ANTICIPATED MERGER OF ASHFORD AND ST PETER'S HOSPITALS NHS FOUNDATION TRUST AND ROYAL SURREY COUNTY HOSPITAL NHS FOUNDATION TRUST

Statement of issues

2 April 2015

The reference

1. On 26 February 2015, the Competition and Markets Authority (CMA), in exercise of its duty under section 33(1) of the Enterprise Act 2002 (the Act), referred the anticipated merger of Ashford and St Peter's Hospitals NHS Foundation Trust (ASP) and Royal Surrey County Hospital NHS Foundation Trust (RSC) for further investigation and report by a group of CMA panel members (the inquiry group).

2. The CMA must decide:

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

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

3. In this statement, we set out the main issues we are likely to consider in reaching our decisions, having had regard to the evidence gathered to date including evidence set out in the phase 1 decision to refer the anticipated merger of ASP and RSC for further investigation (the reference decision[1]). This does not preclude the consideration of any other issues which may be identified during the course of our investigation.

4. We are publishing this issues statement in order to assist parties submitting evidence to focus on the issues we currently envisage being relevant to our

[1] The full text of the decision can be found on the case page.

inquiry and to invite parties to notify us if there are any additional relevant issues which they believe we should consider.

5. Throughout this document, where appropriate, we refer to ASP and RSC collectively as 'the parties'.

Background

The parties

6. ASP has two hospital sites in Surrey: St Peter's Hospital in Chertsey and Ashford Hospital in Ashford. ASP 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 financial year ended March 2014, all of which were in the UK.

7. RSC, like ASP, is a large acute trust with services typical of a district general hospital. It is also the specialist tertiary centre for cancer in Surrey, West Sussex and Hampshire. It provides a range of acute services to a population of around 320,000 from its main hospital site in Guildford. Royal Surrey has approximately 520 beds and had revenues of £281 million in the financial year ended March 2014, all of which were in the UK.

8. 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 transaction involves the merging trusts being dissolved and a new single trust established. More information on the parties and the transaction can be found in the reference decision.

The services that the parties provide

9. The parties both offer, to some extent, the following services for inpatients, day-cases and outpatients:

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

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

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

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

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

Models of competition in the provision of NHS healthcare services

10. The CMA considers that there are two different models of competition in the provision of NHS healthcare services: [2]

(a) **Competition in the market**, that is, competition for patients, which occurs where patients have a choice between providers of the same service. Patient choice occurs mainly in respect of routine elective services (that is, planned services), as well as maternity services.

The majority of prices for services are set centrally in accordance with tariffs which are determined nationally on a hospital-by-hospital basis, which means that prices for comparable services can vary from hospital to hospital.[3] As there is a fixed price for each elective procedure, hospitals will increase their revenue by treating more patients. Providers are motivated to compete on quality in order to attract patient referrals and hence income. The effect of competition to attract patients is to focus provider decisions on factors that matter to patients and GPs. There are many different aspects of quality, including clinical and non-clinical factors. Specifically, the aspects of quality which may be affected by a reduction in competition include clinical factors, such as infection rates, mortality rates, ratio of nurses or doctors to patients, equipment and best practice; and non-clinical factors, such as waiting times, access, clean-liness and parking facilities. Some of these aspects of quality relate to specialties (such as departmental standards) while others relate to hospital-wide quality (such as facilities). Patients and GPs assess quality in a number of different ways and have access to differing sources of information.

(b) **Competition for the market**, that is, competition for contracts from the commissioning or tendering entity to provide services. It occurs where providers compete to be one of a limited number of providers of a service.

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[2] *CMA guidance on the review of NHS Mergers (CMA29)*, July 2014, paragraphs 6.48–6.55.
[3] We note that the prices that NHS commissioners pay providers for healthcare services can be determined locally rather than nationally in a range of circumstances (see Monitor and NHS England guidance: NHS providers and commissioners: submit locally determined prices to Monitor).

Providers may compete on quality and price. This is the case, for instance, in specialised services.

Market definition

11. The purpose of market definition is to provide a framework for the CMA's analysis of the competitive effects of a proposed merger.

12. Market definition is a useful analytical tool, but not an end in itself, and identifying the relevant market involves an element of judgement. The boundaries of the market do not determine the outcome of the CMA's analysis of the competitive effects of a merger in any mechanistic way. In assessing whether a merger may give rise to an SLC, the CMA may take into account constraints outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others.[4]

Product scope

13. In its phase 1 reference decision, the CMA, in line with its previous cases and guidance on NHS mergers,[5] adopted the following segmentations for defining the relevant product market:

    (a) Each specialty was generally considered a separate product market.

