creation of that situation may be expected to result in an SLC within a market or markets in the UK. However, pursuant to section 33(2)(c) of the Act, the CMA believes that the RCBs brought about by the Merger outweigh the SLC and any adverse effects of the SLC concerned.
211. The Merger will therefore **not be referred** under section 33 of the Act.

Sheldon Mills
Senior Director, Mergers
Competition and Markets Authority
15 March 2018

ANNEX 1 – TABLE OF ELECTIVE SPECIALTIES THAT FAILED FILTERS

	Elective Specialty	Referral %						Number of referrals (FYs 14/15 & 15/16)						SLC	
		BHFT anchor			DTHFT anchor			BHFT anchor			DTHFT anchor				
		OP	IP	DC	OP	IP	DC	OP	IP	DC	OP	IP	DC		
1	Chemical pathology				91*						294				N
2	Clinical haematology		44	59					184	4841					N
3	Nephrology	46						356							N
4	Medical oncology			82			58*			7889			16177		N
5	Occupational therapy	70						175							N
6	Stroke/TIA	44						609							N
7	Breast surgery	55						1450							Y
8	Dietetics	57*			42*			250			145				Y
9	Endocrinology/ Diabetics	41						1406							Y
10	Geriatric medicine	47*						428							Y
11	Orthodontics	45						945							Y
12	Orthotics	52						1503							Y
13	Paediatrics			66						292					Y
14	Physiotherapy	84			48*			4329			13960				Y
15	ENT		40	42*					579	2247					Y
16	Gastroenterology /Hepatology	50	68	45				3339	148	6312					Y
17	General surgery	54	58	53				13006	1944	9539					Y
18	Gynaecology	43	59					10847	985						Y
19	Maternity		44						14175						Y
20	Ophthalmology			45						5762					Y
21	Oral/Maxillofacial surgery	54		59				3696		372					Y
22	Rheumatology	53		59			44*	2110		2468			3536		Y
23	Trauma & Orthopaedics	52	47	55				9415	1910	3979					Y
24	Urology	40	55					6266	1146						Y

* These figures are from the CMA's referral analysis. In the Parties' referral analysis these settings did not fail the filters. All other figures are from the Parties' referral analysis.

ANNEX 2 – REVENUE AND PATIENTS AFFECTED IN THE ELECTIVE SPECIALTIES WHERE THE CMA FOUND A REALISTIC PROSPECT OF AN SLC

Specialty	Elective Revenue £000s (FY 16/17)	Total unique elective patients (FY 16/17)
1. Breast surgery	BHFT: [REDACTED]	BHFT: [REDACTED]
2. Dietetics	BHFT: [REDACTED] DTHFT: [REDACTED]	BHFT: [REDACTED] DTHFT: [REDACTED]
3. Endocrinology / Diabetics	BHFT: [REDACTED]	BHFT: [REDACTED]
4. ENT	BHFT: [REDACTED]	BHFT: [REDACTED]
5. Gastroenterology / Hepatology	BHFT: [REDACTED]	BHFT: [REDACTED]
6. General surgery	BHFT: [REDACTED]	BHFT: [REDACTED]
7. Geriatric medicine	BHFT: [REDACTED]	BHFT: [REDACTED]
8. Gynaecology	BHFT: [REDACTED]	BHFT: [REDACTED]
9. Maternity	BHFT: [REDACTED]	BHFT: [REDACTED]
10. Ophthalmology	BHFT: [REDACTED]	BHFT: [REDACTED]
11. Oral / Maxillofacial surgery	BHFT: [REDACTED]	BHFT: [REDACTED]
12. Orthodontics	BHFT: [REDACTED]	BHFT: [REDACTED]
13. Orthotics	BHFT: [REDACTED]	BHFT: [REDACTED]
14. Paediatrics	BHFT: [REDACTED]	BHFT: [REDACTED]
15. Physiotherapy	BHFT: [REDACTED] DTHFT: [REDACTED]	BHFT: [REDACTED] DTHFT: [REDACTED]
16. Rheumatology	BHFT: [REDACTED] DTHFT: [REDACTED]	BHFT: [REDACTED] DTHFT: [REDACTED]
17. Trauma & Orthopaedics	BHFT: [REDACTED]	BHFT: [REDACTED]
18. Urology	BHFT: [REDACTED]	BHFT: [REDACTED]
Total SLC specialties	[REDACTED]	[REDACTED]

Source: Information provided by the Parties. Only includes revenues and patients in the settings where an SLC was identified.

ANNEX 3 – DETAILED ANALYSIS OF THE PROPOSED RCBs

1. This Annex is structured as follows:
 - (a) The CMA first summarises the nature and scale of each proposed RCB.
 - (b) The CMA then considers whether the proposed RCB would improve outcomes for patients and/or commissioners, whether it may be expected to accrue within a reasonable period from the Merger and whether it is unlikely to accrue without the Merger (or a similar lessening of competition).
 - (c) Finally, the CMA concludes whether each proposed RCB is an RCB within the meaning of section 30 of the Act.

Cross-cutting RCBs

Workforce improvements

Proposed RCB

2. The Parties told the CMA that BHFT faced significant difficulties recruiting a sustainable clinical workforce due its relatively small size. They said that BHFT's persistent clinical staff shortages, coupled with the high use of locum and agency staff, had led to significant gaps in medical leadership and engagement, which directly influenced clinical standards.
3. The Parties said that the Merger will create a larger organisation, which will be more attractive to medical staff due to the increased opportunity to sub-specialise and more flexible rotas. The Parties said that DTHFT's teaching hospital status, offering the opportunity to participate in research trials and provide more cutting-edge services to patients, will further improve staff recruitment and retention. The Parties submitted that these changes will benefit patients as a larger, more resilient and better engaged workforce will lead to higher quality care.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

4. NHSI advised the CMA that the Merger was likely to lead to workforce improvements, including better recruitment, staff retention and improved morale, which would lead to better quality of care for patients.
5. NHSI advised the CMA that the merged trust would be able to recruit on a trust-wide basis, which would help to address the challenges faced by BHFT

as a result of its size and reputation. NHSI advised the CMA that the larger combined workforce was likely to provide patients with greater access to sub-specialists, and provide medical staff with the ability to sub-specialise and work on a reasonable frequency on-call rota, as well as teach and participate in research.

