

Terms of reference and conduct of the inquiry

Terms of reference

1. On 8 January 2013 the OFT made the following reference to the CC:
 1. In exercise of its duty under section 33(1) of the Enterprise Act 2002 ('the Act') to make a reference to the Competition Commission ('the CC') in relation to an anticipated merger, the Office of Fair Trading ('the OFT') believes that it is or may be the case that—
 - a. arrangements are in progress or contemplation which, if carried into effect, will result in the creation of a relevant merger situation because:
 - i. enterprises carried on by or under the control of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust will cease to be distinct from enterprises carried on by or under the control of Poole Hospital NHS Foundation Trust; and
 - ii. the value of the turnover in the United Kingdom of the enterprise being taken over exceeds £70 million as specified in section 23(1) of the Act; and
 - b. the creation of that situation may be expected to result in a substantial lessening of competition within any market or markets in the UK for goods or services, including the provision of several routine elective (hospital-based) care specialties and non-elective care.
 2. Therefore, in exercise of its duty under section 33(1) of the Act, the OFT hereby refers to the CC, for investigation and report within a period ending on 24 June 2013, on the following questions in accordance with section 36(1) of the Act—
 - a. whether arrangements are in progress or 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 within any market or markets in the UK for goods or services.

(signed) **CLIVE MAXWELL**
Office of Fair Trading
8 January 2013

Interim measures

2. We took steps to ensure that the operations of RBCH and PH were not further integrated during the course of our inquiry.
3. Both RBCH and PH gave **interim undertakings** to the CC under **section 80** of the Act on 7 March 2013 for the purpose of preventing pre-emptive action by ensuring the separate management of RBCH and PH whilst our inquiry was ongoing. Following breaches of the undertakings notified to us in July 2013, we received

assurances from the parties regarding compliance with undertakings on 16 September 2013.

Conduct of the inquiry

4. On 8 January 2013, we posted on the CC website an [invitation to express views to us](#) about the merger and, on 18 January 2013, we posted an administrative timetable for our inquiry.
5. We also invited a wide range of interested third parties to comment on the merger. We sent detailed questionnaires to a number of NHS acute hospitals, NHS community hospitals, private hospitals, NHS commissioners and to Monitor and we gathered oral evidence through ten hearings with selected third parties. Evidence was also obtained through further written requests. [Summaries of our hearings](#) with third parties are published on our website.
6. On 28 January 2013, we published an [issues statement](#) on our website, setting out the areas of concern on which the inquiry would focus.
7. Members of the Inquiry Group, accompanied by staff, visited the premises of both RBCH and PH and were given presentations on the operation of their services.
8. We commissioned GfK NOP Social Research to carry out patient and GP surveys to assist us in understanding the current choice set offered in the local area for elective treatments, and how these might be affected by the merger of RBCH and PH. The [results of the surveys](#) were published on the CC website on 8 April 2013.
9. On 9 April 2013 we [extended the period of the reference](#) because RBCH and PH had each been unable to supply information and documents specified by us in notices issued to them under [section 109](#) of the Act.
10. We received written evidence from RBCH and PH, and a [non-confidential version of their initial submission](#) is on our website. We also held separate hearings with RBCH and PH on 24 April 2013 and further separate hearings with RBCH and PH on 11 June 2013.
11. In the course of our inquiry, we sent to RBCH and PH and other parties some working papers and extracts from those papers for comment. We also sent RBCH and PH an annotated issues statement prior to the hearings we held with each on 24 April 2013.
12. On 11 June 2013 we [ended the period of extension](#). The period within which the report on the reference was to be prepared and published was revised to end on 26 August 2013. A revised [administrative timetable](#) was published on 11 June 2013, replacing the initial timetable published on 18 January 2013.
13. On 11 July 2013, we published a [Notice of provisional findings](#), a non-confidential version of our [provisional findings](#) and a [Notice of possible remedies](#) on our website. A further, [Supplementary notice of remedies](#) was published on 12 July 2013. [Non-confidential versions of responses to our provisional findings report and Notice of possible remedies](#) are published on our website.
14. On 5 August 2013, we issued a [Notice of extension](#) to allow sufficient time to take account of the revised relevant customer benefits identified by RBCH and PH on 11 July 2013 (as described in the Supplementary remedies notice of 12 July 2013) and any comments received in response to them. This changed the statutory

deadline to 21 October 2013. A revised [administrative timetable](#) was published on 5 August 2013.

15. We held separate response hearings with RBCH and PH on 7 August 2013 and also held response hearings with selected NHS commissioners.
16. We held a public drop-in session in the Dorset region on 5 September 2013 to invite views from local residents on our [provisional findings](#) and [Notice of possible remedies](#).
17. We sent RBCH, PH, Monitor, Dorset CCG, West Hampshire CCG and NHS England (Wessex) a remedies working paper for comment.
18. A non-confidential version of our final report has been placed on our [website](#).
19. We would like to thank all those who have assisted in our inquiry.

Forecast financial performances for RBCH, PH and merged entity

Introduction

1. This appendix provides an overview of the forecast financial performances of RBCH and PH as stand-alone trusts and as a merged entity.
2. We were provided with the May 2012 Annual Plans submitted by the parties to Monitor and with a financial forecast for the merged entity. These forecasts were based on the assumption that the merger was completed at the beginning of 2013/14. We requested updated forecasts for the parties on a stand-alone basis which the parties provided, setting out forecasts to 2015/16.
3. Following review of these forecasts, the parties submitted revised stand-alone forecasts based on actual results achieved in 2012/13, and also including the reallocation of merger-specific savings. These revised forecasts were received on 15 May 2013. We reviewed the revised forecasts and questioned the parties regarding the reallocation of the savings.
4. On 31 May 2013 the parties provided us with their 2013/14 Annual Plans which they would submit to Monitor as the basis for its financial assessment of each trust. These included forecasts for 2014/15 and 2015/16, and had been updated from the forecasts provided on 15 May 2013 to adjust for a reallocation of cost savings. We used these forecasts as the basis for our assessment of the parties' financial positions, and these are the forecasts we present below. We used the income generation figures provided in the 15 May 2013 forecasts—this level of detail was not included in the Monitor submission.

RBCH forecast stand-alone performance

5. The forecast stand-alone performance for RBCH is detailed in Table 1.

TABLE 1 RBCH forecast profit and loss account, 2013 to 2016

	£ million			
	Financial year ending 31 March			
	2013*	2014	2015	2016
Operating income	249.2	[✗]	[✗]	[✗]
Income generation†	N/A	[✗]	[✗]	[✗]
Total operating income	249.2	[✗]	[✗]	[✗]
Operating expenses	-250.0	[✗]	[✗]	[✗]
Cost Improvement Plans	8.5	[✗]	[✗]	[✗]
Total operating expenses	-241.5	[✗]	[✗]	[✗]
Operating surplus	7.7	[✗]	[✗]	[✗]
Non-operating income	0.4	[✗]	[✗]	[✗]
Non-operating expenses	-4.5	[✗]	[✗]	[✗]
Total comprehensive surplus	3.6	[✗]	[✗]	[✗]

Source: RBCH response to CC questions and Annual Plan to Monitor 2013/14.

*RBCH actual 2012/13 performance as per management accounts.

†Figures as included in the forecast bridge provided on 15 May 2013.

Forecast assumptions

Operating income

6. RBCH forecast total operating income to increase by £[£] million over the three-year period. This was driven by income generation of £[£] million in 2014/15 and 2015/16. This would offset the assumed tariff deflation of [£] per cent in these years, and would lead to £[£] million extra income in each year above the level of tariff deflation. RBCH made the assumption that the trust would secure [£] with the CCGs in these years with the reduction in tariff [£] by [£] and new best practice tariffs. RBCH noted that this income was for additional activity planned for 2013/14 not covered in the contract with the CCGs and would therefore be added to the baseline contract for future years. RBCH told us that the [£] income was the estimate of the level of income the trust might be able to secure, and the contracts would be negotiated during the period leading up to the new financial year, but the £[£] million increase would be [£] by RBCH as a result of [£] payments from the CCG following previous [£] of income. The additional income was assumed to have marginal costs at [£] per cent.

Operating expenses

7. Operating expenses were forecast to increase by £[£] million over the forecast period from 2012/13. This forecast increase was largely due to:
- (a) assumed pay cost inflation of [£] per cent in 2014/15 (£[£] million) and [£] per cent in 2015/16 (£[£] million) (this included a national pay award of [£] per cent, pension and NI increases, and incremental pay rise with pay bands and clinical excellence awards). RBCH noted that, as with PH, it had Agenda for Change contracts with the majority of staff which required the trust to make additional payments in line with the pay bands and awards (this is detailed further below for PH);
 - (b) assumed drug cost inflation of [£] per cent in 2014/15 and 2015/16 (£[£] million). RBCH noted that these costs would be covered through 'pass through' contracts, and the income for these was included in additional income;
 - (c) assumed clinical supply (non-pay) cost inflation of [£] per cent in 2014/15 (£[£] million) and [£] per cent in 2015/16 (£[£] million). RBCH noted that this was for utility cost increases and clinical negligence premiums rising by [£] per cent a year;
 - (d) assumed additional cost pressures of £[£] million across 2014/15 and 2015/16. These were assumed to include pension enrolment costs (£[£] million), IT project cost provisions for a planned joint IT programme with PH (£[£] million), and additional clinical costs required to meet the Royal Colleges recommended consultant cover in A&E and Acute Surgery (£[£] million);¹
 - (e) non-recurring costs of £[£] million in 2014/15 and 2015/16 which would partially offset the inflationary cost increases in these years. RBCH noted that these were non-recurrent costs in relation to the IT strategy, which included spend on PCs and mobile technology; and

¹ However, we noted that the parties indicated that these costs would not be incurred absent the merger, as set out in paragraphs 290–291 of Appendix M.

- (f) Cost Improvement Plan (CIP) generating cost savings of £[~~8~~] million over the three years (£[~~8~~] million over 2014/15 and 2015/16), offsetting some of the cost increases. These cost savings are outlined further below.
8. Operating expenditure in 2013/14 included an uncommitted contingency of £[~~8~~] million in relation to PbR activity reserve. RBCH noted that this contingency would carry forward into 2014/15 and 2015/16 if it was not utilized in 2013/14. This would improve performance in these years should the contingency not be required and be released, as was the case in 2012/13.
 9. RBCH had included a £[~~8~~] million redundancy provision during 2012/13, which is still held in the balance sheet. [~~8~~]
 10. The inflationary percentage cost increases assumed by [~~8~~]. The trusts told us that the cost increases for each trust will vary because of a range of factors including case mix, and that as the increases were forecasts, the calculations were their best estimates.

CIP

11. We were provided with a forecast CIP by RBCH which indicated that £[~~8~~] million of savings could be generated over 2014/15 and 2015/16 on a stand-alone basis. In addition, we were provided with a schedule of merger-specific savings which showed further savings of £17.4 million on a merged basis. We reviewed these savings and investigated the extent to which these were merger specific. In particular, we considered that where the parties had requested that certain activities be excluded from the prohibition on further integration set out in the interim undertakings on the basis they were not merger specific, the cost savings associated with these activities should not be included in the merger-specific savings forecast for the merged entity only, but should also be included in the stand-alone financial forecasts for the parties. See further paragraph 35ff below regarding the financial forecast for the merged entity.
12. We were then provided with an updated forecast CIP schedule by RBCH which indicated that £[~~8~~] million of savings could be generated over 2014/15 and 2015/16 on a stand-alone basis.
13. The updated savings largely occur across medicine (£[~~8~~] million), anaesthetics (£[~~8~~] million) and IT development (£[~~8~~] million), and these are detailed in Table 2 below.

TABLE 2 RBCH CIP, 2014/15 and 2015/16

£'000

<i>Clinical savings</i>	
Acute surgery	[£]
Anaesthetics	[£]
Cancer care	[£]
Cardiology	[£]
Maternity	[£]
Medicine	[£]
Paediatrics	[£]
Pathology/pharmacy/therapy	[£]
Radiology	[£]
Specialist services	[£]
Surgical specialties	[£]
Trauma and orthopaedics	[£]
Total clinical savings	[£]
<i>Corporate savings</i>	
Chief Executive	[£]
Finance	[£]
Human Resources	[£]
IT	[£]
Nursing	[£]
Operations	[£]
Service development	[£]
Total corporate savings	[£]
Total RBCH stand-alone savings	[£]

Source: RBCH response to CC questions and Annual Plan to Monitor 2013/14.

Note: The detail of the CIP was provided by the parties separately to the Monitor submission. However, the total figures reconcile with the Monitor submission.

PH forecast stand-alone performance

14. The forecast stand-alone performance for PH provided by the parties is detailed in Table 3 below.

TABLE 3 PH forecast profit and loss account, 2013 to 2016

£ million

	Financial year ending 31 March			
	2013*	2014	2015	2016
Operating income	194.9	[£]	[£]	[£]
Income generation†	5.1	[£]	[£]	[£]
Total operating income	200.0	[£]	[£]	[£]
Operating expenses	-199.2	[£]	[£]	[£]
Cost Improvement Plans	3.3	[£]	[£]	[£]
Total operating expenses	-195.9	[£]	[£]	[£]
Operating surplus	4.1	[£]	[£]	[£]
Non-operating income	0.1	[£]	[£]	[£]
Non-operating expenses	-2.9	[£]	[£]	[£]
Total comprehensive surplus/deficit	1.3	[£]	[£]	[£]

Source: PH response to CC questions and Annual Plan to Monitor 2013/14.

*PH's actual performance for 2012/13 as per management accounts. PH reported an audited deficit of £8.4 million in 2012/13. the difference between the surplus in the management accounts and the audited deficit is an impairment of £9.7 million.

†Figures as included in the forecast bridge provided on 15 May 2013.

15. In the financial year ended 31 March 2013, PH reported a deficit of £[£] million (driven by an impairment of £[£] million). The operating surplus of £1.3 million was lower than the reforecast surplus of £[£] million due to reduced donated income of

£[~~XX~~] million, following delays in some items of capital expenditure, which was offset by a decrease in non-pay costs of £[~~XX~~] million.

16. During 2012/13, PH agreed [~~XX~~] contract income with the Dorset PCT cluster of £[~~XX~~] million [~~XX~~] activity and the under-funding of non-PbR services. In addition, PH was provided with additional income of £[~~XX~~] million to cover additional merger and transition costs which were charged during 2012/13.²
17. We noted that PH's board minutes for a meeting on 26 September 2013 noted that it had achieved a surplus for August, bringing the cumulative surplus for the five months to £211,000 compared to a plan of £98,000; that its savings delivery was slightly ahead of plan and it expected to deliver its full year target.

Forecast assumptions

Operating income

18. Total operating income was forecast to increase by £[~~XX~~] million from 2012/13, but would then remain flat through the forecast period. The principal assumptions for the increase in operating income were:
 - (a) income generation during the three-year period (2013/14 to 2015/16) of £[~~XX~~] million, driven by:
 - a £[~~XX~~] million increase in the contract value in 2013/14 agreed with the Dorset CCG. PH has told us that this agreement was reached in order to help the trust to achieve a successful merger with RBCH, but was not directly dependent on the merger. The basis of the agreement was an estimate, provided by PH, of the level of income required by the trust in order to achieve a small surplus of £[~~XX~~] million in 2013/14, and was not based on any discussions of services and activity. The increase of £[~~XX~~] million therefore includes 'transitional funding' of £3.3 million provided by the Dorset CCG. PH assumed that this transitional funding was non-recurring and would not be available following 2013/14;
 - a full year of revenue from the private patient unit which opened in the second half of 2012/13. PH expected to generate additional income of £[~~XX~~] million from the full year effect of the new inpatient unit. PH did not expect any further increase in private patient revenue;
 - additional income of £[~~XX~~] million generated in 2014/15, and £[~~XX~~] million in 2015/16 from contracts negotiated at 'flat cash' which will offset the assumed tariff deflation in these years. PH told us that this related to an agreement with the Dorset CCG that income in [~~XX~~] would remain at the income level of [~~XX~~]. PH noted that tariff deflation would be offset in [~~XX~~] by elements including an increase in best practice tariffs, an increase in patient volume/activity and CQUIN income, however, it told us that this was only a working assumption and it would not be possible to provide further details of this at this stage. PH assumed that the additional income would incur marginal costs at [~~XX~~] per cent, which it considered to be a conservative estimate based on past experience. It had previously used a marginal cost figure of [~~XX~~] per cent. A larger increase in additional income was required in 2014/15 as it was assumed

² PH finance report, 12 months to March 2013.

that the ‘transitional funding’ of £3.3 million would not be recurring and would have to be replaced by additional activity;

- (b) tariff deflation of 1.3 per cent in 2013/14 and 1.4 per cent in 2014/15 and 2015/16 (total impact of £[~~XXX~~] million), and non-recurring income of £[~~XXX~~] million during 2013/14 (largely relating to funding for ‘winter pressures’ and to support merger costs), offsetting the income generation; and
- (c) a decrease in donated income of £[~~XXX~~] million as the donated income in 2012/13 of £[~~XXX~~] million was unusually high as it included two major donations.

Operating expenses

19. Operating expenditure (including depreciation) was forecast to increase by £[~~XXX~~] million from 2012/13 over the forecast period. This increase was driven by:
 - (a) cost inflation increasing operating expenses by £[~~XXX~~] million during the forecast period, with assumptions for:
 - pay cost inflation of [~~XXX~~] per cent a year (which included a national pay award of 1 per cent, pension and NI increases, and pay increments as staff move through the pay bandings and clinical excellence awards). PH noted that almost all staff within the NHS were paid under national agreements—Agenda for Change contracts to cover staff, and Consultant contracts. These contracts provide annual increments for staff within a band until the top band is reached, and an inflationary uplift dictated centrally. PH also noted that the Government had imposed a 1 per cent pay cap but this excluded the pay increments and clinical excellence awards which were paid to medical staff;
 - clinical supply (non-pay) inflation of [~~XXX~~] per cent. PH told us that this covered utility cost increases and clinical negligence premiums which were rising by [~~XXX~~] per cent. PH told us it assumed that the costs for the IT strategy were included within cost inflation; and
 - drugs cost inflation of 6.0 per cent. PH told us that the drugs cost increases would be reimbursed through its managed contract for high-cost drugs, and this was part of its flat cash assumptions;
 - (b) CIP generating cost savings of £[~~XXX~~] million in 2013/14 and £[~~XXX~~] million across 2014/15 and 2015/16, partially offsetting the inflationary cost increases. These are outlined further below;
 - (c) other cost pressures in 2013/14 of £[~~XXX~~] million, which included investment in additional staff cover across different services and pathways; and
 - (d) additional clinical cost pressures of £[~~XXX~~] million estimated by PH during 2014/15 and 2015/16. These cost pressures were estimated in order for PH to provide the recommended clinical cover by the Royal Colleges in the areas of [~~XXX~~].³
20. Combined, this resulted in total cost inflation of [~~XXX~~] per cent in 2014/15 and [~~XXX~~] per cent in 2015/16.

³ However, we noted that the parties indicated that these costs would not be incurred absent the merger, as set out in paragraphs 290–291 of Appendix M.

21. PH noted that it had £[£] million in reserve in its balance sheet for redundancies. We would have expected these costs to be released by PH on a stand-alone basis. However, PH told us that redundancy costs might be required on a stand-alone basis should the trust experience financial pressures.

CIP

22. PH provided a forecast CIP which indicated that £[£] million of savings could be generated over 2014/15 and 2015/16 on a stand-alone basis. As noted in paragraph 11 above in relation to RBCH, as a result of questions regarding the savings which may be generated by the merged entity, we were provided with an updated forecast CIP schedule which indicated that £[£] million of savings could be generated over 2014/15 and 2015/16 on a stand-alone basis.
23. These cost savings will largely be generated from IT development (£[£] million), medicine (£[£] million) and paediatrics (£[£] million).

TABLE 4 PH CIP (2014/15 and 2015/16)

	£'000
<i>Clinical savings</i>	
Acute surgery	[£]
Anaesthetics	[£]
Cancer care	[£]
Maternity	[£]
Medicine	[£]
Paediatrics	[£]
Pathology/pharmacy/therapy	[£]
Radiology	[£]
Specialist services	[£]
Surgical specialties	[£]
Trauma and orthopaedics	[£]
Total clinical savings	[£]
<i>Corporate savings</i>	
IT	[£]
Nursing	[£]
Operations	[£]
Service development	[£]
Total corporate savings	[£]
Total PH stand-alone savings	[£]

Source: PH response to CC questions and Annual Plan to Monitor 2013/14.

Cash balance

24. PH initially forecast that it would run out of cash during the financial year 2014/15,⁴ however, the revised forecast to Monitor shows PH forecasting a very low cash balance from the end of 2014/15, if it continues to operate as a stand-alone organization. Detailed in Table 5 are the forecast cash balances provided by PH in its Annual Plan.

⁴ Joint main party initial submission, paragraph 126.

TABLE 5 PH forecast cash balance, 2013 to 2016

	<i>£ million</i>		
	<i>Financial year ending 31 March</i>		
	<i>2014</i>	<i>2015</i>	<i>2016</i>
Cash balance as at 1 April	[X]	[X]	[X]
Net surplus/deficit	[X]	[X]	[X]
Depreciation	[X]	[X]	[X]
Capital expenditure (including donated)	[X]	[X]	[X]
Financing	[X]	[X]	[X]
Cash balance as at 31 March	[X]	[X]	[X]

Source: Annual Plan to Monitor 2013/14.

*PH Annual Plan is assuming there will be a £[X] million drawdown of a non-commercial loan.

25. The decline in PH's cash balance to £[X] million in 2015/16 is largely driven by the forecast net deficits of £[X] million and £[X] million generated during 2014/15 and 2015/16, respectively, and capital expenditure of £[X] million (including charity-funded expenditure) forecast over the three-year period. This includes IT development costs (£[X] million) and refurbishment costs in relation to the Maternity unit (£[X] million).
26. We noted that these forecast deficits were [X] per cent and [X] per cent above those set out in Monitor's notification of a formal investigation into PH's compliance with its licence: 'Specifically the Trust states that it is: projecting a deficit in 2014/15 of c.£8m and 2015/16 of c.£14m; forecasting a balanced position in 2013/14 only due to "an explicit commissioner subsidy of £3.3m".'⁵
27. PH told us that to avoid showing a negative cash balance in its Annual Plan (which Monitor templates did not allow) it assumed that £[X] million of financing would be drawn down during 2014/15 and 2015/16 which would prevent it from running out of cash (though PH has told us its cash balance would be negative during the final quarter of 2014/15 before the receipt of the loan). The Annual Plan notes that this will be a non-commercial loan, however, PH has told us it was assuming this would be provided in 'some form of emergency finance' in order for the trust to continue to pay its staff and suppliers, rather than to finance capital expenditure.
28. PH told us that most of the trust's capital expenditure programme could not be deferred or delayed, and that the forecast capex programme included adjustment for items which were deemed by the board not to be essential for patient safety over the next 12 months, and could be delayed until the merger was agreed. This resulted in £[X] million being deferred from 2013/14 (this is netted down to £[X] million following additional capital items included).
29. PH noted that the £[X] million of IT development capex was a joint strategy with RBCH. The PH board did not consider that these IT costs could be reduced or delayed, and it was essential that the IT strategy should be implemented as quickly as possible. This was due to (a) patient safety being dependent upon a robust IT infrastructure, and (b) RBCH and PH already having shared systems, and therefore it would not be possible to implement the IT strategies of the two trusts independently. As noted in Table 4 above, this would generate £[X] million of cost savings during 2014/15 and 2015/16.

⁵ See Monitor's Notification of a formal investigation into compliance with the Trust's Licence.

30. We also noted that the forecast cash balance included public dividend capital (PDC)⁶ payments of £[~~XX~~] million across 2014/15 and 2015/16, although the trust is forecast to run out of cash and require a loan during 2014/15. The Annual Plan includes an assumption of a £[~~XX~~] million non-commercial loan in 2014/15 and 2015/16. The PDC dividend charge is based on a trust's net asset position, and would therefore still arise for PH. We have also been told by Monitor that the PDC dividend payment is required irrespective of whether a trust has surplus cash or is making operating deficits.
31. We noted that the merged trust forecast included a provision for a loan and asked PH whether it had considered seeking a loan. PH told us that it had never formally applied for external borrowing (or to increase its public dividend capital). PH noted that before making any loan application the board would have to approve a business case which demonstrated that the trust could afford the interest costs and repayment terms of such a loan, which it considered would not be possible as the trust was forecasting a deteriorating cash position. However, the cash flow position was deteriorating due to forecast capital expenditure, which would be offset in the event of debt financing. Debt financing would be considered if it was believed that the forecast capital investment would generate a return for the trust.

PH forecast sensitivity

32. PH's forecasts are highly sensitive to the underlying assumptions and small changes in these assumptions alter the forecast deficits. We considered the sensitivity of the forecasts to the underlying assumptions for 2014/15 and 2015/16 to highlight the impact on the forecast deficit.
33. We have considered in the sensitivity the effect of the following changes:
- (a) PH achieves efficiency requirements of [~~XX~~] per cent⁷ in 2014/15 and [~~XX~~] per cent⁸ in 2015/16;
 - (b) PH is still able to generate the additional activity and income forecast, with the support of the CCG; and
 - (c) PH avoids the assumed additional clinical cost pressures of £[~~XX~~] million to meet the Royal Colleges' recommendations.
34. These adjustments result in forecast deficits of £[~~XX~~] million in 2014/15 and £[~~XX~~] million in 2015/16, an improvement of £[~~XX~~] million across both years. This exercise was carried out to understand the sensitivity of the forecasts to changes in underlying assumptions and does not indicate that we found that these elements should be amended in the forecast.

Merged trust forecast performance

35. The forecast performance of the merged trust provided by the parties is detailed in Table 6 below.

⁶ PDC is a type of public sector equity finance based on the excess of assets over liabilities at the time of establishment of the predecessor NHS Trust.

⁷ This figure was determined using estimates of [~~XX~~] per cent tariff deflation, [~~XX~~] per cent pay cost inflation and [~~XX~~] per cent drug cost inflation in 2014/15.

⁸ This figure was determined using estimates of [~~XX~~] per cent tariff deflation, [~~XX~~] per cent pay cost inflation and [~~XX~~] per cent drug cost inflation in 2015/16.

TABLE 6 Merged trust forecast profit and loss account, 2013 to 2016

	£ million		
	<i>Financial year ending 31 March</i>		
	2014	2015	2016
Operating income	[☒]	[☒]	[☒]
Income generation	[☒]	[☒]	[☒]
Total operating income	[☒]	[☒]	[☒]
Operating expenses	[☒]	[☒]	[☒]
Cost Improvement Plans	[☒]	[☒]	[☒]
Total operating expenses	[☒]	[☒]	[☒]
Operating surplus	[☒]	[☒]	[☒]
Non-operating income	[☒]	[☒]	[☒]
Non-operating expenses	[☒]	[☒]	[☒]
Total comprehensive surplus/deficit	[☒]	[☒]	[☒]

Source: Response to CC questions.

Forecast assumptions

Operating income

- 36. The merged trust was forecast to increase its total operating income from the combined revenue of £[☒] million generated by the parties in 2012/13, to £[☒] million in 2015/16.
- 37. This increase was principally driven by the parties forecasting the merged trust to increase income by £[☒] million during 2014/15 and 2015/16, which would offset the assumed tariff deflation of [☒] per cent during these years. We noted that this was the combined additional income generated by the parties on a stand-alone basis (as outlined in the PH and RBCH stand-alone sections) with no additional income achieved as a merged entity.

Operating expenditure

- 38. The merged trust's operating expenditure (including depreciation) was forecast to increase by £[☒] million from 2012/13 over the forecast period. This was largely driven by:
 - (a) inflationary cost increases of £[☒] million during 2014/15 and 2015/16 which are experienced by the trusts on a stand-alone basis, as outlined above;
 - (b) operating costs of £[☒] million during 2014/15 and 2015/16 relating to the new income opportunities (new income was assumed to incur marginal costs at [☒] per cent);
 - (c) CIP generating additional cost savings of £13.7 million over what can be achieved by the trusts on a stand-alone basis (total CIPs as a merged entity would be £[☒] million), which offset the inflationary cost increases. These are outlined further below; and
 - (d) merger efficiency savings of £[☒] million during 2014/15 and 2015/16, in relation to clinical cost pressures for additional consultants which were assumed not to be required on in the event of a merger. These savings arise from reconfiguring five clinical areas (which we discuss further in Section 9 of our report). The main

savings are from not increasing the consultant cover in each party's A&E and emergency surgery departments.⁹

Other costs

39. We noted that the parties did not include any information communication costs in the merged forecast, or any further transition or merger-related costs which we would have expected to be included. The parties told us that any additional costs of reconfiguration were factored into the forecasts. However, any inefficiencies or additional recurring costs created by the merger were not separately identifiable in the forecasts.
40. As a result of the significant capital expenditure programme planned by the parties, detailed further below, we would expect an increase in depreciation over the forecast period, which is not included. As these are not cash costs, increasing the depreciation charge in the merged forecasts would not affect the parties' ability to invest in capital projects but would affect the surplus/deficit position of the merged trust.

CIP

41. The CIPs that the parties estimated the merged entity could generate were £[§] million during 2014/15 and 2015/16. £13.7 million of these savings were assumed to be merger dependent by the parties, to be generated over and above what the parties could generate as stand-alone entities.
42. The parties initially provided us with information indicating that the merger could result in £17.4 million of merger-specific savings. As a result of our questions (see paragraph 11) regarding whether certain savings were merger specific, the parties revised their estimate of merger-specific savings. We noted that it was not clear to us that all of the £13.7 million of savings outlined as merger specific can only be achieved through merger—for example, [§] purchasing a new [§]. We have investigated further the extent to which the savings outlined in Table 7 below can only be achieved through merger in the context of our analysis of RCBs (see Section 9 of our report). For the purposes of our assessment of the counterfactual, our conclusion would not change if we had found that some of the merger-specific savings were in fact not merger specific, although we would expect that if that were the case, each party's financial position in the stand-alone counterfactual would be slightly improved.
43. We set out details of the merger-specific savings described in paragraph 41 above in Table 7 below. The savings in Table 7 are forecast to occur during 2014/15 and 2015/16, and will then occur on a recurrent basis. However, the parties noted that they had not undertaken a detailed analysis of additional cost savings beyond this period.

⁹ However, we noted that the parties indicated that these costs would not be incurred absent the merger, as set out in Appendix M, paragraphs 290–291.

TABLE 7 Merger-specific savings

	Reforecast £'000
<i>Clinical savings</i>	
Acute surgery	[☒]
Cancer care (incl haematology)	[☒]
Cardiology	[☒]
Maternity	[☒]
Medicine	[☒]
Pathology/Pharmacy/Therapy	[☒]
Radiology	[☒]
Specialist services	[☒]
Surgical specialties	[☒]
Trauma and orthopaedics	[☒]
Total clinical savings	[☒]
<i>Corporate savings</i>	
Chief Executive	[☒]
Management structure	[☒]
Finance	[☒]
Human Resources	[☒]
Nursing	[☒]
Operations	[☒]
Service development	[☒]
Total corporate savings	[☒]
Total merger-specific savings	13,690

Source: RBCH and PH responses to CC questions.

- 44. The majority of the clinical savings identified by the parties arise from reductions in the number of medical staff and reductions in the number of beds (arising from reduced length of stays for patients). There are also some smaller savings in clinical services arising from a reduced need for administration and IT support.
- 45. Since our provisional findings, the parties have told us that the merger-specific savings forecast should be reduced by £0.3 million as the initial estimate was based on consolidating maternity services on one site, which is no longer proposed as a potential relevant customer benefit of the merger. This would reduce merger-specific savings to £13.4 million. We have taken this into account in our analysis of RCBs in Section 9. For the reasons noted in paragraph 42 above, it does not change the counterfactual analysis.
- 46. The corporate savings largely arise from having one rather than two corporate functions, a single management function and corresponding reductions in staff.
- 47. We consider these in more detail in Section 9.

Capital expenditure

- 48. The merged trust was forecast to spend £[☒] million on capital expenditure over five years from 2013/14 to 2017/18 (the parties also forecast £156 million capital expenditure over a seven-year period). The parties stated that this expenditure would be financed by:
 - (a) The annual depreciation charges of about £[☒] million in each of its first [☒] years before any surplus in that year (ie the trust will generate cash of £[☒] million in these years in the event that it breaks even on an accounting basis). These annual depreciation charges would amount to £[☒] million over five years.
 - (b) £[☒] million was expected to come from [☒] and [☒] over the five-year period.

