

# Anticipated merger of Ashford and St Peter’s Hospitals NHS Foundation Trust and Royal Surrey County Hospital NHS Foundation Trust

**ME/6511/14**

The CMA’s decision on reference under section 33(1) of the Enterprise Act 2002 given on 18 February 2015. Full text of the decision published on 12 March 2015.

**Please note that [X] indicates figures or text which have been deleted or replaced in ranges at the request of the parties for reasons of commercial confidentiality.**

## Contents

SUMMARY .....	2
Theories of harm.....	4
Horizontal unilateral effects – Elective acute services .....	4
Exceptions to the duty to refer – Relevant customer benefits .....	7
ASSESSMENT.....	9
Parties and background to the merger.....	9
Jurisdiction .....	10
Background and rationale for the merger.....	10
Counterfactual.....	13
Frame of reference .....	15
Competitive assessment.....	23
Third party views.....	44
Conclusion on unilateral effects analysis .....	44
Exceptions to the duty to refer .....	44
Decision .....	54
ANNEX A: GP REFERRAL ANALYSIS .....	56
Introduction .....	56
Summary of methodology and dataset .....	56
Detailed explanation of the methodology .....	57
Potential limitations of the methodology.....	58
Proportional and ordinal methodology .....	60
ANNEX B: MARGINAL GP (EXPOSURE TO COMPETITION) ANALYSIS .....	63
ANNEX C: DETAILED SPECIALTY LEVEL ANALYSIS.....	65

Specialties where the CMA considers on the evidence available that it is or may be the case that the merger would result in an SLC .....	65
Other specialties which may raise competition concerns .....	77
Specialties where the CMA does not find a realistic prospect of an SLC .....	84

## SUMMARY

1. Ashford and St Peter's Hospitals NHS Foundation Trust (**ASP**) and Royal Surrey County Hospital NHS Foundation Trust (**RSC**) plan to merge to form a single NHS Foundation Trust (the **merger**). ASP and RSC are together referred to as the **parties**.
2. The decision to merge was taken in April 2014 and made public on 3 May 2014. The parties engage in activities which constitute 'enterprises' within the meaning of the Enterprise Act 2002 (the Act) and which will cease to be distinct as a result of the merger. The turnover test is met. The Competition and Markets Authority (**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. The statutory 40 working day deadline for a decision is 18 February 2015.
3. ASP and RSC are both Surrey-based foundation trust hospitals with a strong record of clinical and financial performances. They both operate district general hospitals across three sites in Chertsey, Ashford and Guildford. ASP serves a local catchment population of 410,000, whilst RSC serves a catchment population of 320,000. ASP had revenues of £246 million in the last financial year; for RSC, this was £281 million. The geographic proximity of their sites leads to a significant overlap between the NHS services they each provide to patients.
4. The parties submitted that the merger was motivated by a number of factors, including funding allocations, centralisation of specialised services, a reaction to the local health economy conditions, and delivering better care to patients close to their home. They also submitted that the merger would deliver rivalry enhancing efficiencies and relevant customer benefits. Monitor has provided advice to the CMA on relevant customer benefits.
5. The CMA has assessed how the merger may impact quality. Patient choice and the Payment by Results system incentivise providers to make spending decisions that affect quality in a way that best reflects the factors that matter to patients and GPs. Specifically, the aspects of quality which may be impacted by a reduction in incentives to compete include clinical factors such as infection rates, mortality rates, ratio of nurses or doctors to patients,

equipment, best practice and non-clinical factors such as waiting times, patient experience, cleanliness and parking facilities. Mergers between providers of NHS services may dampen these incentives to improve quality, if they serve to remove a significant alternative for patients and thereby significantly reduce the competitive constraints on the merging providers.<sup>1</sup>

6. With respect to product market definition, the CMA found that each specialty constitutes a separate market, consistent with previous decisions it has adopted in the context of mergers involving NHS providers.<sup>2</sup> Within each specialty, the CMA treated (i) outpatient and inpatient activities as separate markets and (ii) non-elective and elective services as separate markets. The CMA considered that private services are separate markets from NHS services<sup>3</sup> and assessed the merger on the basis of its impact on competition in the market and competition for the market, separately.
7. In relation to competition in the market, the CMA analysed competition for the provision of NHS elective inpatient and outpatient services and private services. In relation to competition for the market, the CMA analysed competition for winning contracts for commissioned NHS elective and non-elective inpatient services and outpatient services, including specialised services.
8. In relation to the geographic market, the CMA identified an overlap between the parties' catchment areas as a starting point. Consistently with the approach adopted in previous cases, it then focused primarily on directly analysing the overlap in GP referral patterns rather than defining more precise geographic frames of reference for each specialty. This analysis takes into account how patient preferences are affected by location by focusing directly on the actual choices made by patients and GPs at each individual GP practice. The CMA did not therefore find it necessary to conclude on the precise scope of the relevant geographic market.
9. The CMA has taken the prevailing conditions of competition to be the relevant counterfactual.

---

<sup>1</sup> *CMA guidance on the review of NHS mergers*, 31 July 2014, CMA29, paragraph 1.5 ([NHS Mergers Guidance](#)).

<sup>2</sup> Also relevant cases from the CMA's predecessor organisations: the Competition Commission (CC) and the Office of Fair Trading (OFT). See for example, the CMA's decision of 14 May 2014 on the anticipated acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust by Frimley Park Hospital NHS Foundation Trust. (Frimley/Heatherwood); also CC, A report on the anticipated merger of The Royal Bournemouth and Christchurch Hospital NHS Foundation Trust and Poole Hospital NHS Foundation Trust, 17 October 2013 (Bournemouth/Poole). The CMA has also taken account of the substance of the NHS Mergers Guidance).

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

## Theories of harm

10. The CMA considered several theories of harm, specifically whether the merger may lead to unilateral effects in the following categories of services separately considering, where appropriate, competition in and competition for the market):
  - The provision of elective acute services, at the level of individual specialties and distinguishing between inpatient and outpatient services.
  - The provision of non-elective acute services.
  - The provision of specialised services.
  - The provision of community services.
  - The provision of services to private patients.
11. The CMA also considered whether the above theories of harm lead to hospital-wide effects. That is, the CMA considered whether the effects of the merger on the parties' incentives to compete across individual product markets (for example elective specialties), may also affect their incentives to maintain the quality or other aspects of their hospital-wide services.

## Horizontal unilateral effects – Elective acute services

12. In assessing these unilateral effects, the CMA takes account of the applicable framework of provision of NHS services in England. As set out in previous decisions and its Guidance, the CMA observes that as providers of publicly-funded NHS services for patients, foundation trusts have many different objectives, in particular to deliver high-quality care for their patients.<sup>4</sup> They also have the objective of ensuring they receive sufficient revenue to cover the costs of such care, and can retain surpluses to invest in new or improved services.<sup>5</sup> As such, foundation trusts have an incentive to compete on quality to attract patients to their hospital and, in particular, to their profitable elective services. There are many different aspects of quality, including clinical (such as infection rates, mortality rates, ratio of nurses or doctors to patients, equipment, best practice) and non-clinical factors (such as waiting times, patient experience, cleanliness and parking facilities). Some aspects of quality (such as mortality rates or waiting times) are directly observable. In other ways, quality can only be judged once the patient has received treatment.

---

<sup>4</sup> Bournemouth/Poole, paragraph 38.

<sup>5</sup> Bournemouth/Poole, paragraph 38.

This means that patients and GPs will assess quality in a number of different ways, including by reference to the general reputation of a hospital.

13. GPs and patients both contribute to choice of provider and will have access to different sources of information. While patients may rely to some extent on their own or others' experiences, GPs are well placed to observe the quality of services and to interpret published information on quality.
14. The CMA notes that aspects of quality cannot be set directly. The quality of a hospital or service is the outcome of many different decisions that are made at many different levels across an organisation. The effect of competition is to focus decisions taken so that account is taken of the factors that matter to patients and GPs. The greater the number and quality of alternative hospitals providing comparable services in the local area, the stronger the trust's incentives will be to focus on delivering those aspects of quality that are important to the trusts' patients and GPs. In this way, the CMA expects competition between hospitals to lead them to make spending decisions that best reflect the factors that matter to patients and their GPs.
15. It is within this context that the CMA has assessed whether there is a realistic prospect of the merger resulting in a substantial lessening of competition (SLC) in elective acute services (and other areas, as set out below). The CMA considered a range of evidence, including GP referral analysis, analysis of the impact of the merger on the parties' exposure to competition (marginal GP analysis),<sup>6</sup> internal documents, the parties' submissions and third party comments including those of Commissioners. The CMA's analysis found that the two trusts have a considerable overlap in the Surrey area, from which they attract patients.
16. The CMA considers that this analysis indicates that the parties compete closely in the provision of NHS services at a trust level and in a number of individual specialties. At a Trust level, RSC is the closest alternative service provider to ASP, in particular, this is driven by the close geographic proximity of the RSC (Guildford) and St Peter's (Chertsey) sites.
17. The CMA considers the evidence indicated that the parties were likely to significantly constrain each other in relation to 16 specialties.<sup>7</sup> The CMA considered further detailed evidence on the impact of networks, consultants and inpatient/day-case splits, and data coding issues.

---

<sup>6</sup> See Annex B for a description of this analysis and the methodology.

<sup>7</sup> ENT, oral and maxillofacial surgery, breast surgery, general surgery, joined audiology and audiological medicine, medical oncology, gynaecology, colorectal surgery, endocrinology, gastroenterology, diabetic medicine, anaesthetics, anticoagulant service, general medicine, geriatric medicine, trauma and orthopaedics.

18. The CMA concludes that there is a realistic prospect of unilateral effects resulting from the proposed merger in relation to:
- (a) inpatient elective acute services in ear, nose and throat (ENT), breast surgery, general surgery, oral and maxillo-facial surgery, medical oncology and gynaecology; and
  - (b) outpatient elective acute services in ENT, joined oral and maxillofacial surgery, breast surgery, general surgery, joined audiology and audiological medicine, medical oncology and gynaecology.

In aggregate, the total number of patients receiving treatment from the parties in these specialities is approximately [75,000–125,000] which is around [20–30]% of total elective activity across the two trusts.

19. In relation to 10 further specialties,<sup>8</sup> the CMA found on the basis of the evidence available that the merger may potentially raise competition concerns, but has not found it necessary to conclude in this regard.
20. In relation to 16 further specialties,<sup>9</sup> the CMA finds, based on the evidence available, that there is no realistic prospect of an SLC in relation to inpatient or outpatient elective acute services on the basis of its analysis.
21. The CMA does not consider there is a realistic prospect of an SLC in relation to unilateral effects in the provision of non-elective acute services; unilateral effects in the provision of specialised services; unilateral effects in the provision of community services; and unilateral effects in the provision of services to private patients.
22. The CMA considered countervailing factors. It did not find evidence of entry or expansion sufficient to offset the SLC in elective services. In relation to rivalry enhancing efficiencies, the CMA considers that the cancer centre proposed by the parties does not meet the requisite standard as a rivalry enhancing efficiency because there is insufficient evidence that the efficiencies in question are likely to occur.
23. The CMA therefore considers that the merger may give rise to a realistic prospect of an SLC as a result of horizontal unilateral effects in elective services.

---

<sup>8</sup> Colorectal surgery, endocrinology, gastroenterology, diabetic medicine, anaesthetics, anticoagulant service, upper gastrointestinal surgery, general medicine and geriatric medicine, trauma and orthopaedics.

<sup>9</sup> Joined ophthalmology and orthoptics, rheumatology, pain management, urology, joined paediatrics, dermatology, neurology, clinical haematology, joined midwife episode and obstetrics, respiratory medicine, orthodontics, cardiology, cardiothoracic surgery, transient ischaemic attack, and vascular surgery.

## Exceptions to the duty to refer – Relevant customer benefits

24. Monitor advised the CMA that relevant customer benefits arise from the merger in respect of 7 day working (improved access to consultants through cross-site rotas) across three treatment areas: gastroenterology, stroke and interventional radiology. Monitor found these benefits would occur most quickly, and with more certainty, through the proposed merger. In relation to the stroke benefit, Monitor saw the benefit as time bound by a commissioner led stroke review (lasting at least a year but not longer than the implementation of the review) but in the other cases did not quantify how much more quickly the benefit would occur through the proposed merger. Monitor indicated that the total number of patients benefiting from these improvements is likely to be between 1,150 patients and 3,200 patients.<sup>10</sup> Monitor advised that the benefits it identified were clinically significant and important for the patients they affect.
25. Monitor did not find relevant customer benefits in relation to a number of further areas advanced by the parties. These were: 7 day working rota benefits in diabetes and neurology, the development of a cancer centre at Ashford Hospital and neonatal cot management.
26. The CMA therefore considered whether the relevant customer benefits identified by Monitor would outweigh the SLCs the CMA has identified, excepting the case from the CMA's duty to refer it for a phase 2 investigation.
27. In exercising its discretion to decide whether the claimed relevant customer benefits are such as to outweigh the SLC concerned and any adverse effects of the SLC, the CMA had 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 and the probability of them occurring.<sup>11</sup>
28. Accordingly, the CMA considered in the round:
  - (a) the strength of its concerns;
  - (b) the size (in terms of patient numbers) and importance to the trust (in terms of proportion of total elective activity) of specialties affected by the CMA's finding of a realistic prospect of a SLC set against the number of patients that the benefits affect;

---

<sup>10</sup> Monitor indicated minimum and maximum patient numbers for some of the benefits so these figures are necessarily approximate.

<sup>11</sup> [NHS Mergers Guidance](#), paragraph 7.26.

(c) the nature and consequences of the benefits;

(d) the possible consequences of quality degradation.

29. The CMA considers, taking account of these considerations, that the relevant customer benefits do not outweigh the SLCs the CMA has found in its phase 1 investigation. The available evidence indicates that the size (in terms of patient numbers) and importance to the trust (in terms of proportion of total elective activity) of specialties affected by an SLC is significantly larger than the number of patients identified by Monitor as receiving Relevant Customer Benefits (RCBs) as a result of the merger.
30. In relation to the likely duration of SLCs and benefits, the CMA noted that some of the benefits that Monitor identified are time limited. In particular, the RCB with respect to stroke services was time bound. The other RCBs in gastroenterology and interventional radiology benefits could potentially occur without the merger (for instance, through partnership) but would occur most quickly and with greater certainty with it. The CMA found that this contrasts with the lack of any evidence to indicate that the SLCs we have identified will be limited in duration. The CMA considers therefore that the duration of the identified SLCs are significantly longer than the duration of the RCBs identified.
31. Finally, while the CMA accepts the Monitor finding that the benefits are clinically significant for those affected patients, it is conscious that a degradation in quality in some specialties (relative to what the quality would be absent the merger) may also be clinically significant to some patients.
32. The CMA does not therefore consider it appropriate to exercise its discretion not to refer the merger under the relevant customer benefits exception.
33. The CMA is therefore considering whether to accept undertakings under section 73 of the Act. The parties have until 25 February 2015 to offer an undertaking to the CMA that might be accepted by the CMA. If no such undertaking is offered, then the CMA will refer the merger pursuant to sections 33(1) and 34ZA(2) of the Act.

## ASSESSMENT

### Parties and background to the merger

#### *Parties*

34. ASP has two hospital sites in Surrey: St Peter's Hospital in Chertsey and Ashford Hospital in Ashford. Its main commissioner of NHS services is North West Surrey clinical commissioning group (CCG), with specialist acute services being commissioned by NHS England through the Surrey and Sussex Area team. Ashford Hospital mainly provides outpatient and day-case care, while St Peter's Hospital offers more complex medical and surgical care, as well as emergency services.<sup>12</sup> The Trust as a whole is a large Acute Trust, serving a population of more than 400,000 people, with 570 beds. It had revenues of £246 million in the last financial year, all of which were in the UK.
35. RSC provides a range of acute services to a population of around 320,000 from its main hospital site in Guildford. Like ASP, it is a large Acute Trust with services typical of a district general hospital and is also the specialist tertiary centre for cancer in Surrey, West Sussex and Hampshire. Its main commissioner is Guildford and Waverley CCG, with specialist acute services primarily being commissioned by NHS England through its Surrey and Sussex Area Team. RSC has approximately 520 beds and had revenues of £281 million in the last financial year, all of which were in the UK.

#### *Transaction*

36. The decision to merge was taken in April 2014 and made public on 3 May 2014. The CMA has seen Board documents corroborating Board approval for the merger and the case for the merger. The parties' estimated timetable for the ASP/RSC transaction envisages the new Trust being formed in mid-2015 following completion of CMA, Monitor and Care Quality Commission regulatory processes (and subject to the outcomes of these processes).

---

<sup>12</sup> BMI Runnymede Hospital is co-located with St Peter's Hospital and provides private patient services. ASP offers limited services to private patients through its agreement with BMI.

## **Jurisdiction**

37. The parties engage in activities which constitute 'enterprises' for the purposes of section 23 of the Act<sup>13</sup> and these enterprises will cease to be distinct as a result of the merger. The parties submitted that the proposed arrangements between their Foundation Trusts (FTs) create a qualifying merger reviewable by the CMA under the merger control provisions of the Act. Revenue for each of the parties is above £70 million; ASP had UK revenues of £246 million for the financial year ending on 31 March 2014, while at RSC it was £281 million.
38. The UK turnover of both parties exceeds £70 million, so the turnover test in section 23(1)(b) of the Act is satisfied whichever form of merger the transaction takes.
39. 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.
40. The initial period for consideration of the merger under section 34ZA(3) of the Act started on 22 December 2014 and the statutory 40 working day deadline for a decision is therefore 18 February 2015.

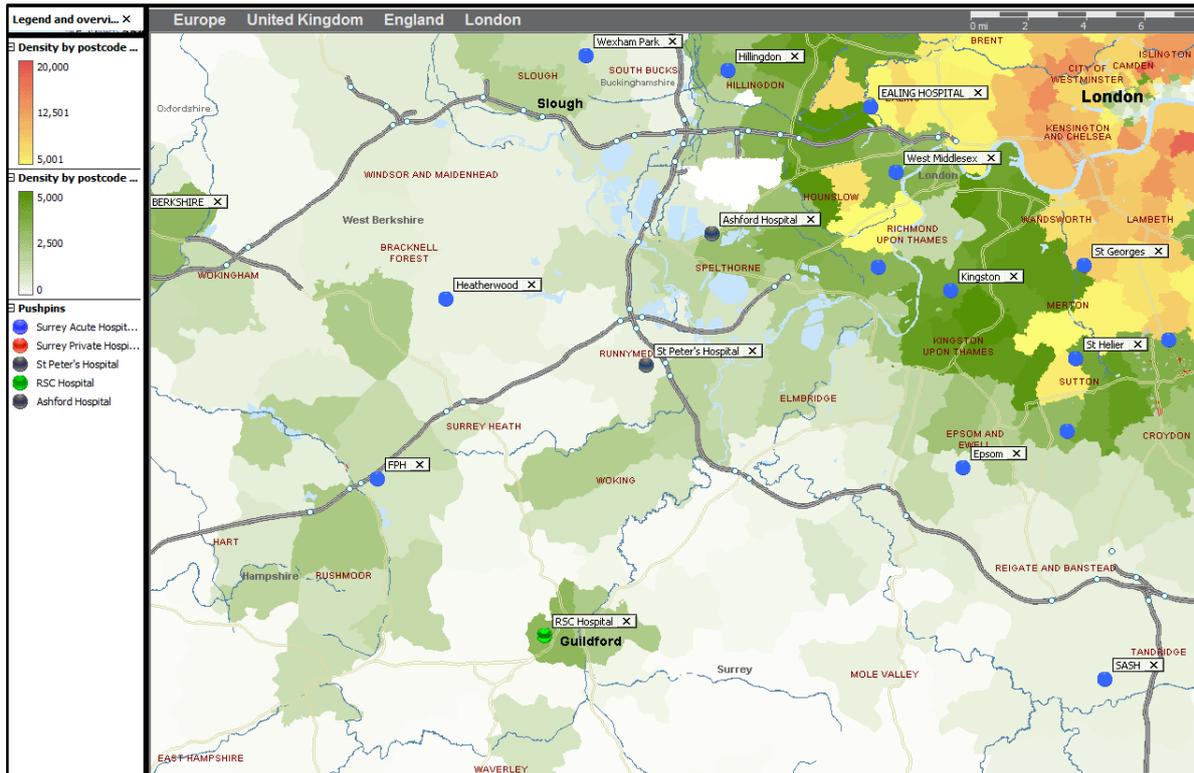
## **Background and rationale for the merger**

41. ASP and RSC are geographically proximate, across three sites, each facing a range of providers around their catchment areas. Ashford Hospital, located in North East Surrey, is bordered by other providers to the north, such as West Middlesex, and others in the Greater London area. Further south and west, ASP's St Peter's site is located to the north of RSC, west of Epsom St Helier and north-east of Frimley Park Hospital. Furthest south the RSC site is bordered by St Peter's, Frimley Park Hospital and (to a lesser extent) Epsom and St Helier and Surrey and Sussex.

---

<sup>13</sup> 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 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 2012 confirmed the CMA's role in assessing the competition aspects of mergers involving foundation trusts.

Figure 1: Providers in Surrey and surrounding area



42. The parties told the CMA that they are both successful FTs, with a good track record of clinical, operational and financial performance. The parties have had a partnership<sup>14</sup> in place since November 2012. Subsequent to that partnership agreement, the parties assessed a number of options for developing the partnership, including carrying on with the current form, other forms of collaboration and a potential merger.
43. The parties submitted that the merger was motivated by the following factors:
  - (a) Funding allocations, coupled with the rising demand for NHS services.
  - (b) A reaction to the local health economy conditions which includes the recent merger between Frimley Park FT (**FPH**) and Heatherwood & Wexham Park NHS Trust (now Frimley Health FT), and the merger between West Middlesex NHS Trust (**WMUH**) and Chelsea and Westminster Hospital FT (see further paragraph 53 et seq. below).
  - (c) Delivering better care to patients close to their home, including the development of new services.