    (b) Within each specialty, the following were considered separately:

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

14. As regards specialty level distinctions, the CMA's view was that demand- and supply-side considerations in the provision of healthcare generally indicate consideration of markets which are no wider than specialties. On the demand side, the CMA's view was that patients and the referring GPs are restricted in their choice of procedures to those that are appropriate to the specific

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[4] *Merger Assessment Guidelines (CC2/OFT 1254)*, September 2010, paragraph 5.2.2.
[5] *CMA29*, paragraphs 6.37–6.39.

healthcare issue with which the patient has been diagnosed. On the supply side, the CMA's view was that supply-side substitution is possible across a core set of procedures, suggesting that considering the competitive effects of the merger at the specialty level is likely to capture the effects on most sets of procedures within specialties.

15. The evidence before the CMA in its phase 1 investigation did not suggest that a different approach from 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.

16. In phase 1, the CMA considered it appropriate to assess outpatient and inpatient services separately, as inpatient providers are readily capable of providing outpatient services but not vice versa.

17. In phase 1, the parties submitted that day-cases and inpatient activity should be considered separately. The CMA did, where relevant, consider inpatient and day-case activity separately in its analysis.

18. We consider that the product market analysis set out above provides a useful framework for assessing the competitive effects of the proposed merger. During phase 2, we will reassess the scope of the product markets on the basis of the evidence we receive during the course of the inquiry. The CMA will consider aggregating some product markets where the conditions of competition are the same across these markets.[6]

Geographic scope

19. In relation to the geographic market, the CMA in phase 1 did not conclude on the exact boundaries of the geographic market as it considered closeness of competition between the parties, using data on referral patterns to provide an insight into patient/GP preferences.

20. The parties compete locally in Surrey and the surrounding area. We will consider the extent of the overlap and the closeness of competition between the parties in the competitive assessment.

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[6] *Merger Assessment Guidelines*, paragraph 5.2.17.

Assessment of the competitive effects of the merger

Counterfactual

21. We will assess the possible effects of the merger on competition compared with the competitive conditions in the counterfactual situation (ie the competitive situation absent the merger). We will therefore consider what would be likely to happen if the merger does not take place.

22. In making our assessment we will consider possible alternative scenarios and decide upon the appropriate counterfactual situation based on the facts available to us and the extent of foreseeable future developments. Further information on the counterfactual is given in the guidance on NHS mergers.[7]

23. Factors that we will consider include, but are not limited to:

    (a) The extent to which there has historically been cooperation, including partnerships and clinical networks, between the parties and between each of the parties and other NHS service providers which has affected the level of competition between them.

    (b) The basis on which services have been organised in the past and the ability of commissioning entities to reconfigure provision of services and therefore change the scope for competition between the parties in the future.

    (c) Financial and clinical difficulties faced by the parties in their provision of services.

24. We will also investigate whether the current level of competition between the parties would change absent the merger due to financial and regulatory changes in the landscape in which they operate.

Theories of harm

25. Theories of harm describe the possible ways in which an SLC could arise as a result of a merger and provide the framework for our analysis of the competitive effects of a merger. We have set out below the theories of harm that we intend to investigate. However, we may revise our theories of harm as our inquiry progresses and new evidence emerges. Also, the identification of a theory of harm does not preclude an SLC being identified on another basis

[7] *CMA29*, paragraphs 6.10–6.32.

following further work by us, or the receipt of additional evidence. We welcome views on the theories of harm set out below.

26. The merger may give rise to the following theories of harm in relation to **competition for patients** (separately for outpatient and inpatient services):

    (a) Theory of harm 1: unilateral effects in the provision of elective acute and maternity services to patients.

    (b) Theory of harm 2: unilateral effects in the provision of non-elective (emergency) acute services to patients.

    (c) Theory of harm 3: unilateral effects in the provision of services to private patients.

27. The merger may give rise to the following theories of harm in relation to **competition for the market**:

    (a) Theory of harm 4: unilateral effects in the provision of specialised services.

    (b) Theory of harm 5: unilateral effects in the provision of community services.

Competition for patients

28. With respect to competition for patients under theories of harm 1, 2 and 3, we will assess whether the merger removes an important current or potential competitor, resulting in a reduced incentive for the merged provider to maintain and provide better quality services to patients (that is, a unilateral effect leading to a SLC).

29. We will consider these theories of harm for each of the overlapping specialities provided by the parties, for inpatient and outpatients separately. We may consider separate markets together, if the conditions of competition are similar.

30. We will also consider whether these theories of harm lead to hospital-wide effects. That is, 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.

Theory of harm 1: unilateral effects in the provision of elective acute and maternity services to patients

31. In our assessment of this theory of harm, we will need to assess the extent and nature of pre-merger competition between the parties, and the extent of competition that would exist post-merger from other providers.