49. The balance of £[☒] million over five years would be funded by a combination of [☒] and [☒], with the merged trust expected to open with cash balances of £[☒] million.
50. In addition, the parties' forecasts do not rely on any long-term borrowing but they told us this could potentially be a source of finance for the merged trust's capital expenditure programme.

Industry background

1. This appendix describes our understanding of the following aspects of NHS structure and regulation that are relevant to our assessment of the merger:
 - (a) What are foundation trusts? In this appendix we consider the powers and obligations of foundation trusts and the extent to which these provide foundation trusts with an ability and incentive to compete in supply of NHS services.
 - (b) How do foundation trusts receive funding? We next consider how NHS services are commissioned. Different NHS services are commissioned by different entities. This section describes how services have been commissioned in the past and how they are commissioned following changes made pursuant to HSCA 2012.
 - (c) Quality regulation of foundation trusts. What regulation exists to maintain and improve the services of acute hospitals? In this section we consider some of the mechanisms designed to safeguard the quality of NHS services.
 - (d) Competition policy and law in the supply of NHS services. This section sets out the competition obligations of NHS providers and commissioners and enforcement mechanisms.
 - (e) To what extent do foundation trusts have incentives to compete? In this section we consider the incentives foundation trusts have to compete under the patient choice framework, the Any Qualified Provider (AQP) regime and PbR.
 - (f) Monitor's regulation of foundation trusts. Finally we consider the role which Monitor has in regulating foundation trusts, in particular its ability to determine whether or not a foundation trust is failing and the mechanisms it has to reduce the likelihood and impact of failure.

What are foundation trusts?

2. RBCH and PH are both foundation trusts. Foundation trusts are public benefit corporations which are required to provide certain NHS services but are also afforded a degree of operational autonomy. The powers and obligations of foundation trusts are set out in legislation. Prior to April 2013, foundation trusts had authorizations which set out the services they were entitled to provide and described their governance arrangements. Authorizations were granted, varied and enforced by Monitor. From April 2013, the authorizations of foundation trusts were replaced by provider licences.
3. The principal purpose of an NHS foundation trust is the provision of goods and services for the purposes of the health service in England and the principal purpose must be stated in the trust's constitution. An NHS foundation trust may do anything which appears to it to be necessary or expedient for the purpose of or in connection with its functions. Foundation trusts are also able to provide goods and services for any purposes related to the provision of services provided to individuals or in connection with the prevention, diagnosis or treatment of illness and the promotion

and protection of public health.¹ Moreover, an NHS foundation trust may carry on other activities for the purpose of making additional income available in order better to carry on its principal purpose.² Contracts between foundation trusts and commissioning entities have to be in the form of standard NHS contracts (see paragraphs 10 and 11).

4. Foundation trusts can retain their surpluses and borrow to invest in new and improved services for patients and service users. This gives them an incentive to maximize their income by taking steps to attract patients for profitable specialties, for example by maintaining and improving service quality. In addition, through the regulatory framework that has been set up, including the PbR regime and the commissioning of services by CCGs, they may compete to provide healthcare services to commissioners, GPs and patients. The remuneration system set out under the PbR regime incentivizes providers of acute elective services to win additional patients (see paragraphs 62 to 73). Foundation trusts are regulated by Monitor. Foundation trusts are also incentivized to be financially healthy via the Monitor regulatory framework, which rates foundation trusts on the basis of their financial stability and has the ability to put failing trusts into special administration (see further below).

Commissioning—how do foundation trusts receive funding?

5. Most of the services provided by foundation trusts, including RBCH and PH, are commissioned by CCGs. This section describes the role of the newly-formed CCGs in commissioning NHS acute services. We also explain the role of other bodies, such as NHS England, in terms of the commissioning of certain services and the supervision and guidance it provides for CCGs.

Clinical Commissioning Groups

6. Between 2006 and 2012, approximately 152 PCTs in England commissioned around 80 per cent of NHS services, including primary care (GPs), dental care, mental health services, community services and services provided in a hospital setting. Strategic health authorities were responsible for the performance management of PCTs. The remainder of NHS services, namely highly specialised, low-volume services, were generally commissioned regionally or nationally by specialised commissioners.
7. HSCA 2012 abolished PCTs and strategic health authorities³ and created CCGs.⁴ CCGs replaced PCTs as commissioners of NHS services. We understand that in some cases there is significant continuity between the PCTs and the new CCGs, with staff and management transferring from the old entity to the new. There are 211 CCGs in the country, and all GP practices in England are members of a CCG. CCGs operated under delegated authority from PCTs before taking on their full statutory responsibilities on 1 April 2013.
8. NHS England has overseen the establishment of CCGs and monitors their financial performance and compliance with their statutory duties (see paragraphs 27ff). In addition, Monitor has the function of investigating complaints relating to potential non-compliance by CCGs with their obligations in terms of patient choice, procurement and anti-competitive conduct. Monitor can open an investigation under the National

¹ The National Health Service Act 2006, [section 43\(2\)](#), as amended by [section 164\(1\)](#) of HSCA 2012.

² *ibid.*

³ HSCA 2012, [sections 33 & 34](#).

⁴ HSCA 2012, [section 10](#).

Health Service (Procurement, Patient Choice, and Competition) (No. 2) Regulations 2013 in two circumstances: on its own initiative for investigations into breaches of the prohibition on anti-competitive conduct,⁵ or in response to a complaint that a commissioner has breached a requirement in regulations 2 to 12 of the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 or regulations 39, 42, or 43 of the Responsibilities and Standing Rules Regulations in circumstances where Monitor considers that the complainant has sufficient interest.

9. CCGs are broadly responsible for commissioning urgent and emergency care (111 services, A&E, ambulance services), out-of-hours primary medical services except where this responsibility is retained by GPs under the GP contract, elective hospital care, community health services, rehabilitation services, maternity and newborn services (but not neonatal intensive care), learning disability services, mental health services and infertility services. Of the total NHS budget of £95 billion, CCGs will receive £65 billion to commission services. It is up to CCGs and the NHS England Area Team to determine how best to configure provision of healthcare services in their local area, in consultation with healthcare providers and bodies providing clinical input, recognizing that at times the providers may have a legitimate driver for change.
10. The NHS Standard Contract 2013/14 (NHS Standard Contract)⁶ must be used by CCGs when entering into contracts for clinical services and by NHS England (see paragraphs 22 to 26 on the commissioning functions of NHS England) when entering into all contracts for non-primary-care clinical services. Commissioning has been carried out within the framework of similar NHS Standard Contracts for a number of years.
11. The NHS Standard Contract requires detailed reporting by providers and compliance (by commissioners and providers) with the patient choice regime.⁷ It requires the commissioner to manage activity via referrals and notify the provider promptly of any anticipated change in referral numbers.⁸ The provider is then required to manage activity in accordance with caseloads, occupancy levels, specified clinical thresholds and activity planning assumptions. The parties must agree an Indicative Activity Plan before the start of each contract year.⁹ The contract states: 'The Co-ordinating Commissioner and the Provider should not agree an Activity Management Plan in respect of any unexpected or unusual pattern of Referrals and/or Activity which they agree was caused wholly or mainly by the exercise of Service Users of their rights under Patient Choice.'¹⁰
12. The NHS Bournemouth and Poole PCT and NHS Dorset PCT (together the Dorset PCT cluster) were the primary commissioners for RBCH and PH. On 31 March 2013,

⁵ Regulation 10.

⁶ The 2013/14 NHS Standard Contract is available on NHS England's website: www.england.nhs.uk/nhs-standard-contract/. It is prepared by the DoH NHS Standard Contracts Team on behalf of NHS England.

⁷ Service conditions 6, 28 and 29, NHS Standard Contract. This includes a requirement (at 29.2) that 'The Parties must not agree or implement any action that would operate contrary to Patient Choice Guidance or so as to impede the exercise of Patient Choice'.

⁸ Service condition 29, NHS Standard Contract, relates to monitoring and management of activity and referrals for the services in accordance with the PbR rules. In addition, service condition 36 requires the commissioner to pay the provider in accordance with national tariff rules.

⁹ The contract requires the provider to notify the commissioner of unusual referral patterns within three operational days of the unusual referral activity, explain the likely cause and submit a report as to how the Indicative Activity Plan is likely to be breached. The parties will then meet to consider the patterns of referrals, activity and the exercise by services users of their rights under patient choice. The parties should then agree a plan to address this—if there is a dispute about the legitimacy of the overactivity levels, the matter can go to mediation and independent adjudication by the Centre for Effective Dispute Resolution or another independent body. Monitor, Contract dispute resolution: advice for NHS foundation trusts (18 March 2011).

¹⁰ Service condition 29.17, NHS Standard Contract.

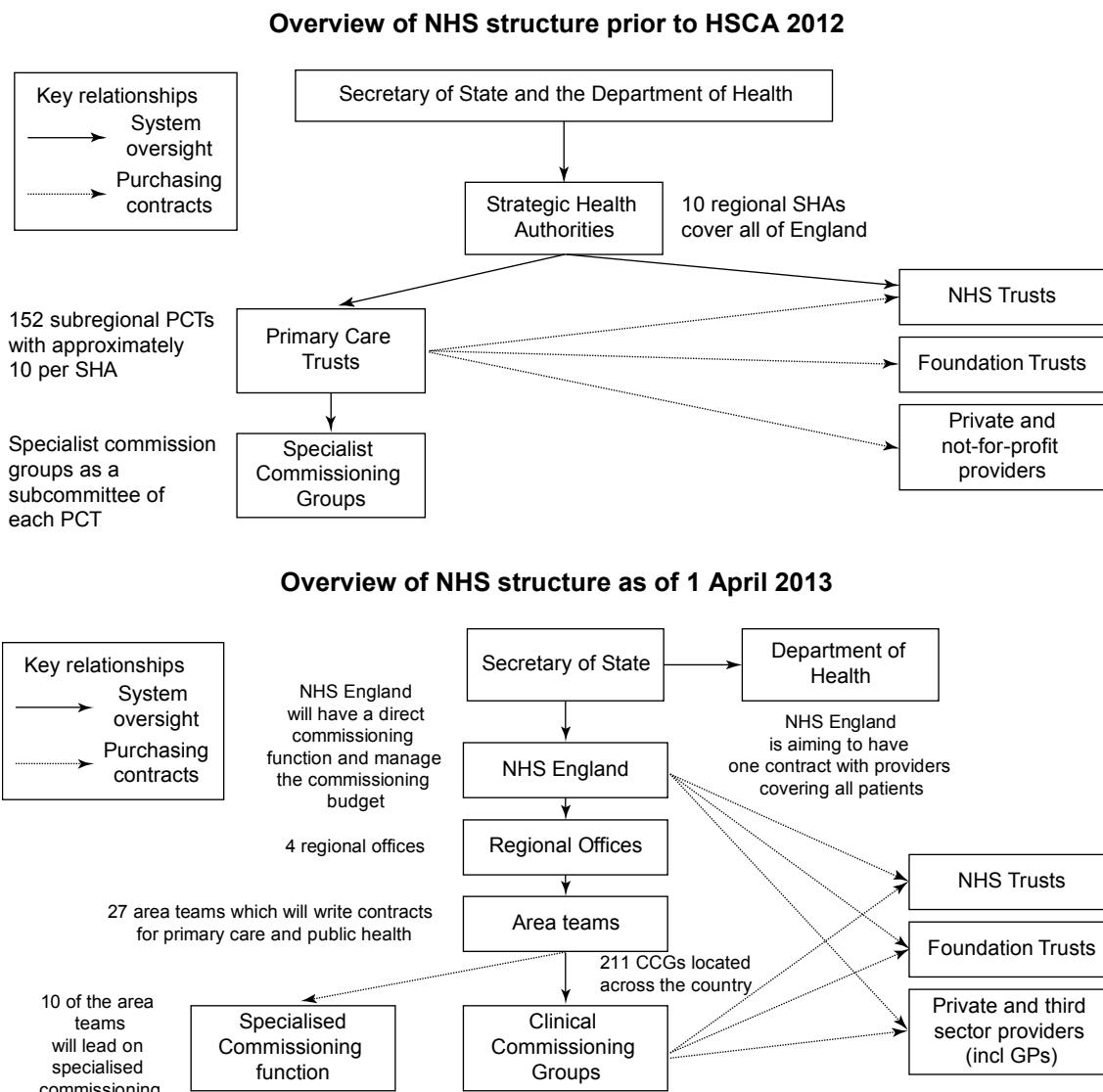
these PCTs ceased to exist and were replaced by one CCG covering all of Dorset and Poole: the Dorset Clinical Commissioning Group (Dorset CCG). Many former staff at the PCTs transferred to Dorset CCG. Prior to 31 March 2013, a significant proportion of RBCH's services were commissioned by the Hampshire PCT. The Hampshire PCT was split into five CCGs. Since that date, the West Hampshire CCG became responsible for commissioning for the area of the population in the two local areas (West New Forest and Totton & Waterside) served by hospitals including RBCH.

NHS England

13. The HSCA 2012 established the NHS Commissioning Board (known as NHS England)¹¹ in October 2012, although it only took on its full functions on 1 April 2013. It is responsible for overseeing the financial situation of CCGs and compliance with their statutory duties and for commissioning specialised services. NHS England has been provided with a commissioning budget of £95 billion for 2013/14 and a mandate from Government in relation to its objectives from April 2013 to March 2015.
14. It is also responsible for the direct commissioning of primary medical services, pharmaceutical services, primary ophthalmic services, dental services (primary, community and hospital), health services for people in prison and in the armed forces and various public health screening services such as immunization and national screening programmes.
15. The commissioning structure for the NHS before and after HSCA 2012 is set out in Figure 1.

¹¹ Section 1H (1) of the National Health Service Act 2006 (following amendment pursuant to [section 9](#) of HSCA 2012).

FIGURE 1
NHS structure before and after HSCA 2012



Source: CC research.

16. NHS England has a concurrent duty with the Secretary of State to promote a comprehensive health service.¹² It is composed of eight directorates, with four regional operations directorates: (a) NHS North of England; (b) NHS Midlands and East; (c) NHS South of England; and (d) NHS London; and 27 local area teams. RBCH and PH are in the NHS South of England region and are covered by NHS England (Wessex) (also referred to as the Wessex Area Team).
17. NHS England has a statutory duty to exercise its functions with a view to securing continuous improvement in the quality of services provided to individuals for or in connection with either the prevention, diagnosis or treatment of illness or the protec-

¹² Ultimately it is the Secretary of State who has ministerial responsibility to Parliament for the provision of the health service in England. Each year the Secretary of State must publish a mandate setting out the objectives of NHS England and any requirements. NHS England is obliged to seek to achieve the objectives in the mandate and to comply with any requirements specified. Its functions also include production of a five- to ten-year strategy to improve outcomes.

tion or improvement of public health.¹³ This statutory duty is to be exercised in conjunction with statutory duties to promote autonomy, choice, reduction of inequality, effectiveness, efficiency, and various other duties.¹⁴

18. In attempting to secure the provision of greater quality services, NHS England is statutorily obliged to have reference to guidelines laid down by the National Institute for Health and Care Excellence (NICE).¹⁵ NHS England works closely with NICE and other bodies in order to establish a Commissioning Outcomes Framework that provides transparency and accountability about the quality of services commissioned by CCGs and their contribution to improving performance against the NHS Outcomes Framework.
19. The Government has set out its mandate for NHS England for the next two years¹⁶ which sets a number of objectives, that NHS England is legally required to pursue. The following objective, with its focus on patient choice and improved payment systems, is of relevance to our inquiry:

To support the NHS to become more responsive and innovative, the NHS Commissioning Board's objective by 2015 is to have:

fully embedded all patients' legal rights to make choices about their care, and extended choice in areas where no legal right yet exists ... and

made significant improvements in extending and improving the system of prices paid to providers, so that it is transparent, and rewards people for doing the right thing.

20. We also note the following objective:

The Board's objective is to get the best health outcomes for patients by strengthening the local autonomy of clinical commissioning groups, health and wellbeing boards, and local providers of services. The Government will hold the Board to account for achieving this; and it will be supported by a process of comprehensive feedback for assessing the Board's performance. ... The objectives in this mandate can only be realised through local empowerment. The Board's role in the new system will require it to consider how best to balance different ways of enabling local and national delivery. These may include: its ability to work in partnership with local authorities and commissioners, particularly through health and wellbeing boards; its duties and capabilities for engaging and mobilising patients, professionals and communities in shaping local health services; its duties to promote research and innovation—the invention, diffusion and adoption of good practice; the transformative effect of information and transparency, enabling patients to make fully informed decisions, and encouraging competition between peers for better quality; its control over incentives such as improving the basis of payment by results, introducing the quality premium for CCGs, and the quality and outcomes framework in the GP contract; leading the continued drive for efficiency savings, while maintaining quality, through

¹³ The National Health Service Act 2006 was amended by section 23(1) of the HSCA 2012 to include this duty. The relevant provision (new section 13E of the National Health Service Act 2006) came into force on 1 April 2013.

¹⁴ National Health Service Act 2006, sections 13C–134P.

¹⁵ The duty to have reference to NICE guidelines is a reference to NICE's power to issue guidelines under section 234 of the HSCA 2012, which came into force on 1 April 2013.

¹⁶ www.gov.uk/government/uploads/system/uploads/attachment_data/file/127193/mandate.pdf.

the Quality Innovation Productivity and Prevention (QIPP) programme; and by spreading better commissioning practice, including redesigning services, open procurement and contracting for outcomes, to ensure consistently high standards across all areas of commissioning.

21. NHS England commissions specialised services and primary care. The primary care services it commissions (see paragraph 14 above) are not relevant to our inquiry and we do not further consider them in this report. We consider its role in commissioning specialised services below.

Role of NHS England in commissioning specialised services

22. Specialised services are provided in relatively few specialist centres.¹⁷ These services treat either rare conditions or those that need a specialised team working together at a centre. These services can be expensive to provide and are often described as high-cost/low-volume services. An assessment against the following four factors will determine whether NHS England will be responsible for the commissioning of a prescribed specialised service: the number of individuals who require provision of service; the cost of providing the service or facility; the number of persons able to provide the service or facility; and the financial implications for CCGs if they were required to commission the service or facility themselves. This means that a specialised service would not be provided by every hospital in England; generally, it would be provided by fewer than 50 hospitals. A large number of specialised services span a wide catchment population of over 1 million people.
23. Specialised services have generally been part of the same NHS Standard Contract as the other acute services commissioned by the relevant PCT. In the Dorset area, specialised services have in the past five to six years been commissioned by the South West Specialist Commissioning Team.¹⁸
24. On 1 April 2013, NHS England took over responsibility for commissioning specialised services.¹⁹ NHS England (Wessex) replaced the South West Specialist Commissioning Team in commissioning specialised services from the parties from 1 April 2013.²⁰
25. NHS England directly commissions specialised services to be provided in a hospital setting and community services.²¹ It is expected that the NHS Commissioning Board will have a single contract with each trust for specialised services,²² and this change was introduced for 2013/14.
26. Prior to the reorganization that came into effect in April 2013, specialised services were defined in law as those having a catchment population of more than 1 million people and only 38 specialised services were defined in the Specialised Services National Definitions Set.²³ The list of specialised services has been refined and

¹⁷ NHS England, Securing equity and excellence in commissioning specialised services: www.england.nhs.uk/wp-content/uploads/2012/11/op-model.pdf.

¹⁸ [South West Specialised Commissioning Team hearing summary](#), paragraph 4.

¹⁹ As set out in the [National Health Service Commissioning Board and Clinical Commissioning Groups \(Responsibilities and Standing Rules\) Regulations 2012](#).

²⁰ [NHS England \(Wessex\) hearing summary](#). There is also a group which commissions some specialised services on a national basis, but neither RBCH nor PH provide any nationally commissioned specialised services and we have not therefore considered these services in detail.

²¹ Specified in [Schedule 4](#) of the National Health Service Commissioning Board and Clinical Commissioning Groups (Responsibilities and Standing Rules) Regulations 2012.

²² [South West Specialised Commissioning Team hearing summary](#).

²³ www.specialisedservices.nhs.uk/info/specialised-services-national-definitions.

services are defined at a greater level of detail, so there are now 143 specialised services (most of which are more narrowly defined services that were previously within the 38 services).²⁴

Role of NHS England in relation to CCGs

27. NHS England has authorized and overseen the establishment of 211 CCGs.²⁵
28. NHS England distributes resources according to a national formula to the 211 CCGs across the country. The 27 area teams are then responsible for monitoring the financial performance of CCGs within their area, along with compliance with their statutory duties. In the area affected by the merger, NHS England (Wessex) will have oversight of the nine local CCGs, overseeing an overall allocation of around £5 billion. £3 billion is provided directly to the nine CCGs for them to commission services according to their local priorities, with the remaining £2 billion allocated to the area team for the direct commissioning of specialised and primary care services.²⁶
29. In carrying out their commissioning functions, NHS England and CCGs are subject to obligations imposed by the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 (relating to patient choice, procurement and anti-competitive conduct) which are applied and enforced by Monitor.

Quality regulation of acute service providers

30. There are many mechanisms designed to safeguard the quality of NHS services, including regulation, Royal Colleges' oversight of professional standards and patient choice. In this section we consider the contractual provisions in the NHS Standard Contract and the role of bodies such as the CQC, NICE and the Royal Colleges. Effective competition provides an incentive to increase quality and in the next section we describe the framework designed to promote quality competition between NHS acute hospitals. We note that some of the regulatory mechanisms designed to safeguard the quality of NHS services may also incentivize hospitals to improve quality. We consider the extent to which the parties are incentivized to compete on quality in our competitive assessment.
31. The Department of Health defines quality in the NHS in terms of patient safety, clinical effectiveness and patient experience.²⁷ Dr Foster Intelligence, a joint venture with the Department of Health, collects and publishes information on a number of variables to monitor the quality of patient outcomes and safety.²⁸ It also publishes a quality account of every trust to understand how providers perform in the three dimensions of quality defined by the Department of Health.

²⁴ The Manual for Prescribed Specialised Services, www.england.nhs.uk/wp-content/uploads/2012/12/pss-manual.pdf.

²⁵ Section 14B of National Health Service Act 2006 (as amended by section 25 of HSCA 2012) and further described in guidance issued in October 2012.

²⁶ NHS England (Wessex) hearing summary.

²⁷ 'High quality care for all', Department of Health, 2008.

²⁸ In doing so, Dr Foster uses the following indicators: Patient safety is measured using death rate indicators (eg death rate for emergency admissions, death rate for heart attack patients, death rate for patients admitted with a broken hip), Patient Safety Incidents reports, the ratio of hospital staff to beds and infections control; clinical effectiveness is measured using unplanned readmission rates for a number of treatments (eg hip replacements, hysterectomies, heart operations), number of patients who received an immediate treatment once arrived at the hospital (eg number of heart attack patients that received aspirin on arrival), the proportion of day-case patients that end up staying longer for treatment and the number of patients that receive some specific treatments as recommended by NICE guidelines (eg the number of patients that are assessed for venous thromboembolism on admission (as recommended by NICE)); and patient experience is measured using national patient surveys to understand whether patients are treated with respect and dignity and whether the hospital communicates clearly with patients and GPs, among other factors. It monitors the number of operations cancelled due to missing notes; waiting times for hospital-based outpatient treatments; and whether the hospital offers an integrated end of life care pathways.

NHS Standard Contract

32. The NHS Standard Contract is a key lever for commissioners to ensure improvements in quality and cost effectiveness.²⁹ Commissioners can use financial levers in the contract to incentivize providers to improve quality and cost effectiveness.
33. The NHS Standard Contract sets out a framework for paying acute hospitals for meeting CQUIN objectives in relation to specific services. The CQUIN payment framework enables commissioners to reward excellence by linking a proportion of providers' income to the achievement of local quality improvement goals. The **framework** aims to embed quality within commissioner-provider discussions and to create a culture of continuous quality improvement, with stretching goals agreed in contracts on an annual basis.³⁰
34. CQUIN for 2013/14 is set at a level of 2.5 per cent value for all healthcare services commissioned through the NHS Standard Contract. One-fifth of this value (0.5 per cent of overall contract value) is to be linked to the national CQUIN goals, where these apply.³¹ National CQUINs are mandatory where they apply (but providers can opt out and payment be withheld). Local commissioners can decide whether they also have a local CQUIN scheme. At least 2 per cent of a provider's total contract payment (from all commissioning entities) will be available for local CQUIN schemes—the number and content being entirely for agreement between provider and commissioner.³²
35. The NHS Standard Contract describes how CQUIN payments should be made, requiring commissioners to set out clearly the proportion of payment associated with each CQUIN indicator and the basis upon which payment will be made.³³ NHS England will nationally define these targets for specialised services, and the CCGs will define the targets locally for services they are commissioning.³⁴ The Guidance states that:

CQUIN monies should be used to incentivise providers to deliver quality and innovation improvements above the baseline requirements set out in the Standard Contract. Commissioners should plan to make challenging but realistic CQUIN schemes available for providers, so that there is an expectation that a high proportion of commissioner CQUIN funding will be earned by providers in-year.

CQC

36. The CQC is responsible for regulating the quality of health and adult social care services. Organizations that provide health and social care services in England³⁵ are

²⁹ Technical Contract Guidance on the 2013/14 Standard NHS Contract.

³⁰ NHS England opened a consultation in July 2013 into whether this system of incentives, rewards and sanctions is used as intended and whether redesign is required. www.england.nhs.uk/wp-content/uploads/2013/07/incent-rew-sanct.pdf.

³¹ The Guidance on CQUIN for 2013/14 states that the full-year financial value of a CQUIN scheme should be calculated as a percentage of the full-year value for all healthcare services commissioned through the NHS Standard Contract and providers should only be paid where they have achieved the agreed CQUIN goals: www.commissioningboard.nhs.uk/files/2013/02/cquin-guidance.pdf.

³² NHS guidance requires that the schemes be fair, legitimate, feasible, clear and properly targeted and based on data perceived as accurate. It states that 'Commissioners and providers may wish to review the NHS CB planning framework and road-test tariff to ensure local schemes do not duplicate or contradict other system levers': www.commissioningboard.nhs.uk/files/2013/02/cquin-guidance.pdf.

³³ Appendix 4 of the NHS Standard Contract sets out the framework for CQUIN payments.

³⁴ **NHS England (Wessex) hearing summary**.

³⁵ Some exceptions apply, particularly regarding the supply of care services to children. See **section 8** of Health and Social Care Act 2008.

required to register with the CQC.³⁶ The CQC sets out 'essential standards of quality and safety' for organizations which provide healthcare or social care services.³⁷ These standards set down minimum acceptable guidelines for a range of quality indicators, including patient safety, suitability of staffing, standards for management, and patient welfare.

37. The CQC also performs inspections³⁸ of particular providers and aims to inspect most hospitals at least once each year, ordinarily on an unannounced basis.³⁹ The CQC may also ask for information from the service providers and receive notifications when various events, incidents or changes take place. The information that the CQC garners regarding a provider will be compiled into a Quality Risk Profile. NHS providers are given access to view their Quality Risk Profiles via a secure website. If the CQC detects a lack of compliance with its standards it can seek a compliance statement, issue a warning, or take civil and/or criminal action depending upon the severity of the breach and whether or not the breach of compliance is a repeat offence.
38. The CQC told us that RBCH was inspected in November 2012 and was found to be fully compliant with the essential standards for quality and safety, as was PH after inspection in January 2013. Details on more recent CQC inspections are set out in Appendix D, paragraph 13.

The Royal Medical Colleges

39. The Royal Medical Colleges are professional medical bodies incorporated by royal charter. Colleges publish medical practice guidelines, including best practice information regarding the administration of their specialty (for example, the Royal College of Midwives provides maternity guidance that the midwife to mother ratio in a maternity unit should be 1 to 28). Colleges play a role in quality maintenance. They frequently make representations to the Department of Health and other professional bodies as those bodies seek to develop their own standards and regulations.
40. Whilst healthcare providers may refer to these guidelines in developing their clinical practice and commissioning bodies may also take account of these guidelines when developing policies for a local area, these guidelines are not legal or formal requirements; for many acute service providers they reflect best practice to take into account when developing policies, areas for change and service aspirations.

National Institute for Health and Care Excellence

41. NICE was established in 1999 as a special health authority, becoming a non-departmental public body under the Health and Social Care Act 2012. NICE has a statutory function of 'giving advice or guidance, providing information or making recommendations about any matter concerning or connected with the provision of NHS services'.⁴⁰ NICE publishes extensive guidance pertaining to clinical medicine. Health professionals within the NHS in England are expected to take NICE clinical

³⁶ Section 10 of the Health and Social Care Act 2008.

³⁷ The CQC has published these standards on its website (www.cqc.org.uk/organisations-we-regulate/registering-first-time/essential-standards).

³⁸ Section 60, Health and Social Care Act 2008.

³⁹ The CQC conducts three types of inspections: (a) scheduled inspections are carried out on a rolling difference; (b) responsive inspections are conducted in response to complaints or concerns that have been raised about a health or social care facility; and (c) themed inspections are also carried out to monitor a certain set of services (eg review of learning disabilities).

⁴⁰ The National Institute for Health and Care Excellence (Constitution and Functions) Regulations 2013

www.legislation.gov.uk/uksi/2013/259/part/2/made.

guidance fully into account when considering the appropriate course of treatment. NICE also publishes guidance pertinent to the use of interventional procedures. The CQC may make use of NICE guidance adherence data as part of its regulatory requirements and adherence is taken into account by the NHS Litigation Authority when assessing risk in NHS trusts.

General Medical Council

42. The General Medical Council (GMC) is the independent regulator for doctors in the UK. Since 1858,⁴¹ it has had statutory authority to oversee the practice of medicine within the UK. The GMC holds a register of suitably qualified doctors and issues them with a licence to practise medicine. The GMC provides guidance on good medical practice for all doctors and has legal powers to restrict or remove a doctor's right to practise medicine in the UK if they do not comply with this guidance. The GMC also regulates medical education and training in the UK. It carries out a programme of quality assurance activity to make sure the standards it sets are being met.⁴² We also noted the role of the Deaneries in medical training.⁴³

Competition policy and law in the supply of NHS services

43. Regulation, however comprehensive, is seen in many sectors as second best to competition and, in our view, differing levels of quality between regulated acute hospitals show that there is scope for factors other than regulation, such as competition, to drive quality. In recent years, government policy has been to extend patients' choice and competition in the provision of NHS-funded healthcare services.
44. This section provides an overview of the law and policy for commissioning and provision of NHS services, focusing in particular on the extent to which NHS foundation trusts are, and will be, expected to compete for patients and to provide services to commissioners.
45. Government initiatives relating to the introduction of competition and choice in the provision of NHS services date back a number of decades. There has been an evolution from a centrally-organized NHS to a situation in which providers and commissioners have increasing levels of autonomy which can be harnessed to ensure that competition will be a meaningful driver of quality. More recently, preparatory steps to facilitate the introduction of more effective competition have included:
- from 1991, splitting the responsibility for providing healthcare from the responsibility for purchasing it (referred to as the purchaser/provider split);⁴⁴
 - from 2003, the establishment of NHS foundation trusts⁴⁵ (into which NHS trusts could convert subject to meeting the criteria) (see paragraphs 2 to 4 above);

⁴¹ Medical Act 1858. The Medical Act 1983 is now the contemporary statutory footing for the GMC.

⁴² More information is available at www.gmc-uk.org.

⁴³ According to the Deaneries' website: The Deaneries are responsible for the management and delivery of postgraduate medical education in addition to supporting the continuing professional development of all doctors and dentists. This includes ensuring that all training posts provide the necessary opportunities for doctors and dentists in training to realize their full potential and provide high-quality patient care. The Deaneries are also responsible for trainers, educational supervisors and educational leaders, their training needs and educational development. www.mmc.nhs.uk/colleges_deaneries/deaneries.aspx.

⁴⁴ The purchaser/provider split was first introduced in 1991 following the NHS and Community Care Act 1990:

www.kingsfund.org.uk/topics/nhs-reform/white-paper/gp-commissioning.

⁴⁵ Pursuant to the Health and Social Care (Community Health and Standards) Act 2003, consolidated into the National Health Service Act 2006.