<sup>14</sup> The partnership provided for a number of areas over which the parties would collaborate. For example [REDACTED].

- (d) Improving existing services to meet current best practice, for example by combining currently sub-scale teams to allow the delivery of effective seven day care.
44. The Outline Business Case (**OBC**) for the merger shows both ASP and RSC in surplus over the past 3 financial years.<sup>15</sup> The parties estimate that, although there will be a significant cost transition in 2014/15, the merged entity would then be in a position to deliver a surplus of around £8 million to £9 million per annum, provided that synergies are delivered at a rapid pace from the outset.<sup>16</sup> Neither ASP nor RSC has experienced severe financial difficulties in the recent past.
45. The parties however submitted that since the OBC their financial situation has changed (North West Surrey CCG also made this observation to the CMA). ASP is now forecasting a financial deficit for 2014/15 of £1.25 million, while RSC is anticipating a surplus of £1.2 million (compared to a surplus of £2.3 million in its original plan). In the parties' view this strengthens their rationale for the merger and would lessen the competitive constraint they would place on each other going forward. The parties have not put forward financial savings or other merger-related financial considerations as a relevant customer benefit of the merger.
46. In respect of other patient benefits flowing from the merger, the parties have submitted an RCB case to Monitor, and Monitor has provided advice (see further paragraphs 169 to 210).<sup>17</sup>
47. The parties have also submitted that the merger is likely to lead to rivalry enhancing efficiencies.<sup>18</sup> Specifically, the parties have submitted that the merger will allow the establishment of a cancer diagnosis and treatment centre (DTC) at Ashford Hospital, creating a more effective competitor for cancer referrals. This is considered further in paragraph 154 below.

---

<sup>15</sup> Merger Notice, Tables 17 and 20. A draft of the Full Business Case was prepared on 20 November 2014 for the trust Boards' review.

<sup>16</sup> See Section 1.6, OBC.

<sup>17</sup> 'Where the CMA believes that it is or may be the case that the merger results or may be expected to result in an SLC which would result in worse outcomes for patients and/or commissioners, the CMA may take relevant customer benefits arising from a merger into account when deciding whether to refer a merger for a Phase 2 investigation. In the context of NHS mergers, this means benefits to patients and/or commissioners.' [NHS Mergers Guidance](#) paragraph 7.3.

<sup>18</sup> Where mergers lead to timely and large efficiencies, these can serve to enhance rivalry and prevent the merger from leading to a significant lessening of competition (SLC). See CMA NHS Guidance paragraph 6.70.

## Counterfactual

48. The CMA assesses a merger's impact relative to the situation that would prevail absent the merger (ie the counterfactual). 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 considers that, in the absence of the merger, the prospect of these conditions continuing is not realistic, or there is a realistic prospect of a counterfactual that is more competitive than these conditions.<sup>19</sup>
49. The parties submitted that the existing conditions of competition (that is, the pre-merger situation) is the relevant counterfactual.
50. The CMA is aware of a number of recent, expected or possible developments, which may affect the provision of NHS services in the area, as outlined below, and took these into account when considering the counterfactual.
51. Commissioners in Surrey are currently reviewing stroke services. They have indicated to the CMA that stroke provision is unlikely to be removed from either party, and that it is too early to indicate the outcome beyond a requirement for 7 day cover by consultants. As discussed further below, Monitor noted that the merger may deliver benefits in stroke services for patients of the parties, but also noted that review of stroke services has indicated delivery of a similar benefit to patients in Surrey upon completion of the review. Given the review is in its early stages and there is no evidence to suggest that it would result in a more competitive outcome in the counterfactual the CMA does not consider it appropriate to adjust the counterfactual from the pre-merger situation in this case.
52. North West Surrey CCG, ASP's main commissioner, told the CMA that it is running a formal competitive procurement for musculoskeletal services and aspects of cardiology and ENT. The commissioner noted that it was likely that as it reconfigures services there would be less activity going through ASP. The commissioner noted that this could mean that the proportion of complex referrals would increase in some specialties. However, the information provided suggested it is not clear what proportion of activity at ASP this would affect, nor whether there would be an increased number of complex referrals to counteract the loss of simple activities (at specialty level it was not possible

---

<sup>19</sup> [Merger assessment guidelines](#) (CC2/OFT1254), September 2010, paragraph 4.3.5 et seq. The [Merger assessment guidelines](#) have been adopted by the CMA (see *Mergers: Guidance on the CMA's jurisdiction and procedure*, Annex D). See also [NHS Mergers Guidance](#), paragraph 5.23.

for the CMA to distinguish between complex and routine activity at this stage). As such the CMA does not consider it appropriate to adjust the counterfactual from the pre-merger situation but has taken account of the potentially lessened competitive constraint which ASP may provide in considering the effect of the merger in these services.

53. The parties noted that the merger between Chelsea and Westminster Hospital NHS Foundation Trust and West Middlesex University Hospital NHS Trust (Chelsea & Westminster/West Middlesex merger),<sup>20</sup> which is expected to complete on 1 April 2015 could result in a new 'super-trust'. The CMA did not receive evidence that the new merged provider would compete in such a different manner as compared to the individual trusts and therefore did not consider it was appropriate to adjust the counterfactual. The competitive constraints posed by the merged trust were taken into account in its competitive effects analysis.
54. FPH has recently merged with Heatherwood & Wexham Park FT. Heatherwood Hospital has a long-standing history of clinical and financial difficulties. One of the stated drivers for the merger was for FPH to develop the services at Heatherwood and Wexham Park FT to a similar standard at FPH. The CMA approached FPH about the future of the newly expanded trust and on the basis of the evidence it received the CMA does not consider it appropriate to adjust its counterfactual from the pre-merger situation in this case.
55. The Shaping a Healthier Future Programme for North West London will lead to a number of reconfigurations of elective and non-elective care. Of particular relevance to this case are changes to West Middlesex Hospital, with plans for it to gain some services from other hospitals in the area. However, these changes are not likely to take effect before late 2017, and their effect is not certain. As in the recent review of the Chelsea & Westminster/West Middlesex merger, the CMA finds that the scope and impact of changes envisaged in the Shaping a Healthier Future Programme are too uncertain, so that it is not appropriate to adjust the counterfactual from the pre-merger situation.
56. Therefore, the CMA considers the prevailing conditions of competition to be the relevant counterfactual.

---

<sup>20</sup> The CMA has recently assessed and cleared two mergers of providers in the area surrounding the parties' hospitals: [Chelsea/WMUH](#) and [Frimley/Heatherwood](#).

## Frame of reference

57. 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 there can be constraints on merger 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.<sup>21</sup>

### **Product scope**

58. The boundaries of the relevant product market are generally determined by reference to demand-side substitution alone.<sup>22</sup> The CMA uses the 'hypothetical monopolist test' as a tool to check that the relevant product market is not defined too narrowly. The relevant product market may potentially be wider than the narrowest market that satisfies the hypothetical monopolist test.<sup>23</sup>

59. In this case, the CMA adopted the following segmentations, in line with previous cases and guidance:<sup>24</sup>

(a) Each specialty<sup>25</sup> is generally considered a separate product market.

(b) Within each specialty, we separately consider:

(i) elective and non-elective care;

(ii) outpatient and inpatient (including day-case care); and

(iii) community and hospital-based care.

(c) Private and NHS-funded services are considered separately from each other.

---

<sup>21</sup> [Merger assessment guidelines](#) (CC2/OFT1254), September 2010, paragraph 5.2.2. The *Merger assessment guidelines* were adopted by the CMA (see [Mergers: Guidance on the CMA's jurisdiction and procedure](#), Annex D).

<sup>22</sup> [Merger assessment guidelines](#), paragraph 5.2.17.

<sup>23</sup> *Ibid*, paragraph 5.2.8.

<sup>24</sup> [NHS Mergers Guidance](#), paragraphs 6.37-6.39.

<sup>25</sup> Services can be classified according to the specialty within which the consultant with prime responsibility for the patient is recognised or contracted to the organisation (main specialty) or the specialised service within which the patient is treated (treatment function). Although specialties do not always uniquely identify sets of distinct services, the classification of services by specialty is broadly used in the NHS and appeared to constitute a reasonable and practical approach to grouping services that have clinical commonalities.

60. The CMA did not receive any evidence or submissions in the present case to suggest a different approach to that taken in previous cases would be appropriate with respect to the distinctions between elective and non-elective care, community and hospital based care, and private and NHS-funded services, and these are not therefore discussed further.<sup>26</sup>
61. As regards specialty level distinctions, demand and supply-side considerations in the provision of healthcare generally warrant markets which are no wider than specialties. On the demand-side, patients and the referring GPs are restricted in their choice of treatments, to those that are appropriate to the specific healthcare issue which the patient has been diagnosed with.
62. On the supply-side, different services (specialties or sub-specialties) could theoretically be aggregated into a broader product market, on the basis of evidence that providers could easily, quickly and profitably switch between these services, in response to a small yet significant reduction in quality of services provided by a hypothetical monopolist.<sup>27</sup>
63. The CMA and its predecessor authorities have previously considered how these factors apply in relation to NHS hospital mergers. In particular, the CC, in the Bournemouth and Poole merger inquiry, noted that whilst some degree of sub-specialisation was present, hospitals which recorded some activity under a specialty tended to offer the most common procedures within that specialty. The CC said that this was consistent with the view that while restricted, supply-side substitution was possible across the core set of procedures within specialties and that most providers offer these core procedures.<sup>28</sup> This would suggest that considering the competitive effects of the merger at specialty level is likely to capture the effects on the most sets of procedures within specialties.
64. For services which are less common such as specialised services, these tend to be provided by fewer hospitals for a number of reasons, not least in order to meet best practice guidelines and/or commissioner requirements for concentrating services into specialist centres (for example to meet minimum volume requirements). Therefore the CC considered the effects of the merger on competition at sub-specialty level, where supply-side considerations meant that these should be separate from the core set of common procedures within specialties.<sup>29</sup>

---

<sup>26</sup> See for example [Chelsea/WMUH](#).

<sup>27</sup> [Merger assessment guidelines](#), paragraphs 5.2.9 to 5.2.20.

<sup>28</sup> Bournemouth and Poole report, paragraphs 5.15 to 5.18.

<sup>29</sup> Bournemouth and Poole report, paragraphs 5.19 to 5.22.

65. As regards the distinction between outpatient and inpatient services, the CC considered it appropriate to assess outpatient and inpatient services separately. It noted that there is 'also an in-between' case where a patient is admitted but the service is completed within the day, where the patient does not stay overnight and are known as day-cases.<sup>30</sup> The CC considered day-cases together with inpatient activity. It noted that there were substantial differences in the provision of inpatient as opposed to outpatient services, such that these should be considered separately. The CC found that the constraint between the two was likely to be asymmetric, since providers that offered services within a specialty as an inpatient service, also offered the service in outpatient settings. The reverse, however, did not generally occur, which would be indicative of differences in the supply of such services, depending on the settings (for example the investment requirements).

*Parties' submissions on day-case, inpatient and outpatient*

66. The parties said that they generally agreed with the approach that the CC, OFT and CMA had taken to date to product market definition in the assessment of healthcare mergers (ie the framework set out above). However they noted that consideration should be given to the impact of the distinction between day-cases and inpatient activity.

67. The parties noted that day-cases were an important part of service provision at their hospital sites. For example, approximately 15% of elective spells<sup>31</sup> at ASP and 21% at RSC in 2013/14 were day-case spell, while inpatient<sup>32</sup> activity accounted for only 3% of elective activity for both parties over the same period.<sup>33</sup> They considered that the CC's approach to day-cases was appropriate given the difficulties with appropriately categorising spells between the inpatient and day-case procedures in previous cases. However they submitted that in the present case, sufficiently disaggregated data was available to allow the CMA to consider the effects of the merger separately between day-case and inpatient services at the level of specialties.

---

<sup>30</sup> Bournemouth and Poole report, paragraph 5.27.

<sup>31</sup> The NHS Information Centre defines a spell as: 'the total continuous stay of a patient using a hospital bed .... The hospital provider spell starts when a consultant, nurse or midwife assumes responsibility for care following the decision to admit the patient.... Each admission as part of a series of regular day/night admissions generates a separate hospital provider spell. A discharge will be the end of the last Consultant Episode (Hospital Provider) ... within that hospital provider spell'. Source: [Health and Social Care Information Centre website](#).

<sup>32</sup> That is, patients requiring an overnight stay. Outpatient services are generally defined as those services which do not require a patient to be admitted to hospital, whereas inpatient services do require patients' admission to hospital (and also involve an overnight stay). There is also an 'in-between' case where a patient is admitted but the service is completed within the day (ie they do not stay overnight): these are referred to as 'day-case' activities.

<sup>33</sup> Parties' submission, paragraph 61.

68. For day-case and inpatient procedures to be part of the same product market, the parties submitted that providers of day-case procedures should be able to start providing inpatient procedures (and vice-versa). However they noted this was not always the case, for the following reasons:
- (a) locally defined pathways may require that inpatient procedures be carried out by certain providers, thereby restricting other providers from these services; and<sup>34</sup>
  - (b) providers of day-case procedures may not have the necessary expertise or facilities to be able to offer inpatient services.
69. The CMA notes that the parties overlap in relation to day-case activity and that (overnight) inpatient activity is a small proportion of elective activity relative to day-cases. As such, the CMA does not consider that making this distinction substantially affects the analysis. Nevertheless, where relevant the CMA has considered inpatient and day-case separately in its analysis.
70. Furthermore, the parties noted that the distinction between outpatient and day-case activity is often a result of coding practices at providers, rather than the services provided and in such cases it would be inappropriate to consider outpatient and day-case procedures separately.
71. The CMA has considered them separately, following previous decisions, on a cautious basis, as the extent to which any coding issues are material is not clear.

*Parties' submissions on relevance of inpatient procedures*

72. The parties submitted the patient's choice is in relation to outpatient procedures only. Patients (who require inpatient care) are either admitted at the hospital where they have their first outpatient appointment or they are referred onto another provider to receive that care. In either case, their choice of provider is only exercised in relation to their first outpatient appointment, not the inpatient treatment.
73. The parties therefore submitted that consideration should be given to the effects of the merger at the specialty level and its impact on the provision of outpatient, day-cases and inpatient procedures, as appropriate within the specialty.

---

<sup>34</sup> The parties submitted that this was the case in relation to maxillo-facial, ENT and ophthalmology, where RSC is the centre for the inpatient services and ASP only provides outpatient and day-case procedures.

74. The CMA considers that a hospital's provision in relation to inpatient elective activity would influence the choice of hospital for the first outpatient referral for a number of reasons. First, the CMA considers that the patient's right to choice in relation to the first outpatient appointment also provides incentives for providers to compete in relation to inpatient activity, since some patients and GPs will choose their first outpatient appointment on the expectation that treatment will involve admission. For these patients and GPs, the choice set will involve those providers which are able to offer inpatient services. Second, the quality indicators for hospitals are typically reported for inpatient services, such that patients' and GPs' choices are likely to be influenced by the quality of the inpatient services irrespective of whether a patient needs (or anticipates that he or she needs) an inpatient treatment.

### *Conclusion on product scope*

75. The CMA has generally assessed the effects of the merger in relation to the following delineations:
- (a) Each specialty is considered separately.
  - (b) Within each specialty, we separately consider:
    - (i) elective and non-elective care;
    - (ii) outpatient and inpatient (including day-case care); and
    - (iii) community and hospital-based care.
  - (c) Private and NHS-funded services are considered separately from each other.
76. The CMA has also considered hospital-wide effects. We consider some parameters of competition may be set at a hospital level so a hospital-wide frame of reference that considers how in aggregate patient GP choice in individual specialty markets may affect competition over these parameters is also appropriate.

### ***Geographic scope***

77. The CC, OFT and CMA have in the past used catchment area analysis<sup>35</sup> to identify the area over which the parties are likely to be important alternatives and as such those where the merger is most likely to affect competitive

---

<sup>35</sup> Catchment area analysis considers where the parties draw the majority of their referral volumes from.

conditions.<sup>36</sup> Where catchment area analysis is used, the CMA generally considers the area from which 80% of patients come.

### *Parties' submissions*

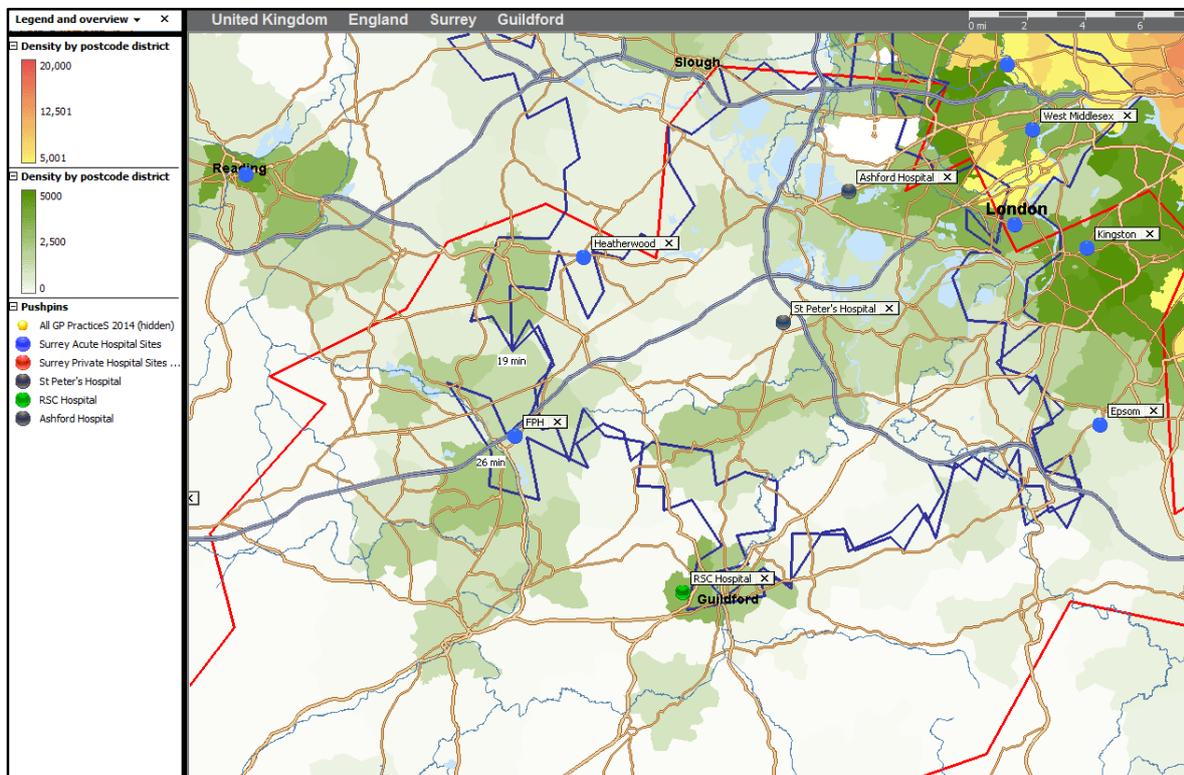
78. The parties told the CMA that the 80% catchment area is likely to significantly under-estimate the constraints that they face and a 90% catchment area may be more appropriate. This was for a number of reasons as follows:
- (a) the catchment areas for neighbouring trusts heavily overlap, meaning that patients in overlapping catchments already have multiple options outside the parties;
  - (b) for patients just outside the 80% catchment area, a small but significant non transitory reduction in quality is likely to lead to significant switching to alternatives, such that a hypothetical monopolist could not profitably lower quality; and
  - (c) the densely populated nature of the local area (particularly in relation to the Ashford Hospital site) means providers affect the competitive behaviour of non-adjacent providers due to a chain of substitution by patients.
79. The CMA considers that transport time catchment area analysis is generally a useful and pragmatic approximation for the analysis of local geographic markets. The CMA notes that catchment areas may be affected by a number of factors, not least the transport infrastructure and population density, such that the catchment areas are not uniform around the parties and their competitors.
80. A catchment area is typically narrower than a geographic market identified using the hypothetical monopolist test. The CMA took this into account in the competitive assessment and used isochrones based on catchment areas as the starting point of reference. As part of the assessment, we also considered the constraints posed on the parties by rivals located further away than that strictly implied by the isochrones. The CMA also used GP referral analysis, which uses patient/GP level choice data to infer the strength of each provider as an alternative choice at the GP practice level and by hospital.
81. The parties submitted that the catchment area based on drive times for RSC was 32 minutes for 80% and 43 minutes for 90% of its elective activity. For St

---

<sup>36</sup> See for example Bournemouth and Poole report, paragraphs 5.54-5.71.