6. NHSI advised the CMA that the Merger was likely to improve staff engagement and morale, mostly due to DTHFT's achievements in this area,⁸⁸ which could positively impact patient care and the patient experience, and may lead to greater service improvement and innovation.
7. The CMA believes that the Merger is likely to help address BHFT's staff recruitment and retention issues, as the ability of the Parties to recruit on a trust-wide basis will eliminate the problems caused by BHFT's size. The CMA believes that this will improve the sustainability of services provided by BHFT, which will improve patient access to services and improve patient outcomes.
8. The CMA believes that the Merger could also drive improved staff engagement and morale across the merged trust, which in turn will improve patient access to the services provided by the merged trust, as well as the quality of those services. The CMA notes that the benefits to DTHFT patients are less clearly identifiable, as DTHFT does not currently face the scale of workforce issues experienced by BHFT.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

9. The Parties told the CMA that, following the Merger, they would rationalise vacancy lists and look to increase recruitment for vacant positions. The Parties told the CMA that developing an aligned culture across the merged trust would be key to delivering the proposed improvements and would underpin all other clinical and organisational changes.
10. NHSI advised the CMA that, following the Merger, the workforce would be shared across the merged trust and, therefore, the current recruitment challenges experienced by BHFT, as well as the reliance on agency staff and locums, would be immediately reduced.
11. NHSI advised the CMA that it would take longer to achieve full clinical integration of departments and clinical teams across the merged trust, including agreements about rotas and sub-specialisation, to create one

⁸⁸ DTHFT's organisational development programme and staff award scheme has been recognised by the CQC. DTHFT is also in the top 20% of acute trusts for staff engagement, whereas BHFT is close to the national average.

organisational culture and purpose, which would ultimately lead to improved staff morale and engagement.

12. NHSI advised the CMA that the Parties were likely to deliver the proposed workforce improvements within a reasonable time following the Merger, because they had the relevant plans in place and had already begun the process for integration.⁸⁹
13. The CMA believes that, due to the planning work undertaken to date, the Parties are well placed to deliver the proposed workforce improvements within a reasonable period following the Merger. The CMA believes that there are a number of additional considerations which support the Parties' plans for post-Merger integration and the realisation of benefits, as outlined in paragraphs 146 to 160 of the decision.

Is the proposed RCB unlikely to accrue without the Merger?

14. The Parties told the CMA that even if BHFT had access to the necessary finances, its ability to attract high calibre clinicians and clinical leaders would not be achievable as a standalone organisation.
15. NHSI advised the CMA that the workforce improvements were unlikely to be achieved without the Merger as BHFT's recruitment challenges were longstanding and BHFT had made repeated attempts to address them without success due to BHFT's limited ability to provide staff with opportunities for sub-specialisation and greater flexibility in relation to rotas.
16. NHSI advised the CMA that, in the absence of the Merger, BHFT could not meaningfully address its workforce issues by recruiting to joint posts with other trusts as this would not be a likely solution for such large numbers of vacancies and would be complex to administer.
17. The CMA believes that the pooling of staff across the merged trust, which is only likely to be achieved through the Merger, is necessary to address the workforce challenges at BHFT.
18. The CMA believes that there are a number of other considerations relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest

⁸⁹ For example, clinical teams from both trusts had already worked together to identify opportunities for improvement and develop plans for the Merger, and the Parties had already conducted an assessment of cultural differences across the two trusts, which would inform the development of their staff programmes and initiatives going forward.

that achieving the proposed benefits without the Merger would be unlikely, as outlined in paragraphs 161 to 174 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

19. The CMA believes that the proposed workforce improvements is an RCB. The proposed improvements are likely to improve outcomes for BHFT patients, may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Clinical services RCBs

Cardiology

Proposed RCB

20. Cardiology is a branch of medicine concerned with the diagnosis, assessment and treatment of patients with diseases and defects of the cardiovascular system.
21. The Parties told the CMA that BHFT's cardiology department faced challenges in relation to clinical sustainability, as some core secondary care services were not provided due to a lack of critical mass of patients and an insufficient number of interventional cardiology consultants, and that BHFT also faced challenges in delivering national clinical best practice due to a lack of medical staff.
22. The Parties said that the Merger will enable the merged trust to implement a single Cardiology service model with consultant cover across all sites, and this will enable BHFT to provide a service that is both safe and of high quality. In particular, the Parties said that the reconfiguration of Cardiology will result in the following patients benefits:
 - (a) The replacement of exercise tolerance tests with computer tomography coronary angiography (CTCA) imaging,⁹⁰ as a first line diagnostic tool to determine whether patients need more invasive cardiac diagnostic and treatment procedures to replace for patients with stable chest pain, will

⁹⁰ CTCA is an imaging test that examines the arteries that supply blood to the heart.

result in more accurate diagnosis and fewer invasive coronary angiographies.⁹¹

- (b) Patients requiring Percutaneous Coronary Intervention (PCI)⁹² will be treated at BHFT, rather than being transferred to another provider, eliminating the need for two separate invasive procedures and the inconvenience of being transferred to another trust for further diagnostics.
- (c) BHFT patients requiring complex pacing devices will be treated at DTHFT, reducing travel times and enabling the patient to be treated closer to home.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

23. NHSI advised the CMA that:

- (a) the Parties' plans to use CTCAs would result in 790 BHFT patients each year receiving more accurate diagnostics in line with national guidance, leading to fewer patients (220 to 260 patients each year) requiring an unnecessary invasive coronary angiography;
- (b) the treatment of 270 BHFT patients requiring PCI at BHFT each year would result in a better experience, as they would no longer be required to travel to another provider for the procedure and they would also avoid the risk and discomfort of having a second invasive procedure;ⁱⁱ and
- (c) the treatment of 30 to 40 BHFT patients requiring complex pacing devices at DTHFT each year would reduce travel times.

24. The CMA believes that the proposed reconfiguration of Cardiology will benefit patients in the form of improved diagnosis, a reduction in invasive procedures and improved experience and access to Cardiology services.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

25. The Parties told the CMA that they planned to implement their proposals for Cardiology within one year following the Merger, and that post-Merger implementation would include the recruitment of an additional radiologist to

⁹¹ Coronary angiography is an invasive procedure, which uses a thin flexible tube, called a catheter, inserted into an artery through an incision in the groin, wrist or arm.

⁹² PCI is the use of a catheter to insert a balloon to stretch open the artery (called an angioplasty) and a wire mesh tube (stent) to hold it open permanently. When undertaken at the same time as coronary angiography, it uses the same catheter and means only one incision is required.

report CTCAs, the creation of a combined rota across the merged trust, and the accreditation of BHFT to perform PCI.⁹³

26. NHSI advised the CMA that, based on the planning and implementation work it had seen so far, the proposed improvements in Cardiology were likely to be delivered within a reasonable timeframe, because:
- (a) NHSI was confident that the merged trust would be capable of recruiting an additional radiologist, given DTHFT's high performing Radiology service;
 - (b) the merged trust was likely to achieve BCIS accreditation, as it would have the required patient volumes and interventional cardiologists, and DTHFT had previously successfully navigated the process to gain accreditation;
 - (c) the Parties were undertaking demand and capacity analysis and modelling across both trusts to accommodate the changes to diagnostics, PCI provision and complex devices provision, and they expected to complete this work prior to the Merger.
27. The CMA believes that, due to the planning work undertaken to date, the Parties are well placed to deliver the proposed reconfiguration of Cardiology within a reasonable period following the Merger. The CMA believes that there are a number of additional considerations which support the Parties' plans for post-Merger integration and the realisation of these benefits, as outlined in paragraphs 146 to 160 of the decision.