- from around 2003, the introduction of PbR, namely the payment of fixed national tariff prices per treatment to NHS acute service providers according to the volume of patient treatments provided. PbR tariffs replaced block contracts that remunerated providers irrespective of the number of patients treated;⁴⁶
- from 2004, the introduction⁴⁷ and gradual extension of patient choice and mechanisms to facilitate the exercise of patient choice, such as the 'Choose and Book' website and the NHS Choices website. In 2009 patients' ability to choose the provider for a first consultant-led outpatient appointment in relation to elective care was also set out in the NHS Constitution;
- from around 2007, the establishment of the AQP model (previously known as Any Willing Provider (AWP)), allowing qualified providers to have a contract with an NHS commissioner to provide certain NHS services;⁴⁸
- from 2004, the provision by independent sector treatment centres (ISTCs) of some NHS services; and
- the application of procurement rules to commissioners; these rules have applied in the past to the extent that commissioners were 'public contracting entities' for the purposes of European procurement rules such as the 2006 Public Contracts Regulations 2006. The HSCA 2012 included provisions regarding the manner in which CCGs and NHS England procure services.⁴⁹ This type of procurement is most relevant when considering competition for the market for NHS services (see paragraph 46 below).

46. We considered the framework within which competition in the provision of NHS healthcare services has been considered in the past, for example by the CCP. As the CCP explained in its Merger Guidelines,⁵⁰ there are broadly speaking two different models of competition in the provision of NHS healthcare services:

- *Competition in the market (ie 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 determined nationally. Competition *in* the market occurs mainly in respect of routine elective (planned) services as well as maternity services. Hospitals are motivated to compete on quality in order to attract patient referrals and hence income.
- *Competition for the market*, which occurs where the commissioning entity uses a competitive process⁵¹ to choose between different providers for the right to provide services to patients.

⁴⁶ Department of Health, [Reforming NHS Financial Flows, Introducing payment by results](#) (October 2002).

⁴⁷ Department of Health, [Choice of Hospital, Guidance for PCTs, NHS Trusts and SHAs on offering patients choice of where they are treated](#) (July 2003).

⁴⁸ This was a development of the more limited patient choice introduced from December 2005 (choice of at least four providers of hospital and specialist treatment or care in England). In 2005, this developed into the 'extended choice network' which comprised independent sector treatment centres as well as NHS providers.

⁴⁹ The regulations explaining how these provisions would be implemented indicate that for NHS services that are not subject to the AQP model, commissioners will need to consider the appropriate means of making improvements to quality and efficiency in the provision of services, including through enabling providers to compete to provide the services and allowing patients a choice of provider. See further Section 6, where we consider competitive tendering in the context of competition for the market.

⁵⁰ [Cooperation and Competition Panel, Merger Guidelines](#) (25 October 2010), paragraphs 6.6–6.13.

⁵¹ By 'competitive processes' we include both situations where commissioners set out to change supplier or a new contract is being awarded, and situations where commissioners consider a new supplier (eg because an existing contract has ended) but are open to keeping the existing supplier.

47. From April 2008, building on and reinforcing the initiatives outlined above, the NHS has been subject to an explicit set of 'Principles and Rules for Cooperation and Competition' (the Principles and Rules), which covered NHS mergers and commissioner and provider conduct.⁵² Two of the main aims of this policy instrument were to encourage providers of NHS services to compete and to ensure that commissioners used competition as a lever to improve quality and ensure value for money. In addition, the NHS Constitution and NHS Handbook set out a patient's right of choice in certain circumstances.
48. Responsibility for developing understanding of, and ensuring compliance with, the Principles and Rules was initially entrusted to the CCP, which produced guidelines setting out how it intended to assess complaints.⁵³ Very broadly, the merger guidelines were based on the merger provisions of the Act and the associated guidelines of the OFT and CC; the conduct guidelines (including those relating to integrated care) were based on the Chapter I/II prohibitions in the Competition Act 1998 (Competition Act) and Articles 101/102 of the Treaty on the Functioning of the European Union as well as the associated block exemptions and guidelines; the procurement guidelines were based on the European procurement rules and the Public Contracts Regulations.
49. The Principles and Rules and the various guidelines issued by the CCP were non-statutory in nature. They may be described as 'soft law' since they were not legally binding but had strong persuasive effect.
50. HSCA 2012 put the system of 'soft law' described above on a statutory footing, with Monitor taking on the investigative and advisory role of CCP with effect from 1 April 2013. HSCA 2012 put the substance of the Principles and Rules of the CCP on a statutory footing through the conditions of Monitor's provider licence and through the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013; HSCA 2012 also gave Monitor powers to enforce the provider licence and obligations in the Regulations. From 1 April 2013 Monitor has concurrent powers with the OFT to apply the Chapter I and Chapter II prohibitions in the Competition Act and Articles 101 and 102 of the Treaty on the Functioning of the European Union. HSCA 2012 set out specific obligations on commissioners and providers in relation to procurement, patient choice and PbR and also introduced a prohibition on anti-competitive behaviour in the provision of NHS services which is against the interests of people who use such services.⁵⁴
51. The CCP's investigations in the context of the Principles and Rules (and more recent interventions of Monitor and the OFT, under the Competition Act in the case of the

⁵² The document is available at: www.gov.uk/government/publications/principles-and-rules-for-cooperation-and-competition.

⁵³ The CCP was created in 2009 as an advisory body to its sponsors, the Department of Health and Monitor. The CCP did not have statutory powers to require information, levy penalties or impose orders or undertakings to remedy infringements. However, mergers that satisfied certain turnover thresholds required notification to the CCP. In addition, the non-statutory procedures put in place by the CCP allowed users, providers and commissioners of NHS services to lodge complaints about alleged non-compliance with the Principles and Rules. If the complaint fell within its remit and satisfied its acceptance criteria, the CCP would investigate and issue advice to the Secretary of State or Monitor as to whether or not the conduct in question was in breach, and if so, how the breach should be remedied. The Secretary of State or Monitor would then issue directions to ensure compliance. Compliance with directions issued by Monitor following a recommendation of the CCP was mandated for foundation trusts via an amendment to their authorizations that took effect from 1 May 2009.

⁵⁴ Condition 2 of the provider licence prevents providers from entering into or maintaining agreements that have the object or effect of preventing, restricting or distorting competition to the extent it is against the interest of healthcare users. Regulation 10 of the [National Health Service \(Procurement, Patient Choice and Competition\) \(No. 2\) Regulations 2013](#) provides that when commissioning NHS services, CCGs and NHS England must not engage in anti-competitive behaviour, unless to do so is in the interests of people who use NHS services, which may include (a) by services being provided in a more integrated way or (b) by cooperation between persons who provide the services in order to improve the quality of services. [Section 62\(3\)](#) HSCA 2012, incorporated into the provider licence and applied to commissioners by virtue of the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013.

OFT⁵⁵) have increased awareness and understanding of the rules relating to competition and choice. The recent legislative developments and the attendant debate and publicity are also likely to have resulted in greater familiarity with these rules.⁵⁶ Importantly, the fact that Monitor now has formal statutory powers of investigation and enforcement (including the ability to impose fines—see further below) is likely to have made clear that the Government expects commissioners and providers to adhere to the framework for choice set out in various NHS legislation, regulation and guidance. In recent months, Monitor has issued a number of useful guidance documents setting out how it sees the system working and how it expects commissioners and providers to comply.^{57,58}

52. We noted that in some respects competition in the provision of NHS services is still developing and that in some circumstances commissioners have a level of discretion as to how and when to use competition as a driver to achieve their objectives. When reviewing various aspects of the relevant markets there was uncertainty as to how any changes would be implemented and we therefore considered whether commissioners would make changes in the foreseeable future on a case by case basis in relation to the relevant services considered.
53. The competition obligations on providers mentioned above exist in tandem with the NHS duty to cooperate and to provide integrated care. We noted that competition and provision of integrated care are not necessarily inconsistent. Moreover, there may be circumstances where anti-competitive activity can be shown by commissioners to be in the interests of the people who use NHS services, for example because services are delivered in a more integrated way. We noted that this is in line with the position previously taken by the CCP. As the CCP explained, models of integrated care were only of concern when they eliminated the advantages to patients and taxpayers that were brought about by competition. In such cases, a closer look at the countervailing benefits to the introduction of the new model of delivery of care would be necessary.⁵⁹

Incentives on foundation trusts to compete

54. In this section we set out our understanding of how patient choice developed in the NHS, in particular how it works with the PbR and AQP systems to incentivize foundation trusts to compete. As noted in paragraph 4 above, foundation trusts are incentivized to compete for additional financial revenue as they can keep their surpluses and failing foundation trusts can be put into special administration (see further paragraph 82 below). However, to ensure that this incentive is linked to the patient choice regime, trusts need to be remunerated for attracting additional patients. This section explains how this remuneration is intended to occur.

⁵⁵ See, for example, the OFT's recent investigation into information sharing between NHS organizations: <http://oft.gov.uk/news-and-updates/press/2012/71-12>.

⁵⁶ See, for example, the fact sheets published by the Department of Health: www.gov.uk/government/publications/health-and-social-care-act-2012-fact-sheets.

⁵⁷ See the Cooperation and Competition section of Monitor's website at: www.monitor-nhsft.gov.uk/regulating-health-care-providers-commissioners/cooperation-and-competition. In addition, the informal advice service of Monitor's Competition and Choice Directorate provides a service for providers and commissioners who have questions about the rules and how to comply with them.

⁵⁸ www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishCCPGuidanceonCA98March13.pdf.

⁵⁹ CCP, *The Implications of Competition Rules for the Delivery of Integrated Care* (14 December 2012); see, for example, paragraphs 16–19 of that document; CCP, *The Implications of Competition Rules for Agreements Involving Providers of NHS-funded Healthcare Services* (22 March 2013), for example paragraphs 21 & 22. See also the response to the question: 'are integrated care and competition mutually exclusive?' in the *Frequently asked questions on integrated care* published by Monitor on its website on 24 June 2013 (www.monitor.gov.uk/regulating-health-care-providers-commissioners/enabling-integrated-care/frequently-asked-questions-i).

Patient choice

55. We focus here on patient choice as described in the 2013/14 Choice Framework (Department of Health, April 2013). Patients have choice of provider in respect of their first consultant-led outpatient appointment for elective care (including for specialist tests) and for maternity services. Patients may, in limited circumstances, as a matter of practice, exercise choice outside the range of circumstances described in the Choice Framework. For example, a person may be in a position to decide to attend one A&E unit in preference to another. It is also possible for commissioners to extend patient choice locally.
56. As noted in paragraph 45 above, successive governments have introduced various mechanisms to provide patient choice in relation to routine elective services. These are summarized in the 2011 CCP report on the operation of any willing provider,⁶⁰ an extract of which is provided below (footnotes have been omitted):

Patients needing routine elective care in England are able to choose between any NHS or independent sector provider of acute elective care in England that is registered with the CQC, has a PCT- or nationally-led contract, and is willing to provide services at the NHS tariff. This policy is referred to as the AWP policy for routine elective care.

Patients' ability to choose their provider of routine elective care has been progressively expanded since the policy of patient choice was first announced in 2000. Following pilot programmes in 2002–04, choice on referral to hospital for routine elective care was introduced for all patients on 1 January 2006. Initially, patients were offered a choice of at least four hospitals (or suitable alternative providers), and a choice of date (and time) for their booked appointment. This was expanded in July 2007, when the choice available to patients requiring orthopaedic care was expanded to include providers on the newly established Extended Choice Network (ECN), and again in 2008, when all patients requiring routine elective care became able to choose between any NHS trust, foundation trust, ISTC, and any provider registered on the ECN or Free Choice Network (FCN).

In January 2009, patients' right to choose was enshrined in the NHS Constitution. The NHS Constitution 2009 stated that patients 'have the right to make choices about their NHS care and to information to support these choices'. The Handbook to the NHS Constitution stated that this right means that, subject to certain exceptions, patients 'have the right to choose the organisation that provides your NHS care when you are referred for your first outpatient appointment with a service led by a consultant.'

By February 2011 patients could choose between approximately 165 NHS acute trusts (including foundation trusts) operating from approximately 300 sites as well as around 15 nationally-contracted independent sector providers of routine elective care operating from a further 175 sites. Patients in certain locations, for certain elective services, may also have the option of choosing additional locally contracted providers, such as former PCT community services provider arms, GPs and other private and voluntary sector providers. This is particularly the case for

⁶⁰ 'Operation of 'any willing provider' for the provision of routine elective care under 'free choice'.

services that were previously provided only in an acute setting but are now available in a community setting.

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

- the Choose and Book system, which allows patients (and GPs acting on patients' behalf) to select their provider of choice and book their first outpatient appointment with that provider;
- PbR, which—in principle—remunerates providers for routine elective care according to patient treatment volumes through a framework of fixed tariffs covering a range of procedures; and
- NHS Choices, which provides performance information on each provider to assist patients in selecting their preferred provider.

The underlying rationale of providing patients with the ability to choose between providers of routine elective care is that the need to attract patients (in order to earn revenue given the PbR system of tariffs) ensures providers have an ongoing incentive to offer the highest quality care. Providers that are successful in attracting patients will be able to earn revenues that, in the case of NHS foundation trusts for example, can be reinvested in other services.

Expectations of the patient choice policy at the time of its introduction were that it would assist in driving down waiting times for routine treatments and, more generally, that it would:

- improve quality and safety in service provision;
- improve health and wellbeing;
- improve standards and reduce inequalities in access and outcomes;
- lead to better informed patients;
- generate greater confidence in the NHS; and
- provide better value for money.

Given the relatively recent introduction of patient choice and competition in routine elective care, patients and providers are still learning how to make the most of this new environment. Patient awareness of their ability to choose their provider is relatively high at 54 per cent, but there is scope for this to increase. There is evidence that patients are exercising choice. There has been rapid growth in the number of NHS patients being treated at private facilities, and CCP analysis shows that a significant proportion of patients are selecting a provider other than their local NHS provider and that the quality of care offered by a provider is a significant factor in explaining patients' choice. There is also evidence of patients responding to adverse patient safety events when they occur at their local hospital by choosing to be treated elsewhere in the following months.

Similarly, there is evidence that providers are still adapting to the operation of patient choice in routine elective care. The King's Fund recently found, in a qualitative study, that the threat of patients choosing a different hospital led some providers to focus more on reputation, and noted that providers spoke about actively seeking to attract patients away from other providers in particular geographical areas and marketing their services to GPs. But, overall, it concluded that direct competition for patients' custom was limited.

Despite patients and providers still being in the process of adapting to choice and competition in routine elective care, there is already evidence that choice and competition is leading to improvements in patient care. A number of recent studies have found that higher levels of competition in the provision of routine elective care have led to improvements in clinical performance and efficiency. For example, academic researchers have found that higher levels of competition in the provision of routine elective care under the current fixed prices regime has led to improvements in clinical performance. As patients become increasingly aware of their ability to choose and exercise this choice, and providers respond to the incentives that this creates, then the quality and efficiency of routine elective care can be expected to improve further as a result of this policy.⁶¹

57. The obligations on providers and commissioners in relation to patients' right to choose their provider of elective services are set out in various NHS documents.⁶²
58. Commissioners are under statutory obligations in respect of patient choice and CCGs and NHS England must ensure that the availability of choice is publicized and promoted.⁶³ Service providers are subject to a licence condition regarding the right of patients to choose. Monitor can take action to enforce compliance with these obligations.⁶⁴ The NHS Standard Contract, used by commissioners when entering into contracts for services, also includes a clause stating that the parties must comply with patient choice guidance.

Any Qualified Provider

59. The AQP model was designed to further facilitate patient choice. In certain circumstances, patients have a right to choose any qualified provider of NHS services.⁶⁵ The AQP model offers rewards to providers that attracted patients by demonstrating high levels of quality, responsiveness and user satisfaction. AQP was defined nationally to apply to routine elective care, with accreditation requirements and contractual terms (ie the tariff) being determined nationally.
60. Potential providers must demonstrate that they are registered with the CQC in respect of the particular service they wish to provide (and, from 2013/14, they must

⁶¹ CCP, [Review of Operation of 'Any Willing Provider' for the provision of routine elective care](#), Final Report (28 July 2011), paragraphs 30–40.

⁶² Including successive versions of the NHS Constitution, NHS Handbook, Annual Operating Frameworks, the 2012/13 and 2013/14 Choice Frameworks, the Principles and Rules for Cooperation and Competition, the NHS Standard Contract and secondary legislation.

⁶³ www.legislation.gov.uk/ukssi/2012/2996/regulation/42/made.

⁶⁴ Monitor, [Enforcement Guidance](#), 28 March 2013.

⁶⁵ In April 2008, NHS-funded patients became able to choose from any provider of treatment or care in England meeting standards set by the CQC and willing to provide treatments at the NHS price. This policy has been described as free choice, Any Willing Provider (www.nhs.uk/choiceintheNHS>Yourchoices/any-qualified-provider/Pages/aqp.aspx) and Any Qualified Provider.

be licensed by Monitor unless they are exempt). They must agree to be reimbursed according to the tariff that commissioners are willing to pay, or the national tariff where applicable. They receive no guarantees of volume/payment and agree to abide by the NHS standard contract terms and conditions. They must be financially and legally sound; additional due diligence may be undertaken in certain circumstances. For elective care, and where a provider meets the relevant criteria, the provider may list its services on the national menu (Choose and Book).⁶⁶

61. Where a provider meets the criteria for provision of services, a commissioner must include that provider on the list of providers, which patients and GPs will then have access to via Choose and Book. Commissioners may also make local decisions to extend the AQP model to services for which there is no national tariff.

Payment by results

62. NHS services in hospitals and in the community are currently priced according to either national or local arrangements. The Department of Health operates a national PbR system, introduced in 2004, in which providers are paid according to the number of procedures they carry out.⁶⁷ Providers are also paid: (a) in accordance with local tariffs—like PbR, paying for what is done, but on a locally negotiated basis subject to rules set by the Department of Health; or (b) under block contracts whereby a fixed amount is payable to cover treatment for a population of patients.
63. Providers are paid a fixed tariff for each patient they treat; in other words, it is an activity-based funding mechanism. The number of services for which a tariff is in place has increased gradually, with a general focus on establishing tariffs for routine elective services in respect of which patients have a choice of provider. PbR currently covers the majority of acute healthcare in hospitals (elective and non-elective), with national tariffs for admitted patient care, outpatient attendances, accident and emergency, and some outpatient procedures. The NHS Standard Contract provides that in respect of services where there is a national tariff, providers will be remunerated in accordance with that tariff for all the relevant services provided.
64. The PbR price for each service (or unit of activity) is intended to cover the cost of service provision. The tariff is based on national average costs reported by NHS providers and a market forces factor (MFF) which takes account of local differences in costs, for example costs of land and labour.⁶⁸ The differences in the cost to provide elective and non-elective care are, to some extent, reflected in the different PbR tariffs for elective and non-elective care. The profitability of emergency non-elective patients is potentially affected by the ‘marginal rate emergency tariff’. Under this rule, only 30 per cent of the normal PbR tariff is paid on all services resulting from emergency admissions once the *total value of all* these services in a given year exceeds the value or ‘baseline’ in 2008/09, and after 2008/09 prices have been adjusted to current year prices (ie 2008/09 volumes are applied to current year prices and this gives the ‘baseline’ above which the marginal tariff is 30 per cent). The intention of this tariff is to give an incentive to support the shift of care out of hospital settings and keep the number of emergency admissions to a minimum.⁶⁹
65. An ‘efficiency reduction’ of 4 to 5 per cent is applied resulting in a tariff deduction each year. These reductions are applied in order to try to ensure that efficiency

⁶⁶ NHS Procurement, Patient Choice and Competition (No. 2) Regulations 2013.

⁶⁷ The national tariff is defined in HSCA 2012, section 116.

⁶⁸ There may also be adjustments to tariff for long or short stays, for specialised services or to support particular policy goals.

⁶⁹ ‘Payment by Results Guidance for 2013–14’: www.wp.dh.gov.uk/publications/files/2013/02/Payment-by-Results-Guidance-for-2013-14.pdf, paragraph 89ff.

savings are generated (efficiency reductions of 5 per cent are required during years 2013/14 and 2014/15, and 4.2 per cent during 2015/16).⁷⁰ It is not based on a detailed consideration of the financial situation of specific trusts but is based on general improvements required for the NHS as a whole, which individual trusts must then build into their financial targets regardless of their particular circumstances.

66. There are a number of schemes that supplement the PbR tariffs as financial incentives to provide a quality of care to patients that exceeds the minimum requirements set by the CQC, including: the CQUIN framework (see paragraphs 33 to 35); and best practice tariffs which are in place for a limited number of services and are intended to be structured and priced to incentivize and reimburse for the costs of high-quality care.⁷¹
67. The PbR Code of Conduct published by the Department of Health aimed to ‘establish the principles that should govern organisational behaviour under PbR and set expectations as to how the system should operate’.⁷² The Code requires commissioners to pay for PbR activity at national tariff rates (section 5) and providers to charge for PbR activity at the national tariff rates (section 6). The Code makes it clear that there is a balance between commissioners and providers using activity plans to manage and predict volumes and ensuring commissioning is not set up in a manner which contradicts a patient’s right to choice set out in the NHS Constitution and via the AQP regime.⁷³ In addition, the NHS Standard Contract (as explained in paragraphs 10 and 11 above) is set out to ensure that commissioners pay for legitimate PbR activity carried out by providers above the Indicative Activity Plan agreed at the start of the year with the commissioner. Where a commissioner fails to comply with the national tariff rules, Monitor may direct the commissioner to take steps, within a specified time frame, to secure that the position is, so far as practicable, restored to what it would have been if the commissioner had agreed to pay the tariff price.⁷⁴
68. RBCH and PH told us that when a tariff did not cover the cost of providing a particular service and they faced a significant shortfall in funds on this service, they could notify the commissioning entity of their intention to withdraw from providing the service. However, the trust could not shut down a mandatory service immediately. First, it needed to give one year’s notice to the commissioner. Second, as this represented a change to its terms of authorization it had to seek Monitor’s approval.⁷⁵
69. From 1 April 2014, Monitor and NHS England will take on responsibility for the national tariff. Monitor will lead on developing the methodology for price setting, calculating prices, enforcing the pricing regime (through its powers under HSCA 2012), setting rules for local modifications and approving them. NHS England will lead on developing the scope and design of currencies (the services to be priced), and setting rules around local variations. Monitor and NHS England will jointly agree the national tariff.
70. Monitor has published some documents indicating its priorities for PbR going forward. *Costing Patient Care* explained that Monitor’s long-term vision is to move towards using the cost of treating each patient rather than the average cost, as the

⁷⁰ [Joint main party initial submission](#), paragraph 112.

⁷¹ [Joint main party initial submission](#), paragraph 88.

⁷² It is reviewed annually and is drafted so that it is consistent with the NHS Standard Contract. The 2013–14 Code is the final Code for which the Department of Health was responsible. It will be for NHS England and Monitor to determine whether a successor document will be published.

⁷³ [PbR Code of Conduct](#), section 8.

⁷⁴ [Section 117\(4\)](#), HSCA 2012.

⁷⁵ Monitor’s approval was not required if a foundation trust wished to cease authorized services.

main source of cost data informing how prices are regulated.⁷⁶ Monitor and NHS England have published a joint discussion paper on the NHS payment system, which notes that they are reviewing, among other things, the 30 per cent marginal rate rule for emergency admissions.⁷⁷ The discussion paper explains that the 2014/15 prices and currencies will be almost exactly the same as the 2013/14 price and currency list, with only essential, system-wide adjustments for factors such as efficiency, inflation and the clinical negligence scheme for trusts.⁷⁸ Monitor told us that it was carrying out work in relation to costs, using a principle for setting prices that prices should be set so as to reflect efficient costs, and Monitor and NHS England are likely to propose a method for determining prices in 2015/16 based on updated cost data instead of the previous year's prices, in order to enable them to send more appropriate price signals and incentives.^{79,80}

71. We also considered the CCP's review into the operation of the 'any willing provider' model for the provision of routine elective care (July 2011). Of particular relevance to this merger and our comments set out in paragraphs 51 and 52 above, we noted that the CCP review found that PCTs were imposing what were, in effect, caps on the number of patients a provider could treat or would be paid for treating. The activity planning provisions of the NHS Standard Contract were found to be one of the vehicles for imposing these restrictions. The arrangements for paying for routine elective care were also being used by PCTs to control levels of routine elective care at providers, and hence patients' ability to choose between providers and providers' ability to compete for patients. The CCP said that these payment arrangements, which included block and capped contracts and implicit threats of non-payment, appeared in many cases inconsistent with the PbR Code of Conduct. As such, they were also likely to be inconsistent with the Principles and Rules, which required that payment regimes were transparent and fair. In November 2011, responding to the CCP's report, the Secretary of State for Health banned PCTs from putting in place caps on operations that do not take account of the healthcare needs of individual patients.⁸¹
72. [⊗]⁸² Monitor provided us with a submission on the reimbursement system for NHS-funded routine elective services which stated that:

The Code of Conduct for Payment by Results in 2013–14 provides that under PbR, anticipated activity volumes for routine elective care are important management tools, but will not determine payment. It goes on to say that the use of rigid caps and floors on activity is inconsistent with the fundamental principle of PbR that payment should be based on the number and complexity of cases treated.

It noted that:

⁷⁶ Monitor also issued [Approved Costing Guidance](#), which contains draft guidance on Monitor's collection of patient-level costing data which will take place in 2013 and 'costing principles' for costing NHS services.

⁷⁷ Monitor and NHS England have published a consultation document on new rules for the 2014/15 NHS payment system, which includes proposals to amend the manner in which the baseline upon which the 30 per cent marginal rate rule may be calculated in some circumstances. See: Monitor and NHS England consult on new rules for the 2014/15 NHS payment system, 3 October 2013. www.monitor.gov.uk/home/news-events-publications/latest-press-releases/monitor-and-nhs-england-consult-new-rules-the-2014/15-nhs-payment-system.

⁷⁸ Monitor/NHS England discussion paper: [How can the NHS payment system do more for patients?](#) (13 May 2013), Introduction (p7), Part Three (p18) and Part Four (p19). See also Monitor call for evidence on the impact of the marginal rate policy: www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-37.

⁷⁹ National Tariff 2014/15 Engagement Document, Monitor and NHS England.

⁸⁰ See also Monitor's 2012 consultation on methodology for approving local modifications to the national tariff; Monitor's 2012 evaluation of the reimbursement system for NHS-funded care (carried out by PricewaterhouseCoopers (PwC)) and Monitor's Fair Playing Field Review, all of which may impact on how it sets and enforces the national.

⁸¹ www.gov.uk/government/news/andrew-lansley-takes-firm-action-to-protect-patient-choice.

⁸² [⊗]

From 1 April 2013, commissioners and providers will be subject to the National Health Service (Procurement, Patient Choice and Competition) (No. 2) Regulations 2013 and the provider licence respectively. Pricing condition 4 of the provider licence requires providers to comply with the national tariff. Commissioners are also required to comply with the national tariff under sections 117(4) and (5) of the Health and Social Care Act 2012. Regulation 10 of the Procurement, Patient Choice and Competition Regulations prohibits anti-competitive behaviour by commissioners (subject to some exemptions). To the extent that block contracts may restrict choice or competition, Monitor may seek to take enforcement action under the Health and Social Care Act 2012, the Procurement, Patient Choice and Competition Regulations, or the provider licence.⁸³

73. In summary, the patient choice and PbR regimes are designed to incentivize acute service providers to compete for patients. The extent to which these incentives work according to policy in the Dorset area is considered in detail in our competitive effects assessment.
74. A further incentive on providers is that if they fail to remain profitable or to maintain quality, the industry regulator, Monitor, has the ability to determine that they are failing and designate restructuring. This process is further described below.

Role of Monitor

75. Monitor was established as a regulator of NHS foundation trusts in 2004.⁸⁴ Following the HSCA 2012, Monitor became the sector regulator for the provision of health services in England.⁸⁵ The main duty of Monitor in exercising its functions is to protect and promote the interests of people who use the NHS by promoting the provision of healthcare services. It must exercise its functions with a view to preventing anti-competitive behaviour in the provision of NHS services which is against the interest of people which use such services⁸⁶ and with a view to enabling NHS services to be provided in an integrated way (if this would improve quality or efficiency or reduce inequality of access or outcomes).⁸⁷
76. Monitor's responsibilities under the new regime include the implementation and supervision of a licensing regime for NHS healthcare service providers, including foundation trusts;⁸⁸ setting national tariffs for NHS healthcare services (together with NHS England);⁸⁹ enforcing compliance with the Procurement, Patient Choice, and Competition Regulations;⁹⁰ enforcing the Chapter I and II prohibition in the Competition Act and Articles 101 and 102 of the Treaty on the Functioning of the European Union concurrently with the OFT in respect of health care services in England; advising the OFT in relation to relevant customer benefits in mergers involving foundation trusts; carrying out a transactional assessment of mergers involving foundation trusts to ensure that the prospective merging parties are legally

⁸³ Monitor also referred to the fact that 'The Operating Framework for the NHS in England 2012/13 states that commissioners are required to review their practices in light of the CCP's report, and the Department's response, to ensure they are compliant with the Principles and Rules. The Operating Framework further provides that any decisions that would restrict patient choice must be taken at Board level and published annually, including the rationale, impact and period of operation.'

⁸⁴ Section 2 of the Health and Social Care (Community Health and Standards) Act 2003.

⁸⁵ Monitor's duties are found in [Chapter 1 of Part 3](#) of HSCA 2012.

⁸⁶ HSCA 2012, section 62(1) & (3).

⁸⁷ HSCA 2012, section 62(4) & (5). See also [section 67](#) which provides how conflicts between duties should be resolved.

⁸⁸ HSCA 2012 Part 3, Chapter 3.

⁸⁹ HSCA 2012 Part 3, Chapter 4.

⁹⁰ Monitor's ability to enforce compliance will also be linked to the provider licence conditions and the commissioner regulations.

constituted, well-governed, financially viable, and guided by a robust post-integration plan (see paragraphs 3.3 to 3.5 of our report); monitoring foundation trusts for financial robustness and good governance; and making arrangements for the implementation of a new failure regime (see paragraph 77ff below). This is not an exhaustive list of Monitor's functions but those that are most relevant to our assessment of the merger.

Monitor's regulation of foundation trusts

77. Under the Monitor Compliance Framework, foundation trusts provided an annual plan and an audited annual report and accounts to Monitor to enable it to monitor the management of foundation trusts.^{91,92} Using this information, Monitor assigned each foundation trust a separate risk score for its financial and governance functions.⁹³ These risk scores were designed to capture the probability that a foundation trust might breach the terms of its authorization. Each foundation trust was given a financial risk rating (FRR) between 1 and 5, with 1 indicating the highest risk and 5 the lowest risk of financial failure.⁹⁴
78. Similarly, foundation trusts were monitored as to their governance performance, according to five key factors:⁹⁵ service performance; reports from key third parties (such as the CQC and the NHS Litigation Authority); mandatory services; certification failures (where NHS foundation trusts materially failed to perform against the requirement elements of their board statements); and other factors (such as failure to meet the standards of other bodies). From these five factors, Monitor gave each foundation trust a governance risk rating of (from best to worst) green, amber-green, amber-red, or red.⁹⁶
79. The Compliance Framework (summarized above) was replaced on 1 October 2013 by Monitor's Risk Assessment Framework.⁹⁷ Monitor will judge whether foundation trusts are well-run using a wider range of information than previously—for example, such as staff and patient satisfaction surveys, staff turnover, and agency numbers. The ratings system utilized by the Risk Assessment Framework is intended to act as an indication as to whether there is cause for concern at a provider. It will not automatically indicate a breach of licence condition or trigger immediate regulatory action.⁹⁸ Figure 2 below summarizes Monitor's approach to provider regulation.⁹⁹

⁹¹ Prior to 1 April 2013, NHS foundation trusts were regulated by Monitor to ensure their continuing compliance with the terms of their authorization as a foundation trust. Pursuant to HSCA 2012, the authorizations of foundation trusts were replaced by licences from 1 April 2013. Monitor published standard licence conditions on 14 February 2013. These include conditions relating to: (a) pricing; (b) choice and competition; and (c) continuity of services. On 27 March 2013, Monitor published draft guidance to explain how providers are expected to comply with the choice and competition conditions in the licence.

⁹² Monitor describes the information that foundation trusts must provide in pp12–13 of its published guidance document [Compliance Framework 2012/13](#) (30 March 2012). This was replaced by Monitor's Risk Assessment Framework in October 2013. The information provided will include details of the trust's strategic priorities along with forecasts of financial and service provision throughout the year and explanations of discrepancies between its actual and projected financial position.