Peter's Hospital, the equivalent figures were 19 and 21 minutes, while for Ashford Hospital these are 26 and 29 minutes. Figure 2 shows the 80% catchment areas and Figure 3 the 90% catchment areas for each of the parties' sites.<sup>37</sup>

**Figure 2: Parties' 80% catchment areas**

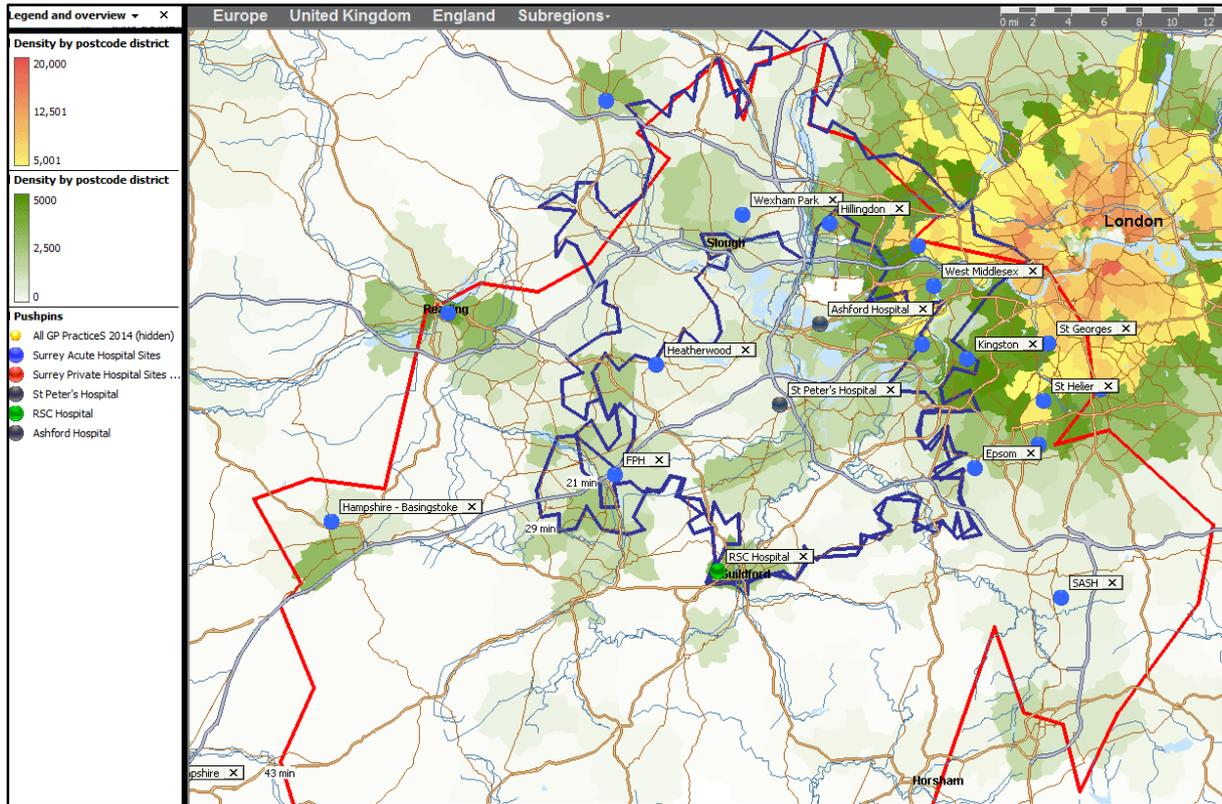


Source: CMA representation of parties' submissions (parties' data).

Notes: Using Microsoft MapPoint; Catchment areas are an approximation of actual catchment areas given, as an example, assumptions about driving conditions implicit in the software; Red line is RSC and blue are ASP.

<sup>37</sup> These calculations are based on Hospital Episode Statistics (HES) elective activity (outpatient first appointment, day-cases and inpatient) data between 1 April 2009 and 31 October 2012 for the parties and their competitors. The data contained missing observations between November 2010 and March 2011.

**Figure 3: Parties' 90% catchment areas**



Source: CMA representation of parties' submissions (parties' data)

Notes: Using Microsoft MapPoint; Catchment areas are an approximation of actual catchment areas given, as an example, assumptions about driving conditions implicit in the software; Red line is RSC and blue are ASP

82. The parties submitted that the RSC catchment area is significantly wider than that for the ASP sites. It extends into Central London and as far as Reading, Horsham and Slough, as well as almost reaching Winchester and Portsmouth in the South. RSC's wider catchment area is a function of the less densely populated area surrounding RSC when comparing to the ASP sites. Furthermore, the parties said that the wider RSC catchment area was a result of the trust's role as a cancer centre, highlighted by the medical oncology specialty catchment area, which is significantly larger than the other specialties. The parties also noted that their catchment areas extended into London, particularly for St Peter's and RSC hospitals.
83. The parties also provided catchment areas by specialty. These are generally consistent with the catchments based on aggregated activity, particularly in relation to St Peter's Hospital. The exception to this are cancer related specialties, such as clinical oncology (radiotherapy) and medical oncology (chemotherapy), which have wider catchment areas.

## *Conclusion on the geographic market*

84. The CMA notes that the parties' 80% catchment areas overlap to a significant degree, which suggests that they are likely to be important alternatives for patients across a significant part of Surrey. The CMA also notes the presence of a number of other providers within or close to the parties' catchment areas and has therefore considered the constraints these parties are likely to play on the merged provider in its competitive effects analysis. However, the CMA has not found it necessary to conclude on the exact boundaries of the geographic market as it has directly considered closeness of competition between the parties, using patient level data and using the location of the GP practice (as a proxy for patient location), which does not rely on exact geographic boundaries.

## **Competitive assessment**

### ***Horizontal unilateral effects***

85. As providers of publicly-funded NHS services for patients, foundation trusts have many different objectives, in particular to deliver high-quality care for their patients. However, they also have the objective of ensuring they receive sufficient revenue to cover the costs of such care, and can retain surpluses to invest in new or improved services. As such, foundation trusts have an incentive to compete on quality to attract patients to their hospital and, in particular, to their profitable elective services. There are many different aspects of quality, including clinical and non-clinical factors. Some aspects of quality (such as mortality rates or waiting times) are directly observable. In other ways, quality can only be judged once the patient has received treatment. This means that patients and GPs will assess quality in a number of different ways, including by reference to the general reputation of a hospital.
86. GPs and patients both contribute to choice of provider and will have access to different sources of information. Hospital services tend to be experience or credence goods, ie quality does not necessarily take the form of qualities that can be measured or observed ex ante and while patients may rely to some extent on their own or others' experiences, GPs are well placed to observe the quality of services and to interpret published information on quality.
87. The CMA notes that aspects of quality cannot be set directly. The quality of a hospital or service is the outcome of many different decisions that are made at many different levels across an organisation. The effect of competition is to focus decisions taken so that account is taken of the factors that matter to patients and GPs. The greater the number and quality of alternative hospitals

providing comparable services in the local area, the stronger the trust's incentives will be to focus on delivering those aspects of quality that are important to the trusts' patients and GPs. In this way, the CMA expects competition between hospitals to lead them to make spending decisions that best reflect the factors that matter to patients and their GPs.

88. The CMA has assessed the impact of the merger on quality. Patient choice and the Payment by Results (**PbR**) system incentivise providers to make spending decisions that affect quality in a way that best reflects the factors that matter to patients and GPs. Mergers between providers of NHS services may dampen these incentives, if they serve to remove a significant alternative for patients and thereby significantly reduce the competitive constraints on the merging providers.<sup>38</sup> Thus the merger may harm competition if it removes an important current or potential provider, resulting in a reduced incentive for the merged provider to maintain and provide better quality services to patients and value for money for commissioners.<sup>39</sup> This effect is known as a horizontal unilateral effect. The CMA assessed whether it is or may be the case that the merger may be expected to result in an SLC as a result of horizontal unilateral effects.

### ***Models of competition in the provision of NHS healthcare services***

89. The CMA considers that there are two different models of competition in the provision of NHS healthcare services:<sup>40</sup>

- (a) **Competition in the market** (that is, competition for patients), which occurs where patients have a choice between providers of the same service. Payments for these services are commonly made according to the PbR tariffs that are nationally mandated prices. The initiatives related to patient choice are relevant to competition in the market, which occurs mainly in respect of routine elective (planned) services as well as maternity services. This incentivises hospitals to compete on quality in order to attract patient referrals and hence income.

In relation to competition to attract patients of NHS services, competition is mostly on quality,<sup>41</sup> rather than on price,<sup>42</sup> as the majority of services

---

<sup>38</sup> [NHS Mergers Guidance](#), paragraph 1.5.

<sup>39</sup> [NHS Mergers Guidance](#), paragraph 6.46.

<sup>40</sup> See for previous cases: [Frimley/Heatherwood](#), paragraphs 18 and ff. See also [Bournemouth/Poole](#), paragraphs 11 and 2.27.

<sup>41</sup> [Bournemouth/Poole](#), paragraphs 6.72-77.

<sup>42</sup> However, it is possible for there to be variations from the national tariff.

are covered by national prices and the PbR regime. The same applies to elective, non-elective, specialised, and community services.<sup>43</sup>

(b) **Competition for the market** refers to competition to attract contracts from the commissioning entity to provide services. It occurs where providers are (or may be) competing to be one of a limited number of providers of a service (for instance for specialised services).<sup>44</sup> Providers may compete on quality and, in some cases, price.<sup>45</sup> The CMA will assess whether the merger will have any impact on:

- (i) a possible competitive tender, where the merger could lead to worse outcomes because there would be fewer bidders;<sup>46</sup> and
- (ii) providers on existing contracts might provide lower quality services, knowing that commissioners have fewer options to replace them post-merger than absent the merger.

Where there is competition to attract contracts to provide services, the CMA's assessment will consider whether the merging providers would be close competitors to supply these services and what other providers would constrain them.

### ***Theories of harm***

90. The CMA has considered the following theories of harm and where appropriate separately considered competition in and competition for the market:

- (a) Unilateral effects in the provision of elective acute services, at the level of individual specialties and distinguishing between inpatient and outpatient services.
- (b) Unilateral effects in the provision of non-elective acute services.
- (c) Unilateral effects in the provision of specialised services.
- (d) Unilateral effects in the provision of community services.

---

<sup>43</sup> Different types of tariffs apply to different services. For example, national prices do not apply to some community services.

<sup>44</sup> This is often the case for specialised services, where there is an expectation of a small number of providers of services that are often costly to provide.

<sup>45</sup> Any Qualified Provider services do not typically restrict the number of providers, so these will not generally feature in an assessment of the effect of the merger on competition to attract contracts to provide services.

<sup>46</sup> This may be reflected in commissioners receiving reduced value for money, including lower quality services or higher prices where services are not subject to a national price.

(e) Unilateral effects in the provision of services to private patients.

91. The CMA has also considered whether the above theories of harm lead to hospital-wide effects. That is, the CMA has considered whether the effects of the merger on the parties' incentives to compete across individual product markets (for example elective specialties), may also affect their incentives to maintain the quality or other aspects of their services.

### **Horizontal unilateral effects in elective acute services**

#### *Methodology and types of evidence used in the assessment*

92. The CMA first considered whether there is a realistic prospect of the merger resulting in horizontal unilateral effects in elective acute services in the broad catchment areas outlined above. In carrying out the assessment, the CMA considered a range of evidence, including:
- (a) **GP referral analysis.** In line with previous CMA, OFT and CC cases, the CMA carried out a ranking analysis of GP referral patterns for all GPs making at least one referral to the parties.<sup>47</sup> GP referral patterns reflect the aggregated choices of hospital providers made by GPs within each GP practice (at a practice level). The CMA has considered the information at specialty level, using Treatment Function Codes as a proxy. The CMA notes that the GP referral analysis approximates diversion ratios by considering past referral patterns and relies on certain assumptions (see Annex A). However, the CMA considers that historical referral patterns offer an insight into patient preferences and by implication the relative importance of the alternative providers of elective inpatient and outpatient services for each GP practice. Therefore these offer an indication of likely responses by patients/GPs in the event of reduction in quality post-merger at the parties' sites. The detailed methodology, the parties' submissions and the CMA's views in relation to this analysis, are discussed in detail at Annex A.
- (b) **Marginal GP analysis.** In an extension to the GP referral analysis, the CMA considered the extent to which the merger reduces the parties' exposure to competition. That is, the CMA has calculated the share of referrals from GP practices which are most likely to be marginal pre and post-merger.<sup>48</sup> By comparing the effect of the merger on the proportion of

---

<sup>47</sup> Bournemouth/Poole, paragraph 6.195 ff.

<sup>48</sup> The CMA has defined this to include GP practices which send between 10% and 70% of their activity to one of the merging parties or the merged entity post-merger. Whilst it is not obvious which threshold the CMA should adopt, we note that the threshold does not materially affect the conclusion on the impact of the merger on the

referrals from such GP practices, the CMA has assessed the effects of the merger on the parties' exposure to competition. See Annex B for a more detailed explanation of the methodology.

(c) **Internal documents.** The CMA considered the parties' views of how competition works in the supply of the relevant services and their views on each other and third party providers, particularly in relation to competitive dynamics in attracting patients.

(d) **Third party comments,** including comments from other providers and commissioners.

### *The parties' arguments*

93. The parties argued that a number of factors should be taken into account when assessing the effects of the merger, particularly at the level of individual specialties. These are addressed below.

#### *The effect of networks and partnerships*

94. The parties submitted that networks and partnership arrangements with other providers (such as the St. Luke's Cancer Alliance and arrangements in place in other specialties such as maxillofacial surgery) should affect the CMA's analysis in two broad ways:

(a) in some networks, the parties submitted that patient choice is eliminated as there is a mandatory pathway in place for treatment at a particular provider meaning that there is no competition or choice amongst participating providers in respect of a portion of activity within the relevant specialty; and

(b) the parties submitted that networks, particularly the St. Luke's Cancer Alliance, have the effect of inflating referrals, because patients or GPs anticipate they might need a referral for more complex or inpatient treatment. The parties argue that within several specialties, there is a subset of patients which are affected by the network, who will likely be referred to the main centre, and a residual set of patients unaffected by the network. The parties submitted this has the effect of inflating referrals to RSC, as it is the hub of the St. Luke's Cancer Alliance. According to the parties, as these referrals are included in the specialty analysis the GP

---

parties' exposure to competition. For example setting thresholds of between 10% and 50% results in a reduction of around 59% of marginal GP activity, whilst with these set at between 10% and 70% the reduction is around 64%.

referral analysis is not a good indicator of preferences in respect of patients who are unlikely to require more complex treatment as it will overstate their preferences in favour of RSC.<sup>49</sup> By analysing the patient sets together, the choices of the patients affected by the network are being used to imply something about the preferences of those not affected by the network.

95. In respect of the first point, the CMA has taken account of the effect of networks where it has evidence that there is only one provider active in the provision of a certain service, eg inpatient services, and that there is therefore no competition because certain types of activity follow a mandatory pathway. The CMA asked the parties to provide information clarifying the extent to which the networks removed choice over entire treatments, which may make up a significant part of a specialty. The parties provided some limited information regarding the manner in which the networks which they are part of currently operate. However, based on the evidence available to the CMA, the CMA considers that in relation to all network specialties with the exception of vascular surgery<sup>50</sup> in this case, there may nonetheless be an overlap between the parties particularly as regards the more routine elements of those specialties. This was particularly the case for the cancer-related specialties.
96. Further, in some specialties, the parties submitted that the network arrangements mean that services are delivered by consultants from another hospital (generally RSC) and that there was accordingly no competition between them. However, in line with previous decisions<sup>51</sup> the CMA does not consider that sharing of consultants in itself removes incentives to compete. The CMA considers that, based on the evidence it received during its investigation, the remuneration of the providers is structured in such a way that the parties retain incentives to attract patients in competition with each other. Accordingly the CMA has assessed the extent of overlap on a specialty-by-specialty basis, taking account of the evidence it received.
97. In respect of the second point at paragraph 94(b), not all services (and therefore not all referrals) are affected by the existence of a network. The parties did not provide information on the relative proportions of network-affected to non-network-affected referrals in any specialty. The parties' arguments are thus difficult to assess. It could be, for example, that routine activity (which might result in a high degree of anticipation of required

---

<sup>49</sup> That is, the submission suggests that the GP referral analysis assumption that patients have homogenous preferences is incorrect.

<sup>50</sup> The parties submitted to the CMA that RSC does not earn any revenue in this specialty from commissioners because of network arrangements with FPH; see further Annex C.

<sup>51</sup> Bournemouth/Poole, paragraphs 6.133 to 6.142.

treatment) makes up the vast proportion of activity and the effect of networks is consequently small (see paragraph 69).<sup>52</sup>

#### *How choice is exercised*

98. The parties submitted their choice of provider is only exercised in relation to their first outpatient appointment, not the inpatient treatment.<sup>53</sup> Therefore the parties submitted that measures of closeness in inpatient activity are irrelevant, given that the patient's choice is in relation to outpatient procedures only. However, as noted above, the parties submitted there may be an anticipation effect for some referrals.
99. The CMA considers that the patient's right to choice in relation to the first outpatient appointment provides incentives for providers to compete in relation to inpatient activity, since some patients and GPs will choose their first outpatient appointment on the expectation that treatment will involve admission. As noted in paragraph 86 above, the CMA does not consider that GPs are only likely to have sufficient understanding of a provider's services to exercise choice in relation to outpatient appointments. This does not mean that in all cases a GP will have foresight of follow-on treatment, but rather that GPs will guide patients in exercising choice based on a range of quality factors, some of which may reflect specialty-level information and others which may relate to hospital-wide quality factors. This quality information relates to both inpatient and outpatient services.
100. On this basis, the CMA has considered the effects of the merger on both inpatient and outpatient activity.

#### ***Elective services – the impact of the merger at hospital level***

101. The CMA considered whether the merger might reduce the parties' incentives to maintain and provide better quality services to patients and value for money for commissioners in the provision of elective services for the individual specialties below (see paragraph 125 and Annex C). In addition, the CMA considered whether the merger might reduce incentives to maintain and improve the quality of services more widely than the individual specialties where the parties appear particularly close alternatives.<sup>54</sup> This is because

---

<sup>52</sup> The CMA agrees with the parties that GPs will have some foresight into treatment that may be required in some circumstances and considers that when choosing provider, and notes the parties' views that this foresight may be stronger when networks are in place.

<sup>53</sup> NHS patients in England have a right to choice of a provider for their first outpatient appointment for elective care.

<sup>54</sup> This arises because certain aspects of quality are set at the hospital level and/or patient choice might be driven by considerations of quality which are only observable at the hospital level. Therefore providers may have

patient choice may be based on aspects of quality which are broader than individual specialties, either because aspects of quality are set at hospital level (for example the availability of facilities) or are reported at hospital level (for example infection control, re-admission and mortality rates). The greater the extent of overlap between providers at specialty level, the greater is the extent to which providers have incentives to improve hospital wide quality, since the potential for gaining additional revenues is greater as a result of the overlap.<sup>55</sup> The CMA has therefore assessed the extent of competition between the parties at a hospital level and the constraint from other providers that would endure post-merger.

102. In considering the impact of this merger at hospital level, the CMA has taken account of the range of competitors surrounding the merging parties (as noted below) and also the fact that the merging parties operate three hospital sites located over a wide geographic area. The set of competitors may differ between sites. The CMA also noted whether there were any population centres located between the parties' sites, where the parties are particularly important alternatives for a large proportion of patients.

#### *Parties' submissions*

103. The parties submitted that there are a number of alternative providers of acute NHS services in the area immediately surrounding their trusts. They note that their typical catchment areas overlap with those of other providers, such that patients and GPs are unlikely to see a significant reduction in the number of alternative providers. Therefore, the parties submitted that the merged entity could not reduce service quality without facing a loss of patients to these alternatives. The parties also made this submission with specific reference to the constraint they face in individual specialties where they overlap.
104. The parties submitted that the constraint that other providers exert is evidenced through internal documents, such as an internal ASP document which states that 'ASP now operate(s) in an increasingly competitive environment where we need to meet the needs of our customers better than our local competitors to be the first choice provider'.<sup>56</sup> The parties also pointed to the fact that they generally monitor a number of other local providers, for example in terms of their offer or the evolution of shares across GP practices. The CMA has carefully considered internal documents alongside the other sources of evidence noted above at paragraph 92. The CMA notes that these

---

incentives to improve the quality of services above the level of the specialty and that mergers between providers which compete closely across a large proportion of their service offering, may lead to unilateral effects at the hospital level.

<sup>55</sup> Bournemouth/Poole, paragraph 6.31.

<sup>56</sup> ASP January 2013 Marketing Report, Appendix 8.17 of the parties' submission.

documents also show that the parties consider each other as competitors in a range of specialties and that they also consider a number of other providers as competitors – the documents indicate that the range of these differs depending on specialty. The CMA has taken this information into account in its specialty level analysis.

105. The parties submitted that on the basis of 80% catchment areas, the majority of GP practices would not experience a material reduction in the number of available providers.<sup>57</sup> However, the CMA notes that these calculations are based on isochrones<sup>58</sup> from the parties' competitors which do not account for their actual catchment areas. That is, isochrones do not consider from where the majority of the Trust's patients are drawn and as such do not account for the geographic dispersion of patients.<sup>59</sup>
106. The CMA considers that this is an important factor as the evidence indicates patient preferences are likely to be driven to a significant extent by location and transport options. In this respect, the referral analysis and marginal GP analysis (discussed further at Annexes A and B) is a more reliable indicator, as it shows the current preferences being made. These revealed preferences will also reflect differences in other non-spatial factors such as quality.

#### *Extent of service overlaps*

107. The parties told the CMA that there are 82 specialties in which either one or both of the parties provides services in the financial year 2013/14. ASP recorded activity in 62 specialties, while RSC recorded activity in 63 specialties. The parties overlap across the majority of large specialties which they provide and account for around 79% of elective outpatient activity and around 85% of elective inpatient activity. Third parties were generally of the view that the parties provided a similar range of high volume District General Hospital services and offered a differentiated subset of specialist services.
108. The parties' catchment areas overlap significantly as can be noted in Figures 2 and 3 above. Figure 4 below shows a plot of GP referrals which are directed towards the parties and other providers. As can be noted therein, the parties' elective activity is drawn from across Surrey, but significantly concentrated around their sites. For example in Guildford, the vast majority of activity is referred to RSC with limited volumes being referred to other providers. The

---

<sup>57</sup> The parties submitted that an additional four GP practices would be in the catchment area of only one trust as a result of the merger.