Is the proposed RCB unlikely to accrue without the Merger?

28. The Parties told the CMA that the reconfiguration of Cardiology services would not be feasible without the Merger as implementing best practice for the assessment and diagnosis of rapid onset chest pain at BHFT would not be possible due to a lack of radiologists. The Parties said that DTHFT was already planning to recruit a radiologist and that this individual, along with DTHFT's existing imaging cardiologists, could serve the merged trust.
29. The Parties also told the CMA that BHFT could not achieve or maintain the accreditation necessary to perform PCI without collaboration with another trust due its lack of lack of interventional cardiologists and the size of its

⁹³ The British Cardiovascular Intervention Society (BCIS) promotes education, training and research in cardiovascular intervention and develops and upholds clinical and professional standards. All hospitals wishing to start a new PCI programme are required to apply to the BCIS for accreditation. BHFT does not currently meet BCIS requirements, as it has insufficient patient volumes and insufficient interventional cardiologists to deliver a sustainable out-of-hours rota.

patient catchment population, and that, while in principle collaboration rather than a merger was feasible, BHFT had identified this need approximately 18 months ago and had made no progress in reaching any such agreement.

30. NHSI advised the CMA that BHFT would not be able to offer CTCA in the absence of the Merger as the improvements in diagnostics were dependent on the recruitment of a reporting radiologist, and BHFT had longstanding problems in recruiting radiologists.
31. NHSI advised the CMA that the provision of PCI at BHFT was dependent on gaining BCIS accreditation, and that BHFT did not meet the required minimum patient volumes or number of interventional cardiologists to achieve accreditation, but that the Merger provided the combined patient volumes and staffing required to meet BCIS standards.
32. NHSI advised the CMA that the provision of complex devices for BHFT patients at DTHFT was unlikely to happen absent the Merger as the Merger would make it easier to change the current pathways so that patients were able to attend the DTHFT site.
33. The CMA believes that the Merger is necessary to ensure the proposed reconfiguration of Cardiology as the combined patient volumes and staff, as well as the expertise and reputation of BHFT, is required to implement the proposed changes to diagnostics, PCI provision and complex devices provision.
34. The CMA believes that there are a number of other considerations relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that achieving the proposed benefits without the Merger would be unlikely, as outlined in paragraphs 161 to 174 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

35. The CMA believes that the proposed reconfiguration of Cardiology is an RCB. The proposed improvements are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Trauma and Orthopaedics

Proposed RCB

36. Trauma and Orthopaedics involves the diagnosis and treatment of a wide range of conditions associated with the musculoskeletal system.

37. The Parties both provide elective and non-elective Trauma and Orthopaedics services. The Parties told the CMA that although DTHFT provided a high-quality service, it faced capacity challenges in relation to orthopaedic surgery, and that although BHFT provided generally good quality care in core elective services, it faced a number of challenges in relation to Trauma services.⁹⁴
38. The Parties said that the Merger will enable them to create a larger Trauma and Orthopaedics service across the merged trust, improving the efficiency, productivity and quality of patient care as follows:
- (a) Non-elective and elective patients currently treated at BHFT will receive improved quality of care in a dedicated Trauma setting at DTHFT.
 - (b) DC patients currently treated at both DTHFT and BFHT will receive treatment at BHFT and at community hospitals in dedicated DC facilities, resulting in reduced cancellation rates for operations, guaranteed admission for operations and improved quality of care.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

39. NHSI advised the CMA that the proposed reconfiguration of Trauma and Orthopaedics would result in the following improvements for patients:
- (a) The centralisation of Trauma services at DTHFT would likely result in improved outcomes for 1,000 BHFT non-elective patients requiring routine Trauma surgery and overnight stay each year, particularly those patients with fractured neck of femur (ie hip fracture),⁹⁵ who would also benefit from improved access to subspecialist surgeons and consultant orthogeriatricians.⁹⁶
 - (b) The centralisation of elective IP surgery at DTHFT would likely improve outcomes and reduce waiting times for 700 BHFT patients each year as the combined consultant rota across the merged trust would provide surgeons with greater opportunity to subspecialise, and there was evidence to suggest that DTHFT was more efficient than BHFT in its utilisation of theatres.
 - (c) The consolidation of elective DC surgery at BHFT would improve outcomes and reduce waiting times, cancellations and the risk of infection

⁹⁴ Unlike DTHFT, BHFT is not a Trauma unit and, as a designated local emergency hospital, it provides surgery for only routine traumatic injuries, such as fractured neck of femur.

⁹⁵ DTHFT's Trauma unit performs better than BHFT on several quality measures for fractured neck of femur patients. For example, in 2016, DTHFT met all the criteria for the best practice tariff for [70-80]% of patients, compared to [50-60]% of BHFT patients.

⁹⁶ Orthogeriatricians specialise in the care of elderly orthopaedic patients.

for 3,225 patients currently treated at DTHFT each year as it would offer these patients some protection from elective IP and non-elective patient flows, and BHFT would adopt DTHFT's enhanced recovery programme to aid patient recovery.

40. NHSI advised the CMA that these improvements would outweigh any increased travel time for those patients who would be required to travel further following the Merger.⁹⁷
41. The CMA believes that the proposed reconfiguration of Trauma and Orthopaedics will benefit patients in the form of improved outcomes and reduced waiting times and cancellations.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

42. The Parties told the CMA that:
 - (a) work had already commenced to develop the timeline for the implementation of the proposed service model, including robust demand and capacity modelling;
 - (b) commissioners were supportive of the planned reconfiguration; and
 - (c) benefits to Trauma and DC patients would be realised within two years following the Merger, and that benefits to elective patients would be realised in the third year following the Merger.
43. NHSI advised the CMA that the key challenges in delivering the proposed reconfiguration of Trauma and Orthopaedics would be ensuring that both BHFT and DTHFT had sufficient bed and theatre capacity to take on DC patients and IP respectively, and that DTHFT would be able to maintain separate non-elective and elective patient flows.
44. NHSI advised the CMA that the Parties had developed sufficient plans at this stage to demonstrate how they would address these challenges and deliver the improvements within a reasonable time.
45. The CMA believes that, due to the planning work undertaken to date, the Parties are well placed to deliver the proposed reconfiguration of Trauma and Orthopaedics within a reasonable period following the Merger. The CMA believes that there are a number of additional considerations which support

⁹⁷ The impact of the reconfiguration on travel times is approximately 15 minutes due to the proximity of the trusts.

the Parties' plans for post-Merger integration and the realisation of these benefits, as outlined in paragraphs 146 to 160 of the decision.