⁹³ [Compliance Framework 2012/13](#), pp32–34.

⁹⁴ This score was derived by assigning each foundation trust a sub-score (1–5) for each of four financial criteria (achievement of plan, underlying performance, financial efficiency, liquidity) and then taking a weighted average of these to produce an overall financial risk rating. Trusts which produced low scores might be subject to additional monitoring and reporting requirements as well as appropriate regulatory interventions, while trusts which consistently perform well might be subject to fewer reporting requirements. See [Compliance Framework 2012/13](#), p24.

⁹⁵ [Compliance Framework 2012/13](#), pp26–29.

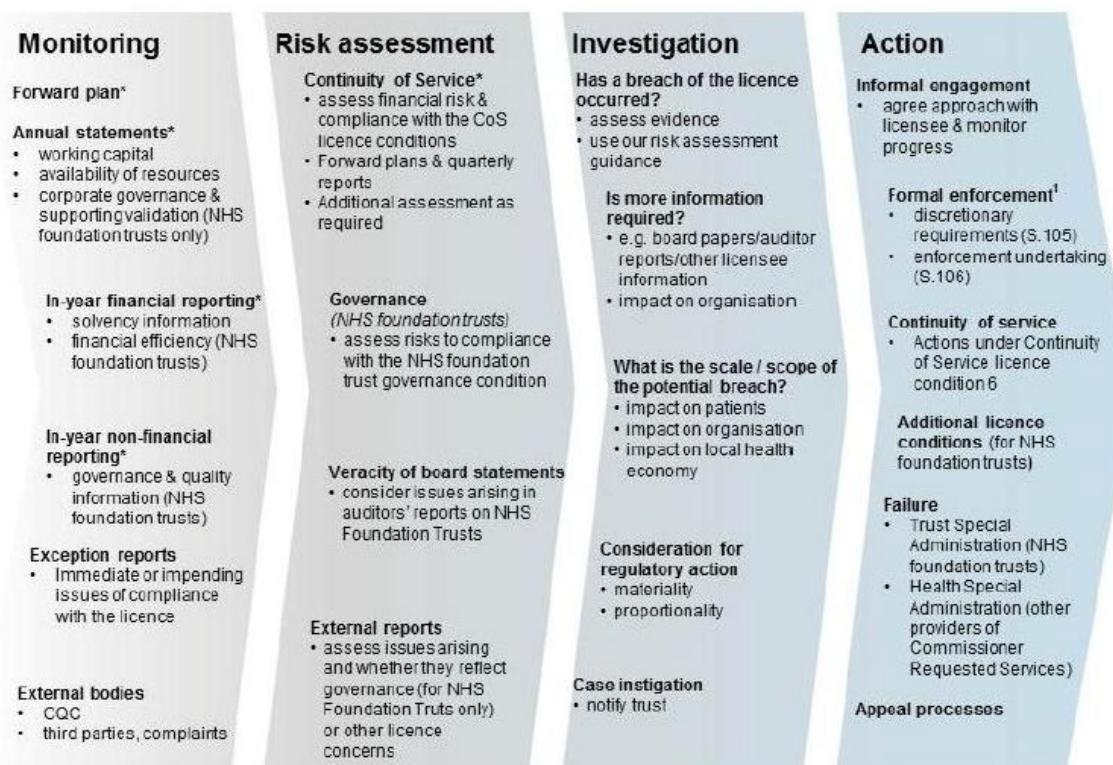
⁹⁶ [Compliance Framework 2012/13](#), p30.

⁹⁷ [The Risk Assessment Framework](#) was published on 27 August 2013.

⁹⁸ Monitor, Risk Assessment Framework, p4.

⁹⁹ Monitor, Risk Assessment Framework, p9.

FIGURE 2
Monitor approach to provider regulation



^{*} Providers of Commissioner Requested Services and NHS foundation trusts

¹ Appeal processes exist for Monitor's formal enforcement powers: for more information refer to the Act

Source: Monitor, Risk Assessment Framework.

80. Monitor states in its Risk Assessment Framework that NHS foundation trusts will be assigned two risk ratings to allow Monitor to identify where there may be cause for concern with (a) a trust's governance ('governance rating') or (b) the sustainability of that trust's provision of key NHS services ('continuity of services risk rating' or 'COS rating').¹⁰⁰ There are three governance ratings, as follows: where a trust's governance provides no grounds for concern, it will be given a green rating; where Monitor identifies a concern but has not taken action, a written description of the trust's difficulty and Monitor's proposed solution will take place; and where enforcement action has begun, Monitor will assign the trust a red rating. Continuity of services risk ratings will be assigned to all NHS foundation trusts, as well. Each foundation trust will receive a rating from 1 to 4 to indicate the level of risk that the foundation trust will not be able to sustainably provide key NHS services.¹⁰¹

Monitor failure regime

81. Foundation trusts found to be in significant breach of their terms of authorization (as assessed against the financial and governance ratings described above) were

¹⁰⁰ Monitor, Risk Assessment Framework, p4.

¹⁰¹ Monitor, Risk Assessment Framework, pp29 & 30.

subject to intervention by Monitor under the Compliance Framework.¹⁰² When a foundation trust was found to be in significant breach, Monitor's first step was usually to ask the trust to set out its plans for returning to compliance at the earliest possible opportunity.¹⁰³ If this proved insufficient, Monitor was statutorily authorized to instruct failing foundation trusts to take or refrain from taking certain actions.¹⁰⁴

82. Under the Risk Assessment Framework, a similar process will be followed: when there are warning signs that a hospital is financially distressed, Monitor will intervene with the aim of encouraging the provider to return to financial sustainability. As described in paragraph 80 above, Monitor will use its governance and continuity of service ratings to identify publicly whether there is cause for concern in relation to a foundation trust. There are a number of steps Monitor can take in these circumstances, including instructing the licence holder to deliver information to commissioners, requiring the licence holder to work with parties appointed by Monitor, and requesting the board to commission a report by independent advisers examining the risks to service continuity and the ability of the licence holder to initiate financial recovery.¹⁰⁵ Monitor stated that 'in exceptional circumstances, where this is not achieved, and financial failure becomes likely, there will be an ordered process—the failure regime—during which [Monitor] may appoint a Trust Special Administrator (TSA) to take control of the provider's affairs and work with commissioners to ensure that patients continue to have access to the services that they need'.^{106,107}
83. The failure of a healthcare provider is a rare event¹⁰⁸ and the failure regime is to be used in exceptional circumstances in order to 'provide a rapid resolution to problems within a significantly challenged foundation trust'.¹⁰⁹
84. As part of its enforcement action for a trust in financial difficulties, Monitor would normally require a trust to develop a strategic plan to return to compliance. Monitor would expect the trust to consider all options through which to do this. When it considered that all internal efficiencies had been explored and no further revenue could be found (either through public or private patient income), Monitor would expect the trust to look at wider strategic options.
85. Under HSCA 2012,¹¹⁰ Monitor has a duty to establish and secure the effective operation of one or more mechanisms for providing financial assistance in cases where a provider of NHS healthcare services is subject to a special administration order. Monitor is considering meeting this requirement potentially through

¹⁰² [Compliance Framework 2012/13](#), p9. In assessing the extent to which a breach is significant, Monitor had regard to the time criticality of the need for intervention, the degree to which the breach is within trust control, the ability of the trust to address the breach independently, the financial stability of the trust, the risk to mandatory services, and the effectiveness of that trust's approach to breaches up to that point.

¹⁰³ [Compliance Framework 2012/13](#), p36.

¹⁰⁴ National Health Service Act 2006, [section 52. Compliance Framework 2012/13](#). Monitor could require trusts to provide additional information, take independent advice, implement a particular practice, or commission an independent review. If it was felt necessary to ensure the foundation trust's compliance, Monitor was also authorized to remove any or all of a failing foundation trust's directors and/or governors either permanently or for a period of time. Section 52 of the National Health Service Act 2006 was omitted by HSCA 2012 and is no longer in force.

¹⁰⁵ Monitor, Risk Assessment Framework, p45.

¹⁰⁶ Monitor, [Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts](#), 5 April 2013, p1.

¹⁰⁷ Monitor states in its [Statutory guidance for Trust Special Administrators](#), p3, that:

The failure regime, to be used in exceptional circumstances, is a transparent and robust process to provide a rapid resolution to problems within a significantly challenged foundation trust. In addition to maintaining the provision of high quality and sustainable services during the time the failure regime is in place, the key objective of a Trust Special Administrator is to develop and consult locally on a draft report, before making final recommendations to Monitor and ultimately to the Secretary of State in a final report.

¹⁰⁸ Monitor, [Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts](#), p2.

¹⁰⁹ Monitor, [Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts](#), p3.

¹¹⁰ Section 135(2).

establishing a ‘risk pool’¹¹¹, which would provide finance to cover the costs of special administration. The nature of any ‘risk pool’ has not been decided.

86. If a trust’s continuity of services rating falls to 2, Monitor states:¹¹²

This rating is likely to represent a material level of financial risk and may represent, eg:

Immediate issues requiring action. Monitor may subsequently investigate whether a CRS provider is in breach of the continuity of services license conditions, including condition 3, and collect additional information from the license holder to determine the extent of its financial situation before deciding whether further regulatory action is required.

An increased level of risk requiring closer monitoring. Monitor may request information on a monthly basis in order to pre-empt or respond quickly to any serious issues should they later emerge.

87. If the continuity of services risk rating falls to 1 (for licence holders demonstrating a significant level of financial risk), the Risk Assessment Framework states that Monitor may:

consider using its powers under the licence to initiate a contingency planning process assessing the financial situation at the CRS provider and the best options to address it in order to minimise disruption to patients; or

maintain a closer degree of monitoring by collecting financial information on a monthly or more frequent basis. Where appropriate, Monitor may also consider formal enforcement as well as specific requirements within the terms of the continuity of services licence conditions themselves, including cooperating with a Monitor-appointed contingency planning team or other financial experts.

88. It also states that: ‘Where the quarterly rating is a 1 or 2, reflecting a potential breach of the licence, we will consider whether closer monitoring, further information or other action under the licence are necessary to establish whether the CRS provider complies with the continuity of services licence conditions and, if not, whether regulatory action is appropriate.’
89. Monitor has produced guidance on the use of TSAs. For a trust to exit the market in the failure regime (ie other than via a merger or other means) it would need to go through a process with a TSA.^{113,114} The special administration regime will apply where the provider is, or Monitor is satisfied that it will be, unable to pay its debts. When the appointment of a TSA takes effect, the NHS foundation trust’s governors, Chair and executive and non-executive directors are suspended from office and the TSA will govern the trust so as to achieve its objective (of securing the continued

¹¹¹ The duty of NHS foundation trusts to pay into the fund according to Monitor’s assessment has been enshrined in Condition 5 of the license conditions which will pertain to NHS Foundation Trusts (Monitor, Risk Assessment Framework).

¹¹² Monitor, Risk Assessment Framework, pp29 & 30.

¹¹³ The guidance states: ‘The appointment of TSAs is one way in which Monitor can take decisive action to deal with NHS foundation trusts that are either unsustainable in their current configuration or at serious risk of failing to deliver sustainable services.’ [Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts](#), p7.

¹¹⁴ Monitor Report: [Mid Staffordshire NHS Foundation Trust: The Case for Appointing a Trust Special Administrator](#) Presented to Parliament pursuant to section 65D(6) of the NHSA 2006.

provision of certain defined NHS services) as quickly and efficiently as is reasonably practicable.¹¹⁵

90. The key objective of the TSA is to secure the continued provision of such of the NHS services provided by the NHS foundation trust at such levels as the commissioners of those services determine, until it becomes unnecessary for the appointment of the TSA to remain in force. Monitor told us that: ‘Dissolution of the trust and the transfer of its services and staff to another foundation trust or to the Secretary of State is just one outcome that may result from a special administration process.’
91. The TSA is required to develop and consult locally on a draft report, before making final recommendations on the future of the organization to Monitor and ultimately to the Secretary of State for Health in a final report.¹¹⁶ The recommendations will outline the action that should be taken in relation to the trust, which will need to ensure the delivery of clinically and financially viable patient services. This could include restructuring of the foundation trust, acquisition by or merger with another foundation trust (following consultation with and the agreement of the proposed merger partner), the reconfiguration of services or dissolution.¹¹⁷ In addition, the TSA is responsible for maintaining the provision of high-quality and sustainable services during the time the failure regime is in place.
92. We noted that following the Francis Report on the failure of MSFT,¹¹⁸ Monitor issued a joint policy statement with the Department of Health, the CQC, NHS England and the NHS Trust Development Authority on changes proposed to the regulation and oversight of NHS trusts and foundation trusts in response to the Francis Report.^{119,120} The policy statement referred to proposed new legislation (the Care Bill), which would require the CQC to develop a new set of quality standards (in conjunction with the Department of Health and NICE). The new legislation would also allow the CQC to issue warning notices to NHS trusts and foundation trusts if the quality of health-care provided required significant improvement.¹²¹ In that event, Monitor would be able to include appropriate conditions in the trust’s provider licence. Moreover, a TSA could be appointed if there is a serious failure by an NHS foundation trust to provide services of sufficient quality.¹²²

¹¹⁵ Monitor, [Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts](#), paragraphs 22 & 23 and 31 & 32.

¹¹⁶ [Ibid](#), p3.

¹¹⁷ [Ibid](#), p17.

¹¹⁸ Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry.

¹¹⁹ The regulation and oversight of NHS trusts and foundation trusts, Joint statement on changes to regulation and oversight of NHS trusts and NHS foundation trusts proposed in response to the Francis report (20 May 2013) <http://www.monitor.gov.uk/home/news-events-publications/our-publications/browse-category/about-monitor/what-we-do/the-regulati>

¹²⁰ The system will be phased in from autumn 2013, with a new system for inspections rolling out from October. Ratings (both aggregated and more detailed service-specific ratings) will be published. There will be a network of local and regional quality surveillance groups to share information and intelligence on quality. The CQC will assume a leading role on these quality oversight and surveillance arrangements, supplemented by its inspection programme (paragraph 7, Joint policy statement).

¹²¹ The CQC already has the power to issue warning notices in certain circumstances under section 29 of the Health and Social Care Act 2008.

¹²² Sections 77–79 of the Care Bill ([HL Bill 45](#), as amended in Committee (30 July 2013)).

Information on quality indicators

Published information on quality of hospitals

1. This appendix provides an overview of the sources of publicly available information on hospital quality and an overview of the information available from these sources for RBCH, PH and other hospitals in and around the wider Dorset area. There are many dimensions of quality in healthcare and indicators range from those that focus on outcomes (eg mortality rates) to more input-focused measures such as the quality of food.
2. Over the course of the inquiry, we noted that many of the quality ratings referred to in this appendix changed. We therefore view them as indicative of current standards but do not place undue weight on any one measure.

NHS Choices

3. NHS Choices is a health information website for the public that assists its users in making choices about their health, from decisions around lifestyle to finding and using NHS services. It uses a number of tools including articles, reports, staff and patient feedback and outcome statistics to compare healthcare providers across primary care (including GPs and dentists) and secondary care.
4. The parties and their main competitors are all listed, reviewed and rated in NHS Choices according to user ratings, responses to patient safety alerts, staff recommendations and mortality rates.
5. As Table 1 below shows, RBCH and PH are rated among the best in the wider Dorset region, with PH having the best mortality rate.

TABLE 1 Information on acute hospitals in the wider Dorset area from NHS Choices as at 10 September 2013

NHS provider	Users rating	Responding to patient safety alerts	Friends and Family test score: inpatient	Recommended by staff	Mortality rate
PH	4 stars	Good	In the normal range (score 67)	66% of staff would recommend it	OK (0.9067)
RBCH	4.5 stars	Good	In the normal range (score 73)	65% of staff would recommend it	OK (1.0218)
Salisbury District Hospital	4.5 stars	Good	In the normal range (score 74)	76% of staff would recommend it	OK (1.0559)
Dorset County Hospital	4.5 stars	Good	In the normal range (score 83)	56% of staff would recommend it	OK (1.0479)
Southampton General Hospital	4 stars	Good	In the normal range (score 71)	67% of staff would recommend it	OK (0.9517)

Source: NHS Choices, accessed 10 September 2013.

Notes:

1. The total number of reviews according to which hospitals are rated is very limited and varies between providers. At the date of access (10 September 2013) PH had received only 34 ratings, RBCH 59, Salisbury District Hospital 46, Dorset County Hospital 34 and Southampton General Hospital 76.
2. Good means that all alerts have been signed off where the deadline has passed.
3. An NHS trust with a mortality number below 1, which is the expected figure taking into account patient characteristics, had fewer deaths, while trusts with a rate above 1 had more deaths than expected.

6. NHS Choices users can rate the overall performance of hospitals according to five specific categories: cleanliness, staff cooperation, dignity and respect, involvement in decisions, and same-sex accommodation. In the first two categories (cleanliness and staff cooperation), RBCH has the highest rating relative to the other hospitals in the area; in dignity and respect PH, RBCH, Salisbury District Hospital and Dorset County have four and a half stars, followed by Southampton General Hospital with four stars. In involvement in decisions, all the hospitals in the area have four stars. In the last category, same-sex accommodation, RBCH and Dorset County are rated the best, followed by PH, Salisbury District Hospital and Southampton General Hospital.
7. NHS Choices lists the departments and services available in each hospital and presents key facts and statistics on some of the treatments available. For example, patients interested in hysterectomy procedures can compare providers using information specifically related to this treatment—eg number of hysterectomies performed per year, the average waiting time, percentage of patients readmitted as an emergency within one month of being discharged and mortality rate. There is similar information also for maternity services—where patients can investigate the type of maternity unit (midwife-led unit or consultant-led unit) that a hospital has, the number of unassisted deliveries and whether there are midwives available for home births. However, there is no such information for other services that are typically offered on a non-elective basis where typically users can only find information where emergency departments are located in a specific geographic area. An exception is in respect of A&E services about which NHS Choices shows patient reviews.
8. NHS Choices also provides an overview of the facilities offered by each hospital in terms of accessibility, accommodation, food and amenities and parking. Patients can therefore use the website to compare providers across a number of additional factors such as whether the hospital has car parking and disabled parking or whether there is access to television in the accommodation.

Care Quality Commission

9. The CQC sets minimum standards of quality and safety that every provider has to meet. It gathers information from inspections, as well as from care staff and the public, to assess health services across England to ensure that government standards on care quality are being met. It monitors 28 standards of quality that cover different dimensions of care including:
 - safety (eg safety and suitability of premises and equipment, cleanliness and infection control);
 - patients' experience (eg respecting and involving people who use services, care and welfare of people who use services, complaints); and
 - timely and efficient access to care (eg notification of other incidents).
10. The CQC compiles Quality and Risk Profiles (QRPs) that bring together a wide range of qualitative and quantitative information about each provider from various sources—eg other regulatory bodies and the NHS Litigation Authority. This information is used to monitor providers' compliance with the essential standards of

quality and safety.¹ The CQC currently shares these profiles only with providers and commissioners; GPs and patients do not have access to this information.

11. However, patients and GPs do have access to information about the inspections carried out by the CQC. They can therefore learn when providers were last inspected, the results of the most recent inspections and, if the regulator considered that some of the standards were not met, the reasons for such judgements.²

¹ The CQC uses 16 of these standards to form a judgement about trusts' compliance. We understand that these standards are those directly related to the quality and safety of care (ie respecting and involving people who use these services, consent to care and treatment, care and welfare of people who use these services, meeting nutritional needs, cooperating with other providers, safeguarding people who use services from abuse, cleanliness and infection control, management of medicines, safety and suitability of premises, safety and suitability of equipment, requirements relating to workers, staffing, supporting workers, assessing and monitoring the quality of service provision, complaints, records). There are five broad standards that the government says people have the right to expect: standards of treating people with respect and involving them in their care; standards of providing care, treatment and support that meets people's needs; standards of caring for people safely and protecting them from harm; standards of staffing; and standards of quality and suitability of management.

² This information is available on the CQC website (www.cqc.org.uk).

TABLE 2 Ratings awarded to local NHS acute trusts by the CQC as at 10 September 2013

	<i>RBCH</i>	<i>PH</i>	<i>Dorset County Hospital</i>	<i>Salisbury District Hospital</i>	<i>Yeovil District Hospital</i>	<i>Southampton General Hospital</i>
Standards of treating people with respect and involving them in their care						
Standards of providing care, treatment and support that meets people's needs						
Standards of caring for people safely and protecting them from harm						
Standards of staffing						
Standards of quality and suitability of management						

Source: CQC 2013 review, as accessed 10 September 2013.

Key:

Meeting this standard	Improvements required
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Notes:

1. The rating shown in the table is based on the last inspections—ie routine inspections and reinspections—carried out by the CQC.
2. Southampton General Hospital belongs to University Hospital Southampton.

12. We compared other hospitals in the wider Dorset Area with PH and RBCH in terms of CQC standards for clinical excellence. As Figure 1 shows, RBCH, Yeovil District Hospital and Southampton General Hospital have been found to be meeting all required standards in terms of:
 - standards of treating people with respect and involving them in their care;
 - standards of providing care, treatment and support that meets people's needs;
 - standards of caring for people safely and protecting them from harm;
 - standards of staffing; and
 - standards of quality and suitability of management.
13. By contrast, the CQC required PH, Dorset County Hospital and Salisbury District Hospital to make improvements in a number of areas.
14. In relation to PH, RBCH and the other hospitals in the wider Dorset area we noted that:
 - PH was last inspected in May 2013 when the CQC found that one standard was not being met: standards of quality and suitability of management.³
 - RBCH was subject to a routine inspection in November 2012 and was found to be fully compliant with the essential standards for quality and safety.⁴ However, the CQC announced that it would be inspecting the trust between August and

³ The CQC found that the provider did not always implement learning and actions from some incidents meaning that at times risks to health, safety and welfare were not managed.

⁴ The Royal Bournemouth Hospital was last inspected in November 2012. Christchurch Hospital was last inspected in August 2011.

December 2013. This decision follows the implementation of a new surveillance model that the CQC has used to identify the trusts that are a priority for inspection because its initial assessment indicated they have a high risk score.⁵ The CQC found that RBCH performed poorly against a number of indicators relating to mortality and it was particularly concerned about high HSMR during weekends and higher than expected mortality rates in a number of specialties/diseases, eg cardiology, neurology and pneumonia.⁶

- Salisbury District Hospital was last inspected in February 2013 when the CQC found that two standards were not being met and required improvements: standards of staffing and standards of quality and suitability of management.⁷
- Dorset County Hospital was subject to a routine inspection in November 2012 and was found not in compliance with two standards: standards of caring for people safely and protecting them from harm and standards of quality and suitability of management.⁸
- Southampton General Hospital was subject to a routine inspection in April 2013 and was found to be fully compliant with all the essential standards. This followed another routine inspection in October 2012, when the CQC found that four of the five standards that patients are entitled to expect were not met and required prompt improvements.

Dr Foster

15. Dr Foster is a provider of comparative information on health and social care services. Dr Foster collects and publishes various data on providers' performance at an aggregate level—ie hospital overall performance—and at a more disaggregated level—ie procedure and consultant levels.
16. Every year Dr Foster publishes annual reports, known as 'Hospital Guides', which contain data on a number of quality measures—eg infection rates, mortality rates and waiting times—for every NHS hospital in the country. In addition to data on traditional indicators of mortality, in the 2012 report, Dr Foster introduced information on the link between quality and clinical efficiency. Patients and GPs can access this data to understand the overall performance of providers and their position relative to other competitors in the area in relation to quality (in terms of mortality rate) and efficiency.
17. Figure 1 below shows the results of this comparison for the wider Dorset area:
 - Hospital Standardized Mortality Ratios (HSMR⁹). A hospital that falls into the upper quadrants has a low mortality rate. The green area identifies those hospitals where the actual rate of death is lower than the expected rate of death. In the same way, the red area at the bottom of the graph identifies those hospitals where the number of patients who died turned out to be higher than expected. A hospital

⁵ The CQC assigns a high risk score when the analysed indicators are more than 2.0 standard deviations above the mean.

⁶ [Letter from the CQC to RBCH](#).

⁷ During its routine inspection the CQC found that patients were not being cared for by enough suitable skilled, qualified and experienced nursing and health care staff and that patient records were not always kept securely to protect patient confidential information.

⁸ Dorset County is currently undergoing a reinspection (as at end September 2013). Routine inspections are different from reinspections that are carried out more often than once a year when a trust is found in breach of one or more of the essential standards.

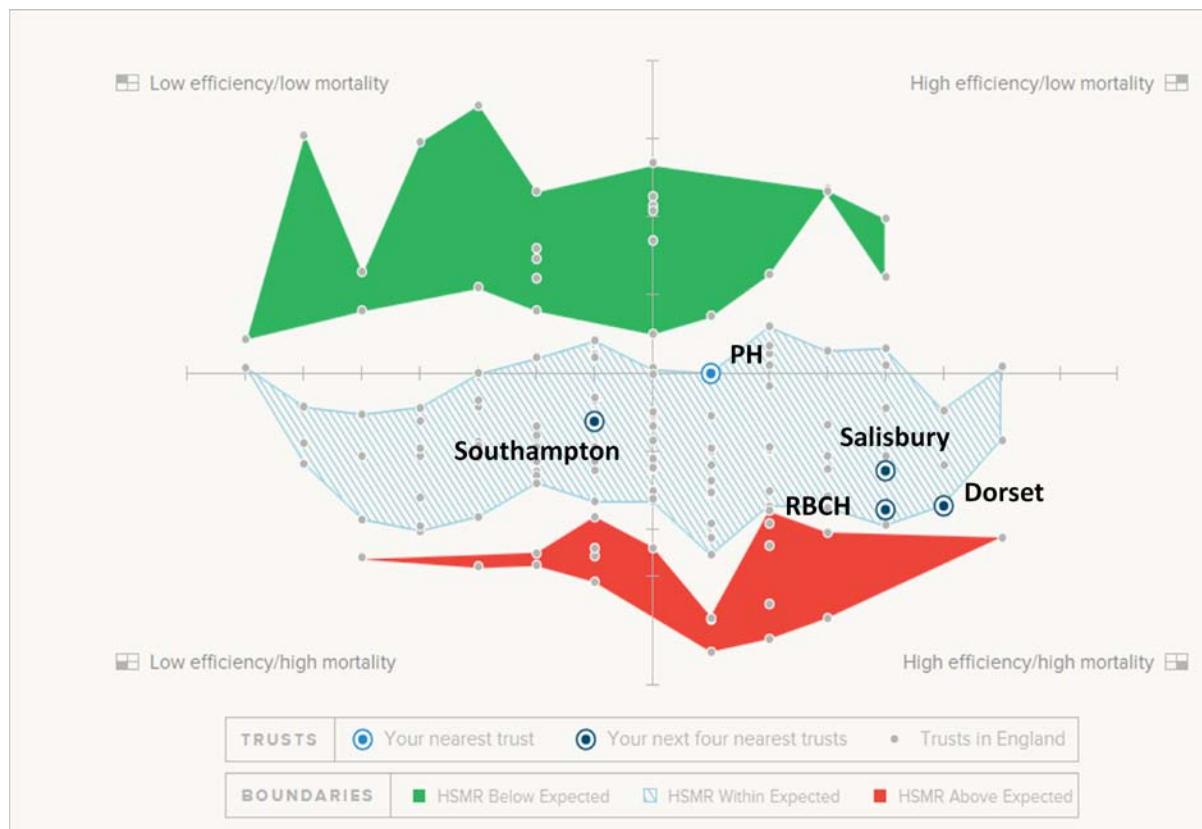
⁹ The HSMR is an indicator of healthcare quality that measures whether the death rate at a hospital is higher or lower than expected. Dr Foster does this by considering those patients with diagnoses that most commonly result in death (eg heart attacks, strokes and broken hips). It works out the expected death rate taking into account a number of patient characteristics—eg age, severity of their illness and whether they live in a more or less deprived area.

that falls into the blue area in the middle of the graph has performed as expected—ie the actual rate of death is broadly in line with expectation given patient characteristics.

- Clinical efficiency. A hospital that falls into the right-hand quadrants is overall highly efficient as measured against 13 indicators of inefficient practice—eg readmissions within a week and 28 days, procedures with limited clinical effectiveness, and long-stay surgical patients.

FIGURE 1

Relative positions of PH, RBCH and third parties—efficiency and mortality, 2011/12



Source: Dr Foster Intelligence—The 2012 Hospital Guide.

18. Figure 1 summarizes the relative performance of the parties and their competitors as follows:
- PH has the (relative) lowest mortality rate as its actual rate of death is 5 per cent less than expected. PH is also an efficient hospital, although it does not perform as well as RBCH, Salisbury District Hospital and Dorset County Hospital.
 - RBCH is more efficient than PH, but it has the highest mortality rate among the five hospitals. Although the number of deaths is still within the expected range, RBCH's rate of death is 8 per cent higher than expected.

- Salisbury District Hospital's performance is broadly in line with RBCH's both in terms of efficiency and quality.¹⁰ It is more efficient than PH, but it has a higher mortality rate.
 - Dorset County Hospital is the most efficient hospital among the five but its rate of death is 7 per cent higher than expected.
 - University Hospital Southampton is the only low efficiency provider in the area but it performs better than RBCH, Salisbury District Hospital and Dorset County Hospital in terms of mortality rate.
19. Dr Foster also collects and publishes data on how providers perform in a number of procedures—eg hip replacement, hysterectomy and pacemaker implantation.
20. Information on the quality of such procedures relates mainly to inpatient elective procedures although some of these procedures (eg pacemaker implantation) can also be carried out following a non-elective admission or in an outpatient setting (eg extraction of wisdom teeth). Dr Foster does not collect information on variables that can evaluate the performance of providers following an emergency admission. We noted that when patients and GPs investigate the performance of, say, RBCH in one of the procedures that it provides, the performances of PH, Salisbury District Hospital, Dorset County Hospital and University Hospital Southampton are always displayed on the same screen, when available.
21. Dr Foster also provides an updated database, a 'Consultant guide', to assist patients and GPs to find the right consultant for their conditions based on a selection filter using the distance that the patient is willing to travel. In addition to general information about consultants (eg registration number, areas of expertise and in which hospitals they work) the guide displays whether a consultant has been assigned a Clinical Excellence Award and, if so, which level.¹¹ As these Clinical Awards are assigned to consultants who perform over and above the standards expected of their roles, they provide information around the quality of consultants.
22. Table 3 below summarizes some quality indicators that patients and GPs may use to assess the performance of PH and RBCH against one another and the national average in those services offered by both the merging parties.¹²

¹⁰ Salisbury District Hospital's rate of death is 4 per cent higher than expected, but within the expected range.

¹¹ There are 12 levels of Awards: Levels 1–8 are awarded locally and Levels 9–12 are awarded nationally.

¹² Table 3 includes all the procedures provided by both merging parties with data currently available on Dr Foster at the date of access. The only services that have been excluded are those where data is not available for one of the merging parties.

TABLE 3 Quality indicators of procedures offered by both PH and RBCH

Procedure	PH				RBCH				National average	
	Waiting time (days)	Inpatient rate	Length of stay (days)	Readmission	Waiting time (days)	Inpatient rate	Length of stay (days)	Readmission	Waiting time (days)	Length of stay (days)
Arthroscopy of the knee	21	63.63	-	-	100	59.96	-	-	77	-
Diagnostic endoscopy of the stomach	29.5	79.01	-	-	28	113.37	-	-	31	-
Extraction of wisdom teeth	97	285.96	-	-	96	14.08	-	-	80	-
Gallbladder surgery	82	-	1.1	154.66	109	-	0.9	79.91	92	1
Hysterectomy	38	-	4.2	75.92	112	-	3.5	51.72	57	3
Pacemaker implantation	36	-	-	79.96	53	-	-	97.97	57	-
Repair of inguinal hernia	91	79.14	-	50.76	96	91.92	-	97.95	87	-
Repair of umbilical hernia	71	50.89	-	96.44	95	92.52	-	165.40	88	-
Therapeutic endoscopy on the stomach	39	43.69	-	156.47	17	59.51	-	86.32	25	-

Source: Dr Foster Health, as accessed 10 September 2013.

Note: The national standard for inpatient rate and readmission is equal to 100.