<sup>58</sup> An isochrone defines a geographic area around a target point based on travel time (in this case drive time). For example the CMA found that on the basis of catchment areas, the majority of GP practices within the Frimley Park Hospital 80 % catchment area are located to the West of the provider. Therefore an isochrone approach would give undue weight to the East of the provider.

parties appear to overlap significantly in the densely populated areas in Surrey between RSC Hospital and St Peter's Hospital such as Woking. The CMA notes that these overlap areas account for significant volumes as indicated by the activity bubbles.

#### **Figure 4: Parties' share of referrals by postcode district**

[✂]

109. The above would suggest that the parties are likely to be important alternatives across a significant proportion of their offering, particularly for areas located between their sites.

#### *Shares of provision*

110. The parties submitted shares of provision for the six CCGs which commission services across Surrey.<sup>60</sup> The parties' combined shares for Surrey-based elective services are 43% for outpatient services and 44% for inpatient services. FPH has a share of 21% for both outpatient and inpatient services. Epsom & St Helier, and Surrey & Sussex each have around 10% share. The CMA considers that these shares are a useful indication of the extent to which the parties overlap across their catchment areas for elective services.

#### *GP referrals*

111. The parties provided calculations of the GP referral analysis at trust level, which indicated that patients' preferred alternative to ASP would be RSC, but for RSC it would be FPH rather than ASP.
112. The CMA sets out the results of its own analysis below and its interpretation of the results, in light of the other evidence collated through its enquiries.
113. The CMA's GP referral analysis shows that RSC as the closest alternative to ASP,<sup>61</sup> with approximately [25–35]% of ASP referrals coming from GP practices where RSC is the next best alternative. The second closest alternative to ASP at a trust level is West Middlesex with [10–20]%.
114. Similarly, looking at a site level, the CMA considered whether the parties are closest alternatives in relation to their St Peter's and RSC hospital sites. The GP referral analysis suggests that RSC is the next best alternative to St Peter's for around [30–40]% of referrals and is a significantly stronger

---

<sup>60</sup> These account for around 90% of CCG commissioned income at ASP and around 82% at RSC.

<sup>61</sup> That is, referrals from practices where ASP is the most popular choice and RSC the second most popular choice account for 30% of ASP's referrals.

alternative than other providers. The 80% catchment areas for St Peter's, RSC and FPH (including Heatherwood and Wexham Park Hospitals) overlap heavily, and with other providers to a much lesser extent.

115. The trust level results also show that RSC's second closest alternative is ASP ([10–20]%); the closest alternative is FPH ([25–35]%). At a trust level the constraint between the parties is therefore asymmetric. The CMA considers that this analysis suggests that the parties are close competitors – in particular that RSC is the closest alternative to ASP, and that this is driven by the close geographic proximity of the RSC and St Peter's sites.
116. A useful way to assess potential effects at hospital level (in addition to the aggregated referral analysis discussed above) is to aggregate the revenues from specialties where competition concerns may arise and consider whether this may be sufficient to affect incentives at a hospital level. This is because the aggregated trust level analysis does not account for the variation in how closely the parties compete in the different specialties.
117. The CMA considered the impact of the merger on competition in individual specialties in paragraphs 125 to 136 below. The CMA has found that the parties overlap across a significant proportion of elective specialties (31) which account for a large share of total elective referrals (around 90% for both parties).<sup>62</sup> The CMA has also found that the merger may lead to a loss of competition in a number of specialties which account for a large proportion of total elective activity for the parties (total patient volumes in the affected specialties are approximately [75,000–125,000] which is around [20–30]% of total elective activity across the two trusts).<sup>63</sup> Therefore the CMA considers that given the impact of the merger at specialty level, the merger may also reduce the parties' incentives to maintain and improve their offer to patients at the hospital level.

#### *Internal documents*

118. Internal documents of the parties suggest that they consider each other as well as other providers in assessing their offer and their share of provision across Surrey.
119. The CMA has seen a number of internal documents which describe plans to defend and grow market share from each of the parties, which often provide a

---

<sup>62</sup> See for example the parties' submissions Tables 8 and 9.

<sup>63</sup> Further, the CMA has not found it necessary to conclude on the merger's effect on competition with respect to colorectal surgery, endocrinology, gastroenterology, diabetic medicine, anaesthetics, anticoagulant service, upper gastrointestinal surgery, general medicine and geriatric medicine (on an inpatient and/or outpatient basis).

detailed plan for individual specialties or narrow geographic areas. For example one ASP internal document notes that the trust [REDACTED]<sup>64</sup> An RSC internal document notes that the trust plans to [REDACTED].<sup>65</sup>

120. Another RSC document notes that ‘... whilst market research indicates that proximity remains the most significant single factor affecting choice of hospital provider – national quality factors and waiting times appear to be assuming increasing importance’.<sup>66</sup> This document and others suggest that patient choice between providers depends significantly on the location of providers and their offer to patients.
121. Collectively, these indicate that the parties have incentives to compete for elective referrals and consider patient choice and constraints from other parties when considering their growth strategies.
122. One ASP internal document states that [REDACTED].<sup>67</sup> Another ASP document states that the trust is planning to [REDACTED].<sup>68</sup> An ASP internal document states that [REDACTED].<sup>69</sup> Other internal ASP documents note [REDACTED].<sup>70</sup>
123. The CMA considers that the evidence on the internal documents suggests that the parties compete with a number of other providers, including each other. The CMA considers this evidence is consistent with the results of the GP referral analysis.

### *Third party views*

124. Third parties (predominantly other providers, but including some commissioners) generally considered the parties as likely to be important alternatives, particularly in relation to patients in areas in between the parties’ sites, such as Woking, but also Guildford, Runnymede and Surrey Heath. Several noted that the merger would significantly reduce patient choice in these areas and more broadly across Surrey. Third parties also said that the impact on patient choice would likely be more profound depending on the way services are configured between their sites and that the merger could lead to reduced access and longer travel times for patients. Some noted that this would lead to reduced competition between providers across Surrey.

---

<sup>64</sup> ASP Operational Plan Document for 2014-16.

<sup>65</sup> RSC Strategic Plan Document for 2013-14.

<sup>66</sup> RSC Forward Plan Strategy Document.

<sup>67</sup> Integrated Business Plan ASP FT Application, September 2010.

<sup>68</sup> ASP Forward Plan Strategy Document 2012-2013.

<sup>69</sup> ASP Marketing Report, June 2012.

<sup>70</sup> ASP Marketing Report, January 2011.

***Horizontal unilateral effects in elective services - the impact of the merger at specialty level***

125. The CMA next considered whether the merger might reduce incentives to improve the quality of services in the provision of any of the 32 elective specialties in which they overlap (Table 1).

**Table 1: Overlap specialties<sup>71</sup>**

1 – ENT
2 – Joined Oral and Maxillo-Facial Surgery
3 – Breast Surgery
4 – General Surgery
5 – Joined Audiology and Audiological Medicine
6 – Medical Oncology
7 – Gynaecology
8 – Colorectal Surgery
9 – Endocrinology
10 – Gastroenterology
11 – Diabetic Medicine
12 – Anaesthetics
13 – Anticoagulant Service
14 – Upper Gastrointestinal Surgery
15 – General Medicine
16 – Geriatric Medicine
17 – Trauma & Orthopaedics
18 – Joined Ophthalmology and Orthoptics
19 – Rheumatology
20 – Pain Management
21 – Urology
22 – Joined Paediatrics
23 – Dermatology
24 – Neurology
25 – Clinical Haematology
26 – Joined Midwife Episode and Obstetrics
27 – Respiratory Medicine
28 – Orthodontics
29 – Cardiology
30 – Cardiothoracic Surgery
31 – Transient Ischaemic Attack
32 – Vascular Surgery

126. The CMA's detailed analysis of the likely effects of the merger in relation to these specialties is detailed in Annex C. For each specialty and against the

---

<sup>71</sup> This table includes some instances where TFCs have been combined to accurately capture an overlap; see Annex A, paragraph A.13.

wider competitive background set out above, the CMA has considered evidence including GP referral analysis results (on inpatient and outpatient bases); implications of networks and consultant-to-consultant referrals, day-case/inpatient split; marginal GP analysis, the parties' submissions and third party comments.

127. Moreover, the CMA carefully considered the parties' arguments surrounding coding issues. The parties submitted that given different providers coded some treatments differently (eg general surgery) the referral analysis is misleading. In particular the parties told the CMA that they were concerned that the CMA had not taken into account the differences between them and FPH, a major provider in the area. For some of the treatment specialties the CMA was able to corroborate with FPH that it did adopt a different coding method to ASP and RSC. However, the CMA does not have sufficient evidence to assess the impact of these coding differences. The parties provided a revised referral analysis which attempted to address the different approach to coding undertaken by FPH in some specialties by reallocating activity from General Surgery or General Medicine for some miscoded specialties, based on RSC's proportion of activity in each affected specialty. However, the CMA had concerns about the methodology used to calculate this proportion. As such, the CMA ultimately relied on its own sensitivity tests (which reallocated some referral activity into an aggregated category). The analysis undertaken is set out in Annex C.
128. On placing weight on the GP referral analysis the CMA has not applied a threshold as an indicator of prima facie concerns. However the CMA notes for all specialties where the CMA considers there is realistic prospect of an SLC, the proportion of referrals where the parties are each other's next best alternative is over 40% on the proportional measure (with most markets being considerably more than that).
129. As a result of this the CMA has found that the merger gives rise to a realistic prospect of an SLC in 13 markets across 7 treatment specialties.
130. The CMA concludes that there is a realistic prospect of unilateral effects resulting from the merger in relation to:
  - (a) Inpatient elective acute services in ENT, breast surgery, general surgery, oral and maxillo-facial surgery, medical oncology and gynaecology; and outpatient elective acute services in ENT, joined oral and maxillofacial surgery, breast surgery, general surgery, joined audiology and audiological medicine, medical oncology and gynaecology.

In aggregate, the total number of patients receiving treatment from the parties in these specialities is approximately [75,000–125,000] per year<sup>72</sup> which is around [20–30]% of total elective activity across the two trusts.<sup>73</sup>

131. In these specialities the CMA considers the available evidence indicates the parties are close competitors. The evidence indicates that the merged trust would face limited constraints from other providers in these specialities, and the CMA did not find evidence to indicate that other factors, such as networks, would remove patient choice. The CMA sets out its detailed assessment and conclusions (including an explanation of the impact on inpatient and outpatient services separately) at Annex C.
132. In relation to joined ophthalmology and orthoptics, rheumatology, pain management, urology, joined paediatrics, dermatology, neurology, clinical haematology, joined midwife episode and obstetrics, respiratory medicine, orthodontics, cardiology, cardiothoracic surgery, transient ischaemic attack, and vascular surgery, the CMA considers, on the basis of its analysis, that there is no realistic prospect of an SLC as a result of the merger in relation to inpatient or outpatient elective acute services. A number of these specialities have referral figures of below 30% on the proportional measure. For those specialities with higher referral figures, the CMA has received other evidence on the basis of which it considers there is no realistic prospect of an SLC. The CMA sets out its findings at Annex C.
133. The CMA has not found it necessary to conclude given its findings above in relation to trauma and orthopaedics, colorectal surgery, endocrinology, gastroenterology, diabetic medicine, anaesthetics, anticoagulant service, upper gastrointestinal surgery, general medicine and geriatric medicine. The CMA sets out its detailed analysis (including an explanation of the impact on inpatient and outpatient services separately) at Annex C.

#### *Conclusion on horizontal unilateral effects in relation to elective services*

134. Accordingly, the CMA considers that there is a realistic prospect that the proposed merger may give rise to an SLC in 13 markets across 7 treatment specialities comprising 6 inpatient markets and 7 outpatient markets. The CMA further considers, given the size and importance of the affected specialities,

---

<sup>72</sup> Based on SUS activity data for 2013/14.

<sup>73</sup> Further, the CMA has not found it necessary to conclude on the merger's effect on competition with respect to colorectal surgery, endocrinology, gastroenterology, diabetic medicine, anaesthetics, anticoagulant service, upper gastrointestinal surgery, general medicine and geriatric medicine (on an inpatient and/or outpatient basis).

that this reduction in competition could also manifest itself in a reduction in the quality of elective services at a hospital level.

135. In relation to 10 further specialties,<sup>74</sup> the CMA finds on the basis of the evidence available that the proposed merger may potentially raise competition concerns, but has not found it necessary to conclude in this regard.
136. In relation to 15 further specialties,<sup>75</sup> the CMA finds, based on the evidence available, that there is no realistic prospect of an SLC in relation to inpatient or outpatient elective acute services on the basis of its analysis.

### ***Horizontal unilateral effects in the provision of overlapping non-elective services***

137. Non-elective care involves the admission of a patient through the Accident and Emergency (A&E) department. The parties overlap across the majority of their non-elective services and this accounts for a significant proportion of the total activity for the parties (around 80% of their combined activity). Generally, a sizeable proportion of non-elective hospital activity originate from GP referrals, where the patient together with the GP exercise a degree of choice. For these referrals, actual and perceived quality differentials are likely to play a role in their choice of provider. Therefore, there may be incentives for providers to compete for such referrals and by implication, mergers between closely competing providers may reduce their incentives to maintain the quality of services and other aspects of their offer to patients in non-elective services. The CMA has examined the provision of non-elective services in terms of competition in the provision of these services and competition for the provision of these services.
138. The parties submitted that non-elective care does not involve patient choice. This is because of the urgent and unplanned nature of this type of care, whereby patients can be expected to attend their nearest A&E department.
139. This was corroborated by the parties' internal documents and third party comments received during the CMA's investigation. The CMA agrees that the majority of non-elective activity relates to A&E attendances where patient choice and quality considerations are not key drivers to treatment location.

---

<sup>74</sup> Colorectal surgery, endocrinology, gastroenterology, diabetic medicine, anaesthetics, anticoagulant service, upper gastrointestinal surgery, general medicine, trauma and orthopaedics and geriatric medicine.

<sup>75</sup> Joined ophthalmology and orthoptics, rheumatology, pain management, urology, joined paediatrics, dermatology, neurology, clinical haematology, joined midwife episode and obstetrics, respiratory medicine, orthodontics, cardiology, cardiothoracic surgery, transient ischaemic attack, and vascular surgery.

140. Further, the CMA considers that the parties' incentives to compete for non-elective activity are likely to be limited because the marginal emergency tariff rate is likely to have reduced the parties' incentives to compete for additional activity and revenues (the parties told the CMA that non-elective A&E activity at all trusts is subject to a cap, whereby any activity in excess of 2008-09 levels is paid at 30% of the normal tariff).<sup>76</sup> Capacity considerations may have further limited incentives to compete, particularly during peak demand periods.<sup>77</sup>
141. In relation to competition for the market, that parties submitted that while possible, there have been no tenders issued for specialised non-elective services over the last 5 years. The parties also said that analysis of NHS England commissioning plans or the local area team for Surrey and Sussex, does not suggest that there are plans to reconfigure specialised services (including non-elective). Commissioners told the CMA that there are plans to repatriate a limited number of specialist services from London (involving the reconfiguration of Vascular Surgery, Renal inpatient and Primary PCI). There are no significant plans to reconfigure non-elective services.
142. The CMA concludes that the merger does not raise a realistic prospect of an SLC in the provision of non-elective services.

#### ***Horizontal unilateral effects in overlapping community services***

143. The parties submitted that the majority of services in Surrey are provided by Virgin Care, who were awarded a 5 year contract by Surrey Health to provide the community services from September 2011. In relation to their own community services, the parties submitted that these are very minimal, either where the trust provides these as part of legacy arrangements or where the trusts have won the rights through tenders to provide these services. The parties further submitted that there was no overlap between their community services.
144. The CMA asked for details of the competitive tenders the parties had participated in. The parties submitted that between 2009 and 2014, the parties participated in 15 competitive tenders. The majority were for Any Qualified Provider (AQP) services, whereby any provider that met the specified terms

---

<sup>76</sup> The parties' main commissioners told the CMA that in the last year both parties had been subject to year-end settlements.

<sup>77</sup> For example in early 2015, St Peter's Hospital experienced capacity shortages due to emergency services demand, resulting in cancellations to planned procedures to handle the increased emergency activity. See the [national health executive website](#).

could offer the services to patients. There was only one occasion where the parties bid for the same tender over this period.

#### *Competition in the market for community services*

145. The parties do not overlap in the provision of community services, with ASP providing some limited services (ASP ophthalmology in Hounslow and RSC physiotherapy in Surrey and Hampshire).
146. The CMA further notes that a significant proportion of the 15 tenders in which the parties participated have related to AQP service provision, which is a two stage competitive process. Bidders compete to be selected as an approved provider for the services, but then patients retain choice over the successful bidders. Therefore this type of competitive interaction retains both elements of competition for the market and competition in the market. This suggests that commissioners in the local area are able to introduce choice and competition in individual service areas, and as such mitigate against the risk of a reduction in competition in the market for community services, which is unlikely to arise as a result of this merger in any event.

#### *Competition for the market in community services*

147. The parties have only bid together in 1 out of 15 tenders during that period. The parties have also competed against a number of other providers
148. The CMA contacted the main CCGs which the parties draw activity from and they did not raise any significant concerns in relation to competition for the market in community services. Few third party respondents noted that historically the parties had avoided head-to-head competition for tenders.
149. Third parties did not raise concerns in relation to the impact of the merger on competition in or for the market in community services. Regarding competition in the market, the parties do not currently overlap in any services. In relation to competition for the market, the CMA notes that there has been very little competitive interaction between the parties historically and they have (in their separate or overlapping tenders) competed against a number of other credible providers.

#### *Conclusion*

150. Taking the above factors into account the CMA considers that the merger does not raise a realistic prospect of an SLC in relation to community services, either in or for the market.

### ***Horizontal unilateral effects in the provision of overlapping private patient services***

151. The parties submitted that they currently provide very limited private patient services. The parties submitted that this was due to the co-location of independently run private patient units. [✂]
152. The parties submitted that given the limited overlap, the merger could not lead to a reduction in competition for private patient services. The CMA did not receive any third party concerns about private patient services, and is further aware of a number of credible alternatives in the area, including Nuffield Health, Spire Healthcare and Ramsay Healthcare, as well as private patient units at NHS providers (for example Parkside Suite which is part of FPH). The CMA has not seen any evidence to suggest that the parties would have been likely to compete more strongly in the provision of private patient services in the future.
153. Given the limited overlap, the lack of third party concern, and the availability of alternatives, the CMA considers that the merger does not lead to a realistic prospect of an SLC in the provision of private patient services.

### ***Rivalry enhancing efficiencies***

154. The parties submitted that the merger will lead to rivalry enhancing efficiencies that will deliver greater competition for patient referrals in a number of key specialties, including breast surgery, urology,<sup>78</sup> ENT and maxillo-facial surgery, through a proposed DTC at Ashford Hospital. The parties said that in addition to the benefits that patients will experience as a result of the new services (for example shorter travel times to radiotherapy and complex chemotherapy), the DTC will result in the merged Trust becoming a more effective competitor for referrals in the key cancer specialties. The parties submitted that the new services will compete for referrals in the area surrounding Ashford Hospital and the merged Trust will have an incentive to invest in the DTC and compete for these referrals.
155. The parties also submitted that the DTC would be a relevant customer benefit within the meaning of the Enterprise Act, discussed below.
156. When assessing whether claimed efficiencies enhance rivalry the CMA will wish to be satisfied on the basis of compelling evidence that the efficiencies in

---

<sup>78</sup> The CMA has not found an SLC in relation to urology. As rivalry enhancing efficiencies must arise in the market where an SLC is found, the CMA has not considered urology further.

question are merger specific and are likely to be timely, likely and sufficient to prevent a SLC from arising.<sup>79</sup>

157. In terms of merger specificity, the parties submitted that the cancer DTC will require the joint personnel and skills of each of the trusts, and the merged trust will be financially stronger than the two trusts would be acting alone, which will allow it to manage the risk of lower than expected demand for the cancer DTC. The parties submitted that establishing a DTC through partnership would take longer than via a merger.<sup>80</sup> The parties put forward that the merger would allow RSC's cancer expertise to be coupled with ASP's ability to attract patients and increase the overall pool of patients using the parties' cancer services across the RSC and ASP sites. The parties submitted that this is unlikely to occur without the merger since cancer treatments are not a strategic priority for ASP.
158. The CMA notes that an efficiency which can be achieved otherwise than through merger is not considered merger specific in the context of rivalry enhancing efficiencies.<sup>81</sup> Instead the CMA assesses the purported rivalry enhancing efficiency against what would be the case without the merger. On a cautious basis, therefore, the CMA does not find that the proposed cancer DTC is merger-specific, because it could equally be achieved through partnership. Nevertheless, the CMA has gone on to consider whether the claimed efficiency is timely, likely and sufficient to prevent an SLC from occurring.
159. The parties further submitted that the DTC will also provide stronger competition for patient referrals in cancer treatments. They submitted that while the DTC will serve some patients that would have been referred to ASP/RSC in any event, it will also compete to attract additional referrals of cancer patients.
160. The CMA has considered how likely this efficiency is to materialise. We spoke to the parties' main commissioners, who, while supportive of the case in principle, considered that the DTC could struggle to attract sufficient volumes. One commissioner submitted that, generally speaking, the business case for the merger was predicated on more optimistic planning assumptions than have proved to be the case, and growth related assumptions about

---

<sup>79</sup> MAG paragraph 5.7.4.

<sup>80</sup> Based on the experience of the cancer treatment centre at East Surrey Hospital in partnership with Surrey & Sussex Healthcare NHS Trust.