Is the proposed RCB unlikely to accrue without the Merger?

46. The Parties told the CMA that the reconfiguration of Trauma and Orthopaedics would not be possible without the Merger, as the changes required utilisation of capacity across the merged trust, and any other form of collaboration would be more limited in scope and would deliver fewer benefits for patients.
47. The Parties also told the CMA that any concerns in relation to the potential loss of income due to the transfer of patients from BHFT to DTFHT, evidenced by previous attempts to arrange for DFTHFT consultants to operate at BHFT sites, would be eliminated under the one organisational structure created by the Merger.
48. NHSI advised the CMA that the proposed improvements were unlikely to accrue without the Merger as, due to the small size of its Trauma and Orthopaedics service, BHFT was unlikely to achieve the improved outcomes for its patients as a standalone organisation due to it being unable to offer patients the required level of sub-specialisation and access to a dedicated Trauma unit.
49. NHSI advised the CMA that, although DTHFT could possibly reconfigure its services (to separate DC services and elective IP surgery), the Merger would make this easier as BHFT had a dedicated DC facility, thus enabling DTHFT to free-up capacity for elective and non-elective activity.
50. NHSI advised the CMA that the multiple service, staff and estate changes required to implement the proposal would likely be too complex to successfully deliver without the Merger, and the implementation of such changes through a looser form of collaboration would be less likely to realise the accountability and single leadership necessary to set the strategic direction, improve efficiencies and patient outcomes.
51. The CMA believes that the Merger is necessary to ensure the proposed reconfiguration of Trauma and Orthopaedics as the Merger provides for the most efficient remodelling of capacity across the merged trusts to optimise the services to be provided to elective, non-elective and DC patients.
52. The CMA believes that there are a number of other considerations relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that achieving the proposed benefits without the Merger would be unlikely, as outlined in paragraphs 161 to 174 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

53. The CMA believes that the proposed reconfiguration of Trauma and Orthopaedics is an RCB. The proposed improvements are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Renal Medicine

Proposed RCB

54. Renal Medicine (ie nephrology) involves the diagnosis and treatment of diseases of the kidney.
55. The Parties told the CMA that DTHFT offered a full Renal Medicine service through its Renal Medicine unit but that BHFT did not currently have a Renal Medicine unit as it did not have sufficient patient volumes to offer a sustainable service. Therefore, BHFT patients were either transferred to DTHFT or (if not well enough to be transferred) were treated at BHFT's intensive care unit.
56. The Parties said that the Merger will enable the implementation of a single Renal Medicine service across the merged trust, resulting in the following patient benefits:
- (a) Timely diagnosis and treatment of Acute Kidney Injury (AKI) at BHFT,⁹⁸ resulting in reduced length of stay and improved mortality for BHFT patients.
 - (b) Improved treatment and reduced length of stay for diagnosed AKI patients at BHFT, through the introduction of on-site nephrologist care, sharing electronic data across sites, and adopting the processes currently in place at DTHFT, resulting in reduced length of stay.
 - (c) An increase in home dialysis rates as the merged trust will take over the management of the Lichfield dialysis clinic,⁹⁹ bringing with it the significant expertise of the current DTHFT Renal Medicine unit, resulting in improved quality of life and greater independence for dialysis patients.

⁹⁸ AKI is sudden damage to the kidneys that causes them to not function properly. It can range from minor loss of kidney function to complete kidney failure.

⁹⁹ The dialysis service at the Lichfield clinic is staffed by BHFT nurses and clinical support staff, but twice weekly consultant sessions are provided by Heart of England NHS Foundation Trust (HEFT) under an SLA.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

57. NHSI advised the CMA that the proposed reconfiguration of Renal Medicine would likely result in improvements for AKI patients treated at BHFT and dialysis patients at BHFT's Lichfield clinic.
58. NHSI advised the CMA that the implementation of NHSE's AKI algorithm¹⁰⁰ at BHFT, through the replacement of BHFT's current paper system with DTHFT's AKI-CB,¹⁰¹ would likely result in more timely diagnosis and appropriate treatment of AKI, in turn leading to a reduced progression of AKI, improved morbidity,¹⁰² improved mortality¹⁰³ and reduced length of stay.¹⁰⁴
59. NHSI advised the CMA that, in addition to the implementation of the AKI algorithm at BHFT, the presence of a consultant nephrologist onsite at BHFT twice a week, increased availability of the formal on-call service and the ability of DTHFT's consultant nephrologists to view BHFT patient records and test results (as a result of having compatible IT systems) would all contribute to improvements to the timeliness and accuracy of diagnosis and the quality of care provided to AKI patients at BHFT.
60. NHSI advised the CMA that the proposed improvements for AKI patients would likely benefit 2,000 BHFT patients each year, including 1,200 patients who were not currently diagnosed as having AKI.ⁱⁱⁱ
61. NHSI advised the CMA that the proposal to bring the Lichfield dialysis service back into the merged trust would likely increase rates of home haemodialysis and permanent vascular access,¹⁰⁵ which in turn would likely reduce travel time and improve quality of life.
62. NHSI advised the CMA that the Parties' proposal to increase home haemodialysis use would enable five patients to commence home dialysis, and that, in the longer term, NHSI expected home haemodialysis rates to improve further up to the levels seen at DTHFT (ie up to 20% of patients).

¹⁰⁰ NHS England's AKI algorithm is best practice for the diagnosis and treatment of AKI. The algorithm identifies whether a patient should be considered to have AKI, and if so, what stage of AKI.

¹⁰¹ DTHFT's AKI-CB is an electronic clinical decision support system used to diagnose and treat AKI patients in accordance with NHS England's AKI algorithm

¹⁰² NHSI advised the CMA that evidence provided by the Parties confirmed that completing the AKI-CB would reduce the deterioration in the condition of AKI patients.

¹⁰³ NHSI advised the CMA that it expected mortality rates for AKI patients at BHFT to reduce significantly to the levels observed at DTHFT, which had the potential to benefit as many as 138 patients each year.

¹⁰⁴ NHSI advised the CMA that length of stay could potentially be reduced by up to 3.4 days from 14.5 days to 11.8 days.

¹⁰⁵ Permanent vascular access involves an insertion of a dialysis route that can be re-used for each dialysis treatment. By contrast, without permanent access, patients typically have a plastic catheter inserted at each dialysis treatment, which typically occurs three times a week.