Awards and recognitions

23. The parties provided us with lists of the awards and recognitions for the high quality of the patient care that each party delivers (including safest hospital of the year award for PH in 2009):

(a) PH has won a number of awards and recognitions for the high quality of the patient care that it delivers. Some of these are set out below:

2009

- CHKS Patient Safety Award Winner. UK's safest hospital.
- CQC Excellent/Excellent rating (one of only 37 trusts to achieve this).
- Commendation in the Outstanding Achievement in Healthcare category in the Health Business Awards.

2010

- Achieved Level 3 (highest) Accreditation with the NHSLA. The first trust in the South-West and South to achieve this level.
- Awarded best hospital for patient experience in the 2010 Healthcare Excellence & Leadership Awards.
- Inpatients rate the trust in the top 20 per cent of Trusts in the country.

2011

- Outpatients rated the trust in the top 20 per cent of trusts in country.
- Cancer services rated in the top 20 per cent of trusts in country and rated in the top ten by a leading cancer charity.
- Whole Trust Accredited as A Practice Development Unit (the first in the country) by Bournemouth University.

(b) RBCH has won a number of awards and recognitions for the high quality of the patient care that it delivers. Some of these are set out below:

December 2008

- RBCH was awarded Healthcare Financial Management Association Healthcare Provider of the Year, in recognition of the contribution by a finance team to excellent performance across the organization.

2009

- RBCH was awarded the Health Service Journal Acute Trust of the year.

May 2011

- RBCH was awarded the Caspe Healthcare Knowledge Systems (CHKS) Safe Hospital of the year.

24. Finally, we noted that in March 2013 RBCH was listed as the second highest scoring trust in England (out of around 150 other trusts) by MHP Health Mandate for patient specified measures of quality.¹³

Monitor ratings for finance and governance

25. All of the main providers of acute healthcare services in the wider Dorset area have already achieved foundation trust status, and are assessed by Monitor on financial and governance grounds.
26. As Table 4 below shows, Monitor has awarded Dorset County Hospital the top rating for governance ('green'), indicating that Monitor had 'no material concerns' about this provider. Salisbury District Hospital and Yeovil District Hospital were awarded the second best rating ('amber-green'), indicating some limited concerns surrounding this trust's terms of authorization. University Hospital Southampton received a 'red' rating indicating that it is likely or in actual significant breach of its terms of authorization. The trusts shown in Table 4 all had healthy financial risk ratings of 3 or above, except PH.

TABLE 4 Governance and financial risk ratings awarded to local NHS acute trusts by Monitor

	<i>RBCH</i>	<i>PH</i>	<i>Dorset County FT</i>	<i>Salisbury FT</i>	<i>Yeovil District Hospital FT</i>	<i>University Hospital Southampton FT</i>
Finance	3	2	4	3	3	3
Governance	Green	Red	Green	Green	Amber-Green	Red

Source: Monitor Risk Rating. At the date of access, 10 September 2013.

Key: 1–5 (highest to lowest risk): red, amber-red, amber-green, green.

Note: On the date of access PH's risk rating showed as 3 but we understand from PH and Monitor it was 2.

27. We noted that:
- As noted in Section 2 of our report, the governance risk rating for PH was amended to red in May 2013 after Monitor raised concerns over its financial sustainability, and in August 2013 its financial risk rating was downgraded to 2.
 - The governance risk rating for Yeovil District Hospital was amended from green to amber-green in May 2013 due to the trust's breach of the A&E 4-hour wait target in the last quarter of 2012. In addition, its financial rating was downgraded from 4 to 3 in November 2012 due to deterioration in the trust's financial position.
 - The governance risk rating for University Hospital Southampton was amended from amber-red to red in May 2013 following the trust's breach of the A&E 4-hour wait target in four out of the previous five quarters. Monitor opened a formal investigation to understand whether the trust's inability to manage its emergency care services represents a breach of its license and, if so, the appropriate regulatory actions to enforce.

Annual reports

28. The parties provided information on quality in their annual reports and we summarize some statistics from the 2012/13 annual reports of RBCH and PH in Table 5.¹⁴

¹³ RBCH Annual Report and Accounts 2012/13.

TABLE 5 Quality indicators in RBCH and PH annual reports

Measure	PH	RBCH	National targets
Hospital-acquired MRSA bacteraemia	4	0	25% reduction compared with 2010/11 baseline
Hospital-acquired pressure ulcer (Grade 3 or Grade 4)	12	13*	-
Patient Environment Action Team (PEAT) Inspection Report	Excellent (environment) Good (food) Excellent (privacy & dignity)*	Good (environment) Good† (food) Excellent (privacy & dignity)*	-
Clostridium Difficile Infections	27	31	30% reduction compared with 2010/11 baseline
Maximum waiting time of 62 days from urgent referral to treatment for all cancers (%)	88	88.6	85
Two-week wait for breast cancer (%)	94	97	93
Maximum waiting time of 4 hours in A&E (%)	95	97.2	95
Maximum 31-day cancer first treatment (%)	100	96.4	96

Source: PH Annual Report (2012/13), RBCH Annual Report (2012/13).

*2011/12 figure.

†Excellent in Christchurch Hospital and Good in Bournemouth Hospital.

29. In its 2012/13 Annual Report, RBCH identified the following areas of quality improvement for 2013/14: reducing harm from inpatient falls, reducing harm from hospital-acquired pressure ulcers, reducing urinary tract infections caused by catheters and reducing hospital-acquired venous thromboembolism (VTE). These are the same priorities identified in 2012/13 as the trust aimed to ensure effective implementation of all new quality initiatives and focused on embedding and sustaining changes. In relation to patient experience, the focus of RBCH for 2013/14 was said to be on reviewing: response to call bells, reduction in noise at night, improve privacy and dignity, patients being asked to give their views on the quality of their care, information at the point of discharge, same-sex bathrooms/accommodation and patients feeling threatened by other patients or visitors. In its strategic plan, RBCH said that over the next three years RBCH's focus would be on a number of priorities which included reducing emergency admissions, infection control, friends and family test, avoidable mortality, patient-reported outcome measures for knee procedures, respiratory care discharge bundle and dementia screening.
30. PH said that in 2012/13 it had made good progress against its three key quality improvement measures—readmissions, delayed discharges and infection prevention—but did not achieve two other improvement targets in the right place or in waiting times in the A&E department principally because of the pressures on hospital admissions throughout the winter. In its 2012/13 Annual Report PH identified the following areas of improvements, as a stand-alone organization, for 2013/14:
- Improve the care of patients with dementia and ensure that patients have a dementia assessment on admission.

¹⁴ PH 2012/13 annual report.

- Increase the right patient in the right place at the right time.
- Increase the percentage of patients who have a VTE assessment on admission.
- Increase the percentage of patients seen and treated within 4 hours in the A&E department.
- Increase the use of day theatres to maximize patient benefit and throughput.

Quality regulation and scope for competition on quality

Guidance and quality standards

31. NHS providers, including foundation trusts, are subject to a range of legal obligations, policy guidance and best practice relating to the quality of health services they provide. Failure to meet some quality criteria may have negative ramifications, in particular:
- (a) Foundation trusts must be registered with the CQC and comply with all relevant essential standards that the CQC has formulated based on statutory requirements. The essential standards relate to the involvement and information of patients, provision of personalized care, treatment and support, patient safety, suitability of staffing and management and the assessment and monitoring of quality of care.¹⁵ If the CQC has a concern about the quality of care being delivered at a foundation trust, it will inform Monitor so that Monitor can ascertain whether the concern could lead to a foundation trust being found in breach of its terms of authorisation. Likewise, if Monitor is made aware of any issues regarding the provision of healthcare by a foundation trust which Monitor considers would help the CQC in its regulatory capacity, Monitor will communicate this to it.
- (b) Medical practitioners have to comply with GMC standards, whose statutory role is to protect, promote and maintain the health and safety of the public by ensuring proper standards in the practice of medicine. The GMC can require trusts to remove medical practitioners that do not meet its standards.¹⁶
32. We considered whether quality standards (such as NICE clinical guidance), national targets (such as waiting time targets) or financial incentives (such as Commissioning for Quality and Innovation (CQUIN)) might remove the ability for the competitive process to influence quality. (See Appendix C, paragraphs 33 to 35, for a description of the CQUIN.)
33. NICE publishes guidance and quality standards pertaining to health services and social care. Its clinical guidelines provide the NHS and others with advice on the management of individual conditions. They are systematically-developed statements to assist professional and patient decisions about appropriate care for specific clinical circumstances. These may be as diverse as antenatal care, breast cancer or schizophrenia. They are developed in association with the Royal Medical, Nursing and Midwifery Colleges.¹⁷

¹⁵ CQC, Guidance about compliance – Essential standards of quality and safety.

¹⁶ Joint main party initial submission, p29.

¹⁷ www.nice.org.uk/aboutnice/whatwedo/what_we_do.jsp.

It also publishes quality standards which

are a concise set of statements designed to drive and measure priority quality improvements within a particular area of care. NICE quality standards are derived from the best available evidence such as NICE guidance and other evidence sources accredited by NICE. They are developed independently by NICE, in collaboration with health and social care professionals, their partners and service users. Evidence relating to effectiveness and cost effectiveness, people's experience of using services, safety issues, equality and cost impact are considered during the development process for both products.¹⁸

34. According to PH and RBCH, NICE quality standards do not provide a comprehensive service specification; they define priority areas for quality improvement based on consideration of the topic area. We further understand that NICE quality standards are not mandatory but they can be used for a wide range of purposes both locally and nationally. Health professionals are expected to take NICE guidance fully into account when exercising their clinical judgement. However, the guidance does not override the individual responsibility of healthcare professionals to make decisions appropriate to the circumstances of the individual patient, in consultation with the patient and/or guardian or carer, and informed by the summary of product characteristics of any drugs they are considering.
35. The Royal Colleges also produce guidelines and recommendations for best clinical practice. However, we understand that these are not binding unless local commissioners choose to insist on them.¹⁹ Similarly, although the Deaneries exercise a role in ensuring quality of service by monitoring ongoing clinical activity to ensure that doctors receive the right opportunities to acquire the needed skills (and they may withdraw training posts if they feel such training opportunities no longer exist), they do not directly regulate quality (although they do influence factors which are likely to affect some aspects of quality).²⁰

CQUIN payments

36. We also considered whether CCGs could use contractual levers to incentivize the parties to provide high-quality services and in so doing either prevent the merger from resulting in lower quality or mimic the effect of competition going forward.
37. The NHS Standard Contract sets out a framework for paying acute hospitals for meeting CQUIN objectives in relation to specific services. Examples of CQUIN goals that Dorset CCG has implemented locally include end-of-life care, reducing patient moves within a hospital, dementia services, discharge planning, and clinical supervision. Guidance on the NHS Standard Contract sets out the expectation that commissioners will cooperate to reach agreement on a single CQUIN scheme per provider in most cases.
38. The parties said that quality increases rewarded under the CQUIN framework applied over and above quality and performance standards set out in the standard NHS contract. The parties told us that the CQUIN payment was part of the managed contracts agreed with commissioners. The contract value agreed at the beginning of

¹⁸ www.nice.org.uk/guidance/qualitystandards/qualitystandards.jsp.

¹⁹ Joint main party initial submission.

²⁰ www mmc.nhs.uk/colleges_deaneries/deaneries.aspx.

the year included the CQUIN payment on the assumption that the provider would work throughout the contractual year towards the achievement of these goals.

39. The parties told us that they had both been awarded the full CQUIN payment over the last three years. This provided £[§] million of revenue for RBCH and £[§] million for PH. RBCH told us that 'The contract value is calculated taking account of anticipated CQUIN payments for quality. The managed contract means that should the trust fail to achieve a quality standard, then the trust would need to [§]'. We understood that each party has a number of CQUIN targets and that in general they comply well, but not fully, with those targets. PH told us that it struggled with those CQUINs that required other health agencies to contribute to the overall delivery (eg High Impact Interventions and A&E admissions). However, the parties' current contracts with Dorset CCG (and with West Hampshire CCG as an associate to that agreement) [§] and so, unless that agreement changes, there is no explicit link between CQUIN compliance and income, although a substantial reduction in compliance might provoke a review of the current arrangements.
40. Dorset CCG told us that it monitored CQUIN as if it were not within the managed contract (see Section 6 of our report for more information on the managed contracts), and the current position was based on good compliance over previous years with the understanding that if full CQUIN payment was assured then it would be invested in the relevant CQUIN areas. It said that if the money was being taken without the delivery of improved CQUIN it would not continue with this approach, so it was in effect paying in advance for the delivery. It said that in general this approach had worked well and both providers would be getting almost all of the CQUIN payments anyway based on their current performance.
41. West Hampshire said that although the contract value was included as part of the risk sharing agreement, the payment relating to CQUIN within the total was adjusted for in accordance with the analysis of the lead commissioner.

Counterfactual

1. This appendix sets out the following supporting information for the counterfactual assessment:
 - (a) views of third parties on the counterfactual;
 - (b) analysis of whether RBCH or PH would be exiting firms in the counterfactual within the meaning of our guidelines;
 - (c) other counterfactual scenarios;
 - (d) guidance provided by the Department of Health on NHS foundation trust special administration;
 - (e) case studies of selected underperforming hospitals; and
 - (f) the CCP's approach to analysis of the counterfactual.

Views of third parties

2. Dorset County Hospital, Salisbury District Hospital and University Hospital Southampton all appeared to believe that the counterfactual would most probably be that the status quo continued, ie business as usual.
3. West Hampshire CCG stated that prior experience would suggest that without the merger 'there is likely to be discussions about further sharing of services because clearly the clinical rotas are under growing pressure because the clinical workforce is not available for some services. Therefore, there is a potential need for more sharing of services'.
4. The Foundation Trust Network¹ (referring to foundation trusts more generally rather than to this specific merger) told us that because of the pressures on foundation trusts we should not assume that the counterfactual was the status quo. It said that in many cases the counterfactual was that both foundation trusts were weakened and patient services were worsened.
5. The South West Specialised Commissioning Team believed that:

PH had probably of the two, the greater financial difficulties in the short-term, and therefore if Poole Hospital's financial viability could not be confirmed, [it] would be worried about quality of services at Poole deteriorating as their financial position deteriorated or their withdrawing from provision and [the commissioner] having to therefore find other new trusts from which to commission the services.
6. NHS England (Wessex) told us that:

¹ The Foundation Trust Network is the membership organization and trade association for NHS acute hospitals and community, mental health and ambulance services that have achieved foundation trust status.

My concern would be that we would see a deterioration in the services, that there was a slow creep, and my concern would be that that would take some time to become very evident and it would take some time for providers as separate entities to do anything about that or for commissioners to act on that.

7. Dorset CCG stated that:

The current financial position of PH is not sustainable in the medium term. It has all but exhausted cost improvements plans of a large scale, and its ability to income generate is limited by the current 30 per cent non-elective tariff cap. Both Trusts are already below the national reference cost average, therefore 'easy wins' will be limited going forward.²

Exiting firm analysis

Analysis of RBCH

8. This part of the appendix sets out further supporting information for our analysis of whether RBCH would remain in the market in the counterfactual.
9. RBCH is currently and has historically been profitable and cash-generative, as explained in paragraph 2.51 of our report: it made a surplus in 2012/13 of £3.6 million (against a planned surplus of £1.9 million).³ It had made a positive comprehensive income in each of the previous five years before this except 2009 (which was impacted by revaluation charges). The total (nominal) comprehensive income for these five years amounted to £42.4 million. In 2012/13 RBCH increased its cash by £8.7 million so that its total cash reserves at the end of 2012/13 amounted to £54.2 million.⁴ It had increased its cash in each of the previous five years before this (other than 2009), from a balance of £25.3 million at the start of 2007/08.
10. RBCH provided us with forecasts showing continuing surpluses on a stand-alone basis of £[REDACTED] million in 2013/14, £[REDACTED] million in 2014/15 and £[REDACTED] million in 2015/16. RBCH also provided cash flow forecasts showing that it is forecasting cash to decrease to £[REDACTED] million by 2015/16, driven by forecast capital expenditure of £[REDACTED] million over the forecast period.⁵
11. We considered the extent to which cost savings have been appropriately classified as merger specific or non-merger-specific, ie whether the anticipated cost savings from the merger could be achieved without the merger (see Appendix B and Appendix M). We have also considered the extent to which the non-merger-specific savings have been appropriately allocated to PH and RBCH, and the latest forecasts presented to Monitor include allocations updated on the basis of our feedback to the parties (see further Appendix B for these forecasts).
12. RBCH's financial risk rating with Monitor has been 4 for the four years ended 2012, and we noted that it achieved a rating of 3 in 2013⁶ (risks have been rated 1 to 5, where 1 represents the highest risk and 5 the lowest). It told us that it anticipated a

² Dorset CCG submission, p2.

³ All RBCH and PH financial periods end on 31 March of the year: for example, the financial year 2012 is the year ended March 2012.

⁴ RBCH Annual Plan to Monitor 2013/14.

⁵ ibid.

⁶ RBCH financial report, 31 March 2013.

risk rating of [REDACTED] under the new rating system (which places greater weight on cash balances and liquidity and under which 4 is the highest rating) for the next few years. RBCH has a green (low-risk) rating for governance.

Analysis of PH

13. This part sets out further supporting information for our analysis of whether PH would remain in the market in the counterfactual.

Comparison with other foundation trusts

14. PH told us that its non-elective case mix was an exception in the NHS. Using data provided by Dr Foster for 127 foundation trusts, the parties identified PH as having the second highest proportion of non-elective inpatient activity once specialist and community foundation trusts were excluded (which left 69 trusts remaining). The closest comparator to PH is Bolton NHS Foundation Trust, a trust which also faces significant financial challenges. PH provided details of each of the trusts with high non-elective case mix, and summarized them as either having income streams which PH does not (whether elective, community or private); and/or, like PH, facing significant challenges.
15. We considered the extent to which PH is exceptional either in terms of its size or its proportion of non-elective services. We then considered how, if at all, this should affect our analysis.
16. We considered whether there was a structural problem such that small foundation trusts may not be viable in the long term. A PH board paper of July 2012 stated that most acute trusts with incomes of less than £400 million may become non-viable in the future. PH is a medium-sized foundation trust—it is not exceptionally small. In Monitor's quarterly report published on 10 June 2013, it noted that of the 81 acute foundation trusts in 2012/13, 20 had revenue below £200 million, 20 had revenue of over £400 million and 41 had revenue between £200 million and £400 million. PH had revenue of just below £200 million. Monitor told us that it had reviewed the Hospitals Estates Facilities Statistics for 2011/12 and found that in terms of number of beds in that sample, PH was an average size for a single-site foundation trust.⁷
17. We considered the Dr Foster data provided by PH. This showed that of 127 foundation trusts included in the data PH had the 23rd highest non-elective focus. PH had then removed from the data those foundation trusts that had a community, specialist, mental health or teaching focus, as well as those that had fewer than 10,000 inpatient spells in 2012. This left a group of 69 foundation trusts of which PH had the second highest non-elective focus with an estimate of 63.9 per cent non-elective activity. There were six further foundation trusts within five percentage points in terms of the proportion of non-elective activity they performed. It appeared from this data that there is a spectrum of foundation trusts and that PH is a foundation trust that has an above-average proportion of non-elective activity. However, it does not appear to be unique in doing so.
18. It appeared to be a widely held belief that non-elective services are structurally loss-making. We understand the arguments that these services may be higher cost than elective services. We asked for information to support the argument that these

⁷ Monitor told us that it examined Hospital Estates Facilities Statistics (HEFS) for the period 2011/12. It appeared that Poole was in the 45th percentile of the sample (based on its having 523 beds at the time), which suggested that Poole is an average size for a single site FT.

services are structurally loss-making—the parties provided us with analysis produced by the Foundation Trust Network for Monitor which showed that after application of the 30 per cent marginal rate only one of the 26 trusts in its analysis consistently reported a surplus for its non-elective emergency services for the period 2010/11 to 2015/16. However, this did not show whether or not the various non-elective services were loss-making before application of the 30 per cent marginal rate.

19. We noted that the fact that PH is currently in surplus and is forecast to remain so this year indicates that it is possible for a hospital with high levels of non-elective services to be profitable, although we noted that this may be due to the subsidy payment from the Dorset CCG. In any event, it was not clear to us that this subsidy was to fund non-elective activity levels: PH had not reached the 2008/09 baseline for non-elective activity and so was not currently penalized by the 30 per cent marginal tariff for non-elective activity. In addition, when asked why it could not close loss-making services, PH noted that many of its loss-making services (and it did not split these between elective and non-elective services, but by specialty) made a positive contribution to fixed costs and when measured against fully allocated total costs, closing them would reduce rather than increase the overall profitability of PH. There are also clinical interdependencies that would be lost.
20. Data provided by PH showed that PH provided a number of profitable non-elective services.
21. PH is operationally successful: the parties' initial submission stated that PH 'has won a number of awards and recognitions for the high quality of the patient care that it delivers, including safest hospital of the year in 2009' as well as other awards.⁸ A board presentation of September 2011 set out that both parties had been clinically successful over many years, winning numerous awards; that both had been more productive and more successful than most other NHS hospitals of a similar size; and that both perform well on productivity benchmarks; although this success would be harder to sustain in the future.
22. Finally we noted that PH had made substantial cost saving efficiencies since its change of governance. The result is that, according to PH it is now 7 per cent more efficient than the average foundation trust. In considering whether PH was exceptional due to the proportion of non-elective services it provides, we first considered whether this proportion of non-elective services were the cause of its forecast losses. PH and RBCH both provide a range of elective and non-elective services. A large proportion of PH's clinical income is derived from non-elective services and A&E (33.1 per cent in 2012/13⁹ compared with 24.2 per cent for RBCH¹⁰).¹¹ However, PH's income has not been affected by the 30 per cent marginal rate paid for non-elective episodes above the baseline as it still provided a lower volume of relevant services than in 2008/09 and so this is not the cause of any financial underperformance of PH, although this may still affect the incentives PH faces to expand its non-elective services.
23. PH's forecast losses were based on a number of assumptions regarding tariff deflation and cost inflation and we were told that its financial difficulties are driven by the high proportion of non-elective services that it provides (and cannot reduce) and a tariff structure that may not fully remunerate it for these services. However, PH noted that these cost increases do not specifically relate to the proportion of non-

⁸ [Joint main party initial submission](#), paragraph 24. See further Appendix D.

⁹ PH 2012/13 management accounts.

¹⁰ RBCH 2012/13 management accounts.

¹¹ [Joint main party initial submission](#), p10.

elective services, and that all NHS acute providers will face broadly the same increase in net costs.

Financial assessment

24. As noted in paragraphs 2.56 and 2.57, in 2010 PH suffered from serious financial and governance failures but is now running a surplus and has previously been cash-generative: PH made an operating surplus of £1.3 million in 2012/13 (against a forecast of £[~~X~~] million) and had a closing cash balance of £[~~X~~] million at the end of 2012/13.¹² This was partly driven by [~~X~~] income of £[~~X~~] million agreed with the Dorset CCG during the year, and £[~~X~~] million with the SHA to cover merger costs.¹³ Apart from 2010 it made a surplus in each of the last five years. In 2011/12 PH increased its cash by £[~~X~~] million so that its total cash reserves at the end of 2011/12 amounted to £[~~X~~] million. It had [~~X~~] its cash in each of the last five years (other than 2009), from a balance of £[~~X~~] million at the start of 2008.
25. PH told us that its cash balances had not increased since March 2012 and were expected to start reducing in FY 2013/14 and also that the surplus it was running was only due to the subsidy provided to it by Dorset CCG.
26. PH told us that it was forecasting to [~~X~~] in 2013/14 (a [~~X~~] of £[~~X~~] million) but that this was due to additional income of £[~~X~~] million agreed with the Dorset CCG, £[~~X~~] million of which was for ‘transitional funding’ not associated with any additional activity. We noted that PH’s September 2013 board minutes indicated that its surplus for the five months to end August was slightly ahead of plan (£211,000 compared with plan of £98,000).¹⁴ PH has stated that the ‘transitional funding’ or subsidy was to support PH before the merger and would not be available going forward if the merger did not proceed.¹⁵ As noted in paragraph 4.21, for the purposes of our analysis we are using the forecasts provided by PH to Monitor in May 2013.
27. PH told us that Dorset CCG would not provide such support indefinitely: it would allow PH to maintain revenue at the same level but that this would need to reflect payment for increased activity rather than any further subsidies provided to support PH’s finances.¹⁶ Dorset CCG confirmed that it would be unlikely to continue such payments. However, in our view this is possible but not certain as Dorset CCG may be faced with the choice of providing PH with ongoing subsidies or PH suffering financial constraints that may affect the quality of its services in the long term: this subsidy may make the difference between PH running a deficit or a surplus in future years. In any event, this does not affect our analysis. PH told us that it would make deficits of £[~~X~~] million in 2014/15 and of £[~~X~~] million in 2015/16 on a stand-alone basis.¹⁷
28. We consider in Appendix B the assumptions that lie behind the PH figures which we have been provided with. The main drivers of PH’s forecast performance are the following:
 - Foundation trusts will need to generate efficiency savings of 5 per cent in 2014/15, and 4.2 per cent in 2015/16. PH provided us with a copy of a letter from Monitor

¹² PH reported a surplus of £1.3 million in its 2012/13 management accounts. The difference between the surplus in the management accounts and the audited deficit is an impairment of £9.7 million.

¹³ [PH 2012/13 annual report](#). This refers to all PH 2012/13 figures included in this appendix.

¹⁴ PH Board minutes, 25 September 2013.

¹⁵ PH stand-alone forecast model, 15 May 2013.

¹⁶ *ibid.*

¹⁷ PH Annual Plan to Monitor 2013/14.

sent to new foundation trusts or trusts undergoing a transaction which set out efficiency guideline figures.¹⁸ PH has used the efficiency guidelines set out in this letter in its forecast assumptions. PH told us that Monitor did not provide workings to support its assumptions but each trust was required to [§]. ([§] has generated tariff deflation and cost inflation assumptions in order to meet these efficiency guidelines.)

- Tariff deflation of 1.4 per cent in 2014/15 and 2015/16. This decrease will be offset to some extent in PH's forecast by increased revenue from either additional activity or additional payments (eg for non-PbR income which is currently under-paid). Even though PH forecasts that it would recoup some of this amount through increased revenue, this has an associated marginal cost of [§] per cent. We also note that in previous forecasts PH has assumed a marginal cost of [§] per cent against revenue from increased activity, but that it has revised this figure to bring it in line with the figure used by RBCH and in the merged trust forecast.
 - Inflationary cost increases, of which the main ones are pay costs at [§] per cent, drug costs at [§] per cent and non-pay costs at [§] per cent. Again these appear to be conservative cost inflation figures (eg national pay rate increases may be closer to [§] per cent, however, this is before incremental pay increases which the trust must pay).
29. PH told us that it had no more scope for additional cost reduction (without the merger) but that it would need to make savings of £[§] million each year in order to break even. It told us that it would continue to make savings under its cost savings plan, but would not be able to achieve the savings required by Monitor over the next three years (using the efficiency guidelines provided by Monitor). It also told us that it had no ability to grow its income, due to its focus on non-elective services and the intense competition for AQP services.

Monitor risk rating

30. PH's risk rating was 3 for the year ended 2012/13. PH is forecasting a closing cash balance of £[§] million for 2013/14¹⁹ and no long-term debt, with the primary focus of the new risk rating on liquidity.²⁰ PH told us that its main risk for 2013/14 was a deteriorating cash position caused by operating deficits and capital expenditure (as the trust has no long-term debt, the measure of capital servicing would have less impact on the trust's rating).
31. PH told us that it was currently forecasting a risk rating decrease to 1 in 2014/15, when the trust was forecasting to run out of cash, and also 1 in 2015/16.²¹ Its Annual Plan to Monitor for 2013/14 assumed that it would need to borrow £[§] million during 2014/15 and 2015/16²² in order to retain a positive cash balance, although it had not identified a source from which it would be able to borrow such an amount. These forecasts were based on a number of assumptions about future costs and tariffs and also the extent to which PH would benefit from non-merger-specific cost savings.

¹⁸ Monitor has noted to us that it does not set efficiency savings requirements for foundation trusts.

¹⁹ PH Annual Plan to Monitor 2013/14.

²⁰ During the course of our inquiry, we received some information from PH indicating that under the new risk assessment framework proposed by Monitor, PH would currently achieve a financial risk rating of [§]. Monitor is proposing new risk ratings of 1–4, where 1 represents the highest risk and 4 the lowest, which means there is sufficient financial headroom and liquidity. This was driven by the cash balance referred to above.

²¹ PH Strategic Plan 2013/14.

²² PH Annual Plan to Monitor 2013/14.

32. We tested these assumptions and noted that a different set of assumptions could generate smaller deficits for PH. For example, efficiency requirements of [X] per cent in 2014/15 and [X] per cent in 2015/16, and, if it were possible, avoiding the additional clinical costs of £[X] million could result in forecast deficits of £[X] million in 2014/15 and £[X] million in 2015/16 (approximately half of the deficits forecast). We also note in Appendix B that there are some savings described by the parties as merger specific that may be achievable by PH (and RBCH) on its own. Although we are not able to quantify these precisely we note that this would slightly improve PH's forecast deficits.
33. We also noted that the time period over which these forecasts extend coincides with the period during which the manner in which the national tariff is calculated may change significantly. In our view, it is possible that any such changes may potentially benefit PH although the precise effect of such changes on PH and their timing cannot be predicted with confidence at this stage.
34. On the basis of PH's forecasts, Monitor opened a formal investigation into PH (as explained in paragraph 4.21). It downgraded PH's governance rating to red. In August 2013, Monitor downgraded PH's financial risk rating from 3 to 2 due to a deterioration in PH's financial position at Q1 2013/14.
35. PH told us that it considered that any changes to improve its performance were not within the power of the board to correct. PH considered that it had already exhausted the avenues available to it to improve its financial position.

Monitor failure regime

36. In order to assess the likelihood of Monitor recommending special administration in the event of a deficit by PH, we considered the Monitor failure regime (as set out in Appendix C, paragraphs 81ff) and what has happened to other trusts that have been struggling.
37. We asked Monitor whether PH was likely to fail in its view, based on the figures we had been provided with and, if so, what that failure would look like and the steps Monitor would take in relation to a failure investigation. Monitor told us that it would assess PH's financial performance in accordance with Monitor's usual risk rating process and drew our attention to its Risk Assessment Framework (which we describe from paragraph 81 of Appendix C). We asked in what circumstances it would move to appoint a special administrator for PH. Monitor said that it considered this on a case-by-case basis and drew our attention to its Risk Assessment Framework. We therefore considered PH's submission regarding failure in light of this Risk Assessment Framework. We noted that on 10 June 2013, in light of the financial deficit predicted by PH, Monitor opened a formal investigation into PH's compliance with its licence,²³ as mentioned in paragraph 4.21 of our report. Monitor told us that, absent of merger, PH will need to work with the local health economy to plan mitigating actions and make the necessary changes to address financial risks. Monitor told us that it would expect all local options to be exhausted before the appointment of a TSA would be considered.
38. Monitor regularly reviews the financial ratings of foundation trusts and as at 31 March 2013, of the 145 foundation trusts, eight are rated 1 by Monitor and another five are rated 2.²⁴ The average rating for a foundation trust during the period to 31 March

²³ www.monitor.gov.uk/home/news-events-publications/latest-press-releases/monitor-announces-investigation-poole-hospital-n.

²⁴ 1 represents the highest risk rating and 5 the lowest.

2013 was 3.4.²⁵ In addition, around half of the foundation trusts have governance ratings which fall below green (ie red, amber-red, amber-green).

39. Monitor noted in its 2012/13 Review of NHS foundation trusts' annual plans that: 'Trusts are forecasting a more challenging 2012/13, with the aggregate Financial Risk Rating (FRR) declining from 3.4 to 3.2, reflecting increased risk. Significantly, 43 trusts (30 per cent of the sector) are forecasting a lower FRR in 2012/13 than they achieved in 2011/12.' It noted particular risks for small acute trusts and mental health foundation trusts. CIPs were expected to be delivered at 4.1 to 4.3 per cent of costs—below Monitor's estimate of required efficiency of 4.5 to 5.0 per cent.
40. Monitor recognized that many foundation trusts might be experiencing financial pressure:

We remain concerned about the financial pressures that the foundation trust sector faces in the medium term. To meet this challenge, trusts will need to understand the forces at work within their local health economy and to develop strategic plans to deal with them. It is increasingly likely there will be a need for more innovative, and perhaps even fundamental, changes to delivery models. Without exception, trusts will need to plan sooner and more effectively for the longer term to ensure they can continue to deliver quality services in the context of ongoing financial pressures.²⁶

41. Monitor also stated:

We expect the gap between those foundation trusts which are able to adapt to the continued pressures and those which are unable to adapt is therefore likely to continue to widen. Our analysis shows that small and medium-sized district general hospitals, trusts with significant PFIs and those located in challenged local health economies face the greatest financial risk. Despite the overall resilience of the sector, we therefore expect an increasing number of individual trusts to be placed in significant breach for financial reasons over the next three years.