<sup>81</sup> Although such a distinction can be made when considering RCBs ([CMA guidance on the review of NHS mergers](#), footnote 94).

repatriations of London Specialist Commissioning have not been supported. These comments cast doubt on the change materialising.

161. Monitor's view on certain aspects of implementation and likelihood in terms of RCBs is also pertinent to the assessment of rivalry enhancing efficiencies. Monitor considers that there are a number of uncertainties around the detailed assessment of the risks and viability of this proposal including: the number of patients who would be attracted to the proposed cancer centre at Ashford Hospital, the response of other hospitals, the actual costs of the proposal and the sensitivity of the proposal to the assumptions (ie how viable it is if some of the assumptions are not borne out).
162. The CMA has taken account of the parties' submissions, the views of the relevant Commissioners, and Monitor's assessment of likelihood of implementation (albeit in the context of RCB analysis but still pertinent to this analysis). On the available evidence in this case the CMA considers that the proposed DTC does not meet the requisite standard as a rivalry enhancing efficiency because there is insufficient evidence that the efficiencies in question are likely to occur. The CMA has therefore not found it necessary to conclude as to whether the proposed DTC would occur in a timely manner or be sufficient to enhance rivalry so that the merger does not give rise to an SLC.

### ***Barriers to entry and expansion***

163. Entry, or 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 considers whether such entry or expansion would be timely, likely and sufficient.<sup>82</sup> To the extent that the parties have made specific submissions about entry in certain specialties, these have been reflected above.
164. The parties have not made any submissions on ease of entry or expansion more generally and no other evidence has been provided to the CMA to indicate that entry or expansion is likely on a significant scale in the near future.
165. Based on previous analysis<sup>83</sup> and in the absence of evidence indicating entry or expansion, the CMA considers that entry or expansion would not be

---

<sup>82</sup> [Merger assessment guidelines](#), from paragraph 5.8.1 and [NHS Mergers Guidance](#), paragraph 6.73.

<sup>83</sup> Bournemouth/Poole, [Frimley/Heatherwood](#), [Chelsea/WMUH](#).

sufficiently timely or likely to prevent a realistic prospect of an SLC as a result of the merger.

### **Third party views**

166. The CMA contacted commissioners, competitors, and patients. The majority of competitors and a small number of commissioners raised some competition concerns regarding a loss of choice in areas where the parties' catchments overlapped.
167. Third party comments have been taken into account where appropriate in the competitive assessment above.

### **Conclusion on unilateral effects analysis**

168. Based on the evidence set out above and in Annexes A-C, the CMA believes that it is or may be the case that the merger may be expected to result in a realistic prospect of an SLC as a result of horizontal unilateral effects in relation to:
- (a) inpatient elective acute services in ENT, breast surgery, general surgery, oral and maxillo-facial surgery, medical oncology and gynaecology; and
  - (b) outpatient elective acute services in ENT, joined oral and maxillofacial surgery, breast surgery, general surgery, joined audiology and audiological medicine, medical oncology and gynaecology.

### **Exceptions to the duty to refer**

#### ***Relevant customer benefits***

169. Section 33(2)(c) of the Act allows the CMA to exercise its discretion not to make a reference under section 33 if it believes that RCBs in relation to the creation of the relevant merger situation outweigh the SLC concerned and any adverse effects resulting from it.
170. Section 30 of the Act defines RCBs:
- (1) *For the purposes of this Part a benefit is a relevant customer benefit if—*
    - (a) *it is a benefit to relevant customers in the form of—*
      - (i) *lower prices, higher quality or greater choice of goods or services in any market in the United Kingdom (whether or not the market or*

*markets in which the substantial lessening of competition concerned ... may occur); or*

*(ii) greater innovation in relation to such goods or services; and*

*(b) the decision-making authority believes ...*

*(3) ... that—*

*(a) the benefit may be expected to accrue within a reasonable period as a result of the creation of the relevant merger situation concerned; and*

*(b) the benefit is unlikely to accrue without the creation of that situation or a similar lessening of competition.*

171. In the context of NHS mergers, Monitor has a specific role in advising the CMA on whether there are RCBs arising from the merger. Section 79(5) of the HSCA requires Monitor to provide advice to the CMA as soon as reasonably practicable after receiving notification that the CMA is investigating a merger involving an NHS Foundation Trust.<sup>84</sup>
172. Specifically, Monitor is required to provide advice on the effect of the merger under investigation on relevant customer benefits for people who use health care services provided for the purposes of the NHS, and such other matters relating to the merger as Monitor considers appropriate.
173. In undertaking its assessments of RCBs Monitor examines the following three questions:
- (a) Is the proposal likely to represent a real improvement in quality, choice or innovation of services for patients or in value for money for commissioners?
  - (b) Is the proposal likely to be realised within a reasonable period as a result of the merger?
  - (c) Is the proposal unlikely to accrue without the merger or a similar lessening of competition?

---

<sup>84</sup> See also [NHS Mergers Guidance](#), paragraph 7.5.

174. Detailed information on Monitor's approach to assessing merger benefits is set out in its guidance *Supporting NHS providers: guidance on merger benefits*.<sup>85</sup>
175. Monitor's advice is not binding on the CMA. However the CMA will place significant weight on Monitor's advice on the patient benefits of the merger.<sup>86</sup> The CMA is conscious that the level of information required to demonstrate a benefit will vary on a case-by-case basis.<sup>87</sup>
176. To qualify as a RCB, that benefit must have accrued or be expected to accrue to relevant patients (and/or commissioners) within the UK within a reasonable period from the merger and would be unlikely to accrue absent the merger.<sup>88</sup> What is a reasonable period will be assessed by the CMA on a case-by-case basis taking account of the nature of the proposed benefit and the circumstances of its implementation.<sup>89</sup> It should be noted that although a RCB must accrue to patients (and/or commissioners) of the merging parties, they need not necessarily arise in the market(s) where the SLC concerns have arisen.

#### *The parties' benefits case and Monitor's advice*

177. The parties submitted a benefits case to Monitor. Throughout the process the CMA has liaised closely with Monitor on the benefits case. On 22 January 2015 Monitor provided the CMA with advice on the parties' claimed benefits pursuant to section 79(5) HSCA. The CMA has placed significant weight on it in this case.
178. The parties put forward that the merger would lead to relevant customer benefits in six areas: gastroenterology services, stroke services, interventional radiology services, neonatal cot management, diabetes and neurology services and development of a cancer centre at Ashford Hospital.
179. Monitor has advised that three of these treatment areas should be taken into account as relevant customer benefits:
- (a) **Gastroenterology: improved care for emergency patients.** The establishment of the shared cross-site rota would enable the parties to establish a shared cross-site rota for consultants on a 1:8<sup>90</sup> basis to

---

<sup>85</sup> Monitor (2014), *Supporting NHS providers: guidance on merger benefits*.

<sup>86</sup> *NHS Mergers Guidance*, CMA 29, paragraph 7.6.

<sup>87</sup> *NHS Mergers Guidance*, CMA 29, paragraphs 7.14 to 7.23.

<sup>88</sup> *NHS Mergers Guidance*, CMA 29, paragraph 7.15.

<sup>89</sup> *NHS Mergers Guidance*, CMA 29, paragraph 7.16.

<sup>90</sup> A 1:8 rota means that there are 8 consultants on the rota and each one works 1 in every 8 days

deliver care out of hours and at weekends on a formal and stable basis. Monitor found that this would be a clinical improvement<sup>91</sup> (including a reduction in mortality rates) realised for 300 emergency patients a year who present at the two Trusts out of hours or at weekends with life-threatening problems, who would otherwise be transferred or have to wait until Monday for treatment. In Monitor's view this proposal is likely to be implemented within a timeframe of 6–9 months following completion of the merger and would be implemented by the parties with greater certainty than through a partnership or individually, and most quickly, through merger.

- (b) **Gastroenterology: treatment and discharge.** Post-merger the parties would establish a shared cross-site rota for consultants on a 1:8 basis, enabling them to deliver weekend ward-rounds. Monitor found this would be an improvement realised most quickly by merger for a subset of 770<sup>92</sup> patients admitted across both Trusts at weekends, who would receive quicker treatment and be discharged more quickly. In Monitor's view this proposal is likely to be implemented within a reasonable timeframe and would be implemented by the parties with greater certainty than through a partnership or individually, and most quickly, through merger.
- (c) **Stroke: improved care for emergency patients (earlier consultant review).** Post-merger the parties would establish a shared cross-site rota for consultants on a 1:6<sup>93</sup> basis, enabling them to deliver weekend ward-rounds and earlier consultant review. Monitor found this would be a clinical improvement, clinically significant for those patients it affects, in emergency treatment for 250 patients admitted at a weekend. In Monitor's view this proposal is likely to be implemented within a reasonable timeframe and would be implemented by the parties with greater certainty than through a partnership or individually, and most quickly, through merger. However, Monitor noted that a commissioner-led review of stroke services is currently underway in Surrey. Monitor considered the outcome of this review is likely to require designated hyper acute stroke units to provide weekend ward rounds. The review is therefore likely to result in the proposed improvement for stroke patients in Surrey whether or not the merger goes ahead. Monitor considered that the parties' proposal is likely to be implemented at least one year before any implementation arising

---

or weekends.

<sup>91</sup> Monitor describes clinical importance as being potentially very important for the patients [the benefit] affects.

<sup>92</sup> This 770 includes some of the emergency patients previously discussed, but it is not known how many of the 770 they represent.

<sup>93</sup> This number includes one vacancy to be filled. A 1:6 rota means that there are 6 consultants on the rota and each one works 1 in every 6 days or weekends.

from the commissioner review (but that the benefit would not persist beyond the implementation of the review).

(d) **Stroke: discharge.** Post-merger the parties would establish a shared cross-site rota for consultants on a 1:6<sup>94</sup> basis, enabling them to deliver weekend ward-rounds and earlier consultant review. Monitor found this would be an improvement for 470 patients present in hospital at a weekend who would receive quicker treatment and be discharged more quickly. In Monitor's view this proposal is likely to be implemented within a reasonable timeframe and would be implemented by the parties with greater certainty than through a partnership or individually, and most quickly, through merger. However, Monitor noted that a commissioner-led review of stroke services is currently underway in Surrey. Monitor considered the outcome of this review is likely to require designated hyper acute stroke units to provide weekend ward rounds. The review is therefore likely to result in the proposed improvement for stroke patients in Surrey whether or not the merger goes ahead. Monitor considered that the parties' proposal is likely to be implemented at least one year before any implementation arising from the commissioner review (but that the benefit would not persist beyond the implementation of the review).

(e) **Interventional radiology: expanded consultant led-care on sustainable and formal basis.** Post-merger, the parties would establish a shared cross-site 1:7<sup>95</sup> out of hours and weekend rota, enabling them to deliver out of hours care on a formal and sustainable basis (at ASP currently a 1:4 rota is operated out of hours, while RSC has an ad hoc rota). Monitor found this would be an improvement for 75 patients a year at ASP, and a clinical improvement for at least 23 at RSC. For the patients at RSC, Monitor considered the improvements would be of clinical significance and importance for the patients they affect, as these patients could currently be transferred to another hospital or have another, more invasive, form of treatment. In Monitor's view this proposal is likely to be implemented within a reasonable timeframe and would be implemented by the parties with greater certainty than through a partnership or individually, and most quickly, through merger.

180. Monitor did not find relevant customer benefits in relation to a number of further areas advanced by the parties. These were: 7 day working rota benefits in diabetes and neurology, the development of a cancer centre at

---

<sup>94</sup> This number includes one vacancy to be filled. A 1:6 rota means that there are 6 consultants on the rota and each one works 1 in every 6 days or weekends.

<sup>95</sup> A 1:7 rota means that there are 7 consultants on the rota and each one works 1 in every 7 days or weekends.

Ashford Hospital (also discussed in detail above at paragraph 154 in relation to rivalry enhancing efficiencies), and neonatal cot management. Further details of why Monitor did not consider these proposals to be RCBs within the meaning of the Act are set out in its advice.<sup>96</sup> The CMA has not received evidence to contradict Monitor's assessment and has accordingly placed significant weight on it. Therefore, it does not provide further details of them here as they are not relevant to its consideration of the exercise of the exception to the duty to refer.

### *Other evidence*

181. In addition to evidence provided by the merging parties and Monitor's advice, the CMA may also take into account relevant evidence from commissioning entities.<sup>97</sup>
182. During the course of the investigation, the parties' main commissioners provided comments to the CMA which indicated that the overall financial case for the merger may no longer be as strong as when the merger and business case was conceived in mid-2014 and also indicated that some of the proposed benefits could potentially be achieved as quickly via partnership as merger. One commissioner also noted that the benefits were not significant in scale. The CMA shared these comments with Monitor and discussed them further. Monitor's advice (which finds that the benefits are achievable most quickly through merger) is unchanged by these submissions.
183. Subsequent to receiving Monitor's advice, the CMA also received information from the parties on their changing financial position and how it strengthened their incentives to realise benefits quickly from the merger. Monitor's view on this submission is that implementing the rota benefits should not incur any material costs for the parties and that these would remain readily implementable within the anticipated timeframe irrespective of the changed financial position submitted by the parties.

### *The CMA's assessment*

184. As set out above, the HSCA provides for a specific role for Monitor in advising the CMA at phase 1 on whether there are relevant customer benefits arising from the merger. Monitor's advice is not binding on the CMA but it will place significant weight on its expert advice when considering whether the benefits claimed are RCBs within the meaning of the Act.

---

<sup>96</sup> Monitor's report on the Ashford St Peter's/Royal Surrey merger: relevant customer benefits.

<sup>97</sup> [NHS Mergers Guidance](#), CMA 29, paragraph 7.14.

185. The CMA notes the approach adopted by Monitor in assessing the benefits claimed by the parties in this case as set out in paragraph 178 above and considers this to be an appropriate framework for assessing the parties' claimed benefits in this case.
186. Having considered Monitor's advice, the views of the commissioners and the circumstances of this case, the CMA believes that the benefits in relation to the treatment areas identified above constitute relevant customer benefits within the meaning of the Act.
187. Specifically, the CMA considers that the benefits in relation to the treatment areas of gastroenterology, stroke and interventional radiology referred to in paragraph 179 are benefits in the form of higher quality of service achievable in a shorter timescale, as compared to any alternative means of achieving them (ie independently or in partnership). Monitor's advice addressed whether the benefits could be achieved independently or through partnership. Monitor noted the difficulty and uncertainty of achieving these, and that in any case they could not be achieved in a similar timescale. Having regard to the evidence received by Monitor and others, the CMA considers that these benefits are unlikely to accrue as quickly without the merger or similar SLC.

*Weighing relevant customer benefits against the SLC in this case*

188. The CMA considered whether the relevant customer benefits identified by Monitor would outweigh the SLCs the CMA has identified, and if so, whether to exercise its discretion.
189. In exercising its discretion to decide whether the RCBs noted above outweigh the SLC concerned and any adverse effects arising from it, the CMA considered the facts and circumstances of this case and had regard both to the magnitude of the benefits and the probability of them occurring. It then set this against the scale of the identified anticompetitive effects and the probability of them occurring.<sup>98</sup>
190. The CMA has considered the appropriateness of both a quantitative and qualitative assessment of both the SLCs and RCBs it has found at the first phase.
191. The parties submitted a suggested framework for weighing adverse effects arising from any SLCs against relevant customer benefits. They noted that there were a variety of aspects to consider, involving the magnitude of benefits and harm (in terms of direct effects and spillover effects), the

---

<sup>98</sup> [NHS Mergers Guidance](#), paragraph 7.26.

likelihood of realisation, timing and duration of the benefit/harm. They suggested that, while not the only possible approach, a framework analogous to that used when considering the application of the de minimis exception would provide for a reasoned and coherent balancing.<sup>99</sup>

192. The parties presented their proposed framework in a quantitative way but noted that it was not their intention that the results of this exercise should be taken to be spuriously accurate or scientific, but rather to enable the CMA to carry out its weighing exercise in a reasonable and informed manner, based on a set of reasonable and conservative assumptions.
193. The CMA considered the parties' proposed framework. The CMA agrees that many of the factors outlined above at paragraph 191 are relevant to its assessment as to whether to exercise its discretion, but has some concerns with this suggested approach. In particular, the parties assume that the impact of the benefits will be felt on an ongoing and unlimited basis, whereas the impact of an SLC would be limited by duration. The CMA notes also that the benefits attributable to the merger may be limited because, based on Monitor's advice, while recognising the associated difficulties and uncertainties, we cannot rule out the possibility that they could be achieved in other ways. The CMA further notes that this merger involves a structural change which may have long term effects on the market, and therefore it is not clear why benefits arising from the merger would last longer than adverse effects. Further, the parties submitted as part of their framework that an SLC is best conceptualised as an increase in price (perhaps as a proxy for an equivalent decrease in quality), whereas benefits can be assumed to have an effect on mortality. The CMA notes that the academic literature indicates that harm to competition resulting in degraded quality can also result in worse clinical outcomes.<sup>100</sup>
194. Overall, the CMA did not consider that the quantitative framework as proposed by the parties is capable of accurately representing the factors to be considered in this case when weighing relevant customer benefits against a realistic prospect of an SLC. The CMA considers that, in line with previous cases, where it is not possible to incorporate benefits and costs into a model it is appropriate to consider in general terms the nature and extent of benefits

---

<sup>99</sup> See in relation to the de minimis exception: Mergers: Guidance on the exceptions to the duty to refer, paragraph 2.6 et seq.

<sup>100</sup> Cooper, Gibbons, Jones and McGuire, 'Does hospital competition save lives? Evidence from the English NHS patient choice reforms', *The Economic Journal*, 121, August 2011; Martin Gaynor, Rodrigo Moreno-Serra and Carol Propper, 'Death by Market Power Reform, Competition and Patient Outcomes in the National Health Service', July 2010 (updated August 2011) Working Paper No. 10/242 Centre for Market and Public Organisation.

and costs on the basis of the evidence available, notwithstanding the fact that it is not possible to accurately assess specific values for them.<sup>101</sup>

195. In adopting this approach the CMA has considered whether any aspects of the assessment are quantifiable but in doing so has not attempted to quantify the claimed benefits or its competition concerns into a common metric (such as a monetary value or number of patients). It has taken account of broad estimates of the number of patients affected by both the RCBs and SLC.
196. Accordingly, the CMA has considered in the round:
- (a) the strength of the CMA's concerns at this stage;
  - (b) the size (in terms of patient numbers) and importance to the trust (in terms of proportion of total elective activity) of specialties affected by the CMA's finding of a realistic prospect of a SLC set against the number of patients that the benefits affect;
  - (c) the nature and impact of the benefits; and
  - (d) the possible consequences of quality degradation.
197. Taking each of these in turn, in terms of the strength of the CMA's concerns, it has found a realistic prospect of unilateral effects in relation to 6 inpatient and 7 outpatient markets. In a further 15 markets the CMA has not found it necessary to conclude on whether the merger raises a realistic prospect of an SLC. Moreover, the CMA notes that it also has concerns over adverse effects at the hospital level. The CMA notes that the competition between the parties' sites as shown by the evidence above on GP referral analysis, internal documents, third party views and proximity of the sites, is strong pre-merger. The CMA considers that at an individual specialty level and given the number of specialties concerned, hospital-wide effects may arise which may have a material impact on the level of choice and, in turn, incentives to maintain or improve quality of services for patients. The CMA believes that, at the present stage of the investigation and on the basis of the evidence currently available to it, that there is a realistic prospect of an SLC. Therefore, the CMA believes the merger could reduce incentives to maintain or improve quality.
198. In relation to 195(b) the CMA notes that its SLC findings comprise inpatient elective acute services in: ENT, breast surgery, general surgery, oral and maxillo-facial surgery, medical oncology and gynaecology; and outpatient elective acute services in ENT, joined oral and maxillofacial surgery, general

---

<sup>101</sup> See for example Competition Commission, Groceries Market Investigation Remittal, Final report, 02 October 2009, Section 6.

surgery, breast surgery, joined audiology and audiological medicine, medical oncology and gynaecology.

199. These include many high volume specialties such as gynaecology, general surgery and oral and maxillo-facial surgery and, in aggregate, the total number of patients receiving treatment from the parties in the specialities where we find a realistic prospect of an SLC is approximately [75,000–125,000] which is around [20–30]% of total elective activity across the two trusts.
200. Set against this Monitor has identified significant clinical benefits which might be expected to affect at least 1,100 patients, but not more than 3,700 patients. These would account for between 0.3% and 0.9% of the parties' total elective services by number of patients. <sup>Endnote 1</sup>
201. The CMA therefore considered that the available evidence indicates that the size (in terms of patient numbers) and significance to the trust (in terms of proportion of total elective activity) of specialties where we find a realistic prospect of an SLC is significantly larger than the number of patients identified by Monitor as benefiting from RCBs.
202. In relation to the likely duration of SLCs and benefits (factor 195(c) above), the CMA noted that some of the benefits that Monitor identified are time limited. Namely, Monitor noted that seven day services in stroke may be realised without the merger in any case (because of a commissioner review of stroke currently underway in Surrey) but the merger would allow the benefits to accrue at least one year before any implementation arising out of the review. Against this the CMA does not have any evidence which indicates whether any of the impacts of the SLCs it has identified at an individual specialty or hospital-wide level will be time limited.
203. The identified benefits associated with gastroenterology and interventional radiology are not time bound which the CMA also took into account. The CMA considers that the benefits in relation to the treatment areas of Gastroenterology, Stroke and Interventional Radiology referred to in paragraph 179 are benefits in the form of higher quality of service achievable in a shorter timescale as compared to any alternative means of achieving them (ie independently or in partnership).
204. However, given the time bound nature of the RCB with respect to stroke services and the fact that whilst the gastroenterology and interventional radiology benefits are not time bound, the CMA considers that they would not occur without the merger – only that they would occur most quickly and with greater certainty with the merger, the CMA considers that the duration of the

potential SLCs are, based on its assessment at this stage, significantly longer than the duration of the RCBs identified.