63. The CMA believes that the proposed reconfiguration of Renal Medicine will benefit Renal Medicine patients in the form of reduced mortality, reduced morbidity, reduced length of stay and improved quality of life.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

64. The Parties told the CMA that, in relation to IP services, they had already commenced the work to establish how sufficient capacity among DTHFT's consultant nephrologists would be ensured to enable them to provide services at BHFT. The Parties told the CMA that the provision of Renal Medicine at BHFT would require the recruitment of an additional consultant, but that this was not expected to be difficult given the strong reputation of DTHFT's Renal Medicine service.
65. The Parties told the CMA that the implementation of AKI-CB at BHFT was part of the wider planned IT changes to be implemented following the Merger and that these changes were a central part of post-Merger integration, which had already been scoped, costed and planned.
66. The Parties told the CMA that the planning of the Lichfield dialysis service would begin immediately following the Merger and that the merged trust would discuss the potential changes with HEFT and review the current service delivered, as well as engaging with staff, commissioners and the local community. The Parties told the CMA that they expected to terminate the contract with HEFT and establish the new service in the second year following the Merger.
67. NHSI advised the CMA that the proposed improvements for AKI patients at BHFT and dialysis patients at Lichfield were likely to be achieved within a reasonable timeframe as the Parties had already started to implement the plans to provide an on-site consultant presence at BHFT, and that this support would be provided in advance of the Merger from February 2018. NHSI advised the CMA that it was satisfied that the Parties would be able to recruit an additional consultant within a reasonable timeframe to realise the improvements for Renal Medicine patients at BHFT.
68. NHSI advised the CMA that the Parties were well placed to implement AKI-CB and achieve improvements for BHFT patients within a reasonable time given DTHFT's success in implementing and embedding AKI-CB at DTHFT.
69. The CMA believes that due to the planning work undertaken to date and the strong reputation and track record of DTHFT's Renal Medicine, the Parties

are well placed to deliver the proposed reconfiguration of Renal Medicine within a reasonable period following the Merger.

70. The CMA believes that there are a number of additional considerations which support the Parties' plans for post-Merger integration and the realisation of these benefits, as outlined in paragraphs 146 to 160 of the decision.

Is the proposed RCB unlikely to accrue without the Merger?

71. The Parties told the CMA that the proposed reconfiguration of Renal Medicine could not be delivered without the Merger as the Merger would provide the nephrology team with clinical ownership of Renal Medicine at BHFT, which would enable it to develop its vision to improve services and drive clinical excellence in a cost-effective manner.
72. The Parties told the CMA that the adoption of AKI-CB at BHFT would be unlikely without the Merger due to the lack of nephrology staff who would raise awareness or champion the system among non-nephrologists, and the Merger would enable the nephrology team within the merged trust to provide the information and training needed for clinicians to understand and incorporate the AKI algorithm and AKI-CB.
73. The Parties told the CMA that, in the absence of the Merger, DTHFT would be unlikely to provide AKI inpatient care for BHFT patients due to a shortage of available consultants at DTHFT and the lack of a financial incentive to provide the service, as evidenced by the Parties' previous unsuccessful attempts to work together in Renal Medicine.
74. The Parties told the CMA that DTHFT had a highly-regarded Renal Medicine service and the highest rate of home dialysis in England, but that it was unlikely to support BHFT's Lichfield dialysis clinic in the absence of the Merger, as evidenced by previous unsuccessful collaboration attempts between BHFT and DTHFT concerning dialysis. The Parties told the CMA that continuing with the current SLA with HEFT would not lead to the same patient outcomes as the Merger, as HEFT had a lower home dialysis rate than DTHFT (12% compared with 40% respectively), as well as a lower rate of vascular access and higher infection rate.
75. NHSI advised the CMA that the proposed improvements for AKI and dialysis patients were unlikely to accrue without Merger as it was unlikely that the implementation of AKI-CB, which was critical to the delivery of the improvements for AKI patients, would be adopted by BHFT without the support of DTHFT consultants to champion the use of the AKI algorithm through the electronic system.

76. NHSI advised the CMA that, in the absence of the Merger, DTHFT would have limited incentives to recruit the additional consultant that would be required to provide support to the Lichfield dialysis service and, instead, BHFT would likely extend the SLA with HEFT, which would result in the continuation of low rates for haemodialysis and permanent vascular access.^{iv}
77. The CMA believes that the Merger is necessary to ensure the proposed reconfiguration of Renal Medicine as the support and expertise of DTHFT consultants, which is predicated on the Merger, is fundamental to the adoption of AKI-CB at BHFT and the improvement in the home dialysis services at Lichfield.
78. The CMA believes that there are a number of other considerations relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that achieving the proposed benefits without the Merger would be unlikely, as outlined in paragraphs 161 to 174 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

79. The CMA believes that proposed reconfiguration of Renal Medicine is an RCB. The proposed improvements are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Stroke

Proposed RCB

80. A stroke is a serious condition that occurs when the blood supply to part of the brain is suddenly cut off, depriving the brain cells of oxygen.
81. The Parties told the CMA that both BHFT and DTHFT provided Stroke services but BHFT did not meet a number of national standards in relation to Stroke care, did not meet the minimum recommended volume of patients to be clinically effective,¹⁰⁶ and was unable to provide a seven-day service.

¹⁰⁶ The Sentinel Stroke National Audit Programme (SSNAP) recommends the treatment of 600 to 1,500 patients each year. BHFT admitted fewer than 400 Stroke patients in 2016/17.

82. The Parties told the CMA that hyper-acute Stroke services¹⁰⁷ at BHFT were at risk of being decommissioned, although commissioners had not to date identified a long-term solution for BHFT's patient population.
83. The Parties said that the Merger will enable the centralisation of hyper-acute Stroke services at DTHFT's hyper-acute stroke unit (HASU) and the provision of a seven-day service for patients across the merged trust, including the provision of Transient Ischemic Attack (TIA)¹⁰⁸ clinics at weekends, which will result in the following benefits:
- (a) Reduced mortality, improved quality of life and reduced length of stay for BHFT's hyper-acute Stroke patients, as these patients will have access to a designated HASU at DTHFT and will receive care in line with national clinical guidelines.
 - (b) Reduced risk of stroke and improved quality of life for BHFT's TIA patients, as these patients will receive care in line with national clinical guidelines.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

84. NHSI advised the CMA that the centralisation of hyper-acute Stroke services at DTHFT's HASU was likely to result in reduced mortality, improved outcomes and reduced risk of complications for 400 BHFT patients each year.
85. NHSI advised the CMA that:
- (a) in 2016, BHFT had a higher mortality rate for Stroke patients than DTHFT, which suggested that the mortality rate for BHFT patients would reduce once these patients were treated at DTHFT's HASU;
 - (b) there was evidence to suggest that centralised systems which admitted Stroke patients to hyper-acute units were significantly more likely to provide evidence-based clinical interventions;
 - (c) following the Merger, both BHFT and DTHFT patients would have improved access to Stroke-trained speech and language therapists, which was likely to lead to more timely assessments of patients with swallowing

¹⁰⁷ The Stroke pathway is organised along a three-stage pathway: hyper-acute, acute and rehabilitation. The hyper-acute stage refers to the first 72 hours following the onset of stroke symptoms, where time critical assessment, diagnostic imaging and treatments are undertaken.