32. We expect to consider the following:

(a) Overlap analysis:

(i) Identification of the overlapping specialities. Hospitals have discretion as to how procedures are recorded, which can lead to the same procedure being recorded differently at different hospitals. We will aim to remove recording inconsistencies in any analysis.

(ii) Sub-specialty-level analysis. Generally within a specialty, providers offer the majority of the most common procedures and may be able easily and quickly to offer procedures they do not currently provide within the specialty. However, providers may not be able to provide all complex procedures, for example because of the equipment or personnel needed. Conditions of competition would, therefore, differ in relation to these complex procedures compared with the specialty as a whole. If we have reason to believe that this is the case, we may consider constraints at a sub-specialty level, depending on availability of evidence.

(iii) Day-cases (where the patient is admitted but is discharged on the same day of the procedure). We will consider whether and where day-cases should be treated as inpatients or outpatients, and any potential impact this has on the analysis.

(b) Closeness of competition analysis:

(i) GP referral analysis. Historical referral patterns offer an insight into GP/ patient preferences and by implication the relative importance of the alternative providers for each GP/GP practice. This gives one measure of the closeness of competition between the parties. We may also be able to consider whether referrals have changed over time, or in response to the closure/opening of facilities. We will also consider further the possible limitations of this analysis and, therefore, the weight that should properly be attached to it, both generally and in relation to individual specialties.

(ii) Marginal GP analysis. In addition to the GP referral analysis described above, we will also undertake analysis in which we consider which GP practices are most likely to choose between the parties' services and the services of other providers, and therefore the ones that are most likely to have an impact on the parties' incentives to compete for patients. We will consider how the number of marginal GP practices may change post-merger, thereby reducing the competitive pressure on the parties.

(iii) GP/patient research. We are commissioning a patient survey to understand patient choice taking place in relation to different outpatient and inpatient services. We are also commissioning qualitative research with GPs.

(c) Incentives analysis:

(i) Networks and partnership arrangements. The parties have been in a partnership since 2012. The parties are also part of network and partnership arrangements with other providers in the local area. We will consider the role of these networks and partnerships, and the impact, if any, on competition for particular (sub-) specialties or more generally.

(ii) Payments. We will consider the structure of payments and any modifications to normal tariffs which may reduce or remove incentives to increase the number of patients treated (if, for example, payments at the margin are no larger than marginal cost of treatment).

(iii) Capacity constraints. The incentives of a provider to compete can be diminished where the provider does not have capacity for additional patients and cannot readily expand capacity. There are various potential measures of capacity, including the number and utilisation of theatres and beds, and staff numbers, although we note that capacity can be difficult to measure. We will consider the extent of any capacity constraints of the parties and other providers in the local area, where relevant.

(d) Competitive responses:

(i) The parties' internal documents. We will consider the internal documents of the parties, particularly those pertinent to how

competition works in the supply of the relevant services and the aspects of quality that may be affected by a reduction in competition.[8]

(ii) Evidence from published literature: we will review evidence from the literature on choice and competition in the NHS.

(iii) The parties' and third party submissions, including, for example, Clinical Commissioning Groups, patients, GPs and other providers.

Theory of harm 2: unilateral effects in the provision of non-elective (emergency) acute services to patients

33. In phase 1 the CMA did not find there to be a realistic prospect of an SLC in relation to unilateral effects in the provision of non-elective acute services.

34. We will seek to confirm the evidence gathered in phase 1. This is subject to any additional evidence we may receive during phase 2. The relevant factors for assessing this theory of harm include:

(a) The extent of patient choice for non-elective acute services. In many cases, patients are not able to exercise choice over non-elective services (for example, when they are taken to hospital by ambulance), and patients may have less access to information on quality considerations compared with elective service. We will, therefore, consider the volume of non-elective activity where patients may have exercised choice and how this affects the parties' incentives.

(b) The profitability of increasing activity given the tariff and cost structures. In phase 1, the CMA considered that the parties' incentives to compete for non-elective activity are likely to be reduced because, in relation to some activities, the parties receive a reduced percentage of the normal tariff for patient volumes above a set level. We will investigate whether the activity levels of the parties are such that the reduced tariffs apply, and the impact of payment to the parties below the normal tariffs, along with any end-of-year settlements, on incentives to compete for non-elective activity.

(c) Capacity constraints. We will consider the extent of any capacity constraints of the parties and other providers in the local area which may limit the providers' incentives to compete.

[8] See paragraph 10 for examples of the different aspects of quality which may be affected by a reduction in competition.

Theory of harm 3: unilateral effects in the provision of services to private patients

35. In phase 1, it was found that the parties offered limited private patient services and there was limited overlap between the parties in the provision of services to private patients. Further, in phase 1 it was found that there were several alternative providers in the area.