205. Finally, in terms of 195(d) above, while the CMA accepts the Monitor finding that the benefits are clinically significant for those affected patients, it is conscious that a degradation in quality in some specialties (relative to what the quality would be absent the merger) may also be clinically significant to some patients. The CMA has not been able to identify the precise harm which could arise from the merger but notes that the aspects of quality which may be impacted by a reduction in incentives to compete include clinical factors such as infection rates, mortality rates, ratio of nurses or doctors to patients, equipment, best practice and non-clinical factors such as waiting times, patient experience, cleanliness and parking facilities.<sup>102</sup> The evidence in this case does not allow the CMA to determine the possible changes in clinical outcomes as a result of either a material reduction in competition or the identified benefits arising from the merger.

#### *Conclusion on the application of the relevant customer benefits exception*

206. For the reasons set out above the CMA considers that the relevant customer benefits do not outweigh the SLCs the CMA has found in its phase 1 investigation. As such, the CMA considers that it is not appropriate for it to exercise its discretion to apply the relevant customer benefits exception.

## **Decision**

207. Consequently, the CMA believes that it is or may be the case that the merger may be expected to result in an SLC within a market or markets in the United Kingdom (that is, 6 elective inpatient services and 7 elective outpatient services across 7 specialties).
208. The CMA has also identified potential competition concerns in 9 other specialties. However in light of the evidence available to it at phase 1 and its conclusions of a realistic prospect of SLCs in the specialties as set out above, the CMA has not found it necessary to conclude on these other specialties.
209. The CMA therefore believes that it may be the case that the proposed merger may be expected to result in an SLC within a market or markets in the United Kingdom.
210. The CMA therefore considers that it is under a duty to refer under section 33(1) of the Act. However, the duty to refer is not exercised pursuant to

---

<sup>102</sup> [NHS Mergers Guidance](#), CMA 29, paragraph 1.5.

section 33(3)(b) whilst the CMA is considering whether to accept undertakings under section 73 of the Act in lieu of a reference. Pursuant to section 73A(1) of the Act, the Parties have until 24 February 2015 to offer an undertaking to the CMA that might be accepted by the CMA under section 73(2) of the Act. If the Parties do not offer an undertaking by this date, if the Parties indicate before this date that they do not wish to offer an undertaking, or if pursuant to section 73A(2) of the Act the CMA decides by 25 February 2015 there are no reasonable grounds for believing that it might accept the undertaking offered by the Parties, or a modified version of it, then the CMA will refer the merger for a phase 2 investigation pursuant to sections 33(1) and 34ZA(2) of the Act.

**Andrea Coscelli**  
**Executive Director – Markets and Mergers**  
**Competition and Markets Authority**  
**18 February 2015**

---

**Endnote 1:** The patients receiving relevant customer benefits are non-elective patients and this activity is not elective activity.

## ANNEX A: GP REFERRAL ANALYSIS

### Introduction

A.1 The CMA assessed the extent to which the parties are important alternatives for patients in the provision of elective services. To this end, the CMA analysed GP referral patterns (**the GP referral analysis**) as an indicator of the closeness of competition between the parties. This exercise is consistent with the focus on referral patterns and market shares found in internal documents, and with past NHS merger reviews carried out by the CMA, OFT, CC and Co-operation and Competition Panel.<sup>103</sup> This annex sets out the methodology and its potential limitations, and explains the CMA's approach in addressing these.

### Summary of methodology and dataset

A.2 The GP referral analysis considers the extent to which providers of NHS services are important alternatives to one another at the GP practice level and as such can be interpreted in a similar way to diversion ratios in other settings.<sup>104</sup> That is, the GP referral analysis uses current GP referral patterns to derive estimates of diversion to other providers, in the event that patients/GPs could not use their current first choice of provider (the anchor hospital).<sup>105</sup> This allows the CMA to specify a next best alternative hospital for each patient-GP pair, and aggregate these to give an indication of the relative strength of each providers with respect to the anchor hospital.

A.3 In this merger review, the CMA has used an extract of the HES dataset provided by the parties. This covers the period 1 April 2009 to 31 October 2012 for each party, although there is only limited data available in some months (November 2010 to March 2011 inclusive). The dataset is derived from raw patient administration data, but has GP Practice/Hospital/Specialty/Point of Delivery combinations as its lowest level of aggregation. It contains information on all GP practices which refer at least one patient to the anchor hospital, although for confidentiality reasons, all numbers lower than five are absent from the dataset.<sup>106</sup> The CMA notes that this suppression of small numbers creates some uncertainty around the

---

<sup>103</sup> [Chelsea/WMUH](#), [Frimley/Heatherwood](#), Bournemouth/Poole.

<sup>104</sup> See for example paragraph 5.2.15 (a) of [Merger assessment guidelines](#).

<sup>105</sup> For example following the worsening its offering in a given specialty.

<sup>106</sup> This means providers which receive few referrals from a given GP practice are omitted from that GP practice's choice set. This resulted in some GP practices in our dataset appearing as referring to only one provider in many specialties, and why in two known overlap specialties the Parties did not appear to receive any activity at all.

results of the referral analysis, particularly for specialties with smaller volumes.

- A.4 The CMA notes that the data provided by the parties appears to show an uncommonly high number of GP practices referring only to the anchor hospital (**anchor only referrals**). On a cautious basis the CMA has excluded these referrals from the share of referrals calculations.<sup>107</sup>
- A.5 In line with previous investigations the CMA has used TFCs to proxy specialties, as these provide the closest match in the data to the type of activity actually carried out (see further paragraphs A.13 below on joined specialties). As a starting point, as discussed in relation to market definition, the CMA has considered first outpatient appointments and inpatient activity separately, but combined day-cases and (overnight) inpatient activity together given (a) the somewhat arbitrary and varying distinctions between the two and (b) the likelihood that similar resources and equipment will often be required for the two, particularly when compared with outpatient activity. Where relevant within specialties, for example where the parties have submitted the overlap in inpatient activity is minimal, the CMA has also considered day-cases and inpatient activity separately.

## Detailed explanation of the methodology

- A.6 The CMA began by aggregating choices made by GP-patient pairs in relation to the provider of elective care, up to the GP practice level. In doing so the CMA assumed that patients within each GP practice have sufficiently similar locations (around the GP practice) and that they value (changes in) quality in much the same way.
- A.7 The CMA then considered where patients of the 'anchor' hospital would switch to if it no longer were an alternative. That is, the analysis approximates diversion ratios by analysing current referral patterns. Current referrals to the anchor hospital are reallocated proportionally to current referrals to all other hospitals (**Proportional Analysis**), or alternatively to the most referred-to non-anchor provider (**Ordinal Analysis**). The rationale for this assumption is that higher frequency of referrals indicates that the providers are likely to be a strong alternative for these patient/GP pairs (for example because of perceptions of quality), such that in the event of a reduction in quality at the anchor provider, a significant proportion of referrals would switch there. Lower

---

<sup>107</sup> The parties have submitted that referrals from anchor only GP practices should be included in the calculations. However, consistent with its analysis of GP referral data in previous cases, the CMA considers that the GP referral analysis is most usefully interpreted as a measure of closeness of competition between the parties similar to a diversion ratio and as such it would not be appropriate to include referrals from practices which refer only to the anchor hospital within the denominator.

ranked providers are given less weight under both approaches (this is particularly of the ordinal approach), since these are considered generally to be weak alternatives to the anchor hospital in the aggregate, even though there may be patient-specific reasons for their choices.

- A.8 The methodology makes an assumption that all GPs are marginal and thus of equal likelihood to switch.<sup>108</sup> It also makes two further assumptions; namely that past shares of referrals and the providers available would be similar to future shares absent the merger. These rely for example on there being no major changes to the relative convenience of providers through infrastructure changes or to the relative quality of providers through service investments.<sup>109</sup>

## Potential limitations of the methodology

- A.9 The GP referral analysis does not directly measure responses to relative changes in quality by patients/GPs but rather shows past GP referral patterns. Therefore, the CMA has conducted some sensitivity tests and uses the GP referral analysis alongside other evidence in deriving its conclusions about the effect of the merger on patient choice.

### **Coding inconsistencies**

- A.10 The parties submitted that coding inconsistencies between trusts lead the referral analysis to misstate the closeness of competition between providers. For example, they argue that coding practices at FPH, where a disproportionately high percentage of activity appears under general medicine and general surgery when compared to the activity in more specific specialties, will understate its significance in the results.<sup>110</sup> FPH confirmed some of these coding practices to the CMA.
- A.11 The CMA acknowledges that the HES data can suffer from errors and inconsistencies, as although detailed guidance exists, there remains scope for hospital discretion to result in varying coding practices between hospitals. This can result in some activities being coded into the same specialty category where it should be separate, and into different categories where it should be together. When comparing across hospitals, this can overstate or understate

---

<sup>108</sup> It does this by specifying a closure of the anchor, which means that *all* GP-patient pairs currently referring to the anchor would have to move.

<sup>109</sup> No such changes have been indicated to us as likely on a significant scale.

<sup>110</sup> The parties provided a referral analysis which included a parameter reallocating activity from Frimley Park NHS FT to Ashford St Peters NHS FT for some miscoded specialties, based on RSC's proportion of activity in each specialty to that of General Surgery or General Medicine. The CMA had concerns about the methodology used to calculate this proportion, and also in relation to the reliability of the model provided by the parties. As such, the CMA ultimately relied on its own sensitivity tests.

the competitive constraint. As a result, the CMA has used evidence from third parties' missing activity in relevant specialties to confirm their service provisions, and interpreted its specialty-level analysis cautiously.

### ***Grouping TFCs to capture overlaps***

A.12 As noted above, the parties provided the CMA with clinical activity data which identifies specialties on the basis of TFCs.<sup>111</sup> The parties however submitted that there were issues with using TFCs as a proxy for product markets in the present case, for two reasons:

- (a) In some cases a TFC may be narrower than a product market and as such it may be appropriate to group certain TFCs into broader groups, to better represent specialties and by implication product markets.
- (b) The way in which activity is reported in TFCs is not consistent across trusts. This can then affect the results of the GP referral analysis, by for example over-stating the extent to which the parties are important alternatives, where other trusts incorrectly code activity under another specialty.

A.13 The CMA has generally assessed the effects of the merger by using TFC specialty definitions as a starting point for the assessment. Following detailed discussions with the parties, the CMA has applied the following changes to this approach:

- (a) General surgery and general medicine: The CMA has considered general medicine and general surgery separately from other activity, albeit noting the impact of coding practices as below.
- (b) Audiology and audiological medicine: The CMA has considered these two TFCs together, otherwise the analysis would erroneously conclude that there was no overlap in these two specialties.
- (c) Oral and maxillo-facial surgery: The CMA has considered these two specialties together.<sup>112</sup>
- (d) Paediatric sub-specialties: The CMA notes that the parties offer the majority of the paediatric sub-specialties and so do neighbouring providers. Therefore the CMA has aggregated the paediatric sub-

---

<sup>111</sup> The parties said that this approach was in line with the Bournemouth and Poole merger inquiry. Furthermore TFC's allowed for a more granular assessment than the alternative of using HRGs as a way to define specialties (since a single code is used to identify all outpatient appointments).

<sup>112</sup> The CMA also notes that information on Choose and Book on RSC's website lists these two as one specialty.

specialties into the general paediatrics specialties. The CMA has however considered the effects of the merger on the individual specialties separately as well.

- (e) Obstetrics and midwife episodes: The CC in its assessment of the Bournemouth and Poole merger noted the linkages between these two specialties (many of the services provided at Royal Bournemouth and Christchurch Hospitals under midwifery were provided at Poole Hospitals under obstetrics) and considered these together. The CMA is of the view these same factors are applicable in this case<sup>113</sup> The parties in the present case agreed to this approach, but noted that supply-side substitution may be inhibited into obstetrics, but submitted this did not make a difference in this case. Therefore the CMA aggregated these two TFCs.
- (f) Ophthalmology and orthoptics: The parties submitted that coding for the orthoptics specialty varies between providers and it is relatively common for this activity to be coded under the ophthalmology specialty. Therefore it would be appropriate to combine these two specialties. The CMA notes that Choose and Book patient information generally lists orthoptics as a subset of ophthalmology.

A.14 In order to further assess coding inconsistencies, the CMA has run a version of its referral analysis aggregating together potentially miscoded specialties. When considered together with the specialty level results, and given that the aggregation contains specialties in which the data does not show activity by the parties, the CMA considers this a useful additional test. Where relevant, the CMA sets out the results of this in its detailed specialty analysis.

## **Proportional and ordinal methodology**

A.15 The parties argued that the proportional methodology was likely to be more representative of closeness of competition between providers of NHS services. The CMA considers that the proportional methodology relies on assumptions about the strength of lower ranked alternatives which are not as restrictive as the ordinal method. It therefore used the proportional methodology as its starting point in this case. However, the CMA also had regard to the ordinal methodology, particularly where this generated substantially different results as a further sensitivity check of the results.

---

<sup>113</sup> See Appendix G, page 2 of the Bournemouth and Poole report.

### ***Switching assumptions***

A.16 The parties argued that it is appropriate to include GP practices only referring to the anchor when calculating the referral ratios, because these practices are in fact also likely to switch following a reduction in their first choice providers' quality. The CMA considers that these practices may also switch. However, as these referrals come from GP practices that are anchor only there is not information on what the next best alternative for these practices would be. Therefore the CMA considers it appropriate to exclude these referrals from the denominator of the referral ratio, effectively assuming that these practices would switch to alternatives in the same proportion as those GP practices which are not anchor only, and which appear the most likely to switch.<sup>114</sup>

### ***GP practice level aggregation***

A.17 The parties argued that GP practices are not single decision making entities, however referral analysis treats them as such. This could imply that the referral analysis overstates the propensity for GP-patient pairs to switch by overlooking cases where GPs refer to only one provider, or misstate the likely destinations of switching patients. The CMA acknowledges that GPs within a practice may have differing preferences. However it considers their characteristics are likely sufficiently homogenous to warrant the simplifying assumption that GP practice level aggregation is appropriate.

### ***Patient pathway***

A.18 The parties presented further critiques of the methodology based on the patient pathway.<sup>115</sup> First, they argued that patients exercise choice of provider when being referred for a first outpatient appointment. However the patient only discovers what (if any) treatment is required in the outpatient appointment. As a result the consultant refers these patients on to an inpatient appointment, which for a further subset of patients may be at another provider if their outpatient hospital does not offer the relevant treatment. As a result, GPs would play no role in inpatient choice, and the provider-preferences of inpatients would not vary systematically with those of outpatients.

A.19 Second, the parties argued that GPs are able to anticipate the effects of networks and will refer patients they consider likely to require admission based on this knowledge. As a result, inpatients requiring admission will select their outpatient provider in anticipation of requiring inpatient treatment. The

---

<sup>114</sup> The inclusion of anchor only referrals in the denominator would dilute the referral ratios by effectively including the anchor hospital as a possible alternative to the anchor hospital.

<sup>115</sup> Final Submission, Paragraph 180.

CMA notes that this cuts across the above argument by assuming that GPs are able to assess the likelihood of admission and that they are aware of provider networks. Third, the parties argue that thresholds of admittance for inpatient appointments can vary across providers despite guidelines. All of these factors, if true, would imply that the inpatient referral analysis could misstate the closeness of competition between the parties.

A.20 Following its use of referral analysis in previous decisions, the CMA first considers it likely that (at least a proportion of) GPs are able to assess a patient's likelihood of requiring inpatient admission. In this case, this is supported by the generally low provider-to-provider referral numbers. Second, whilst the CMA does not rule out the possibility that the 'anticipation effect' argued by the parties reduces provider-to-provider referrals where there are networks, the CMA considers that any effect will be limited to those specialties where networks exist, and the effect within these will be further limited where networks affect a small proportion of patients. Third, whilst the CMA acknowledges that thresholds for admittance may vary, the CMA notes the existence of guidelines. The parties did not provide any further information on this point for the CMA to assess.

### ***Conclusion***

A.21 Overall, whilst GP referral analysis assumptions seem reasonably plausible and have precedent from past merger reviews, it is true that referral analysis should be taken only as an indicator of relative competitive constraints, and must be considered in the round with the broader assessment and evidence base.

## ANNEX B: MARGINAL GP (EXPOSURE TO COMPETITION) ANALYSIS

- B.1 The CMA has also separately considered the extent to which the merger reduces the competitive constraint faced by the parties, such that it results in reduced incentives for the merged provider to maintain and provide better-quality services to patients and value for money for commissioners. In doing so, the CMA has generally considered the impact of the merger on patient choice and competition by assessing whether the parties are close alternatives to each other across their entire catchment, such as the results of the GP referral analysis.
- B.2 In an extension to the GP referral analysis, the CMA has considered how the merger affects the parties' exposure to competition in relation to those GP practices which are most likely to be marginal (**marginal GP analysis**). This analysis relies on the assumption that those GP practices which send the majority of their patients to one provider, are likely to have strong preferences towards that provider (for example because of geographic proximity) and as such are less likely to be responsive to relative changes in quality. From the provider perspective, these practices are more likely to be considered captive and as such less likely to drive provider decisions about investment in their offer to patients. On the other hand, for GP practices where the parties receive very few referrals, current preferences may be indicative that they are not likely to consider the parties as realistic alternatives and as such less likely to drive provider decisions.
- B.3 The CMA notes that the marginal GP analysis fits with the views of the parties on patient choice and competitive conditions. That is, internal documents suggest that the parties generally consider GP practices which are at the edges of their catchment areas as exercising choice and as such are contestable. In trying to grow their share of referrals in these contestable areas, internal documents suggest that the parties seek to understand drivers for the referral patterns and implement service change and/or promotional activity to try and gain additional referrals.
- B.4 For example one RSC internal document states that [REDACTED]<sup>116</sup> Another RSC document notes that [REDACTED].<sup>117</sup> An ASP document states that [REDACTED]<sup>118</sup>

---

<sup>116</sup> RSC Integrated Business Plan, March 2009, page 52.

<sup>117</sup> RSC Strategic Plan Document for 2013-14, page 8.

<sup>118</sup> ASP Integrated Business Plan, September 2010, page 62.

B.5 Therefore the CMA has defined GP practices which send a significant proportion of their referrals<sup>119</sup> to one of the merging parties as likely to be marginal. If a marginal GP practice sends the vast majority of referrals only to the merging parties pre-merger, post-merger it would send referrals to a single provider and so would no longer be marginal. The CMA looks at the effect of the merger by comparing the proportion of the parties' referrals that come from marginal GP practices pre and post-merger. Figures 1 to 3 show the parties' combined pre-merger and post-merger marginal GP activity for their elective services. A significant proportion of marginal activity is from GP practices which are located between the parties' sites, such that the effect of the merger would appear to be significant on the parties' exposure to competition.

### Figure 1: Pre-merger marginal activity



CMA workings of parties' data.

### Figure 2: Post-merger marginal activity



CMA workings of parties' data.

### Figure 3: Combined results



CMA workings of parties' data.

The map above combines the marginal GP practices featured in figures 1 and 2 above. Note that there may be instances where the pre and post marginal activity remain the same, so the represented circles may obscure some activity.

---

<sup>119</sup> The CMA has defined this to include GP practices which send between 10 and 70% of their activity to one of the merging parties or the merged entity post-merger. Whilst it is not obvious which threshold the CMA should adopt, we note that the threshold do not materially affect the conclusion on the impact of the merger on the parties' exposure to competition. For example setting thresholds of between 10 and 50% results in a reduction of around [55–65]% of marginal GP activity, whilst with these set at between 10 and 70% the reduction is around [60–70]%. The CMA adopted a lower bound of 10% in order to cautiously exclude instances of marginal GP practices which were located some distance from the parties. Given that geographic proximity is likely to play a significant role in patient choices, the CMA considers these exclusions appropriate. The CMA notes that the CC in Bournemouth/Poole used a 50% threshold and then ran the analysis as a sensitivity check on 70% threshold.

## **ANNEX C: DETAILED SPECIALTY LEVEL ANALYSIS**

- C.1 The CMA considered the extent to which the proposed merger may reduce the parties' incentives to maintain or improve the quality of services or other aspects of their offer to patients. The CMA considered whether the parties are particularly close alternatives for patients and GPs in relation to elective services for individual specialties. The CMA analysed GP referral patterns, using the methodology set out in Annex A above, and cross checked the results of this analysis against other evidence.
- C.2 Where the evidence indicated that the parties may be close competitors in a specialty, the CMA carried out a more detailed assessment of that specialty.
- C.3 To assess the strength of the competitive constraint removed through the merger, the CMA relied on the parties' submissions, referral patterns, marginal GP analysis, internal documents and third party comments (where relevant). The results of this analysis are set out below. This Annex groups the analysis into three categories – categories where the CMA considers that there is a realistic prospect of an SLC; categories where the CMA has identified potential competition concerns, but has not found it necessary to conclude in this regard, and categories where the CMA considers there is no realistic prospect of an SLC.