¹⁰⁸ A TIA or mini-stroke is caused by a brief interruption in blood supply to a particular area of the brain, followed by a complete resolution of symptoms within 24 hours. A TIA is often an important warning sign of a more serious stroke, heart attack or other vascular event.

issues (dysphagia), which could reduce complications, such as stroke-associated pneumonia (SAP).

86. NHSI advised the CMA that as complications, such as SAP, may increase length of stay, reducing complications should contribute to a reduction in length of stay for some patients. It added that a reduction in length of stay for all hyper-acute Stroke patients would depend on the effective operation of DTHFT's Early Supportive Discharge service at BHFT (see paragraph 92).^v
87. NHSI advised the CMA that the provision of weekend access to TIA clinics for 70 to 80 BHFT patients each year would mean that these patients were treated within 24 hours (in line with national guidelines), which would reduce the risk of a subsequent stroke.
88. The CMA believes that the reconfiguration of Stroke services will benefit patients in the form of reduced mortality, reduced risk of complications, improved outcomes, and reduced risk of a subsequent stroke following a TIA.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

89. The Parties told the CMA that they intended to complete the centralisation of hyper-acute Stroke services by February 2019 and the single point of referral for TIA patients (with access to weekend clinics for BHFT patients) soon after the Merger.
90. The Parties told the CMA that the key steps for delivering the proposed changes were:
 - (a) obtaining agreement with the ambulance service that Stroke patients in the BHFT catchment area would be brought to DTHFT's HASU;
 - (b) increasing capacity at DTHFT and reconfiguring beds at both DTHFT and BHFT to accommodate the additional BHFT hyper-acute patients at DTHFT;
 - (c) recruiting an additional Stroke consultant (in addition to filling current vacancies at DTHFT);
 - (d) obtaining agreement with commissioners and the community provider to extend DTHFT's Early Supportive Discharge programme to cover BHFT patients attending the HASU following the Merger;
 - (e) reconfiguring rotas to reflect the new arrangements; and

- (f) establishing transitional arrangements until DTHFT's HASU can accommodate BHFT patients.
91. NHSI advised the CMA that the Parties had developed sufficient plans to demonstrate that the proposed reconfiguration of Stroke services was likely to be delivered within a reasonable time following the Merger, and that local commissioners supported the proposed changes.
92. NHSI advised the CMA that the Parties needed to achieve further progress with commissioners and local community services providers to agree plans for extending and improving the efficiency of the Early Supportive Discharge programme for BHFT patients, which would give NHSI greater confidence that length of stay could be reduced due to efficient discharge planning, as well as due to a reduction in complications (see paragraph 86).
93. The CMA believes that, due to the planning work undertaken to date and the support of local commissioners, the Parties are well placed to deliver the proposed reconfiguration of Stroke services within a reasonable period following the Merger.
94. The CMA believes that there are a number of additional considerations which support the Parties' plans for post-Merger integration and the realisation of these benefits, as outlined in paragraphs 146 to 160 of the decision.

Is the proposed RCB unlikely to accrue without the Merger?

95. The Parties told the CMA that, despite the long-standing intention of local commissioners to address the sustainability of hyper-acute Stroke services at BHFT, and the Parties' previous attempts to deliver Stroke services across the two trusts through a partnership, there had been no reconfiguration of Stroke services. The Parties told the CMA that the inability to reconfigure services to date was primarily due to the loss of income associated with a redirection of BHFT patients to DTHFT. They said that the Merger would eliminate any concerns in relation to a loss of income as Stroke services (and corresponding income) would come under the control of the merged trust.
96. The Parties told the CMA that, absent the Merger, commissioners may decide to remove Stroke services from BHFT, but the adverse impact on interdependent services may explain the reluctance of commissioners to take such steps.
97. NHSI advised the CMA that, since 2014, it had been an intention of commissioners to achieve better outcomes for Stroke patients by ensuring that BHFT hyper-acute patients had access to a clinically and financially stable HASU, but no plan had been taken forward to date as BHFT could not

withstand the loss of income arising from the redirection of hyper-acute patients to another provider.

98. NHSI advised the CMA that, given the difficulties that the Parties and commissioners had experience to date, the proposed improvements were unlikely to accrue without the Merger. NHSI advised that BHFT did not have sufficient patient numbers to develop its own clinically and financially stable HASU.
99. The CMA believes that the Merger is necessary to ensure the proposed reconfiguration of Stroke services as the Merger eliminates BHFT's financial concerns in respect of the redirection of hyper-acute BHFT patients to DTHFT, which has undermined previous attempts by the Parties and commissioners to improve services.
100. The CMA believes that there are a number of other considerations relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that achieving the proposed benefits without the Merger would be unlikely, as outlined in paragraphs 161 to 174 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

101. The CMA believes that the proposed reconfiguration of Stroke services is an RCB. The proposed improvements are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Radiology

Proposed RCB

102. Radiology is the use of medical imaging techniques, such as x-ray imaging, ultrasound scanning, magnetic resonance imaging (MRI) scanning and computerised tomography (CT) scanning, to diagnose, treat and manage medical conditions. Radiology services are used to support many other clinical services provided by a hospital and, therefore, are fundamental to successful service delivery.
103. The Parties told the CMA that Radiology services at BHFT were not currently sustainable due to a significant and longstanding shortage of consultant

radiologists, which was the result of difficulties in staff recruitment and retention.¹⁰⁹

104. NHSI advised the CMA that, although the recruitment of radiologists was a national issue,¹¹⁰ BHFT faced particular challenges due to the small size of its Radiology service, which provided limited opportunities for consultants to subspecialise and less flexible rotas.
105. The Parties said that the Merger will stabilise and develop the Radiology service at BHFT as it will result in the creation of a consolidated Radiology department across the merged trust under DTHFT's clinical leadership and management, enabling the merged trust to recruit the necessary additional consultants. The Parties said that the stabilisation of the Radiology service at BHFT will provide the following patient benefits:
- (a) It will prevent BHFT patients from having to travel to other providers to receive treatment, thus reducing travel time, increasing convenience and bringing patients closer to friends, family and carers.
 - (b) An increase in the quality and reliability of imaging reports will result in an increase in the accuracy and timeliness of diagnoses.
 - (c) Reduced waiting times for scans and results will drive reduced time to treatment and potentially reduce unnecessary admissions via Accident and Emergency.
 - (d) An improved patient experience through the efficient planning of convenient appointment times.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

106. NHSI advised the CMA that the proposed reconfiguration of Radiology was likely to benefit a large number of BHFT patients as Radiology was a core part of a hospital's operation and, therefore, it impacted many services and the patients accessing those services. NHSI advised the CMA that in 2016/17, BHFT recorded over 170,000 patient spells.
107. NHSI advised the CMA that at least 6,000 BHFT patients were likely to benefit from the implementation of coupled diagnostics¹¹¹ and zero waits initiatives,¹¹²

¹⁰⁹ Only [20-30]% of consultant posts are substantively filled at BHFT. BHFT and DTHFT recently held a joint recruitment trip to India to recruit radiologists, and [REDACTED].