42. As noted in Appendix C, the intention is for special administration only to be used in exceptional circumstances and this is highlighted by there being 19 foundation trusts in significant breach of their terms of authorization during 2012/13 with 16 foundation trusts in deficit during the year, and only one of these trusts is currently in special administration (Mid Staffordshire NHS Foundation Trust (MSFT), which had specific serious clinical problems).
43. This process is not immediate. In the case of MSFT, the trust was found by Monitor to be in significant breach of its terms of authorization as a foundation trust in March 2009 on grounds of poor governance and a failure to meet its general duty to exercise its functions effectively, efficiently and economically. However, it was only put into special administration, after a consultation process and a detailed review of its clinical failures, in April 2013.²⁷ We set out from paragraph 60 below information on MSFT and one other foundation trust which has also struggled and the NHS trust which was put into administration in 2013 by the Secretary of State. We also

²⁵ Monitor report—Performance of the Foundation Trust sector, year ended 31 March 2013.

²⁶ www.monitor-nhsft.gov.uk/home/browse-category/reports-nhs-foundation-trusts/nhs-foundation-trusts-quarterly-reports/2012-2013-1.

²⁷ www.monitor-nhsft.gov.uk/home/news-events-publications/latest-press-releases/monitor-announces-appointment-trust-special-admi. See also Monitor Report presented to Parliament pursuant to s.65D(6) of the National Health Service Act 2006.

reviewed the CCP's consideration of failing firm arguments put forward in a number of merger cases involving NHS hospitals.

Other counterfactual scenarios

44. This part sets out further supporting information for our analysis of counterfactual scenarios other than those relating to exit for either of the parties.

Other options for RBCH

45. RBCH and PH commissioned McKinsey & Co (McKinsey) during November 2011 to prepare a report on the costs and benefits of the merger. The report considered either closer collaboration and/or a merger with PH. The McKinsey report concluded that synergies could occur in a number of services,²⁸ and recommended the early merger between the two trusts. The report was discussed at an RBCH board meeting held on 11 November 2011. The report also considered whether each trust could deliver on its individual cost saving programmes and concluded that these would not be fully achievable without the merger.
46. In addition to the McKinsey report, described in paragraph 4.53, RBCH also considered a number of other options should the merger not proceed or not be considered as desirable by the board.²⁹ RBCH told us that it had considered five possible options.³⁰ The options were appraised as follows:
- *Option 1:* Cooperate further with PH; this would not ensure financial viability of the two trusts as key savings would not be realized, nor would it allow for the consultant-led changes that the merger would allow.
 - *Option 2:* [☒]; [☒] this strategy may not be very effective as the tariff used to remunerate providers changes significantly from year to year (by as much as 20 per cent). [☒] It was noted also that [☒] is likely to be strongly resisted by commissioners.
 - *Option 3:* [☒]; this would lead to some patients receiving poorer care and in some cases care being more expensive to provide than before.
 - *Option 4:* Merge with other trusts than PH. RBCH approached [☒] regarding a potential merger (these parties were approached at the same time as RBCH approached PH). However, none of these parties expressed any interest in the proposal,³¹ and RBCH did not consider that a merger with one of these trusts would be as beneficial as a merger with PH given that the distances involved would limit the scope for shared clinical services.
 - *Option 5:* [☒]; this was identified as an opportunity to be pursued irrespective of the merger but RBCH subsequently noted that it believed that it would not be able to [☒].

²⁸ Joint main party initial submission.

²⁹ *ibid.*

³⁰ These options were discussed at the 24 November 2011 meeting of the board alongside the McKinsey report. *ibid.*, paragraph 171.

³¹ *ibid.*

Other options for PH

47. PH provided us with a detailed description of the process leading up to the merger in its submission titled 'Diagnosis of PH's unsustainable future', which divided this process into four time periods. First, from approximately autumn 2009 to March 2010, PH's previous senior management³² took steps to address its financial problems. We understand that at this time a merger with RBCH was being discussed at PH but on the change of management, these discussions were put on hold pending management addressing the immediate financial difficulties of PH. Second, from approximately April 2010 to January 2011, the current management focused on the immediate financial difficulties of the trust.
48. Thirdly, from approximately February 2011 to April 2012, the current management turned its attention to the longer-term viability of the trust. There were several board meetings in 2010 and 2011 which considered possible options for PH and these culminated in a board meeting of September 2011 which discussed eight possible options of which 'three clear front runner options' for PH's long-term viability were identified: a horizontal merger with RBCH; a vertical merger with [REDACTED]; and remaining as a stand-alone organization. The strategy director added that this option required the PCT to agree to support it with additional funding. In November 2011 McKinsey produced a report setting out the parties' CIP plans, the need for both parties to achieve substantial savings and the risk that PH would struggle to achieve these. This report also identified the merger with RBCH as the best option to remedy the parties' long-term problems. At the end of 2011, PH presented its financial performance to Monitor and explained that its preferred option to address ongoing challenges was to merge with RBCH. Monitor advised PH to consider all options to secure the long-term future of the trust's services.
49. Finally, from approximately May 2012 until present, PH's senior management investigated alternatives to the merger and reappraised PH's long-term options. In May 2012 PH's board expressed concern that the merger might not be approved by the competition authorities and requested that alternatives be developed.
50. A paper presented to the board of PH in July 2012 noted that there may be a combination of changes that would allow PH to survive but these would require a 'transformational approach to meeting the needs of the local population'. It also said that commissioners could not be expected to fund services outside of the national tariff arrangements and this would only happen in exceptional circumstances. Finally, it presented a number of possible options which were then used to create three scenarios/models for the board to consider: franchise, vertical integration, and partnership. Each of these required PH to become profitable through combinations of focusing on profitable services, reducing unprofitable services or services which it could not fund.
51. These three alternative options to the merger were:
 - *Option A:* Under the *franchise model*, the trust would enter into a contract for a set period of time. During this period, the franchise partner would take full operational control of the trust and accept all risks. Four options of implementing franchise were proposed. All those options depended on the ability of the franchisee to squeeze the current unprofitable business model sufficiently to allow PH to return to balance and the franchisee to make a profit.

³² As noted in paragraph 2.15, PH's management changed during 2010/11.

- *Option B:* Under the *vertical integration model*, PH would have to exit the provision of certain services and enter in partnership or merge with other foundation trusts, in preference [§]. A&E would be reduced or closed and maternity would be ‘lotted’ with other services. Under this model, PH would also consider hosting services of other trusts.

- *Option C:* Under the *partnership model*, PH would try to find a partner that would assist it with managing its finances and allow operational change necessary for the trust to remain viable. The difference between the franchise and the partnership model is that under the partnership model, the partner would receive a fixed fee and the risk transfer would be more limited. This model would also involve important divestments of the least profitable services.

52. PH told us that these options were rejected as substandard in clinical terms and that the board was unconvinced by these options for the following reasons. Option B seemed hypothetical as the best candidate for a merger—[§]—did not want a merger with PH. Options A and C were novel, untested models without evidence showing that they could work in the NHS. Moreover, none of these options would allow the trust to deliver the patient benefits that could be achieved by merging with RBCH.
53. On 8 May 2012 it entered into an MOA with RBCH.
54. In 2012 PH commissioned PwC to reappraise the eight options, and the PH board discussed the options again at the September 2012 meeting.³³ Of the eight options, PH told us³⁴ that it had concluded (and that PwC had confirmed) that a merger with RBCH would be ‘by far the most beneficial outcome in the long run ensuring greatest stability and best opportunity to comply with Royal College guidance in particular with respect to providing a seven day a week consultant delivered model of emergency care’.³⁵
55. PH told us that it had discarded the other options for the following reasons. The option of merging with [§] would not allow it to deliver significant clinical benefit especially compared with other options available. In addition, the Strategy Director’s report identified that PH would only remain viable as a stand-alone trust if the PCT agreed to support it with additional funding.
56. PH therefore considered in detail a merger with [§] and RBCH.
57. A merger with [§] would not bring the same patient benefits to PH as a merger with RBCH. Also it would not allow integration of haematology and consolidation of A&E services because [§] does not provide any level 3 haematology and its A&E catchment area does not provide sufficient overlap with PH’s A&E. The proximity of RBCH and PH means that they are unusually well placed to centralize and reconfigure services without having a material impact on patient access times. A merger with [§] would not bring the opportunities for non-elective care consolidation either but brought a different type of benefit in the form of integration of patient pathways—PH’s acute patients often continue their follow-on rehabilitation in the community services facil-

³³ The OFT was first approached regarding the merger in late 2011, with the parties seeking a formal response to a letter to the OFT in January 2012.

³⁴ [Joint main party initial submission](#), paragraph 166.

³⁵ PwC’s appraisal ranked the various options by giving them a score. According to this appraisal system the RBCH merger option scored highest (143 points), followed by [§] and then remaining stand-alone came third of the eight with a score of 121. The remaining options were all given a score less than 100 points. Given that the parties told us that the [§] option was hypothetical, it appears to us that the next best feasible option to the RBCH merger considered by PwC was remaining stand-alone.

ties of [XX].³⁶ Joint management of these pathways would have delivered important patient benefits. However, in PH's view these were not as high as the benefits delivered by the merger with RBCH. Moreover, PH was concerned that [XX] had recently embarked on a major process of restructuring and therefore would not be in a position to absorb further change. Finally, the options of merger with [XX] and [XX] were considered by the board to remain hypothetical since neither organization expressed an interest to merge with PH.

Department of Health guidance on NHS foundation trust special administration

58. Monitor has produced guidance for Trust Special Administrators appointed to NHS foundation trusts.³⁷ However, in guidance provided to creditors and suppliers of foundation trusts³⁸ the Department of Health states that the circumstances which could result in an NHS foundation trust being put into special administration include where:
 - the trust faces financial challenges which are too severe to turn around by providing short-term financial support, which would lead to lower-quality services and therefore represent poor value for money for the taxpayer (in these cases the Department of Health would not provide additional support outside the special administration process);
 - the trust is either unsustainable in its current configuration or at serious risk of failing to deliver sustainable services; or
 - the trust is, or is likely to become, unable to pay its debts. Monitor is required to consult the relevant foundation trust, the Secretary of State, CQC, NHS England and the relevant commissioners before it can enact the failure regime and appoint an administrator.
59. The purpose of the special administration process is to ensure the continued delivery of patient services in accordance with the commissioner's specifications. The possible outcomes for a trust which is placed into administration include:
 - merging with or being acquired by another trust;
 - reconfiguration of services and exit from administration;
 - development of a sustainable business plan and exit from administration; and
 - dissolution if it is considered that the trust is not sustainable. In this instance, Monitor will be required to make an order which must provide for the transfer of all of the trust's liabilities to another trust or to the Secretary of State.

Case studies of struggling hospitals

60. In order to assess the likelihood of PH's exit from provision of acute healthcare services, we considered how likely it was to be put into special administration (as a necessary preliminary step to exiting the market). We considered the examples of two NHS foundation trusts and one NHS trust which have experienced significant

³⁶ [XX]

³⁷ Monitor, [Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts](#) (5 April 2013). See Appendix C of this report for further details.

³⁸ Department of Health letter to creditors and suppliers of NHS trusts and Foundation Trusts, dated 28 February 2013.

clinical and financial difficulties. We were aware of two trusts that were put into special administration, Mid Staffordshire NHS Foundation Trust (MSFT) and South London Healthcare NHS Trust (SLHT), and Monitor referred us to Peterborough and Stamford Hospitals NHS Foundation Trust (PSFT), to which Monitor had appointed a contingency planning team. PSFT, despite its significant debts and having an FRR rating of 1 for several quarters, received significant NHS funding and, to date, has not been placed in administration. However, the contingency planning team found that PSFT was financially unsustainable in its current form. Monitor told us that: ‘the Contingency Planning Team will shortly make an independent recommendation on the future configuration of services currently supplied by PSFT to ensure that they are delivered on a sustainable basis for the benefit of the local population.’

Mid Staffordshire NHS Foundation Trust

61. MSFT was found by Monitor to be in significant breach of its terms of authorization in March 2009 as a result of poor governance and a failure to meet its general duty to exercise its functions effectively, efficiently and economically. In addition, a 2009 review was conducted by the then Healthcare Commission into reported high levels of patient mortality and poor standards of care. MSFT received significant external financial support from the Department of Health in order to pay its debts as they fell due: £21 million was received during 2011/12 and a further £21 million was provided for 2012/13.
62. When it became apparent that MSFT could not find a way to sustain both financial balance and high-quality clinical services, Monitor appointed a Contingency Planning Team to MSFT to investigate how services could be delivered on a sustainable basis. The team reported to Monitor in January 2013 its conclusion that the trust in its current form was neither financially nor clinically sustainable in the long term. The team recommended that Monitor should consider using its power to appoint a TSA.
63. In its report to Parliament setting out the reasons for appointing a special administrator in the case of MSFT, Monitor stated that:

The Trust’s historical clinical failings are widely recognised and the impact of these failures, as well as the financial consequences of rectifying the clinical performance, has resulted in an organisation which is unable to achieve financial balance and which will require significant additional funding from the Department of Health in order to continue to operate. The Trust, working with its commissioners within the local health economy, has not been able to bring about a sustainable financial position. There is no demonstrable track record of delivering radical change to date in the local health economy. Furthermore there is no strategic plan in place to address these significant challenges into the future. There is broad acceptance across the health economy locally, as well as within the wider community of stakeholders including the Department of Health and the NHS Commissioning Board, that there is an urgent need to address the position. The scope of the TSAs, the ability to work across conventional or established stakeholder and organisational boundaries, and the timeframe in which the TSAs are required to develop a solution, means that it is the best mechanism to bring about the required level of change. The initial findings of the CPT suggest that services will have to be restructured in order to provide a

clinically robust solution for patients. Previous solutions have stalled due to the lack of a single decision maker.³⁹

64. MSFT is a 344-bed trust employing around 3,000 staff. There were deficits of £19.9 million in 2011/12, and £13.9 million in 2010/11, and a further underlying deficit of £18.8 million was forecast for 2012/13. These financial difficulties were driven by the decline in its operational and clinical performance. Additionally, MSFT's estates costs of 6 per cent of income was significantly less efficient than the national average for foundation trusts of approximately 1 per cent.
65. In addition to the clinical problems at MSFT, it was considered that the continued delivery of deficits with no plan for resolution was unsustainable and meant that vital resources would be diverted away from other parts of the NHS to maintain safe and high-quality services at the trust.⁴⁰
66. Following the recommendation of the CPT that the trust was neither clinically nor financially sustainable in its current form, the trust was put into special administration on 16 April 2013.
67. On 19 June 2013, Monitor gave the TSA an additional 30 working days to come up with a solution for making health services currently provided by MSFT clinically and financially viable.
68. The TSA published its draft recommendations for the future of MSFT on 31 July 2013. The TSA recommended that paediatric inpatient and major emergency surgery no longer be provided at MSFT and that no babies should be born at MSFT. The TSA also recommended that MSFT as an organization be dissolved to allow for the TSA's draft recommendations to work in a way that does not negatively impact the safety at other hospitals or their financial position. The TSA recommended that the services at Stafford and Cannock Chase hospitals be managed and delivered by other organizations in the future.⁴¹ The formal consultation process in respect of these draft recommendations commenced on 6 August 2013 and closed on 1 October 2013. Both Stafford Council and local campaigners have stated that they are prepared to take legal action if the draft recommendations are implemented.

Peterborough and Stamford Hospitals NHS Foundation Trust

69. In October 2011 PSFT was found by Monitor to be in significant breach of three terms of its authorization: its general duty to exercise its functions efficiently, economically and effectively; its governance duty; and its duty to remain financially viable.
70. PSFT, the commissioners and Monitor attempted to improve its performance, but in February 2013 Monitor appointed a CPT to work with the trust to review the clinical and financial problems, and to develop a plan to address these issues. In April 2013 PSFT gave formal legally binding undertakings that it would take steps to put right potential breaches.
71. The CPT reported on 7 June 2013 that PSFT was financially unsustainable in its current form. The trust had built up a deficit of £37 million by the end of 2012/13, and needed one-off support from the Department of Health of £44.1 million. The trust's

³⁹ [Mid Staffordshire NHS Foundation Trust: The Case for Appointing a Trust Special Administrator](#), paragraphs 73–76.

⁴⁰ *ibid*, paragraph 33.

⁴¹ <http://tsa-msft.org.uk/wp-content/uploads/2013/07/Consultation-document.pdf>, p42.

forecasts for the next five years showed a continuing deficit of £38 million or more each year, and a cash shortfall of at least £40 million a year.⁴²

72. Other findings of the report were:

- (a) The estate issues contributed an estimated £22 million to the deficit and included the under-utilization of Peterborough City Hospital.
- (b) Peterborough City Hospital was provided under a PFI agreement that was costing £40 million a year and had 31 years left to run. With inflation, the PFI was likely to represent a greater proportion of trust costs in future years. However, ending the arrangement would trigger a very substantial one-off payment.
- (c) In addition to the estates issue, the CPT identified that the deficit was partially caused by operational issues (such as £5 million of unpaid medical activity and £10 million of performance improvements which could be made) which were then factored into the trust's forward plan.

73. The CPT recommended that PSFT implement a recovery plan, which would take five years to fully implement, involving:

- undertaking a comprehensive programme of cost efficiencies to help the trust cut £10 million off the annual deficit;
- inviting bids from other providers to make better use of the underutilized estate, develop new services and generate extra income;
- facilitating joined-up working across the local health economy through a regional steering group to align the activities of commissioners and providers; and
- seeking government financial support to fund the residual deficit.

74. On 12 September 2013 Monitor announced that it had accepted this analysis as well as the CPT's recommendation that the trust itself should lead the implementation of this plan over the next few years. Monitor has secured a formal agreement from PSFT to implement the recovery plan. The trust is not in special administration, although if the trust fails to deliver on its commitments, Monitor retains the power to appoint a TSA.

South London Healthcare NHS Trust

75. SLHT was established as a merger of three NHS trusts: Bromley Hospitals, Queen Elizabeth Hospital and Queen Mary's Sidcup. The merger was seen as a solution to achieve cost and operational synergies among three trusts facing their own significant, individual challenges.⁴³
76. An explanatory memorandum was prepared by the Department of Health in order to make provisions for the appointment of a TSA to take effect on 16 July 2012.⁴⁴ The memorandum sets out that the trust had a long-standing history of underperformance. In the three years since its formation, SLHT generated a total deficit of £154 million. In the financial year 2011/12 it reported a deficit of £65 million, making it

⁴² www.monitor.gov.uk/home/news-events-publications/latest-press-releases/independent-report-finds-peterborough-and-stamfo.

⁴³ Explanatory memorandum to the South London Healthcare NHS Trust (appointment of Trust Special Administrator) order .

⁴⁴ ibid.

the most financially challenged trust in the NHS. The trust was also projecting further total accumulated deficits of £196 million in the years between 2012/13 and 2016/17. One of the major pressures on SLHT's financial position was the £89 million annual cost of servicing the debt of its five PFIs.

77. SLHT received additional public dividend capital of £182.9 million in the three years to 2011/12. This enabled the trust to have a closing cash balance of £6.5 million in 2011/12. Without this additional financial support, the trust would have been insolvent.
78. In addition, there were a number of areas of inefficiency in SLHT's estate management which included (a) a lack of consolidation of clinical services across sites, (b) a lack of centralization of back-office function such as medical records, and (c) an excess of freehold space held by SLHT.⁴⁵
79. SLHT was also failing to meet key clinical standards, meeting only 16 of the 23 key standards in the Department of Health National Performance Framework. As regards the referral to treatment time, it was the only trust in London that failed to meet both the 90 per cent and 95 per cent standard for admitted and non-admitted waits throughout 2011/12. SLHT had a historical record of poor A&E performance and was consistently ranked in the bottom 10 per cent of NHS trusts for A&E wait times nationally. In 2010/11, SLHT was found by the CQC to be non-compliant with essential standards of quality and safety in eight areas. In 2011/12, further CQC visits were made to all three of the trust's main sites, which resulted in confirmation that all essential standards were being met at two of the trust's hospitals, with all but one met at Queen Mary's Sidcup.
80. The TSA published draft recommendations on 29 October 2012 and consulted locally on them from 2 November to 13 December 2012. On 8 January 2013 the final report of the TSA was published and on 31 January 2013 the Secretary of State for Health announced that he accepted the broad recommendations of the report which were:
 - SLHT will be dissolved by October 2013, with each of its hospitals taken over by a neighbouring hospital trust;
 - the three hospitals within will be required to make the full £74.9 million of efficiencies identified by the TSA;
 - all vacant or poorly utilized premises will be vacated, and sold where possible; and
 - the Department of Health will pay for the excess costs of the PFI buildings at the Queen Elizabeth and Princess Royal Hospitals and write off the accumulated debt of SLHT.
81. On the basis of advice from the Medical Director of the NHS, the Secretary of State made some changes to the reconfiguration of services across the trust's sites and those of other local providers (King's College Hospital NHS Foundation Trust, Guy's and St Thomas' NHS Foundation Trust and University Hospital Lewisham NHS Trust).
82. In July 2013 the High Court ruled that the Secretary of State for Health had breached provisions of the National Health Services Act 2006 and acted outside his powers

⁴⁵ [ibid](#), p16.

when he announced casualty and maternity units at Lewisham Hospital would be downgraded. The challenge was brought by Save Lewisham Hospital and the London Borough of Lewisham. The Department of Health has announced that it will appeal the High Court's decision and press ahead with other changes in relation to SLHT.

CCP approach to counterfactual analysis

83. In our assessment of whether or not PH would be likely to exit from provision of acute healthcare services, we considered the CCP's approach to assessing the failure of NHS hospitals as part of its assessment of mergers.
84. The CCP's published guidance on mergers⁴⁶ states that the CCP begins its analysis of a merger by establishing a counterfactual.⁴⁷ Where a merger involves an organization which, absent the merger, would have become subject to the relevant failure regime, it would be appropriate to measure the effect of the merger on quality against the situation that would occur if the failure regime was triggered. If a merger involves an organization which, absent the merger, would have exited the market, then this would be the relevant counterfactual. In this context, the CCP will consider whether the service provider is genuinely facing failure, and whether all options, including reorganization, have been considered and rejected; and whether the implementation of the failure regime would have a lower adverse impact on patients and/or taxpayers than the merger.⁴⁸
85. We also considered the CCP's approach in mergers where the parties had contended that one of them was in financial difficulties, bearing in mind that the way the CCP assesses mergers is not identical to ours.
86. We noted that when the parties had contended that the pre-merger situation of one of them was unsustainable (usually in the context that the merger was considered necessary in order to achieve NHS Foundation Trust status), the CCP tended to use as the counterfactual a situation in which the relevant service provider:

would either merge with another organisation in a transaction that would not give rise to a material adverse effect on patient choice and competition (or any competition concerns that were raised by the transaction would be successfully remedied) or another solution would be found. In other words, in the counterfactual scenario each of the merger parties would continue to operate independently of one another.⁴⁹

⁴⁶ CCP, Merger Guidelines, 25 October 2010. Available at: www.ccpanel.org.uk/referrals-to-ccp/mergers.html.

⁴⁷ *ibid*, paragraph 6.41.

⁴⁸ *ibid*, paragraphs 6.88–6.93.

⁴⁹ See, for example, the CCP's decision in the Merger of Trafford Healthcare NHS Trust with Central Manchester University Hospitals NHS Foundation Trust (2012) and the CCP's decision in the Merger of Scarborough and North East Yorkshire Healthcare NHS Trust with York Teaching Hospital NHS Foundation Trust (2012).

Market definition

1. This appendix sets out supporting information for our product and geographic market definition analysis.

Product market definition

Supply-side factors within a specialty

2. This section sets out the views provided by the parties and third parties regarding factors influencing supply-side substitution within a specialty and our assessment of evidence concerning the range of treatments provided by acute hospitals and the costs of expansion within specialties.
3. The parties stated that consultants typically had the expertise required to provide a range of routine services within each given specialty and that 'given that consultants are required to maintain a minimum level of training and expertise across their whole specialty, their ability to substitute between treatments is, in broad terms, delineated by that medical specialty'; that 'for many specialties, other inputs into routine NHS services ... are also common across different treatments within the specialty'; and concluded that providers of a particular specialty 'have the capacity to serve the full range of routine treatments within that specialty'.¹
4. We considered the answers submitted by a number of providers in response to the following questions that the OFT asked: 'How easy is it for consultants to switch between providing treatments within their specialty? For example, are consultants expected to be trained to provide all sub-specialties? Do consultants regularly switch between providing sub-specialty treatments?'
5. One private hospital provider's ([%]) response appeared to support the view set out above, stating that:

Switching (into the provision of a new medical treatment within a specialty the hospital already provides) is fast, common and subject to low switching costs. Often, a hospital can switch to a new medical treatment without requiring capital expenditure and using existing equipment and consultants.

It said it:

continuously works with consultants to introduce innovative medical procedures as they become available as a result of developments in medical practice. The extent to which investment is required in order to develop particular procedures within a specialty varies significantly. For instance, it is easiest to provide new treatments within the existing theatre environment, where only minor investment into instrumentation (typically <£10,000) and theatre staff training would be required. That said, even a full scale ITU can be installed and operational inside a year for around £1.2 million.

¹ Joint main party initial submission, paragraphs 188 & 189.

6. Other providers expressed a different opinion:
- Hampshire Hospitals NHS Foundation Trust stated that:

Consultants are becoming increasingly sub-speciality trained, with reduced breadth but increased depth. This is particularly the case in elective care such as orthopaedics, but also in non-elective services such as cardiology. The upshot is that small and medium sized DGHs² are struggling to achieve the scale of activity required to maintain services across clinical sub-specialties.
 - Similarly, Dorset County Hospital told us that:

It is generally difficult for consultants to switch between treatments within their specialty. Increasing specialisation has limited the number of consultants who undertake certain work. For example, orthopaedic surgeons will specialise in shoulders or knee and ankle joints. Many surgeons used to be general surgeons but that is now rare.
 - University Hospital Southampton responded along the same line stating that:

Consultants are not usually able to provide treatments different to what they have been trained to do at subspecialty level. Following Centre designation and centralisation we have super-specialised services so have existing expertise that we would not wish to devalue or destabilise; consultants cannot swap specialism under these arrangements.
7. Salisbury District Hospital submitted that whilst consultants tended to specialise in some specific areas, for instance, shoulder surgery, spinal surgery or hip revisions within the orthopaedics specialty, they were trained to provide general orthopaedic care which meant that they were able to care for patients in outpatients and diagnose conditions and to undertake a core set of routine planned cases. However, it also acknowledged that the consultants' degree of specialisation had substantially increased as a result of changes to training as well as recommendations that 'clinicians should be caring for minimum numbers'.
8. To test the ability of providers to provide a range of treatments within a specialty, we analysed all elective procedures provided by PH, RBCH, Dorset County Hospital, Salisbury District Hospital and University Hospital Southampton in the period April 2010 to December 2012.³ Together these hospitals provided around 4,500 non-elective procedures and almost 6,000 elective procedures. We assessed the extent to which hospitals overlapped in the provision of procedures at a specialty level, focusing on inpatient services as this is where difficulties in relation to supply-side substitution are more likely to be relevant.
9. In order to perform this analysis, we made a number of assumptions to allocate procedures to specialties.
- (a) In principle, every Finished Consultant Episode (FCE) may contain a number of procedures but in SUS data⁴ there is only one specialty assigned for each FCE

² District General Hospitals.

³ This is the period covered by the data of all five trusts considered.

⁴ See Appendix G for further details on the activities covered by SUS.

which usually refers to the dominant (the most relevant) procedure received by the patient⁵ (in practice there is some discretion in how the specialty is assigned and it may reflect the specialty area within which the consultant whose care the patient is under typically practices). In using the SUS data we made the assumption that all procedures within an FCE fell under the same specialty as the dominant procedure.⁶ We acknowledge, however, that in some cases a patient might receive procedures relating to different clinical areas as part of the same FCE. Even so, it seemed likely that the majority of the procedures within an FCE belong to the same specialty, as they are meant to treat the same healthcare problem.

- (b) Some procedures turned up under more than one specialty and therefore could not be uniquely associated to a specialty. For the purposes of the analysis below, we assigned each procedure to a specialty on the basis of the most common specialty under which the procedure is classified.⁷
10. On the basis of these assumptions, while not perfect, we believed that the outcome provided a reasonable representation of the actual distribution of procedures within specialties. We considered that the analysis was capable of providing insights into the set of routine services within each specialty that every hospital tends to provide.
11. Table 1 shows the results of the analysis of procedures overlap at specialty level (for elective services) among the five hospitals listed in paragraph 8 for the period April 2010 to December 2012. In the table we reported the specialties in which we observed some volume of activities for all five hospitals in the considered period.

⁵ The dominant procedure represents the procedure that the [Healthcare Resource Group](http://www.datadictionary.nhs.uk/data_dictionary/data_field_notes/h/hosp/hrg_dominant_grouping_variable-procedure_de.asp) grouping algorithm identified as having the greatest effect upon the resources consumed by a patient (see www.datadictionary.nhs.uk/data_dictionary/data_field_notes/h/hosp/hrg_dominant_grouping_variable-procedure_de.asp).

⁶ We considered the 'treatment specialty' as provided in the SUS data of the hospitals. For the reasons discussed in Section 6 we reallocated general surgery and general medicine episodes according to the methodology discussed with the parties (see Appendix G for details on the methodology and its limitations).

⁷ We excluded the procedures for which we could not identify the most common specialty because a treatment appears to be evenly distributed between two or more specialties.

TABLE 1 Analysis of overlap at procedures (OPCS4) level by specialty—elective inpatient services

Specialty	Count of OCPS-4 procedures	Overlapping procedures across all five hospitals	Overlapping procedures weighted by activities (%)
General surgery	209	48	92
Urology	358	56	72
Breast surgery	89	32	91
Colorectal surgery	254	97	98
Upper gastrointestinal surgery	109	9	54
Vascular surgery	219	10	11
Trauma & orthopaedics	894	305	91
ENT	322	23	22
Ophthalmology	374	36	34
Oral surgery	301	37	70
Maxillo-facial surgery	11	0	0
Neurosurgery	330	8	51
Plastic surgery	327	60	72
Paediatric surgery	134	12	37
Cardiac surgery	267	4	6
Thoracic surgery	93	5	14
A&E	2	1	61
Pain management	57	24	92
Paediatric trauma and orthopaedics	99	12	52
Paediatric gastroenterology	9	1	12
Paediatric endocrinology	5	1	35
Paediatric clinical haematology	4	1	99
Paediatric clinical immunology and allergy service	7	1	9
Paediatric medical oncology	21	1	14
General medicine	209	77	96
Gastroenterology	15	2	75
Endocrinology	8	4	63
Clinical haematology	73	28	92
Hepatology	5	1	35
Rehabilitation service	15	1	5
Cardiology	125	16	74
Paediatric cardiology	33	0	0
Dermatology	109	52	94
Respiratory medicine	40	2	50
Nephrology	5	1	0
Medical oncology	34	21	96
Neurology	19	6	87
Rheumatology	17	7	97
Paediatrics	25	4	85
Gynaecology	378	127	87
Clinical oncology (previously radiotherapy)	33	3	7
Interventional radiology	200	20	61
Total/average	5,838	1,156	74

Source: CC analysis of data provided by PH, RBCH, Dorset County Hospital, Salisbury District Hospital and University Hospital Southampton.

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12. We found that when all five hospitals we considered were active in a specialty, they tended to provide a set of procedures that represented the large majority of the volume of activity provided by the combination of the five hospitals in that specialty (as suggested by the fact that above 50 per cent of the volume of activity in many specialties related to procedures that all five hospitals provided—see final column in Table 1).⁸ On average, the five hospitals overlapped on procedures that represented 74 per cent of the total activities carried by these hospitals in the elective specialties considered (76 per cent in relation to non-elective services).
 13. This suggested that although a level of sub-specialism was present (ie not all hospitals provided all procedures), when a hospital operated in a specialty it tended

⁸ Many of the cases where the percentage was lower than 50 per cent involved specialties with a small number of procedures. The only major exceptions were vascular surgery, cardiac surgery, ophthalmology and ENT, but even in these specialties the overlap procedures tended to be more common than the non-overlap ones.

to provide the most common procedures associated with that specialty. This was consistent with the view that supply-side substitution within specialties is likely to apply at least to a core set of procedures. It also indicated that the same hospitals were, in the main, competing to supply the same core set of routine procedures within each of these specialties.