### **Specialties where the CMA considers on the evidence available that it is or may be the case that the merger would result in an SLC**

#### ***ENT***

- C.4 The parties overlap in the provision of ENT in outpatient and day-case services. They submitted that they do not overlap in elective inpatient services, as under clinical network arrangements, all patients referred to ASP that require an elective inpatient admission in ENT are admitted at RSC.
- C.5 The parties submitted that it would not be appropriate to group day-case and elective inpatient activity together given ASP could not readily start providing this service. They submitted that regarding day-case, the choice available to patients is the same as for outpatient treatment. The CMA notes that the number of inpatient referrals is much smaller than day-case referrals and analysing the day-case data separately does not materially affect the results of the referral analysis.
- C.6 The referral analysis suggests that the parties are strong alternatives to one another across outpatient and inpatient (day-case) services. For example RSC is the next best alternative to ASP in circa [50-60]% of outpatient and

circa [75-85]% of inpatient (and day-case) referrals on the proportional methodology. Further, ASP is RSC's best alternative in around [35-45]% of referrals for each of outpatient and inpatient (and day-case) services. For day-cases alone, RSC is the best alternative for [65-75]% of ASP's reallocated referrals, whilst ASP is the best alternative for [20-30]% of RSC's reallocated referrals.

- C.7 The parties submitted that network arrangements whereby RSC provides inpatient services influence the referral analysis (inflating RSC's referral ratio), because patients or GPs anticipate they might need a referral for more complex or inpatient treatment. Similarly they submitted that a significant proportion of ENT referrals are cancer related. As with other cancer-related specialties, the parties submitted that RSC's status as a cancer centre influences GP referral patterns. As such, they submitted that limited weight should be placed on the referral analysis.
- C.8 For routine procedures, the CMA considers that the evidence available to it does not indicate that anticipation of the network arrangements for more complex treatment would be likely to have a significant effect on initial GP referral decisions, since inpatient activity (excluding day-case) is a low proportion of total referrals. This is also reflected by the fact that provider to provider referrals are only around 16% of total inpatient activity at RSC. In addition, the CMA considers that it is not clear to what extent RSC's status as a cancer centre should influence GP referral patterns for more routine procedures.
- C.9 Internal documents and third party comments also indicated that the parties compete in ENT. The CMA notes that an ASP internal document from 2011 states that it has been trying to increase market share in Central Surrey and Cobham, which appears to be a marginal area as it is in between ASP, RSC and Epsom St Helier. A commissioner suggested that the main alternatives for ENT services in the area are ASP, RSC and FPH; the merger would therefore result in a 3 to 2 reduction in that area.
- C.10 As with other cancer-related specialties, the parties submitted that they face strong competition from other Acute Trust Cancer Centres, as GPs could refer to hospitals such as Royal Marsden, Imperial, UCLH, and would fear a knock-on effect on other cancer specialties in the event of any deterioration of quality (ENT revenues are £2-3 million per year, compared to overall cancer revenues at RSC £85 million per year). However, the CMA does not have sufficient evidence to suggest that such knock-on effects would occur, for example if quality relating to more routine procedures were to deteriorate. The CMA also notes that it has found that there is a realistic prospect of an SLC as a result of the merger in Medical Oncology below.

- C.11 The CMA assessed how the merger affects the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [55–65%]%. Pre-merger around [15–25]% of activity for both parties was from such practices, whereas post-merger this falls to around [5–15]%. This indicates that the merger significantly reduces the parties' exposure to competition.
- C.12 The parties told the CMA that the competitors they face are the same whether for outpatient services or elective inpatient. They submitted that substantial choice will remain post-merger, as using 80% catchment areas, 11 of the 29 GP practices where referrals are primarily going to ASP and RSC would be in the catchment area of at least 3 Acute Trusts post-merger. The CMA acknowledges this but, as noted in its geographic market definition section, does not place significant weight on the parties' catchment area analysis.
- C.13 Taking the above factors into account, the CMA considers there is a realistic prospect of an SLC as a result of the merger in ENT in both outpatient and inpatient (day-case) services.

#### ***Joined oral and maxillofacial surgery***

- C.14 The parties overlap in the provision of oral and maxillofacial surgery in outpatient and day-case services. They submitted that they do not overlap in elective inpatient services, as under clinical network arrangements, all patients referred to ASP that require an elective inpatient admission in oral and maxillofacial surgery are admitted at RSC.
- C.15 The parties submitted that it would not be appropriate to group day-case and elective inpatient services together in this specialty given ASP could not readily start providing inpatient services. The CMA considers that inpatient referrals are likely to account for a relatively small share of day-case and inpatient referrals combined (for example this accounted for around 8% of RSC activity in the 2013/14 financial year in this specialty). Furthermore, the CMA has considered the effects of such referrals below, by considering day-case referrals separately and analysing the extent of provider-to-provider referrals.
- C.16 As noted in Annex A, paragraph A.(c), the CMA has combined referral data from a number of different treatment function codes to capture the overlap in this specialty.
- C.17 The referral analysis suggested that the parties are important alternatives, although this is asymmetric. RSC is the next best alternative for [60–70]% of inpatient (and day-case) ASP referrals on the proportional methodology and

for [30–40]% of outpatient referrals, again on the proportional methodology. FPH is RSC's top ranked alternative, with ASP the next best for [25–35]% of outpatient referrals. When considering day-case patients only on the proportional methodology, the referral analysis suggested that [60–70]% of ASP's reallocated referrals move to RSC. On the basis of the ordinal analysis, which is more likely to exclude weak alternatives within GP practices (for example referrals where the anchor is first, are re-allocated to the second-placed alternative, with no referrals going to lower ranked alternatives), when ASP is the anchor RSC is its next best alternative in [40–50]% of referrals for outpatient and [70–80]% of referrals of inpatient services. When RSC is the anchor, ASP is its next best alternative for [30–40]% of outpatient referrals.

- C.18 The parties told the CMA that it is appropriate to consider the effect of maxillofacial surgery network arrangements and the parties' combined position in oral surgery and maxillofacial surgery. RSC provides support to FPH in the provision of oral surgery (high risk dentistry) at FPH. Patients with maxillofacial elements are transferred to RSC.
- C.19 The parties also submitted, as with a number of other specialties, that RSC's status as a cancer centre leads to the GP referral analysis overstating its closeness as a competitor to ASP, as maxillofacial surgery is a specialty from which many cancer diagnoses may stem. The parties submitted that, as it is skewed by the cancer network arrangements, the referral analysis is not a good indicator of preferences for patients referred for maxillofacial treatment for whom cancer is not likely to be a concern. As such, they submitted that limited weight should be placed on the referral analysis.
- C.20 The CMA considers that the merger may still remove the incentive for the parties to compete for more routine elective referrals, despite the maxillofacial network arrangements and the cancer network. The evidence available to it does not indicate that anticipation of the network arrangements for more complex treatments would be likely to have a significant effect on initial GP referral decisions. In this respect, the CMA notes that inpatient activity (excluding day-case) is a low proportion of total referrals. Further, the CMA considered the extent of provider to provider referrals and found that they only account for around 4% of RSC referrals.
- C.21 Internal documents did suggest that networks may limit competitive threat from other providers; one RSC internal document noted that network arrangements protects it against the risk of competition in relation to maxillofacial services. The parties submitted that of the 73 practices which send the largest share of referrals to one of the parties, 64 of these would be in the catchment area of at least one other Acute Trust. The CMA acknowledges this

but, as noted in its geographic market definition section, does not place significant weight on the parties' catchment area analysis.

- C.22 The CMA notes that the merger reduces the proportion of activity which is derived from marginal GP practices by [75–85]%. Pre-merger around [5–15]% of activity for both parties was from such practices, whereas post-merger this falls to around [0–5]%. This indicates that the merger significantly reduces the parties' exposure to competition.
- C.23 The parties submitted that FPH now provides maxillofacial services through the Heatherwood site; London North West Healthcare Trust provides the services at the Heatherwood site and in the parties' view it would be easy for London North West Healthcare Trust to extend this arrangement to the Frimley site following the merger in event it is not happy with the parties' service. Based on evidence received during its investigation the CMA considers that the future of maxillofacial services at the Heatherwood site is not clear. Further, the CMA notes that both the Frimley and Heatherwood sites are unlikely to be strong alternatives for the ASP sites, as indicated by the trust-level results.
- C.24 Taking the above factors into account, the CMA considers there is a realistic prospect of an SLC as a result of the merger in oral and maxillofacial surgery in relation to inpatient (day-case) and outpatient services.

### ***Breast surgery***

- C.25 The parties overlap in the provision of breast surgery in outpatient, day-case and elective inpatient services.
- C.26 The referral analysis indicated that the parties are each other's closest alternatives for both outpatient and inpatient activity. RSC is ASP's next best alternative for [60–70]% of outpatient and around [65–75]% of inpatient (and day-case) activity using the proportional methodology. The equivalent figures for RSC are [40–50]% and [35–45]%. On day-cases alone, using the proportional methodology ASP would receive [70–80]% of RSC's reallocated referrals, whilst RSC is the best alternative for [30–40]% of ASP's referrals.
- C.27 The CMA considers that this indicates the parties are each other's closest alternative with other providers being a weak alternative. For example West Middlesex appears only a weak alternative to ASP, being the next best alternative to ASP in only around [10–20]% of referrals using the proportional measure.
- C.28 The parties have submitted that FPH codes this specialty under the general surgery specialty, meaning its importance as an alternative provider is not

reflected in the referral analysis as a result. The CMA confirmed this was FPH's coding practice, however its impact is not clear. To test the sensitivity of its results the CMA has calculated the GP referral analysis which combines the specialties where the parties argue that differences in coding practices between providers undermine the reliability of this analysis and notes that the results identify the parties as significant alternatives.<sup>120</sup> According to this analysis, RSC is still the next best alternative to ASP (accounting for around [25–35]% of outpatient and around [30–40]% of inpatient referrals), whilst ASP was the second best (after FPH) to RSC (accounting for around [10–20]% and [10–20]%)<sup>121</sup> of referrals in each case – all using the proportional measure.

- C.29 The parties have also submitted that RSC's status as a cancer centre (i) makes it more likely to receive referrals and (ii) inflates the referrals because of provider to provider referrals. However, the CMA considers that it is not clear why RSC's status as a cancer centre should limit competition between ASP and RSC for more routine procedures. The evidence available to it does not indicate that anticipation of the network arrangements for more complex treatments would be likely to have a significant effect on initial GP referral decisions. The CMA notes that inpatient activity (excluding day-case) is a very low proportion of total referrals and that only [0–10]% of referrals into RSC are provider to provider.
- C.30 An internal document from October 2011 notes lost market share in the Woking area (between parties' sites), in outpatient breast surgery.<sup>122</sup> This supports the referral analysis, in that it is suggestive of competition between the parties, most notably in the Woking area, which third parties have identified as an area of significant geographic overlap between the parties.
- C.31 The parties submitted that they face strong competition from other Acute Trust Cancer Centres, as GPs could refer to Royal Marsden, Imperial, UCLH, and would fear a knock on effect on other cancer specialties in the event of any deterioration of quality (Breast Surgery revenues are £2 to 3 million per year, compared to overall cancer revenues at RSC £85 million per year). However, the CMA does not have sufficient evidence to suggest that such knock-on

---

<sup>120</sup> Following submissions by the parties on the effect of coding practices, the CMA has run the GP referral analysis on the following group of specialties: general medicine, transient ischaemic attack, vascular surgery, upper gastro-intestinal surgery, general surgery, breast surgery, colorectal surgery, endocrinology, gastroenterology, diabetic medicine and geriatric medicine. The CMA notes that this grouped approach is likely to significantly underestimate the extent to which the parties are close alternatives and is only intended to provide a sensitivity check of the referral analysis.

<sup>121</sup> Excluding referrals to Surrey PCT as an entity for inpatient referrals with RSC as the anchor, which the CMA could not attribute to a current provider of NHS services.

<sup>122</sup> [REDACTED]

effects would occur, for example if quality relating to more routine procedures were to deteriorate.

- C.32 Further, the extent of competition from these other parties may be limited. For example, the CMA was told that Royal Marsden does not have diagnostic facilities in Surrey to attract referrals from GPs and that the majority of its referrals are linked to either more complex cancers or where the patient chooses to receive their treatment in London for ease of access (for example accessing chemotherapy closer to work). The third party was sceptical about the extent to which it could compete.
- C.33 The CMA notes that RSC is the hub in the St Luke's Cancer network (comprising FPH, ASP, SAS, Hampshire FT) and has an agreement to provide services at SASH. An RSC internal document says that network arrangements serve to mitigate against the threat of competition. This would suggest that such arrangements could limit the extent to which RSC competes with other providers for elective referrals for cancer care which is provided by RSC through the network. However, the CMA notes that (as mentioned above) only 6% of referrals into RSC are provider to provider. The evidence available did not indicate that a substantial proportion of activity is complex activity which is only provided at RSC. In any event, the CMA considers that in line with the other evidence presented above, the merger could remove the incentive for the parties to compete for more routine elective referrals.
- C.34 The CMA assessed how the merger changes the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [50–60]%. Pre-merger [10–20]% of ASP and [20–30]% of RSC activity was from such practices, whereas post-merger this falls to around [5–15]%. This indicates that the merger significantly reduces the parties' exposure to competition.
- C.35 The parties submitted that patients and GPs would continue have a significant degree of choice post-merger such that the merger does not affect their incentives significantly. Using 80% catchment areas, the parties submitted that 17 of the 40 GP practices which currently send the largest proportion of referrals to ASP and RSC would be in the catchment area of at least three other Acute Trusts. The CMA acknowledges this but, as noted in its geographic market definition section, does not place significant weight on catchment areas.
- C.36 The CMA further notes that the breast surgery specialty accounts for a significant volume of referrals and revenues for both parties (between 1.5 and 2.5% in each case). Therefore it is likely to be a significant driver for competition between the parties. Hence, there is a possibility that loss of

competition in this specialty may affect hospital-wide incentives to compete as well as specialty specific incentives.

- C.37 Taking the above factors into account, the CMA considers there is a realistic prospect of an SLC as a result of the merger in Breast Surgery for both outpatient and inpatient services.

### **General surgery**

- C.38 There are a number of complications in the way activities are coded as general surgery. The parties submitted that there has been a significant change in coding practice at ASP in recent years and ASP instead records activity that previously would have been coded as general surgery under more specific specialties (mainly colorectal surgery, upper gastrointestinal surgery and vascular surgery). This appears to be particularly the case in outpatient services. On the other hand, RSC records activity a significant proportion of activity that would normally be recorded under colorectal surgery and upper gastrointestinal surgery, in the general surgery TFC. Similarly, other Trusts may apply differing coding rules to determine what is included in the general surgery TFC.
- C.39 Notwithstanding these issues, the CMA considers that it is still appropriate to assess general surgery as a separate specialty. In this regard it notes that internal documents suggest that the parties consider general surgery as a separate specialty, and consider the extent of competition within this specialty. For example an internal ASP document from 2011 notes that there has been a [✂].
- C.40 The CMA considers that a proportion of activity that the parties carry out would generally be classified under general surgery and general medicine. Given the specifics of this case, the CMA has considered the effects of the merger on the provision of general surgery separately from other specialties. As noted above, as a sensitivity check, the CMA also aggregated the general surgery and general medicine TFCs together with the specialties over which there are coding linkages for the purposes of the GP referral analysis.
- C.41 The parties submitted that only limited weight can be placed on the results of the GP referral analysis in relation to this specialty, taking account of the coding variability discussed above.
- C.42 The referral analysis suggests that RSC is the next best alternative to ASP for both outpatient referrals ([25–35]%) and inpatient referrals ([40–50]%) using the proportional measure. FPH is an important alternative and to a lesser extent the BMI at Runnymede. For example FPH is the next best alternative to

ASP in around [25–35]% of referrals, the same as RSC. However, the CMA considers that the results from the GP referral analysis in this specialty are likely to substantially understate the extent to which the parties compete in this specialty, since ASP codes a significant amount under other specialties and FPH codes a significant amount of activity under this specialty that would otherwise be coded under other specialties.

- C.43 Therefore, a sensitivity check, the CMA combined the specialties which the parties suggest are subject to coding issues (general medicine, vascular surgery, upper gastro-intestinal surgery, general surgery, breast surgery, colorectal surgery, endocrinology, gastroenterology, diabetic medicine, geriatric medicine and transient ischaemic attack). This includes specialties where the parties submitted they do not overlap, and as such may significantly underestimate the extent of closeness of competition across overlap specialties. On the basis of this combined analysis RSC is still the most important alternative to ASP for both outpatient referrals (circa [25–35]%) and inpatient referrals (circa [35–45]%) using the proportional measure. The CMA notes that even under this approach, which does not take account that the parties may compete more closely in some of the included specialties than in others (and includes non-overlap specialties, potentially overestimating the true numbers), the parties appear to be close competitors.
- C.44 The CMA also assessed how the merger affects the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [55–65]%. Pre-merger around [40–50]% of activity for ASP and around [10–20]% for RSC was from such practices, whereas post-merger this falls to around [5–15]%. This indicates that the merger significantly reduces the parties' exposure to competition.
- C.45 Taking the above factors into account, the CMA considers there is a realistic prospect of an SLC as a result of the merger in General Surgery in inpatient and outpatient services.

### ***Audiology and audiological medicine***

- C.46 The parties overlap in the provision of outpatient audiology and audiological medicine. As noted above, the parties take a different approach to coding activity in audiology, with ASP coding as audiology and RSC coding as audiological medicine; as set out above the CMA has combined referral data to avoid missing a substantive overlap.
- C.47 The referral analysis suggests that the parties are very close alternatives in the combined specialty for outpatient services. For example RSC is the next best alternative for [70–80]% of referrals with ASP as the anchor, using the

proportional measure, while the equivalent figure for RSC is around [30–40]% on the proportional measure. RSC is most often the best alternative for ASP, where ASP is the second best alternative for RSC after Frimley Park.

- C.48 The parties submitted that the reliability of the referral analysis is limited in this specialty by coding issues at other Trusts, meaning that they do not appear in the referral analysis. The parties submitted that patients can be broadly split into three categories of hearing loss, levels 1, 2 and 3 with coding issues in particular at level 3 (sudden loss of hearing), which could be coded as ENT. As a sensitivity check, the CMA ran the GP referral analysis on a combined ENT, audiology and audiological medicine group. This shows that RSC is the best alternative to ASP for around [50–60]% of referrals on the proportional measure, whilst ASP is the best alternative to RSC for around [20–30]% of referrals on the proportional measure. These would suggest that even allowing for the coding inconsistencies, that the parties are close alternatives to each other for patient referrals.
- C.49 The parties further submitted, similar to other specialties, that the clinical network in place is inflating the referral figures to RSC. Patients who are initially referred to these other specialties but have complex requirements are referred on to RSC, resulting (according to the parties) in inflated RSC figures. The parties submitted that RSC provides complex treatment services on behalf of ASP and FPH. In this respect the merger parties may not overlap in the provision of complex audiology treatments. However, provider to provider referrals for audiological medicine are less than 1% of total RSC referrals (the CMA did not receive the equivalent figure for audiology).
- C.50 The CMA also assessed how the merger affects the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [85–95]%. Pre-merger around [5–15]% of activity for ASP and around [15–25]% for RSC was from such practices, whereas post-merger this falls to around [0–5]%. This indicates that the merger significantly reduces the parties' exposure to competition.
- C.51 The parties submitted that market entry has taken place in relation to age-related hearing loss services, for example through AQP processes, pointing to RSC winning a 2012 contract to provide services in the former Berkshire East and Berkshire West PCTs. However, the CMA understands that AQP are tender processes whereby a number of providers bid to offer the services alongside other providers. A subset is chosen from the bidders and patients retain the right to choose among these services. Therefore AQP processes can typically be viewed as a two-stage competitive process, first to be on the list of approved bidders and second to gain referrals through patients' choice. Therefore the merger may significantly reduce patient choice in this area.

C.52 Taking the above factors into account the CMA considers there is a realistic prospect of an SLC as a result of the merger in audiology and audiological medicine in outpatient services.

### ***Medical oncology***

C.53 The parties overlap in the provision of medical oncology (which includes chemotherapy) for both outpatient and inpatient (day-case) referrals.

C.54 The referral analysis suggests that RSC is a significant alternative to ASP, being the next best alternative for over [80–90]% and around [60–70]% of outpatient and inpatient referrals respectively, using the proportional measure. ASP is the next best alternative to RSC for outpatient services, for around [30–40]% of referrals at RSC. This suggests that the parties are close alternatives to one another.

C.55 The parties submitted in relation to this specialty that there is no patient choice in relation to this specialty, as no separate referrals are made in respect of chemotherapy treatments. Rather, the parties submitted the treatment follows a previous outpatient appointment in another specialty, made where a GP suspects a patient may have cancer. The parties have submitted that cancer is frequently diagnosed in breast surgery, colorectal surgery, gynaecology, respiratory medicine, urology, dermatology, maxillo-facial surgery and ENT.

C.56 Although this specialty is not delivered on a standalone basis, the CMA nonetheless considers that there may be important aspects of patient choice exercised in relation to medical oncology, as both the delivery of a given specialty (eg quality of service in ENT) and the provision of chemotherapy treatment (eg quality of service, convenience of location of supporting chemotherapy treatment which may be required) may factor into a patient or GP's decision on referral where cancer is a suspected diagnosis. Further, the CMA considers on the evidence available to it that patients may be able to request a referral to their closest hospital for chemotherapy treatments.

C.57 As with other cancer-related specialties, the parties submitted that patient flows in the specialty are skewed by RSC's status as a cancer centre. However, the CMA considers that in line with the other evidence presented above, the merger could remove the incentive for the parties to compete for more routine elective referrals.

C.58 Taking the above factors into account the CMA considers there is a realistic prospect of an SLC as a result of the merger in medical oncology in both outpatient and inpatient (day-case) services.