¹¹⁰ [REDACTED].

¹¹¹ Coupled diagnostics allows patients to schedule follow-up diagnostic and clinical appointments at the end of their initial consultation.

¹¹² Zero waits initiatives allow images to be taken the same day as (or soon after) the initial clinical appointment, or soon after.

which should reduce waiting times for follow up appointments following the initial consultation and the number of patients who do not attend their appointments.

108. NHSI advised the CMA that the stabilisation of Radiology services at BHFT would enable the merged trust to reduce the outsourcing of scans, resulting in financial savings and a reduction in the levels of reporting discrepancies, which can delay diagnoses.
109. The CMA believes that the reconfiguration of Radiology will benefit patients in the form of higher quality and more reliable imaging reporting (leading to more accurate and timely diagnosis), reduced waiting times for scans and results, and more convenient appointment times.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

110. The Parties told the CMA that the reconfiguration of Radiology services would take place over the first two years following the Merger and that this would include:
 - (a) rolling out coupled diagnostics and zero wait times initiatives at BHFT;
 - (b) introducing DTHFT's policies and protocols across the merged trust;
 - (c) securing accreditation from the Imaging Services Accreditation Scheme (ISAS);¹¹³
 - (d) recruiting additional radiologists and increasing the number of trainees from six to 21; and
 - (e) developing a single monitoring system across the merged trust.
111. NHSI advised the CMA that it had reviewed the Parties' implementation plans for the reconfiguration of Radiology and said that these plans demonstrated that the Parties had assessed what was required to bring the two services together. NHSI advised that, given the planning undertaken to date, the strong clinical engagement, and DTHFT's track record in running a high performing Radiology service, the proposed reconfiguration should be delivered in a reasonable timescale.

¹¹³ The ISAS is jointly owned by The Royal College of Radiologists and the Society and College of Radiographers, who have developed the standard in consultation with imaging services across the country. Accreditation to professional standards is supported by the CQC and NHS England.

112. NHSI advised the CMA that the merged trust would be able to recruit the necessary additional radiologists due to Dnot THFT's ISAS accreditation and the ability of radiologists to subspecialise.^{vi}
113. NHSI advised the CMA that the merged trust would be able to reduce its reliance on the outsourcing of scans in a reasonable timescale through the additional planned recruitment and an extension of radiographer reporting at DTHFT.^{vii}
114. The CMA believes that, due to the planning work undertaken to date and the reputation of DTHFT's existing Radiology service, the Parties are well placed to deliver the proposed reconfiguration of Radiology within a reasonable period following the Merger.
115. The CMA believes that there are a number of additional considerations which support the Parties' plans for post-Merger integration and the realisation of these benefits, as outlined in paragraphs 146 to 160 of the decision.

Is the proposed RCB unlikely to accrue without the Merger?

116. The Parties told the CMA that the stabilisation of BHFT's Radiology service was dependent on the expertise, management and governance infrastructure that would be provided by DTHFT's radiologists across the merged trust. The Parties told the CMA that BHFT would be unable to gain ISAS accreditation without the Merger as BHFT was unlikely to meet the criteria, particularly in relation to leadership and management. The Parties told the CMA that, in the absence of the Merger, there would be no reason for DTHFT to support BHFT in the stabilisation and development of its Radiology service.
117. The Parties told the CMA that, although previous attempts to improve the Radiology service at BFHT had been partially successful, the service remained critically understaffed and, in 2013, the Royal College of Radiologists review recommended that BHFT develop closer cooperation with DTHFT. However, the Parties had not managed to successfully work together. The Parties told the CMA that only the Merger would enable the necessary recruitment of additional staff as the merged trust would be able to offer clinicians the opportunity to subspecialise and more flexible rotas.
118. NHSI advised the CMA that the proposed reconfiguration of Radiology was unlikely to happen without the Merger as BHFT would be unable to address its workforce issues as a standalone organisation, particularly given the national shortage of radiologists. NHSI advised that candidates would be more attracted to the Radiology service at BHFT if it was part of larger, high performing service across the merged trust.

119. NHSI advised the CMA that, apart from DTHFT, there was no other trust which could provide BHFT with the necessary support to stabilise and develop its Radiology service, particularly given DTHFT's high performance and innovative improvements, such as its coupled diagnostics and zero waits initiatives.^{viii}
120. NHSI advised the CMA that neither BHFT nor DTHFT could reduce its reliance on the outsourcing of reporting in the absence of the Merger as only the merged trust would have the increased capacity to bring a greater proportion of reporting in house.
121. The CMA believes that the Merger is necessary to ensure the proposed reconfiguration of Radiology at BHFT as the Merger provides BHFT with the management and expertise it requires from DTHFT to stabilise and develop its Radiology service. The Merger also provides BHFT with the necessary scale to successfully recruit additional radiologists and reduce its reliance on the outsourcing of reporting.
122. The CMA believes that there are a number of other considerations relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest that achieving the proposed benefits without the Merger would be unlikely, as outlined in paragraphs 161 to 174 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

123. The CMA believes that the proposed reconfiguration of Radiology is an RCB. The proposed improvements are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

Cancer

Proposed RCB

124. Cancer is a condition where cells in a specific part of the body grow and reproduce uncontrollably. The cancerous cells can invade and destroy surrounding healthy tissue, including organs.
125. The Parties told the CMA that both BHFT and DTHFT were recognised as providers of cancer pathways and treatments but that DTHFT provided a range of diagnostics and treatments for cancer patients, including patients with complex cancers, whereas BHFT provided a more limited range of cancer services.

126. The Parties said that the Merger will enable the merged trust to adopt a single service model for Cancer, which will result in the following patient benefits:
- (a) Patients in BHFT's southern catchment population, who are currently referred to providers other than DTHFT, will be brought into DTHFT's catchment for specialised services, thus reducing the risk of DTHFT losing some of its specialist Cancer services. Consequently, the local population will have ongoing access to a wide range of specialist services at DTHFT rather than needing to travel to hospitals further afield.
 - (b) The adoption of a single service model will eliminate service variation and enable the streamlining of pathways by, for example, eliminating the need for two multi-disciplinary team (MDT) meetings for complex Cancer patients referred from BHFT to DTHFT. This will result in reduced time to treatment, improving patient experience and reducing anxiety.
 - (c) Improved diagnostic accuracy due to the planned reconfiguration of Radiology services (see paragraphs 106 to 123) and by bringing BHFT's Pathology services inhouse to be provided by DTHFT.¹¹⁴
127. The Parties presented case studies on Urology Cancer and Upper Gastrointestinal (GI) Cancer as examples of the benefits that would arise from the Merger.