36. We will seek to confirm the evidence gathered in phase 1. If the evidence gathered in phase 1 is confirmed, and there is no evidence that the situation would be different in the future, it does not seem likely at this stage that there will be a SLC in the provision of services to private patients.

Competition for the market

37. With respect to competition for the market, where there is competition for contracts to provide services, under theories of harm 4 and 5, we would expect to investigate whether:

    (a) in the event of a competitive tender the proposed merger could be expected to lead to worse outcomes because there would be fewer bidders (which 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); and

    (b) providers under existing contracts might provide lower-quality services, knowing that commissioners have fewer alternative possible providers of those services, and therefore commissioners would be less likely to switch away from the existing provider.

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

39. We will also consider whether the partnership between the parties, and the parties' network and partnership arrangements with other providers in the local area have an impact on competition for the market.

Theory of harm 4: unilateral effects in the provision of specialised services

40. In assessing this theory of harm, we expect to consider the following:

    (a) The extent of competition between the parties to win contracts. We will consider the extent to which the parties have competed to win contracts for the same specialised services, or could be expected to compete in the

future. We will analyse tender data in respect of services for which the parties have bid.

(b) Future reconfiguration of services. We will consider if commissioners have any plans to reconfigure services, such that there may be tenders for these services in the future. We will consider the extent to which the parties are both capable of offering the services that might be reconfigured, whether the parties would be likely to bid to provide these services, and which other providers would be likely to bid.

(c) Commissioner views. We will take into account third party submissions as appropriate and in particular, seek commissioners' views on reconfiguration and the closeness of the parties in bidding for specialised services.

41. We will analyse both elective and non-elective specialised services. The evidence considered in phase 1 showed that there have been no tenders issued for specialised non-elective services for a number of years and there were no significant plans to reconfigure non-elective services.

42. We will seek to confirm the evidence gathered in phase 1 and to consider the likelihood of reconfiguration of services. If the evidence gathered in phase 1 is confirmed, and reconfiguration of non-elective services is unlikely, it does not seem likely that there will be an SLC in non-elective specialised services.

Theory of harm 5: unilateral effects in the provision of community services

43. In phase 1, it was found that the parties do not currently overlap in the provision of community services because the parties provide different services in different geographical areas. Therefore, the parties are not currently competing in the market for patients.

44. Further, in phase 1 it was found that the parties have only bid against each other in one out of 15 tenders during 2009 to 2014, and that the parties competed against a number of other providers.

45. We will seek to confirm the evidence gathered in phase 1. If the evidence gathered in phase 1 is confirmed, it does not seem likely at this stage that there will be an SLC in community services.

Countervailing factors

46. We will investigate whether there are countervailing factors which are likely to prevent or mitigate any SLC that we may find. In particular, we intend to consider the following:

(a) Entry and expansion. We will consider whether entry and/or expansion could occur to constrain any market power of the merged entity.

(b) Buyer power. We will assess the extent to which the bargaining power of commissioning entities would be sufficient to protect customers from the effects of an SLC.

(c) Efficiencies. We will examine any arguments made in relation to efficiencies arising from the merger and the evidence put forward. In particular, we will examine whether any potential efficiencies are rivalry-enhancing and could be expected to offset any loss of competition.

47. We are not currently aware of any other countervailing factors but will consider any other that are suggested to us.

Possible remedies and relevant customer benefits

48. Should we conclude that the merger may be expected to result in an SLC in any market(s), we will consider whether, and if so what, remedies might be appropriate, and will issue a further statement.

49. In any consideration of possible remedies, we may have regard to their effect on any relevant customer benefits (RCBs) in relation to the merger and, if so, what these RCBs are likely to be and which customers would benefit.

50. The parties have told us that the merger will deliver RCBs in the form of:

(a) Clinical benefits from:

(i) seven-day consultant-led services for patients across their main specialities on a sustainable basis;

(ii) Consolidation of certain services, including the development of a Diagnostic and Treatment Centre at Ashford Hospital;

(iii) greater integration of care with community and social services; and

(iv) exploiting innovation and technology, including information technology.

(b) Cost savings (through merger-specific synergies and savings through seven-day working) that will convert into patient benefits in the form of capital investments. The parties estimate that approximately £79 million more in capital expenditure would take place under the merger scenario compared with the situation in which ASP and RSC remain separate.

51. We welcome views and evidence on these or other RCBs and note that the existence or otherwise of RCBs will not prejudice our decision as to whether the merger may be expected to result in an SLC.

Responses to the issues statement

52. Any party wishing to respond to this issues statement should do so in writing, by no later than 5pm on 16 April 2015. Please email ashford.surrey@cma.gsi.gov.uk or write to:

Project Manager
Ashford/Surrey merger inquiry
Competition and Markets Authority
Victoria House
Southampton Row
LONDON
WC1B 4AD