Limitations to expansion within a specialty

14. The parties submitted⁹ that the scope for supply-side substitution within specialties was more limited in relation to the treatment of some complex and specialist cases (ie some ‘sub-specialties’ within specialties). The parties pointed to the need to undertake a minimum number of procedures per year as a major obstacle to supply-side substitution when complex treatments were involved. The reason was twofold: first, clinician associations recommended that clinicians perform a certain minimum number of procedures annually in order to gain the experience they needed to provide a consistently high quality of care; second, a certain volume of annual procedures was required to achieve the minimum scale that allowed the provider to cover the fixed costs incurred in the provision of the treatment.¹⁰
15. Salisbury District Hospital referred to clinical sustainability, ie the need to perform a minimum number of procedures annually, as a major obstacle to expansion within specialties. Even when economically viable, small-scale entry might not be feasible if consultants were required for clinical reasons to perform a minimum number of procedures every year in order to get the authorization to provide that service. When the catchment population from which hospitals drew their patients was not large enough, entry could then only occur through the replacement of a current provider.
16. The parties also submitted that the availability of spare capacity was a further potential obstacle that might prevent providers from supplying services in relation to those sub-specialties where they were not already active. Also, they told us that switching capacity across sub-specialties might be constrained by consultant time and the availability of appropriately trained staff and equipment, even when beds and theatres could be reapportioned from one clinical specialty to another.¹¹ We note that this is a general issue in increasing output within an existing sub-specialty rather than something that applies only to new sub-specialties.¹²
17. To investigate whether it was more difficult to expand into certain sub-specialties, we asked foundation trusts in the region if they had in the past five years expanded their activities within a given specialty in which they were already active. Dorset County Hospital mentioned three cases related to breast services, acute oncology and haematology care and specified that it started providing a new breast reconstruction service in a relatively short time frame (four to six months). However, it also said that this time frame was highly dependent on the scale of the new service provided (ie the smaller the scale the simpler and quicker was the process that the provider had to go through). University Hospital Southampton mentioned as examples that it had made a step increase in cystic fibrosis and transcatheter aortic valve implantation (TAVIs) as agreed with commissioners. Salisbury District Hospital mentioned examples of expanding the scope of activities in cardiology, and in breast, colorectal and vascular surgery.

⁹ [Joint main party initial submission](#), paragraph 190.

¹⁰ [Joint main party initial submission](#), paragraph 191.

¹¹ [Joint main party initial submission](#), paragraph 243.

¹² See Appendix J for an analysis of capacity at the parties’ sites.

18. In order to assess hospitals' ability and incentive to supply-side substitute across sub-specialties we asked foundation trusts in the region to tell us what costs were involved in entering these sub-specialties where the parties told us that they 'focus on significantly different subspecialty services within a given specialty'.¹³ Table 2 summarizes the responses provided by Dorset County Hospital and [X] in relation to the additional resources and the costs required to expand within specialties that currently only one of the merging trusts provides.¹⁴
19. The parties submitted an estimate of the capital costs that PH would need to incur in order to start providing [X] and [X] services. They estimated costs of approximately £[X] million (£[X] million for four catheter labs, £[X] million for equipment and £[X] million for a new ward) which is considerably higher than the estimates provided by [X] and Dorset County Hospital.
20. Interventional cardiology was viewed by both Dorset County Hospital and [X] as a relatively expensive subspecialty to enter into due to the significant capital costs involved. [X] also estimated high capital expenditure to start providing paediatric services in surgery and ophthalmology. Other subspecialties required lower investments, on average in the order of £500,000 or less.
21. While there were some significant discrepancies, the estimates submitted by [X] and Dorset County Hospital both indicated that expanding into the listed sub-specialties involved non-negligible costs that amounted to, at minimum, some hundreds of thousands of pounds. Also, many sub-specialties entailed capital investment and some of these costs may be sunk (ie costs that cannot be recovered when exiting from the market). Sunk costs of this nature usually make supply-side substitution more difficult as they involve irreversible investments that may undermine the incentive to quickly shift capacity between services (although clearly the extent to which these represent a barrier to expansion depends on their magnitude relative to the income earned from the new service). Finally, providers cannot simply shift capacity from other areas within the specialty but they need to develop dedicated capacity in the form of new equipment, laboratories, additional theatre capacity, etc. This does not rule out that expansion into sub-specialties can be feasible and viable over a longer horizon but it suggested that supply-side substitution is less likely to apply to some sub-specialties (whether this sub-specialism relates to services commissioned by the CCG or by NHS England).
22. In summary, we found that, while there may be some particular procedures/clusters of procedures within specialties that providers cannot easily and quickly start to supply, all acute hospitals tend to provide a core set of routine services in specialties in which they are active and therefore we consider it appropriate to aggregate the supply of these services at specialty level on the basis of supply-side factors. We took into account the limitations of this approach when quantifying overlaps.¹⁵

¹³ We focused on these sub-specialties as, in addition to the market definition assessment, they were also relevant to analysing the overlap between the parties.

¹⁴ [X] generically indicated different types of resources that may be required ('appropriately skilled staff, outpatient clinic facilities, diagnostic expertise and equipment, beds, intensive care support, theatres and relevant equipment for the procedures') but did not provide information separately by sub-specialty, nor did it provide any cost estimates.

¹⁵ See Section 6 and Appendix G.

TABLE 2 Costs to start providing services in sub-specialties where only one of the merging parties is not yet active

Specialty	Sub-specialty	Additional resources required under the assumption that the provider already provide other services within the specialty	Costs estimate to purchase the additional resources (£)	Dorset County Hospital	Costs estimate to purchase the additional resources
Cardiology	Interventional cardiology; angiography, percutaneous coronary intervention (PCI); electrophysiology-ablation; complex devices and stress echos (sub-specialties of cardiology)	Cardiac catheter laboratory, qualified staff (medical, nursing and scientific), equipment and consumables and monitoring.	Capital costs of new build £[£] Variable costs £[£]	Additional cath lab, further staffing ie medical staff, x-ray, nursing.	£2 million
Surgery	ERCP; pancreatic surgery (benign); hepatobiliary surgery; upper gastro-intestinal cancer surgery; bariatric surgery (sub-specialties within upper GI surgery)	ERCP—radiology equipment, screening room & staff, skilled staff including pre- and post-operative support.	ERCP—£[£]	Additional theatre capacity, beds, specialist bariatric equipment. Staffing ie medical staff, nursing, cardiac technicians, dietetics.	£1 million
Surgery	Pelvic floor surgery; Endometriosis surgery (sub-specialties within lower GI surgery)	Ablation equipment and training for staff. NB these are sub-specialties within gynaecology and urology, not general surgery.	Variable costs £[£]	Theatre capacity, staffing, not minor specialist equipment.	<£500k
Surgery	Adrenal surgery (sub-specialty within endocrine surgery)	Competence of staff to perform surgery and care for patients post operatively, Onsite laboratory, Onsite access to consultant endocrinologists (physicians).	Variable costs £[£]	Theatre capacity, staffing, not minor specialist equipment.	<£500k
Surgery	Diagnostic and resectional sarcoma surgery (sub-specialty within sarcoma surgery)	Would need support of cancer network and assurance that required number of procedures are performed to make service acceptable to Royal Colleges and sustainable.	N/A	Theatre capacity, staffing, not minor specialist equipment, histopathology.	<£500k
Surgery	Elective minor and intermediate general paediatric surgery (sub-specialty within paediatric surgery)	Staff competence and experience (surgical, anaesthetic & nursing staff), theatre equipment, onsite children's ward.	Capital costs £[£] Variable costs £[£]	Theatre capacity, staffing, not minor specialist equipment. Dedicated paediatric capacity to increase.	£500k–£1 million

<i>Specialty</i>	<i>Sub-specialty</i>	<i>[§]</i> <i>Additional resources required under the assumption that the provider already provide other services within the specialty</i>	<i>Costs estimate to purchase the additional resources (£)</i>	<i>Dorset County Hospital</i>
Dermatology	Mohs surgery (sub-specialty of dermatology)	Specialised staff, onsite laboratory and technical staff, equipment, theatre suite/laboratory where Mohs surgery can be performed.	Capital costs £[§] Variable costs £[§]	Theatre capacity, staffing, not minor specialist equipment, histopathology. £500k
Ophthalmology	Paediatric ophthalmology (sub-specialty of ophthalmology)	Inpatient and outpatient facilities appropriate for treatment of children, specialist children's nursing staff, competence and experience of medical and optometry staff.	Capital costs £[§] Variable costs £[§]	Theatre capacity, staffing, not minor specialist equipment. Dedicated paediatrics capacity to increase. £500k–£1 million

Source: Dorset County Hospital and [§].

Supply-side factors between specialties

23. We asked the parties and the major NHS acute hospitals¹⁶ in the area to provide estimates of the investments involved in starting supplying services focusing on a number of different specialties¹⁷ in which the parties told us they did not currently overlap. Table 3 summarizes the information we collected.

TABLE 3 Costs/investments to start providing services in specialties where providers are not yet active

Specialty	PH/RBCH	Dorset County Hospital	[☒]
Clinical oncology	[☒]	[☒]	[☒]
Medical oncology	[☒]	[☒]	[☒]
ENT	[☒]	[☒]	[☒]
Neurology	[☒]	[☒]	[☒]
Oral surgery	[☒]	[☒]	[☒]
Maxillo-facial surgery	[☒]*	[☒]	[☒]
Paediatrics	[☒]	[☒]	[☒]
Trauma	[☒]	[☒]	[☒]
Orthopaedics	[☒]	[☒]	[☒]
Ophthalmology	[☒]	[☒]	[☒]
Vascular surgery	[☒]	[☒]	[☒]
Urology	[☒]	[☒]	[☒]
GU Medicine	[☒]	[☒]	[☒]
Obstetrics	[☒]†	[☒]	[☒]
Respiratory medicine	[☒]	[☒]	[☒]

Source: RBCH and PH, Dorset County Hospital and [☒].

*PH told us that maxillo-facial surgery was likely to be at least as expensive as oral surgery and possibly more expensive because this service is more specialised.

†Obstetrics is discussed in more detail in relation to the benefits case.

24. The magnitude of the investment varied from specialty to specialty with clinical oncology consistently viewed by hospitals as the most expensive specialty to enter into. Orthopaedics and paediatrics also appeared to require substantial investments to start providing the associated services.¹⁸
25. We were told that starting the provision of services in new specialties may require investments in, among other things, theatre and ward facilities, medical staff, beds, dedicated equipment, laboratories, etc. We noted that some of these costs appear to be sunk and also that a non-negligible proportion of these costs appear to be not easily divisible (in particular, equipment and development of additional theatre and ward facilities) and thus cannot be scaled to accommodate small-scale expansion. These features make substitution across specialities less likely to occur in the relevant time frame for supply-side substitutability.

¹⁶ We received information from four of the five hospitals we asked.

¹⁷ We focused on these specialties as, in addition to the market definition assessment, they were also relevant to analysing the overlap between the parties.

¹⁸ The figures submitted by the parties only cover the capital expenditure while Dorset County and [☒] figures cover both capital expenditure and also other expenses required to start providing inpatient services in those specialties (eg they also include the cost of recruiting additional consultants and staff). We noted that the estimates submitted by hospitals differed considerably and this might reflect the extent to which individual hospitals already offer complementary services and/or the scale on which entry is envisaged. The parties tended to indicate higher costs than the other foundation trusts, despite the fact that the parties' figures should only cover a portion (ie capital costs) of the total expenditure involved in entering the specialties. However, in relation to [☒] estimates the parties submitted that they are '[☒] unrealistic and substantially underestimate entry costs'.

Outpatient versus inpatient services

26. This section sets out: information provided by the parties regarding supply-side substitutability between inpatient and outpatient activity; and information from the parties and third parties regarding the distinction between stand-alone outpatient services and those outpatient services provided as part of a care pathway.
27. The parties told¹⁹ us that supply-side substitution from inpatient care into outpatient-only activity within the same speciality was likely to be possible because:
- (a) All inpatient providers of a given specialty would also be providers of outpatient activity in that specialty (in order to provide the relevant linked before-and-after outpatient services discussed above). They would therefore already have outpatient clinics in place within a given specialty. This would be true whether or not that provider was active in elective care only, non-elective care only, or both. The parties said that this was also true for each of them, ie they carried out outpatient activity in all the specialties where they had some inpatient activity, whether elective or non-elective.
 - (b) The facilities and other inputs necessary to provide outpatient services were less complex and costly than those required for inpatient activity. This meant that inpatient providers would readily be in a position to expand their outpatient activity within a given specialty. In simple terms, an outpatient service could be provided with access to a medical staff and a suitable clinic facility—inpatient providers could access both of these inputs.
28. According to Dorset County Hospital, while providing outpatient services required additional resources even if a hospital already provided inpatient services, it did not make sense to offer inpatient services without offering outpatient services for the same specialty as any decision to separate the two types of service (ie inpatient and outpatient) ‘would fragment the patient pathway which would bring inefficiencies into the system and a lack of continuity for the patients’.
29. University Hospital Southampton submitted that outpatient services required different kit and equipment for diagnostic testing compared with inpatient services but also that ‘virtually all inpatient services have outpatients’ except minor exceptions such as orthodontics and allergy which were just outpatient services. Salisbury District Hospital indicated that the skill set for people who worked within the outpatient and inpatient areas was ‘different and not interchangeable’ and that ‘dedicated facilities for outpatient treatment and care are required’. However, Salisbury District Hospital did not give any examples of providing inpatient services without also providing outpatient services for a particular specialty.
30. Outpatient activity includes first and follow-up consultant appointments as well as diagnostic procedures and treatments that do not require admission. Table 4 sets out the ten most common outpatient activities (by volume) in the wider Dorset region (measured by Healthcare Resource Groups (HRG)²⁰) and shows that a high proportion of activity (both by volume and value) relates to consultations, rather than diagnostic tests or procedures.

¹⁹ Joint main party initial submission, paragraph 205.

²⁰ HRGs are standard groupings of clinically similar treatments which use comparable levels of healthcare resource.

TABLE 4 Most common outpatient services in wider Dorset region—Apr 2010 to Nov 2012

HRG description	Volume		Value	
	% of total	Cumul total %	% of total	Cumul total %
Non-admitted face-to-face attendance—follow-up	55.8	55.8	39.5	39.5
Non-admitted face-to-face attendance—first attendance	30.5	86.2	43.1	82.6
Vitreous retinal procedures—category 1	1.2	87.4	1.9	84.5
Other procedures for non-trauma	1.0	88.4	1.2	85.7
Phototherapy	1.0	89.4	1.0	86.7
Minor mouth or throat procedures 18 years and under without CC	1.0	90.3	1.3	88.0
Multi-professional non-admitted face-to-face attendance—follow-up	0.8	91.1	0.8	88.7
Minor ear procedures 19 years and over without CC	0.8	91.9	1.1	89.9
Non-admitted non-face-to-face attendance—follow-up	0.6	92.6	0.0	89.9
Skin therapies level 3	0.4	93.0	0.7	90.6

Source: Dorset and West Hampshire CCG activity data.

31. In some cases, outpatient services will form part of an admitted care pathway, for example being assessed in an outpatient clinic before (or after) being admitted to have elective surgery or as a precursor or follow-up to emergency/non-elective treatment.²¹ In some cases patients can receive these services from the same provider, integrated with their inpatient activity. In other cases outpatient services will be offered on a stand-alone basis (ie not associated with an inpatient spell), for instance to patients with long-term conditions such as diabetes which are managed through regular check-ups. We considered whether it was appropriate to distinguish stand-alone outpatient services from those provided as part of a care pathway and the scope for competition in inpatient services.
32. The parties submitted that outpatient services associated with an inpatient pathway could be regarded ‘as part of the relevant inpatient market (since all inpatient providers will tend to provide the relevant associated outpatient facilities)’.²² The parties said that outpatient services not linked to an inpatient spell (outpatient-only services) should instead be considered separately. The Foundation Trust Network said that by ‘treating inpatient and outpatient services as separate markets, there also appears to be an element of double counting, as the two elements are usually part of the same care pathway’.
33. We agreed that outpatient care is often provided as part of a care pathway which also includes inpatient activity, and we took this into account in our analysis of competitive effects. However, we did not consider it appropriate to consider them as being in the same market. We observed that outpatient and inpatient services within the same care pathway were often provided separately; for example, both parties offered initial diagnostic appointments in specialties where they did not provide inpatient services. This may be because patients and/or GPs do not always have accurate foresight of the care pathway, or it may be because some patients prefer to have their first appointment at a particular hospital even if they know they will not be admitted to that hospital. Similarly, we know that CCGs are encouraging some parts of the pathway to be provided outside an acute environment; and there are also ‘step up’ and ‘step down’ services, like physiotherapy and rehabilitation, which can be

²¹ The information provided by a third party hospital (Dorset County Hospital) indicated that the proportion of outpatient appointments associated with an admitted care pathway (ie inpatient treatments) was approximately 20 per cent.

²² Joint main party initial submission, paragraph 202.

done in both settings. As such we considered it appropriate to maintain a distinction between outpatient and inpatient services so that we could analyse competition in outpatient services where the parties did not overlap on an inpatient basis. We also recorded outpatient revenues separately from inpatient revenues to avoid double-counting.

34. The parties told us that there was no national guarantee of choice for inpatient services²³ and patients had the right to choose care only in relation to the first outpatient appointment. We understand on this basis that the parties are suggesting that there is no, or very limited, competition for inpatient services as once a patient has chosen their outpatient provider they are 'locked in' with that provider even for the associated inpatient activity. If this were the case, hospitals would compete just to attract referrals for outpatient services and inpatient services may be seen as add-on services over which no choice is exercised.
35. We considered that what a hospital provides in relation to inpatient elective activity (including the scope and quality of that activity) would influence the choice of hospital for the first outpatient referral for a number of reasons. First, there will be instances where the patients or the GPs have good foresight of the entire care pathway (which includes outpatient and inpatient activity) and they may therefore be expected to consider the quality of both the outpatient and the inpatient services and to give appropriate weight to the quality of the inpatient services based on their relative importance in the care pathway. Second, the quality measures typically collected and considered in the healthcare sector refer to a large extent to indicators that are specific to the quality of inpatient services—in other words, quality of the provision of inpatient services plays a role as signal of the overall quality provided in a hospital (see also Appendix D).²⁴ The choices of patients and GPs are therefore likely to be influenced by the quality of the inpatient services irrespective of whether a patient needs (or anticipates that they need) an inpatient treatment.
36. We also noted that in some cases, patients are referred for the first outpatient appointment to healthcare providers that cannot provide inpatient care. In such circumstances healthcare practitioners would choose to refer to another hospital on the basis of some assessment of the relative quality of the hospitals located in the area.^{25,26} Patients may also be referred back to their GP for a decision over the inpatient provider to be taken. Dorset CCG, for instance, set out a 'Hospital Generated Inter-Specialty Referral Policy (2011–2012)' which provides that consultant-to-consultant referrals should be permitted in a limited and clearly defined number of cases. In the remaining cases patients should be referred back to the GP, who is in charge of determining the next steps.

²³ Joint main party submission, 'The role of Competition in the merger of RBCH and PH FTs'.

²⁴ For example, Dr Foster gathers and publishes information on the length of stay, post-operation mortality, revision rate, infection control, HSMR which are mostly indicators relevant for inpatient services' assessment.

²⁵ Dorset CCG's 'Hospital Generated Inter-Specialty Referral Policy (2011–2012)' says that (paragraph 3.3) 'GPs will review the information from the Consultant and decide whether the condition can be managed within Primary Care or if a referral is required' and clearly states that 'The GP is responsible for ensuring the Patient is fully engaged in the process and for offering choice at point of referral'. Alternatively there may be a consultant-to-consultant referral. When patients are referred for the first appointment to healthcare structures that cannot provide inpatient care, and even if patients have no control over the choice of the inpatient provider, we expect that consultants would take a decision on the basis on some assessment of the relative quality of the hospitals available in the area (as well as the convenience of hospital locations from the patient's perspective).

²⁶ In some cases outpatient-only providers may be staffed with consultants employed by the other hospitals, who may thus be likely to refer to consultants working in the same structure. However, this is not always the case. For example, RBCH mentioned the case of orthodontics, which is an RBCH outpatient-only service that is provided by RBCH consultants. Similarly, PH mentioned restorative dentistry as an instance of specialty which is a PH outpatient-only service that is provided by PH consultants.

Elective versus non-elective services

37. This section sets out evidence from the parties and third party NHS providers which we took into account in assessing the degree of supply-side substitution between elective and non-elective services.²⁷
38. The parties submitted that non-elective services required developing ‘additional capacity and facilities that are not normally required for routine elective care’. These ‘principally include 24/7 rotas of senior clinical decision makers (“the rota”), increased capacity in NCEPOD48 theatres, the emergency department, rapid access diagnostics and in the intensive care unit (“ICU” or “ITU”).’²⁸
39. The parties also submitted²⁹ that they did not have financial incentives to expand their non-elective volumes or substitute into non-elective services. They submitted that, due to the additional facilities and capacity requirements, non-elective care was typically more costly to provide compared with elective care and PbR tariffs only partially reflected the additional costs involved in the provision of emergency services versus elective services. The parties also told us that the existing contracts with the local commissioners provided that non-elective service volume above the 2008/09 level was only paid at 30 per cent of the tariff rate and the parties were already operating close to or above the 2008/09 baseline levels.
40. The parties further argued³⁰ that there were significant limitations on providers’ ability and incentive ‘to switch their resources from non-elective care into elective care’. The parties pointed at ‘long term investments in staff and facilities’ and ‘fluctuations in national tariff rates’ that generated significant uncertainty over the profitability of switching capacity from non-elective to elective services as material obstacles, although they did not specify the nature and size of these investments. The parties also submitted that some services required clinical critical mass to ensure safe care in the provision of both elective and non-elective services, which would seem to suggest that entry into a new service on a small scale would generally not be feasible.
41. We asked third party acute hospitals in the area if they have in the past five years started providing elective services related to non-elective services that they were already providing (within a given specialty), or the opposite. Both Dorset County Hospital and Salisbury District Hospital told us that they had not.
42. We also asked third party acute hospitals if it makes sense to offer non-elective services without offering elective services within the same specialty, and for what kind of specialties this may hold true.
 - (a) Dorset County Hospital replied that it would not make sense as ‘consultants need to provide services on elective basis to maintain skills and competency to provide non-elective services’.
 - (b) Salisbury District Hospital told us that it believed it was not common to see NHS district general hospitals that provided only elective services and hospitals that provided only non-elective services because resources required (such as clinicians, diagnostic and theatre equipment) were the same. However, it also

²⁷ See Section 5 for further details on the difference between elective and non-elective services.

²⁸ [Joint main party initial submission](#), paragraph 194.

²⁹ [Joint main party initial submission](#), paragraphs 197, 254 & 255.

³⁰ [Joint main party initial submission](#), paragraph 199.

stated that a ‘model where you provide an elective service on one site and a non-elective service on another site seems to work as well’.

(c) University Hospital Southampton told us that:

Most services have an elective and non-elective pathway flow; some services such as Cardiac Surgery a[re] more emergency driven but still have an elective service; it is vital for the Trust’s financial stability to have a balanced flow of elective (planned) and non-elective (emergency) activity (circa 50:50) because financially any over-performance of the latter is only paid at marginal rates whereas elective is full PbR tariff; the elective programme supports delivery of the Trust’s educational role as a leading teaching hospital; and specialist services such as Cardiac bring the expertise to the Trust and attract high calibre staff.

43. Dorset County Hospital and Salisbury District Hospital also suggested that there were benefits to providing jointly elective and non-elective services within a given specialty. These benefits ranged from continuity of care and improved consistency of patient care, increased level of efficiency (better planned utilization of staff and other resources) to staff training and development. They indicated that additional staffing and theatre capacity would be required to start offering elective services if one hospital already provided non-elective functions. Providing non-elective services required out-of-hours provision, and as a consequence on-call rotas for staff at all levels, that would not be needed if only elective functions were provided.

Geographic market

44. In this section, we present our view on the geographic aspects of the provision of healthcare services in the area surrounding the merging trusts.
45. The parties submitted³¹ that analysis of existing referral patterns significantly underestimated the size of the relevant geographic market and that the appropriate geographic frame for the assessment of the merger is at least 40 to 60 minutes’ travel time.
46. As location is important to patients/GPs when they choose a hospital, hospitals providing the same services in different locations are not perfect substitutes for one another, and hospitals that are near one another may be expected to exert a stronger competitive constraint than hospitals located further away.

Catchment areas

47. We used a catchment areas analysis to identify the extent of the areas (expressed in terms of travel distance from the hospital) from which a large proportion of patients originate. Catchment areas analysis has been used in several previous inquiries by the OFT and the CC³² and has been used by the CCP in its investigations of hospital mergers. This analysis is commonly used to help understand the geographical coverage of the various providers, and the extent to which the parties overlap with each other and with their competitors.

³¹ Joint main party initial submission, paragraph 222.

³² See *Commentary on retail mergers—a joint report by the OFT and the Competition Commission*, April 2011.

48. Catchment areas are a means to identify the geographic area within which RBCH and PH derive a large percentage of their patients. Their use is pragmatic. As our *Merger Assessment Guidelines* note,³³ a catchment area will typically be narrower than the geographic market identified using the hypothetical monopolist test. We took regard of this when carrying out our competitive assessment and used isochrones based on our catchment area analysis as the starting point for our competitive assessment. As part of the assessment, we also considered the constraints posed on the parties by rivals located further away than implied by the isochrones.

Data and methodology

49. The parties provided us with information on their patient activities for the last three years. The data submitted contained details on the referring GP practice for each episode and the corresponding location (as determined by the postcode of the GP practice), which we have considered as a proxy for the patients' location.
50. Using MapInfo software, we estimated the drive-time between the sites of the merging hospitals and all the GPs' locations from which they drew patients.^{34,35} We then calculated the drive-time that captured 80 per cent of the patients treated by each merging hospitals.³⁶
51. Previous studies on the healthcare sector and the CCP's past merger decisions³⁷ suggest that patients' willingness to travel may vary depending on the type of service and the conditions under which the service is provided (elective versus non-elective versus outpatient). We have therefore considered how the drive-time that defines catchment areas based on an 80 per cent threshold varies depending on the specialty and the conditions of service provision.
52. The results for PH are reported in Table 5.³⁸

³³ Paragraph 5.2.25.

³⁴ We were not able to calculate the drive-time related to approximately 100 GPs' locations as we could not capture the associated postcodes. However, these GP practices overall represent a small proportion of the parties' referrals (less than 1 per cent of the total episodes carried out by the parties in the period January 2010–December 2012) and therefore unlikely to affect the results significantly.

³⁵ For a few GP surgeries we could not calculate meaningful MapInfo drive-time estimates. This in particular occurs for GP practices located offshore. As very few episodes are associated with those GP surgeries (representing less than 0.1% of the total episodes carried by the parties in the last three years) and are therefore unlikely to have any material effect, we excluded them from our analysis.

³⁶ Drive-times will vary based on assumptions on travel speed, which in turn depend on time of day and other factors. We based our drive-times on estimates for off-peak travel (in the day between morning and evening rush hour). However, the exact speed used is less important than the fact that it is consistently applied (ie varying the speed would affect the drive-time that captured 80 per cent of patients, but would not affect the geographical area).

³⁷ See, for example, [Report by the CCP on the merger of Dartford and Gravesham NHS Trust with Medway NHS Foundation Trust](#), 10 October 2012; [Report by the CCP on the merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust](#), 15 December 2011; [Report by the CCP on the merger of the Royal National Throat, Nose and Ear Hospital of the Royal Free Hampstead NHS Trust with University College London Hospitals NHS Foundation Trust](#), 14 March 2012.

³⁸ In relation to three specialties listed in Table 1 (hepatobiliary and pancreatic surgery, ophthalmology and vascular surgery), PH told us that it did not provide them on an elective basis and therefore any drive-times relating to these specialties 'will consequently be spurious'. PH also pointed at some specialties which showed very low activity volumes at its site (adult cystic fibrosis, gynaecological oncology inpatients, nephrology, neonatology and obstetrics, paediatric sub-specialties) and for which therefore the drive-time estimates could be spurious due to small sample size. We note below (paragraph 53) that volumes related to some specialties are very low and these may therefore result in unreliable estimates. However, to define the catchment areas we eventually consider the drive-time across all specialties (paragraph 58). In addition, PH indicated a number of specialties that were either not separate specialties or where there would not be overlap between the parties absent the merger. As to the former set of specialties (which include anaesthetics, clinical immunology and allergy and transient ischaemic attacks), as we note above, we eventually consider the drive-time across all specialties to define the catchment areas, therefore the final drive-time will be independent from the way episodes are classified within specialties. As to the second set of specialties (clinical haematology, hepatology, medical and clinical oncology, pain management), we set out our view in Section 6. For geographic market definition purposes the scope of this analysis is to estimate how far on average PH's patients travel to reach the hospital irrespective of whether a specialty/service is, or is likely to be, an overlap.

TABLE 5 Drive-time within which PH draws 80 per cent of its patients split by specialty and conditions of provision*

Specialty description	Elective	Non-elective	Outpatient	minutes	Total number of episodes
General surgery	19.3	18.3	19.3		42,503
Urology	-	-	15.3		4,418
Breast surgery	22.1	16.5	-		1,418
Colorectal surgery	18.3	17.9	-		8,688
Hepatobiliary & pancreatic surgery	-	0.3	-		2
Upper gastrointestinal surgery	16.5	18.3	-		1,523
Vascular surgery	25.6	18.8	15.9		1,826
Trauma & orthopaedics	26.2	26.2	25.6		96,008
ENT	26.2	26.2	23.0		45,911
Ophthalmology	20.8	-	13.9		8,132
Oral surgery	26.2	35.3	26.2		45,072
Restorative dentistry	-	-	35.2		4,043
Maxillo-facial surgery	21.6	35.2	-		1,151
Neurosurgery	-	-	31.2		250
Cardiothoracic surgery	-	-	19.3		358
Paediatric surgery	22.0	26.2	21.2		3,135
Thoracic surgery	-	18.3	-		1
Accident & emergency	25.9	20.8	18.3		14,419
Anaesthetics	-	-	21.6		823
Pain management	21.2	18.3	22.1		12,265
Paediatric respiratory medicine	-	-	11.8		167
Paediatric medical oncology	-	26.2	22.1		653
Paediatric diabetic medicine	-	-	22.1		1,204
Paediatric cystic fibrosis	-	-	21.2		134
General medicine	18.3	18.3	17.9		79,099
Gastroenterology	19.2	18.3	25.9		6,720
Endocrinology	35.2	19.3	-		557
Clinical haematology	19.3	17.9	18.3		23,833
Hepatology	14.2	13.3	-		287
Diabetic medicine	16.5	19.3	-		489
Clinical genetics	-	-	20.8		915
Rehabilitation service	34.5	43.0	23.5		1,944
Palliative medicine	16.5	14.2	14.2		2,295
Cardiology	15.8	16.5	16.5		30,697
Paediatric cardiology	-	-	26.2		898
Anticoagulant service	-	-	16.5		1,164
Transient ischaemic attack	-	6.5	16.5		1,097
Dermatology	23.0	22.1	21.6		57,054
Respiratory medicine	16.5	16.5	35.2		4,841
Adult cystic fibrosis service	-	62.2	31.3		106
Nephrology	2.5	5.5	-		2
Medical oncology	23.5	23.0	25.6		13,311
Neurology	33.2	26.7	25.6		13,215
Rheumatology	17.3	19.3	17.9		36,600
Paediatrics	20.8	22.1	21.6		49,664
Paediatric neurology	-	17.3	23.0		1,107
Neonatology	23.5	20.9	20.8		2,976
Geriatric medicine	15.9	18.3	15.9		35,217
Obstetrics	20.7	20.7	18.3		58,460
Gynaecology	23.0	20.9	20.8		38,257
Gynaecological oncology	0.3	8.9	35.2		1,140
Clinical oncology (previously radiotherapy)	26.2	26.7	28.2		52,321
All specialties†	22.1	20.7	22.0		808,627

Source: CC elaboration of PH data.