Is the proposed RCB likely to improve patient and/or commissioner outcomes?

128. NHSI advised the CMA that the proposed changes to Cancer services were likely to represent improvements for patients by smoothing pathways and reducing the time that some patients waited for treatment.
129. NHSI advised the CMA that the Merger would likely enable the Parties to streamline Cancer pathways and reduce waiting times, benefitting 184 patients each year as follows:
- (a) Bringing Pathology services for some BHFT Cancer patients inhouse to DTHFT would likely reduce the time patients must wait for biopsy results, make it more likely that the pathologist who analysed the patient's biopsy was able to attend the MDT meeting to discuss the patient's results, and ensure that DTHFT consultants had confidence in the results.

¹¹⁴ BHFT's Pathology services is currently provided by Coventry and Warwick Pathology Service, which is managed by University Hospitals Coventry and Warwickshire NHS Trust.

- (b) The merged trust would be able to reduce the time for diagnostics by stabilising and developing BHFT's Radiology services (see paragraphs 106 to 108).
- (c) The merged trust would likely reduce the number of MDT meetings as the Merger would enable clinicians from both trusts to develop relationships and standardise the process for MDTs.

130. The CMA believes that the streamlining of Cancer pathways will benefit patients in the form of reduced time to treatment.

Can the proposed RCB be expected to accrue within a reasonable period from the Merger?

131. The Parties told the CMA that it anticipated implementing the necessary changes to achieve the streamlining of Cancer pathways by the end of 2019. The Parties told the CMA that, prior to the Merger, they would work together to reorganise the pathways and engage with Coventry and Warwick Pathology Service, BHFT's current provider of Pathology services, to negotiate the early removal of Cancer Histopathology from BHFT's Pathology contract.

132. NHSI advised the CMA that the Parties had developed sufficient plans to demonstrate that the proposed improvements to Cancer pathways were likely to be delivered within a reasonable time following the Merger. NHSI advised the CMA that the Parties had:

- (a) set out steps for reviewing existing Cancer pathways and developing and standardising new pathways;
- (b) commenced negotiations with Coventry and Warwickshire Pathology Services to transfer some Cancer Histopathology to DTHFT; and
- (c) begun demand and capacity analysis and modelling to ensure that DTHFT had sufficient capacity to accommodate the reallocated Pathology work.

133. NHSI advised the CMA that the strong level of engagement and work that had been performed to date, as well as the ongoing collaboration between the trusts' leadership teams, demonstrated that the Parties would be able to deliver improved Cancer pathways.

134. NHSI advised the CMA that it could not determine whether the proposed reconfiguration of Upper GI Cancer was likely to be delivered within a reasonable time following the Merger as NHSE, the commissioner of

specialist services, was currently evaluating its service specifications for some specialist Cancer services, including for upper GI cancer. NHSI said that NHSE intended to issue a new service specification by Summer 2018. NHSI advised the CMA that NHSE would make a commissioning decision against the revised service specification but that the outcome of the process was still some time away and would require a period of consultation.

135. The CMA believes that, due to the planning work undertaken and the clinical leadership and engagement demonstrated to date, the Parties are well placed to deliver the streamlining of Cancer pathways within a reasonable period following the Merger. The CMA believes that there are a number of additional considerations which support the Parties' plans for post-Merger integration and the realisation of these benefits, as outlined in paragraphs 146 to 160 of the decision.
136. The CMA believes that the reconfiguration of Upper GI Cancer is unlikely to be delivered within a reasonable period following the Merger, as this service is subject to a commissioner-led reconfiguration and the outcome of that process is uncertain and some time away.

Is the proposed RCB unlikely to accrue without the Merger?

137. The Parties told the CMA that the Merger would enable the implementation of a single service model for Cancer, which would align the interests of all clinicians in having seamless and direct pathways for Cancer treatment. The Parties told the CMA that, in the absence of the Merger, the referral of patients between two trusts would remain in place and the Parties would not have the framework within which to change pathways.
138. NHSI advised the CMA that the Merger would facilitate the proposed improvements in Cancer pathways as, although the Parties could potentially achieve some aspects of their proposals as independent organisations, longstanding pathways arrangements were difficult to change without a common governance structure and the commitment of clinicians to drive through change.
139. The CMA believes that the Merger will provide the Parties with the single strategic direction and governance structure to efficiently streamline Cancer pathways, which, in the absence of the Merger, would be far more difficult and time consuming to achieve.
140. The CMA believes that there are a number of other considerations relevant to the Merger and the CMA's assessment of the proposed RCBs, which suggest

that achieving the proposed benefits without the Merger would be unlikely, as outlined in paragraphs 161 to 174 of the decision.

Is the proposed RCB an RCB within the meaning of the Act?

141. The CMA believes that the streamlining of Cancer pathways is an RCB. The proposed improvements are likely to improve outcomes for patients, may be expected to accrue within a reasonable period from the Merger and are unlikely to accrue without the Merger.

ENDNOTES

ⁱ In relation to paragraph 165, the reference to 'BHFT could not provide' should read 'BHFT could not continue to provide'.

ⁱⁱ In relation to paragraph 23(b) of Annex 3, the reference to 'requiring PCI at BHFT each year' should read 'requiring planned PCI at BHFT each year'.

ⁱⁱⁱ In relation to paragraph 60 of Annex 3, the reference to 'diagnosed' should read 'recorded'.

^{iv} In relation to paragraph 76 of Annex 3, the reference to 'BHFT would likely extend the SLA with HEFT, which would result in the continuation of low rates for haemodialysis and permanent vascular access' should read 'BHFT would likely extend the SLA with HEFT, which would be likely to result in the continuation of lower rates for haemodialysis and permanent vascular access'.

^v In relation to paragraph 86 of Annex 3, the reference to 'a reduction in length of stay for all hyper-acute Stroke patients would depend on the effective operation of DTHFT's Early Supportive Discharge service at BHFT' should read 'a reduction in length of stay for all hyper-acute Stroke patients would depend on the merged organisation improving the Early Supportive Discharge service at BHFT'.

^{vi} In relation to paragraph 112 of Annex 3, the reference to 'the merged trust would be able to recruit the necessary additional radiologists' should read 'the merged trust would be likely to recruit the necessary additional radiologists'.

^{vii} In relation to paragraph 113 of Annex 3, the reference to 'the merged trust would be able to reduce its reliance on the outsourcing of scans' should read 'the merged trust would be likely to reduce its reliance on the outsourcing of scans'.

^{viii} In relation to paragraph 119 of Annex 3, the reference to 'apart from DTHFT, there was no other trust which could provide BHFT with the necessary support' should read 'apart from DTHFT, it was not aware of other trust which could provide BHFT with the necessary support'.