## **Gynaecology**

- C.59 The parties overlap in the provision of outpatient, day-case and elective inpatient gynaecology services.
- C.60 The referral analysis suggests that the parties are each other's next best alternative for GP referrals in outpatient services and RSC appears to be the next best alternative to inpatient services at ASP. On the basis of the ordinal analysis, which is more likely to exclude weak alternatives within GP practices (for example referrals where the anchor is first, are re-allocated to the second-placed alternative, with no referrals going to lower ranked alternatives), when ASP is the anchor RSC is its next best alternative in [40–50]% of referrals for outpatient and [40–50]% of referrals of inpatient services. When RSC is the anchor, ASP is its next best alternative for [45–55]% of outpatient referrals. The proportional methodology shows lower results, however ASP still remains RSC's best alternative in over [35–45]% of referrals. The referral analysis also suggests that each party faces only one other significant alternative (West Middlesex at ASP and FPH at RSC). Other providers are not such strong alternatives, suggesting that the merger may significantly alter the constraint that the parties faced pre-merger.
- C.61 The CMA also assessed how the merger affects the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [20–30]%. Pre-merger around [5–15]% of activity for ASP and around [10–20]% for RSC was from such practices, whereas post-merger this falls to around [5–15]%. This indicates that the merger reduces the parties' exposure to competition, albeit to a lesser extent than for some of the specialties discussed above.
- C.62 The parties submitted that there are a significant number of GP practices that have another choice, hence competition will be preserved post-merger. Using 80% catchment areas, 25 out of the 31 GP practices which the parties submitted drive the assumption that the parties are each other's next best alternative will be in the catchment area of at least 1 Acute Trust other than the parties. There would be 22 in the catchment area of 3 Acute Trusts using 90% catchments. The CMA acknowledges this but, as noted in its geographic market definition section, does not place significant weight on catchment areas.
- C.63 The CMA notes that there are some indications of competition from independent providers in the parties' internal documents. An internal document notes that [redacted].<sup>123</sup> However other internal documents note that

---

<sup>123</sup> ASP: Marketing Report – JULY 2014.

independent providers can only offer the routine elements of the specialty, suggesting that the extent to which they constrain providers of the whole suite of acute services, might be limited.

- C.64 Taking the above factors into account, the CMA considers there is a realistic prospect of an SLC as a result of the merger in gynaecology in outpatient and inpatient services.

### **Other specialties which may raise competition concerns**

- C.65 The CMA has also identified potential competition concerns in the following specialties. However, given the available evidence on these, and the outcome of its assessment in the specialties above, the CMA has not found it necessary to conclude on the following specialties.

#### ***Upper gastrointestinal surgery***

- C.66 It was not possible to run the referral analysis in this specialty as the dataset provided to the CMA indicated that no GP practice referred to the parties. This is at least partly a result of the suppression of small numbers (see further Annex A).
- C.67 The parties submitted that activity in this specialty at RSC is largely coded under general surgery, and that other NHS Trusts code the specialty in a similar way. They pointed to the fact that Frimley FT, Epsom FT, Kingston FT, WMUH FT, Basingstoke FT and others do not record any activity in the specialty, despite (to the best of the parties' knowledge) providing services. However the CMA notes that even under the combined GP referral analysis, the parties appear to be close alternatives (see for example Annex C, paragraph C.43). The parties further submitted that other trusts in the area providing this service are Surrey and Sussex, Guy's, and Hillingdon. Private providers would include BMI Runnymede and BMI Mt Alvernia. The CMA considers that the extent to which each of those competitors may constrain the behaviour of the parties will be influenced by a number of factors, not least patient travel distance to the clinic and the quality of services.
- C.68 Without referral data or other evidence indicating the magnitude of competition between the parties the CMA has not been able to assess the constraint posed by these third party trusts.
- C.69 As regards private providers, CMA notes that internal documents of the parties generally noted that the constraint from private providers is generally limited to routine procedures. In previous cases the CMA has taken the

constraint from private providers in respect of acute services to be limited.<sup>124</sup> Even if the CMA were to conclude that private providers provided a significant constraint, this would at most, be limited to routine referrals and notes that the merger may raise competition concerns in relation to complex procedures.

### ***Colorectal surgery***

- C.70 The parties overlap in the provision of outpatient, day-case and elective inpatient services.
- C.71 The referral analysis suggested that the parties' are close alternatives in relation to inpatient referrals: ASP is RSC's best alternative in over [50–60]% of inpatient and outpatient referrals (on both the proportional and ordinal measures), whilst RSC is ASP's best alternative for [90–100]% of inpatient referrals using either the proportional or ordinal methodology. This last implies that there are no GP practices sending patients to ASP for inpatient treatment which also refer to any other provider except RSC. The CMA acknowledges that these figures in part arise from high numbers of GP practices which refer only to one provider: when these are included, the only notable percentage is that ASP is RSC's best alternative for [30–40]% of referrals. The inpatient results are overall characterised by few credible alternatives for each party.
- C.72 The parties submitted that the reason why the referral analysis results suggest that a significant proportion of GP practices do not have an alternative provider for colorectal surgery is that most neighbouring Trusts code this as general surgery. RSC also codes some of its activity as general surgery, which may in fact mean the referral analysis understates competition between the parties.
- C.73 The CMA assessed how the merger affects the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [10–20]%. Pre-merger around [0–10]% of activity for ASP and around [0–10]% for RSC was from such practices, whereas post-merger this falls to around [0–10]%. This indicates that the impact of the merger on the level of marginal activity is limited. However the parties' exposure to competition already appears limited in this specialty and the CMA cannot exclude that the reduction in activity derived from marginal GP practices is sufficient to harm incentives to maintain or improve the quality of services.

---

<sup>124</sup> Bournemouth/Poole at 6.11, footnote 132. 'We did not consider that private hospital providers significantly constrained NHS acute hospitals in the provision of NHS acute services [...]'.

C.74 The CMA notes that ASP reports increases in referrals for colorectal surgery from Guildford & Waverley CCG, and that this 'looks to be as a result of the outreach vascular clinics that are taking place in the Guildford area and the associated publicity'.<sup>125</sup> Guildford is the location of RSC, which the CMA considers implies ASP is targeting their market share. This was reflected in commissioner comments.

### ***Gastroenterology***

C.75 The parties overlap in the provision of outpatient, day-case and elective inpatient services.

C.76 The referral analysis suggests that the parties are close alternatives to each other in relation to gastroenterology, across outpatient and inpatient referrals. RSC receives a high share of re-allocated referrals for inpatient referrals from ASP (of around [40–50]% on the proportional methodology). Using the ordinal methodology, this figure increases to [50–60]%.

C.77 The parties submitted that Frimley Park FT codes gastroenterology under the general medicine TFC, so no referrals are recorded to it in this specialty and it does not appear as a competing provider even though it delivers the service. This was confirmed by Frimley. However, it is unclear how significant the constraint is. The CMA further notes that even under the combined GP referral analysis, the parties appear to be close alternatives (see Annex C, paragraph C.43).

C.78 The parties further submitted that using 80% catchment areas, all 19 GP practices where the parties are closest alternatives, are in catchment areas of at least two Acute Trusts other than the parties (three of at least three Acute Trusts); using 90%, 17 are in catchment areas of at least three Acute Trusts. The CMA acknowledges this but, as noted in its geographic market definition section, does not place significant weight on catchment areas because the extent to which each provider may constrain the behaviour of the parties will be influenced by a number of factors, not least patient travel distance to the clinic and the quality of services.

C.79 The CMA assessed how the merger affects the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [30–40]%. Pre-merger around [10–20]% of activity for ASP and around [10–20]% for RSC was from such practices,

---

<sup>125</sup> ASP: Marketing Report – JULY 2014.

whereas post-merger this falls to around [0–10]%. This indicates that the merger significantly reduces the parties' exposure to competition.

C.80 The parties submitted that private providers are an alternative in this specialty, and that a significant number of referrals are directed to BMI Healthcare. In this regard the CMA notes that internal documents to the parties generally note that the constraint from private providers is generally limited to routine procedures. Further, in previous cases the CMA has taken the constraint from private providers in respect of acute services to be limited.<sup>126</sup> Therefore, even if the CMA were to conclude that private providers provided a constraint, this would at most, be limited to routine referrals and that the merger may raise competition concerns in relation to more complex gastroenterology procedures.

### ***Endocrinology***

C.81 The parties overlap in the provision of outpatient services.

C.82 The referral analysis suggests that the parties are each other's closest alternatives, although the constraint that ASP imposes on RSC is most significant. For example ASP accounts for around [50–60]% of reallocated referrals and RSC for 40% of ASP's reallocated referrals using the proportional methodology. Using the ordinal methodology, RSC comprises [50–60]% of ASP's reallocated referrals.

C.83 The parties submitted that that the reason many GPs appear not to have an alternative provider is that neither Frimley nor Epsom code under this specialty – instead coding under diabetic medicine. However the CMA notes that the results for the diabetic medicine GP referral analysis Frimley Park does not appear in the results and Epsom and St Helier are a weak alternative to RSC. Furthermore, in relation to general medicine, under the combined specialties GP referral analysis (which includes general medicine), the parties appear to be close alternatives.

C.84 The parties further submitted that using 80% catchment areas, 25 out of 27 GP practices in catchment areas of at least one Acute Trust other than the parties; using 90%, 26 of 30 are in catchment areas of at least three Acute Trusts. The CMA acknowledges this but, as noted in its geographic market definition section, does not place significant weight on catchment areas because the extent to which each provider may constrain the behaviour of the

---

<sup>126</sup> Bournemouth/Poole at 6.11, footnote 132. We did not consider that private hospital providers significantly constrained NHS acute hospitals in the provision of NHS acute services [...].

parties will be influenced by a number of factors, not least patient travel distance to the clinic and the quality of services.

- C.85 The CMA assessed how the merger affects the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [50–60]%. Pre-merger around [10–20]% of activity for both parties was from such practices, whereas post-merger this falls to around [0–10]%. This indicates that the merger may significantly reduce the parties' exposure to competition.

### ***Diabetic medicine***

- C.86 The parties overlap in the provision of diabetic medicine services on an outpatient basis.
- C.87 Referral analysis suggests that the parties may be close competitors, as on a proportional measure the referral figures are [40–50]% ASP to RSC, and [30–40]% RSC to ASP using the proportional methodology.
- C.88 The CMA assessed how the merger affects the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [10–20]%. Pre-merger around 10% of activity for ASP and around 13% for RSC was from such practices, whereas post-merger this falls to around 10%. This indicates that the merger may have a limited effect on the parties' exposure to competition.

### ***General medicine***

- C.89 The parties submitted that they overlap in relation to general medicine provided in outpatient, inpatient (including day-cases) and non-elective referrals.
- C.90 The CMA notes that RSC records comparatively few referrals in the general medicine specialty as a result of ensuring that more specific specialties are used for recording activity that would otherwise fall under the general medicine category.
- C.91 The CMA has not been able to run the GP referral analysis as a result of the coding practices at RSC. Under the combined specialty results (which includes general medicine referrals) described above in paragraph 43, the parties appear close alternatives, particularly for ASP referrals (where RSC is the next best alternative for around [25–35]% of outpatient and around [35–45]% of inpatient activity) using the proportional methodology. The CMA notes that the combined analysis includes specialties where the parties

submitted they do not overlap and as such significantly under-estimates the extent of closeness of competition across overlap specialties.

### ***Geriatric medicine***

C.92 The parties overlap on inpatient and outpatient bases. The proportional measure is [40–50]% ASP to RSC and [20–30]% RSC to ASP on an outpatient basis using the proportional methodology. The CMA could not run the referral analysis on inpatient services as the data appeared to show the parties did not provide these services.

C.93 The CMA did not receive any other evidence with respect to the provision of Geriatric Medicine.

### ***Anaesthetics***

C.94 The referral data on anaesthetics show [70–80]% ASP to RSC on an outpatient basis and [40–50]% RSC to ASP (also on an outpatient basis) on the proportional measure.

C.95 The CMA assessed how the merger affects the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [40–50]%. Pre-merger around [60–70] % of activity for ASP and around [20–30]% for RSC was from such practices, whereas post-merger this falls to around [20–30]%. This indicates that the merger significantly reduces the parties' exposure to competition.

C.96 The parties submitted that patients are not referred on this basis but instead the service is provided as a part of an overall treatment for the patient, thus anaesthetics is indelibly linked to other treatment services. Further, the parties submitted that anaesthetics is recorded in the data since it is used for pre-operative assessments.

C.97 The CMA notes that in Poole/Bournemouth the CC found an SLC with respect to the provision of anaesthetics, as there was an element of pre-operative consultation in respect of which patient choice could be exercised. However, in that case the central question was whether the provision of anaesthetics should be better coded to the related specialty for which the anaesthetics was provided and, if were to be done, whether there would be a significant worsening in the referral data of the related service.

C.98 There are no coding issues with respect to Anaesthetics in the present case, however, the parties confirmed that the recorded activity does relate to pre-operative consultations. The CMA notes that both the GP referral analysis and

the marginal GP analysis are based on a small number of referrals, which would warrant cautious interpretation of their results.

### ***Anticoagulant services***

- C.99 The referral data show on a proportional measure [60–70]% ASP to RSC and [40–50]% RSC to ASP on an outpatient basis, using the proportional methodology.
- C.100 The parties submitted the specialty is provided by a pathology JV and there is accordingly no competition between the merger parties in this specialty. However, the CMA notes that there is a possibility that the arrangement may end after 5 years, and so the merger may still represent a loss of competition between them.

### ***Trauma and orthopaedics***

- C.101 The parties overlap in the provision of outpatient, day-case and elective inpatient services.
- C.102 The referral analysis suggests that the parties are close alternatives. However, the data also show other providers, in particular FPH and West Middlesex, are being chosen by patients. The CMA's analysis also indicates that BMI may offer a credible choice to some patients. On the basis of the ordinal analysis, RSC is the main alternative to ASP, which accounts for around [35–45]% of next best alternative referrals. The proportional measures are below [25–35]%.
- C.103 The CMA assessed how the merger affects the parties' exposure to competition. The merger reduces the proportion of activity which is derived from marginal GP practices by [20–30]%. Pre-merger around [5–15]% of activity for ASP and around [10–20]% for RSC was from such practices, whereas post-merger this falls to around [5–15]%. This indicates that the merger reduces the parties' exposure to competition, albeit to a lesser extent than in some of the specialties discussed above.
- C.104 The CMA notes that internal documents from both parties suggest that they consider trauma and orthopaedics as a potential growth area. There are already significant volumes from this specialty, which accounts for around 14% of elective activity at the parties' sites.

## Specialties where the CMA does not find a realistic prospect of an SLC

C.105 The CMA has not found that merger raises a realistic prospect of an SLC in regard to the overlap specialties listed below:

- Ophthalmology and orthoptics
- Rheumatology
- Pain management
- Clinical haematology
- Joined midwife episodes and obstetrics
- Respiratory medicine
- Orthodontics
- Cardiology
- Transient ischaemic attack
- Joined paediatrics
- Urology
- Dermatology
- Neurology
- Cardiothoracic surgery
- Vascular surgery

C.106 The majority of these specialties, have referral data figures of below 30% (on both the proportional and ordinal measures) and are not discussed separately. In previous cases the CMA has not considered competition concerns arising at such levels,<sup>127</sup> as the figures indicate that the parties are one of a number of providers which GPs and patients see as options. Those specialties with referral data above 30% are joined ophthalmology and orthoptics, urology,

---

<sup>127</sup> Frimley Park; Chelsea & Westminster/West Middlesex.

joined paediatrics, rheumatology. Moreover, no referral data is available in relation to cardiothoracic surgery and vascular surgery.

- C.107 In **joined ophthalmology and orthoptics** the parties overlap in the provision of outpatient and day-case services. RSC is the designated regional provider of ophthalmology elective inpatient services, and ASP offers orthoptics (an outpatient only TFC). As discussed at Annex A, paragraph A.13, the CMA has assessed the effects of the merger in relation to a combined ophthalmology and orthoptics specialty.
- C.108 The proportional version of the referral analysis does not suggest that the parties are particularly close constraints: for outpatient services [10–20]% of ASP's reallocated referrals go to RSC, and [20–30]% of RSC's go to ASP. For inpatient (and day-case) services, [20–30]% of ASP's reallocated referrals go to RSC, whilst [10–20]% of RSC's go to ASP. Using the ordinal methodology gives higher results for ASP's inpatient services: here, [40–50]% of reallocated inpatient (and day-case) referrals go to the former using the ordinal methodology.
- C.109 However, the referral analysis indicates that Moorfields is a closer competitor for ASP inpatients than RSC, and Frimley Park is a closer competitor for RSC than is ASP.
- C.110 The CMA assessed how the merger affects the parties' exposure to competition. Post-merger around [10–20]% of the merged entity's activity would be from GP practices which are likely to be marginal. This indicates that whilst the merger would reduce the level of marginal activity (by around [25–35]%) post-merger, the merged entity would continue facing constraints from other providers.
- C.111 The parties submitted that coding issues affect this joined specialty, as many trusts do not code orthoptics, and instead code under ophthalmology – hence the rationale for grouping the specialties. However, parties submitted that their coding practice across both orthoptics and ophthalmology is resulting in a greater number of first outpatient appointments for the same level of overall activity compared with other Trusts. ASP and RSC are recording a first outpatient appointment in each of ophthalmology and orthoptics for the same patient, while in Trusts that only code in ophthalmology will record a first outpatient appointment and a follow-up outpatient appointment for the equivalent patient interaction. The parties submitted that this will show up in the GP referral analysis as a greater number of referrals to ASP and RSC due to the greater number of first outpatient appointments, resulting in ASP having an inflated share of referrals at each GP practice, and correspondingly higher Ordinal and Proportional Measures. The CMA notes to the extent this

argument is valid, it would only affect the outpatient numbers (where numbers are in any event low).

- C.112 Irrespective of the issues surrounding coding the CMA considers that that Moorfields and Frimley Park will continue to offer patients choice after the merger and will impose a competitive constraint on the merged entity. Therefore the CMA considers that the merger does not give rise to a realistic prospect of an SLC in relation to ophthalmology and orthoptics.
- C.113 In **urology**, the referral data are [30–40]% on the ordinal methodology ASP to RSC (on an outpatient basis). Referral data RSC to ASP are low and on the proportional methodology, the ASP to RSC outpatient figure drops to [30–40]%. Further, the CMA has found that both FPH and West Middlesex University Hospital will continue to offer patients choice after the merger and a competitive constraint on the merged entity. A long tail of other competitors exists in this specialty: the four next closest competitors have combined referral ratios of [50–60]%. Therefore the CMA considers that the merger does not give rise to a realistic prospect of an SLC in relation to urology.
- C.114 In **joined paediatrics**, the parties overlap in the general Paediatrics TFC in outpatient, day-case and elective inpatient services, and also several more specific Paediatrics TFCs. Following a suggestion from the parties, the CMA combined the activity from these TFCs into one larger group called Joined Paediatrics.
- C.115 Using the ordinal methodology, RSC is ASP's next best alternative in [30–40]% of cases for outpatient services, although on this methodology Royal Marsden becomes the strongest competitor with a referral ratio of [40–50]%. Further, other measures remain low. The marginal GP analysis suggests that the merger does not reduce the parties' exposure to competition, reducing the proportion of activity from marginal GP practices by around [0–5]%.
- C.116 ASP's integrated business plan in its FT application documents highlights West Middlesex University Hospital as its main competitor for Paediatric Services. This is corroborated by the referral data.
- C.117 The parties argued that activity in the Paediatric Oncology specialty may be driving this result in relation to the Cancer Network.<sup>128</sup> They further submitted that ASP and RSC both consider the key alternative to be St George's

---

<sup>128</sup> The CMA has not run its referral analysis on day-cases separately from inpatients.

Healthcare NHS Trust, Great Ormond Street Hospital NHS Foundation Trust and Guy's and St Thomas' Hospitals NHS Foundation Trust.

- C.118 Given the available options for patients after the merger the CMA considers that the proposed merger does not give rise to a realistic prospect of an SLC in relation to paediatrics.
- C.119 In **rheumatology** the ordinal measure is marginally over [35–45]% on an outpatient basis (ASP to RSC, [20–30]% RSC to ASP). However, the proportional measures are low. However, the referral data and the CMA's market testing exercise show that the merged entity will continue to face competition from West Middlesex University Hospital which receives [35–45]% of referrals. Given this constraint the CMA considers that the proposed merger would not give rise to a realistic prospect of an SLC in relation to rheumatology.
- C.120 The parties have only a small presence in **cardiothoracic surgery**. Indeed, they submitted that the outpatient clinics they hold are run by consultants from St George's, and that revenues are less than £30,000 per Trust. No referral data are available for this specialty. However, given the extremely small extent of the parties' activities, based on the evidence it received the CMA does not consider that the proposed merger gives rise to a realistic prospect of an SLC in relation to cardiothoracic surgery.
- C.121 In **vascular** treatments the parties submitted that RSC's services are provided by FPH. Routine services are provided by FPH at the RSC site while complex services are performed at the FPH site. Moreover, RSC has not earned any revenue in this specialty over the period where the referral data indicates there may be an overlap.<sup>129</sup> Given the effective lack of overlap between the parties based on the evidence it received the CMA does not consider that the proposed merger gives rise to a realistic prospect of an SLC in relation to vascular surgery treatments.

---

<sup>129</sup> The parties submitted that while the HES dataset does record some *Vascular Surgery* activity at RSC (around 2,800 spells over April 2009 to October 2012 compared with around 13,000 spells at ASP), RSC believes that this may be a result of its patient administration system logging the activity that Frimley Park Hospital has carried out at RSC, and this subsequently being incorrectly reported through HES as RSC activity. Consistent with this activity being carried out by Frimley Park Hospital NHS Foundation Trust, RSC has not earned any revenue from vascular surgery over this period.