*Our estimate is based on 3 calendar years of data—ie 2010, 2011 and 2012—and we excluded the services provided to private patients.

†The 'All specialties' figure reflects the drive-time that captures 80 per cent of PH's referrals irrespective of the specialties in which patients were treated.

53. The figures in Table 5 suggest that there is a tendency on average to drive slightly further for elective and outpatient services (22 minutes) than for non-elective (21 minutes) and that the difference in the drive-time between the various conditions of service provision was limited and amounted to a few minutes. There are significant variations across some specialties (eg oral surgery, rehabilitation, neurology). However, longer travel times arise when the number of activities is small (and there-

fore a few outliers may severely affect the average) and/or when few hospitals offer the specialty (and hence patients are obliged to travel further, on average, but it does not imply anything different about their willingness to travel).

54. Similarly, we noted variations between specialties within elective, non-elective and outpatient services but, as above, figures that differed significantly from the aggregated figure across all specialties generally corresponded to a very small sample of activities (see final column). The weighted (by activity) average differences between the specialty drive-time and the drive-time across all specialties for PH are indeed limited, namely 3.3 minutes for elective, 2.2 minutes for non-elective and 3.4 minutes for outpatient services.³⁹
55. Table 6 reports the drive-times of patients that were treated at RBCH.^{40,41}

³⁹ These figures were obtained as the average of the difference in absolute value between the specialty drive-time and the drive-time across all specialties (ie the figures reported in the last row of Table 1), weighted by the volume per specialty undertaken by the trust.

⁴⁰ Given that the data available to us did not distinguish between Royal Bournemouth and Christchurch sites, we have used the postcode of Royal Bournemouth to estimate the drive-time as it is the larger site and it is therefore more likely to reflect the destination point of the large majority of RBCH's patients. Nonetheless, we note that the drive-time between Royal Bournemouth and Christchurch amounts to only 6.8 minutes and thus we would not expect major differences in our results if information on the exact sites was available.

⁴¹ Similarly to PH, RBCH submitted that (a) it does not provide on an inpatient basis some of the specialties listed in the table (ENT, obstetrics, medical and clinical oncology, neurology, paediatric surgery, hepatobiliary & pancreatic surgery, trauma & orthopaedics) and the drive-times relating to the following activities 'will consequently be spurious'; (b) a number of specialties are either not separate specialties or where there would be no inpatient overlap between the parties absent the merger (anaesthetics, clinical haematology, clinical immunology and allergy, hepatology, oral surgery, pain management, physiotherapy, occupational therapy, dietetics, orthotics, diagnostic imaging, transient ischaemic attacks); and (c) some specialties have very low activity volumes at RBCH (A&E, interventional radiology, genitourinary medicine, nephrology, orthodontics, thoracic surgery) and therefore the drive-time estimates for these services could be spurious due to small sample size. See footnote 38, for further information as to how we considered these points.

TABLE 6 Drive-time within which RBCH draws 80 per cent of its patients split by specialty and conditions of provision*

Specialty description	Elective	Non-elective	Outpatient	minutes	Total number of episodes
General surgery	16.6	17.1	17.5		18,028
Urology	20.2	20.2	17.9		66,250
Breast surgery	16.6	14.7	15.5		20,846
Colorectal surgery	14.7	16.6	15.6		25,145
Hepatobiliary & pancreatic surgery	7.1	-	26.8		907
Upper gastrointestinal surgery	20.1	17.1	20.6		15,303
Vascular surgery	20.5	20.5	17.9		12,128
Trauma & orthopaedics	20.5	20.5	20.5		129,173
ENT	46.0	241.0	15.6		14,638
Ophthalmology	20.5	23.0	20.2		155,306
Oral surgery	14.8	-	16.6		11,790
Orthodontics	-	14.2	20.5		32,021
Cardiothoracic surgery	-	-	14.8		397
Paediatric surgery	14.7	18.4	-		61
Thoracic surgery	-	7.8	-		1
Accident & emergency	11.0	17.0	14.2		64,448
Anaesthetics	-	-	20.3		10,207
Pain management	17.0	14.7	17.1		6,502
General medicine	15.2	15.6	14.8		66,798
Gastroenterology	14.7	16.6	14.7		28,697
Endocrinology	17.0	15.2	17.5		8,852
Clinical haematology	15.6	16.6	15.2		46,576
Hepatology	16.6	12.2	14.0		9,836
Diabetic medicine	17.0	14.8	16.6		27,493
Clinical genetics	-	-	13.1		390
Clinical immunology and allergy service	-	-	16.7		144
Rehabilitation service	13.0	23.0	12.3		30,975
Palliative medicine	14.7	14.7	14.7		12,446
Clinical immunology	-	-	20.3		182
Allergy service	-	-	37.8		2,056
Cardiology	20.6	17.5	19.7		77,539
Transient ischaemic attack	-	20.5	15.6		1,957
Dermatology	17.0	20.5	17.0		62,221
Respiratory medicine	17.0	15.6	14.8		41,323
Programmed pulmonary rehabilitation	-	-	14.7		1,345
Genitourinary medicine	15.5	13.5	-		10
Nephrology	-	26.2	-		5
Medical oncology	14.8	15.2	16.6		27,129
Neurology	8.5	19.7	17.1		4,165
Rheumatology	17.0	17.1	15.6		40,579
Paediatrics	-	-	13.0		2,803
Well babies	9.4	11.2	-		2,001
Geriatric medicine	15.6	15.6	14.7		27,945
Obstetrics	41.3	11.0	11.0		11,318
Gynaecology	14.7	13.8	14.7		43,290
Midwifery service	-	11.2	11.0		19,285
Physiotherapy	-	-	13.1		145,424
Occupational therapy	-	-	16.7		20,339
Podiatry	15.4	-	-		499
Dietetics	-	-	20.3		8,513
Orthoptics	-	-	17.9		22,257
Orthotics	-	-	16.6		8,054
Clinical oncology (previously radiotherapy)	16.6	16.8	13.5		259
Interventional radiology	17.9	17.5	26.8		375
All specialties†	17.5	17.0	17.0		1,386,713

Source: CC elaboration of RBCH data.

*Our estimate is based on 3 calendar years of data—ie 2010, 2011 and 2012—and we excluded the services provided to private patients.

†The 'All specialties' figure reflects the drive-time that captures 80 per cent of RBCH's referrals irrespective of the specialties in which patients were treated.

56. The outcome for RBCH is broadly consistent with that of PH. Variations in drive-time between elective, non-elective and outpatient are present but they tend to be limited. Likewise, differences in drive-time between specialties are of small magnitude and appear to be driven by a few 'outlier' observations. The weighted average difference

in absolute value between the drive-time at specialty level and the drive-time across all specialties for RBCH amounted to 2.7 minutes for elective, 1.0 minutes for non-elective and 2.5 minutes for outpatient.⁴²

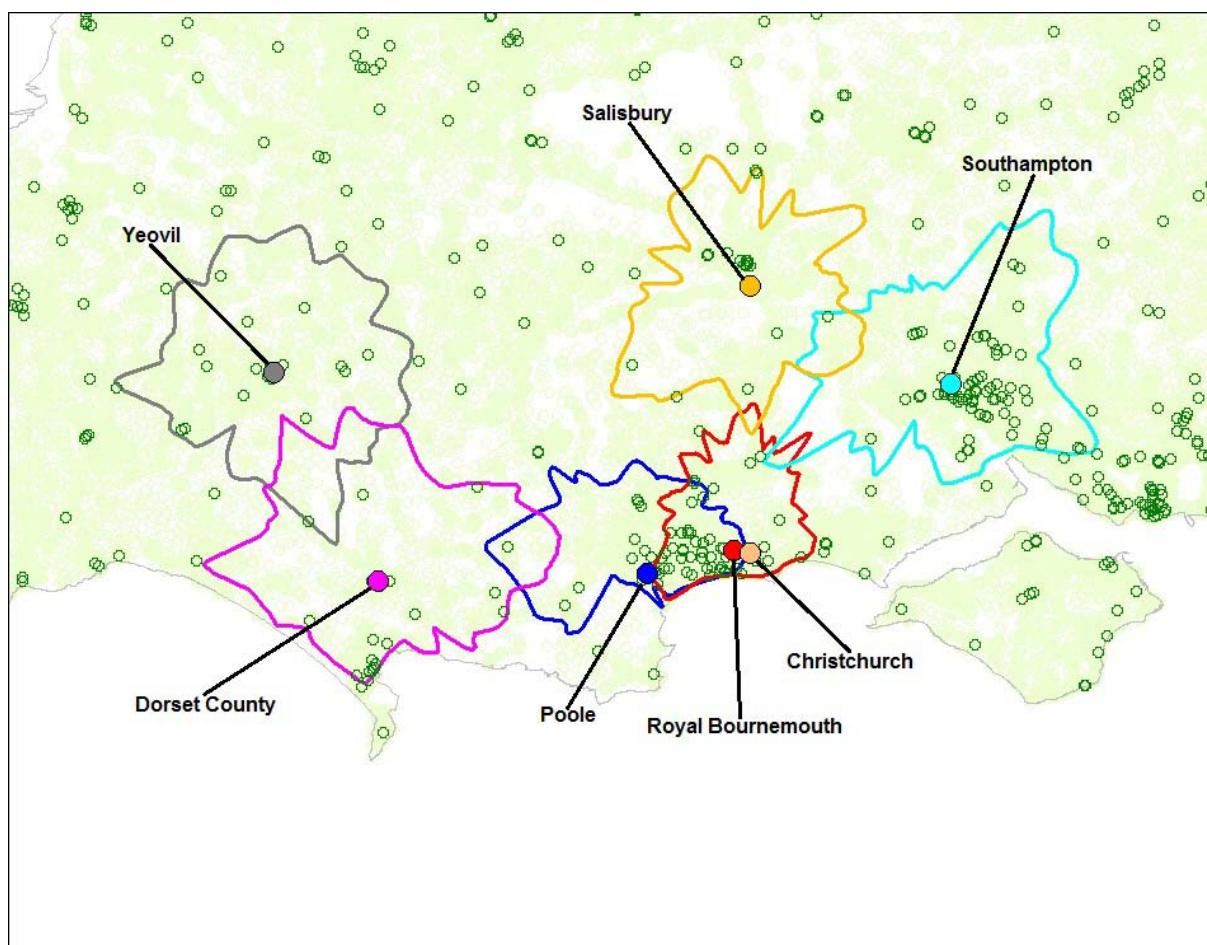
57. On average, PH's patients travelled slightly further than RBCH's. The drive-time across all specialties to PH is 4.5 minutes, 3.7 minutes and 5.0 minutes respectively for elective, non-elective and outpatient services, longer than the drive-time to RBCH.
58. While we acknowledged that there were differences in the drive-time between specialties and conditions of provision, the drive-time across all specialties per hospital (22 minutes for PH and 17 minutes for RBCH) appeared to be sufficiently representative of the typical drive-time of the merging trusts' patients, and we therefore used these to draw the isochrones⁴³ around each party's main site.
59. Figure 1 shows the areas within an isochrone of 22 minutes around PH and of 17 minutes around RBCH. Although we were primarily interested in the behaviour of patients within the catchment areas of the parties, we also illustrated catchment areas of rival acute general hospitals using an isochrone equal to the higher of the parties (22 minutes; though we note that using the lower figure would not affect our conclusions).

⁴² See footnote to paragraph 54.

⁴³ Each isochrone shows all the points that can be reached within a certain drive-time, starting from the central point.

FIGURE 1

Catchment areas based on 80 per cent threshold

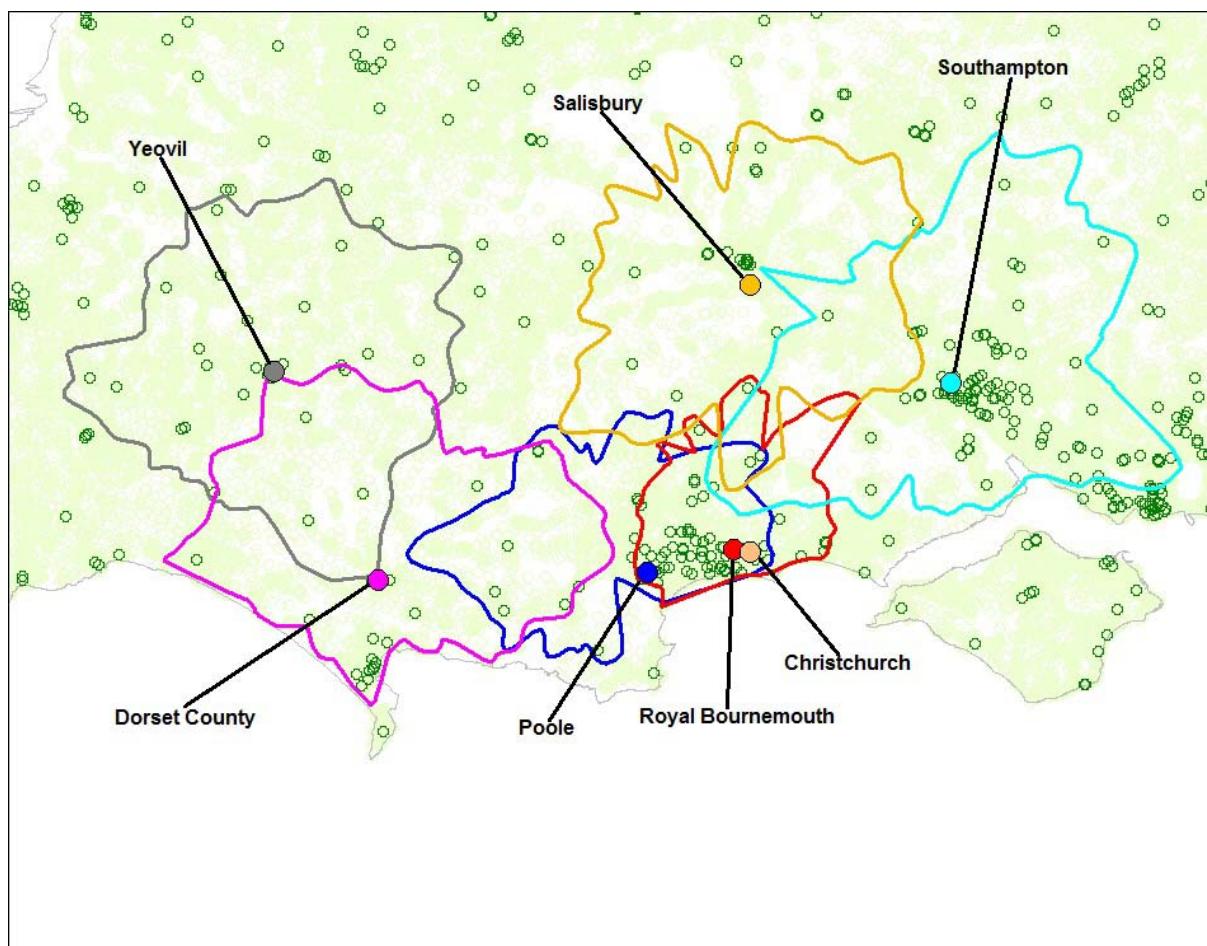


Source: CC elaboration of RBCH and PH data.

60. The overlap in the parties' catchment areas covers 41 GP practice areas. We note that, based on the assumption that the other NHS acute foundation trusts have a broadly similar geographical reach to the parties, these GP practices do not lie within the catchment areas of any other hospitals.
61. To check the sensitivity of our results, we flexed the catchment area threshold to include in the geographic area a larger proportion of patients (90 per cent) treated by the parties' hospitals. Increasing the threshold leads to isochrones of 28 minutes for PH and 21 minutes for RBCH. We again used the larger threshold for rival hospitals. The outcome is shown in Figure 2.

FIGURE 2

Catchment areas based on 90 per cent threshold



Source: CC elaboration of RBCH and PH data.

62. Enlarging the isochrones increased the number of GP practices in the region in which the parties overlap (59), but all except three of these still do not lie within the catchment areas of any other hospitals.
63. To check that these catchment areas reflected areas where providers seemed to have strong competitive activity, we also looked at the parties' share of referrals at GP practice level. Whilst we were aware that past referral flows do not necessarily reflect the actual patients' willingness to travel,⁴⁴ referral patterns can provide useful indications on the degree of substitutability between hospitals and therefore on the incentives that a hypothetical monopolist controlling both merging trusts would have to impose a small but significant reduction in quality. Referral patterns are informative of patients' actual choices which in turn reflect, at least to some extent, patients' preference for hospitals (*revealed preferences*). A high share in a given GP practice can then suggest that local patients (or the GP offering guidance) have a strong preference for the hospital and therefore are less likely to switch away in response to a quality variation. By contrast, a more even distribution of hospital shares at a practice would indicate that patients consider other hospitals as credible substitutes

⁴⁴ This is particularly the case in the absence of significant differences in the quality of services provided by hospitals. When quality across hospitals is similar, patients are likely to travel to the nearest hospital and therefore past patient flows may not be informative as to how patients trade off quality and distance. See Appendix K for further discussion on this point.

and that the geographic market should be enlarged accordingly. We also noted that RBCH uses referral patterns to analyse competition in this manner (for example in its 2013/14 annual plan to Monitor).

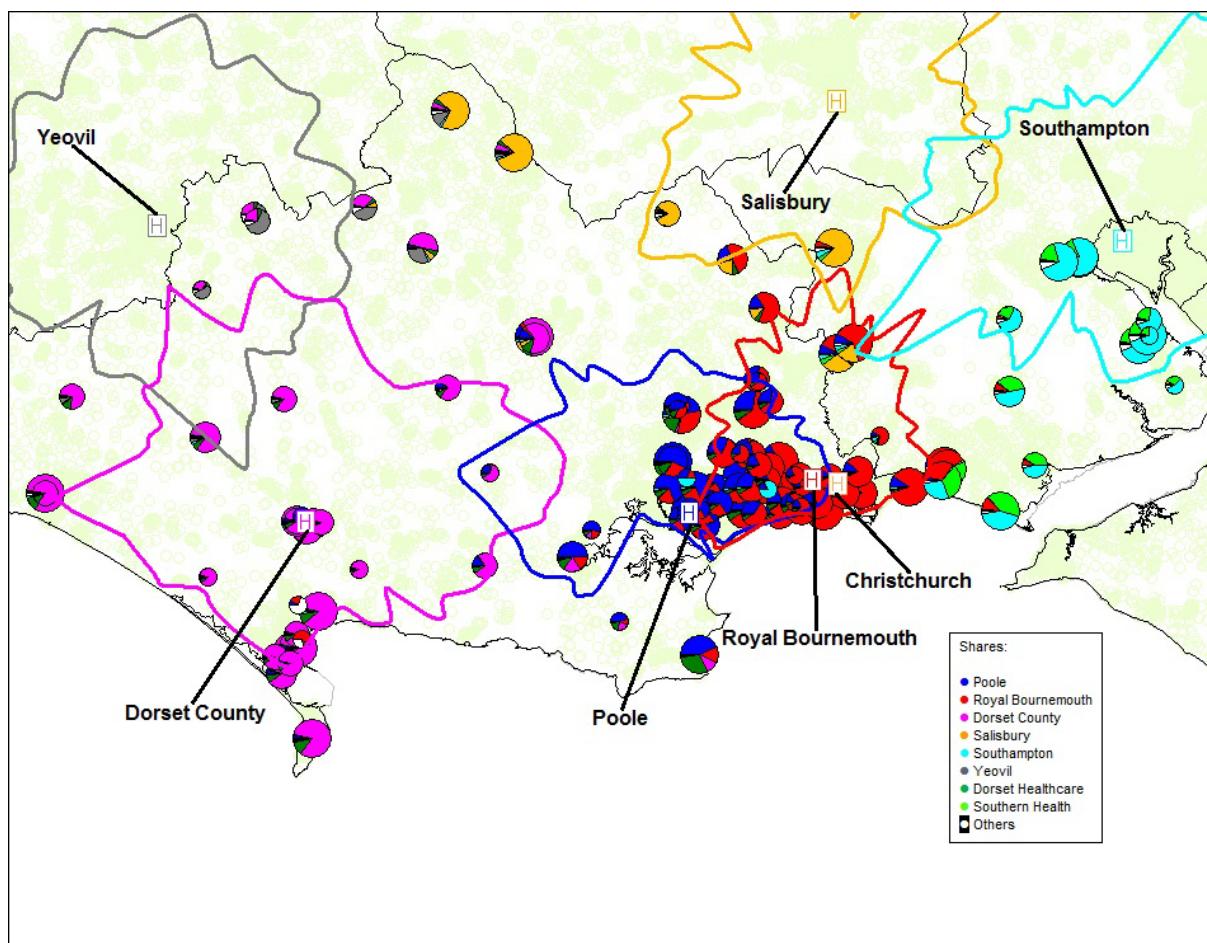
64. Our analysis is based on the referral data provided by Dorset and West Hampshire CCGs which overall cover 132 GP surgeries in the wider Dorset area. Considering all types of service (ie elective, non-elective and outpatient), we estimated each hospital's share of the total episodes for patients in each GP practice in the period April 2010–November 2012.
65. In Figure 3 below each circle represents a GP practice. The dot sizes are proportional to the total number of episodes related to patients from that GP practice. The pie chart within each circle shows the share of the major providers, by volume of treatments.^{45,46} The circles vary in size according to the number of treatments of patients from each practice, so larger practices are represented by larger circles. Figure 3 depicts the acute hospitals' share of referrals from GP practices in the area together with the acute hospitals' catchment areas (based on 80 per cent threshold) as previously identified (see above). Figure 4 shows shares of elective episodes only and does not differ significantly from Figure 3. We found that shares of non-elective and outpatient episodes (not shown here) are also similar.

⁴⁵ It is not straightforward to depict meaningful shares of overall activity since not all activity is carried out by all providers, and we wanted to restrict analysis to activity where there is more than one supplier. In the two figures below, we omitted all specialties where one provider was responsible for more than 95 per cent of activity. The only large specialty omitted as a result is nephrology, which has a high volume of outpatient activity but is only provided by Dorset County.

⁴⁶ Historically, Dorset PCT and Poole & Bournemouth PCT were responsible for the provision of a small proportion of activity. We understand that this activity is now carried out by DHUFT and have attributed that activity accordingly. Similarly, Hampshire PCT's former activity is now provided by, and attributed to, Southern Health NHS Foundation Trust.

FIGURE 3

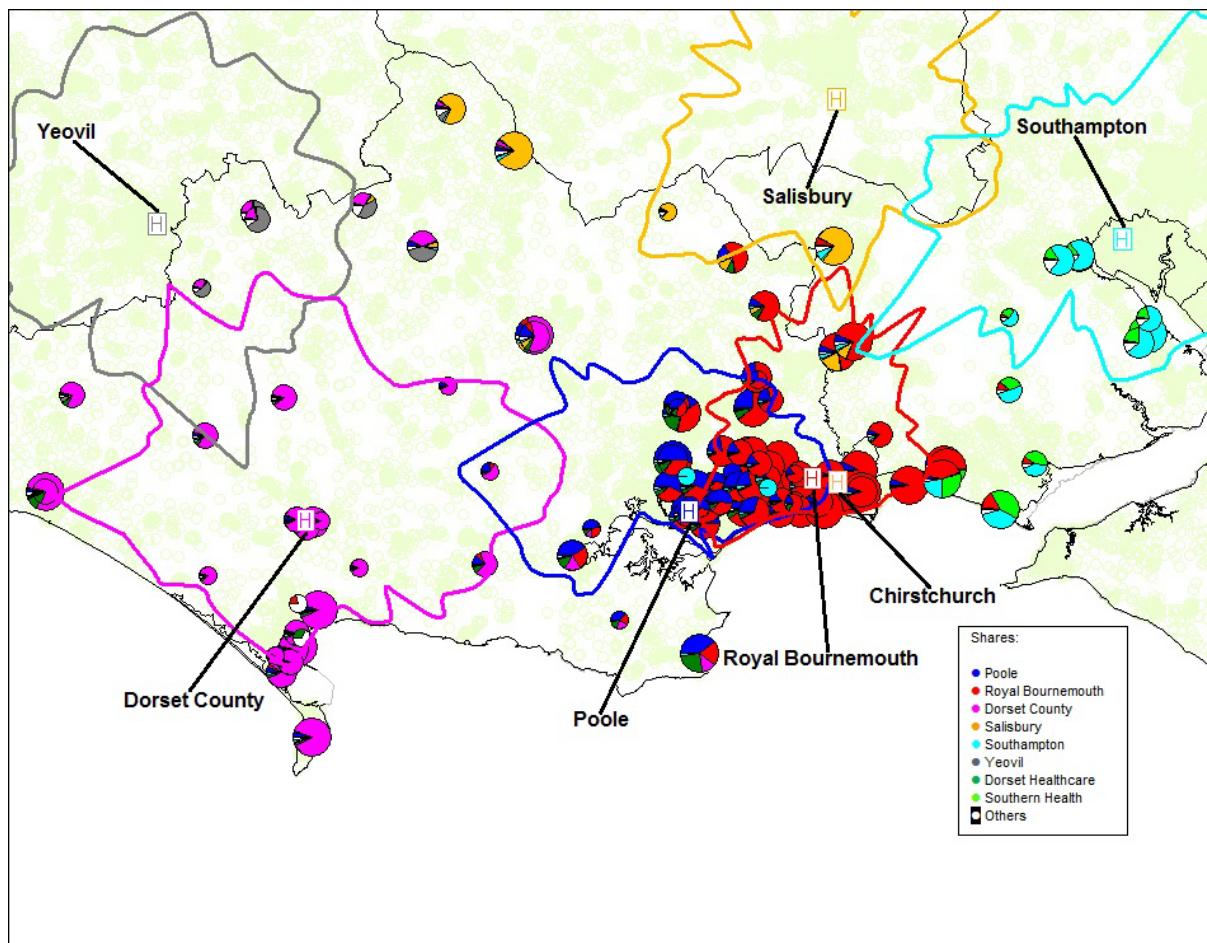
Hospitals' share of GP practice referrals and catchment areas—all services



Source: CC elaboration of RBCH and PH data. Dorset CCG and West Hampshire CCG data.

FIGURE 4

Hospitals' share of GP practice referrals and catchment areas—elective services



Source: CC elaboration of RBCH and PH data. Dorset CCG and West Hampshire CCG data.

66. Figures 3 and 4 illustrate that patients' choices of hospital are broadly consistent with the catchment areas we have used in Figure 1. Within PH's catchment area, PH tends to have a large share of patients; with RBCH's catchment area, RBCH tends to have a large share of patients; and for practices in the overlap area, both parties tend to have a large share of patients, whilst other hospitals have a very small share. The geographical area over which the parties attract a significant share of patients is broadly similar to the catchment areas we defined. With rare exceptions, hospitals do not attract significant shares of patients outside these catchment areas.⁴⁷ A few GP practices fall outside the catchment areas of any acute hospital, and patients at these practices appear to use a range of different hospitals.
67. Within its catchment area PH's average share of referrals at a GP practice (weighted by volume) was around 40 per cent, while outside its catchment area the average share is substantially lower, around 6 per cent. Similarly, RBCH's average share within its catchment area (60 per cent) is significantly higher than the share related to GP surgeries outside its catchment area (9 per cent).

⁴⁷ The most obvious exceptions are two GP practices close to RBCH and PH, respectively, where University Hospital Southampton attracts the majority of patients. Each of these practices made a very small number of referrals.

68. When combined, the parties' share is on average 84 per cent for those GP practices that lie within either PH's or RBCH's catchment area and drops to 10 per cent for the GP practices outside the parties' catchment areas. This suggests that patients travelling to hospitals other than RBCH or PH represented only approximately 16 per cent of the overall patients coming from GP practices within either of the parties' catchment area.
69. These figures include also services that are provided by only a hospital or a subset of hospitals in the region and they may therefore result in understating or overstating patients' actual preference for a given hospital. To address this problem we estimated the hospitals' share at GP practice level focusing on the treatments that are provided by all five major acute hospitals in the wider Dorset region.^{48,49} If we restrict our analysis to treatments over which patients could actually exercise a choice between all five, it appears that the proportion of patients travelling to hospitals other than RBCH or PH is less than 7 per cent of the overall referrals coming from GP practices within either of the parties' catchment area. This further supports the view that in the areas where the parties draw the large majority of their referrals, patients seem to have a strong preference to be treated in either of the merging trusts' site.

⁴⁸ ie RBCH, PH, Dorset County Hospital, Salisbury District Hospital and University Hospital Southampton.

⁴⁹ See Appendix H, paragraphs 51–53 and Table 3, for further details on the methodology we followed to identify the treatments provided by different hospitals.

Overlap analysis

1. Table 1 below (updated as per footnote 1) sets out the parties' view on the overlaps at a specialty level between them.¹ This showed:

- (a) Eighteen overlaps where the parties overlapped in relation to inpatient elective care (for all these specialties they also overlapped in relation to outpatient services).²
 - Of these overlaps, they shared consultants between them in relation to three.³
- (b) Thirty-four overlaps where the parties overlapped in relation to outpatient care.
 - Of these overlaps, they shared consultants between them in relation to ten and they shared consultants with other hospitals in relation to four.⁴
- (c) There are 20 overlaps in relation to non-elective care.

¹ The parties submitted information on their overlaps using, in relation to some specialties, a different classification compared with that adopted in SUS. For a matter of comparability with the overlap analysis we carried out, we presented the specialty overlap submitted by the parties based on the SUS classification. More specifically, we considered:

- trauma & orthopaedics as a single specialty;
- maxillo-facial surgery and oral surgery as two distinct specialties; and
- paediatric respiratory medicine, paediatric medical oncology, paediatric diabetic medicine, paediatric cystic fibrosis, paediatric cardiology, paediatric surgery, paediatric neurology and paediatrics as distinct specialties.

² This did not include trauma & orthopaedics. The parties told us that 'Orthopaedics is an elective service, and adult inpatient orthopaedics services are only available at RBCH and not PH'. By contrast trauma services 'are essentially non-elective and are only provided by PH and not RBCH. There is a cohort of Trauma patients initially admitted and brought into PH who are then stabilised at home before they receive their Trauma surgery. This Trauma surgery is described as elective. However, only PH has the facilities, equipment and associated back-up to provide this elective Trauma surgery'. We also note that the parties stated in their [initial submission](#) that they shared consultants in relation to trauma, and later clarified that 'the majority of orthopaedic surgeons are employed by RBCHFT, but work across both trusts, providing elective orthopaedic work at RBCHFT and Trauma work at PHFT'. Furthermore, in relation to orthopaedics the parties submitted that elective paediatric orthopaedic service was only provided at PH but not at RBCH.

³ Palliative medicine, cardiology and maternity (gynaecology).

⁴ Hepatobiliary & pancreatic surgery, cardio-thoracic surgery and clinical genetics are provided by University Hospital Southampton. Vascular surgery is provided as part of a regional service provision involving Salisbury District Hospital.

TABLE 1 Summary of parties' view on specialty level overlaps—elective, non-elective and outpatient services

Specialty	Inpatient elective	Inpatient non-elective	Outpatient
General surgery	X	X	X
Urology	-	-	X
Breast surgery	X	X	X
Colorectal surgery	X	X	X
Hepatobiliary & pancreatic surgery	-	-	X
Upper gastrointestinal surgery	X	X	X
Vascular surgery	-	-	X
Trauma & orthopaedics	-	-	X
ENT	-	-	X
Ophthalmology	-	-	X
Oral surgery	-	-	X
Cardiothoracic surgery	-	-	X
A&E	-	X	-
Pain management	-	-	X
General medicine	X	X	X
Gastroenterology	X	X	X
Endocrinology	X	X	X
Clinical haematology	-	-	X
Hepatology	X	X	X
Diabetic medicine	X	X	X
Clinical genetics	-	-	X
Rehabilitation service	X	X	X
Palliative medicine	X	X	X
Cardiology	X	X	X
Transient ischaemic attack	X	X	X
Dermatology	X	X	X
Respiratory medicine	X	X	X
Medical oncology	-	-	X
Neurology	-	-	X
Rheumatology	X	X	X
Paediatrics	-	-	X
Geriatric medicine	X	X	X
Maternity*	-	X	X
Gynaecology	X	X	X
Clinical oncology	-	-	X

Source: RBCH and PH.

* We amalgamated obstetrics and midwifery service into a single specialty 'maternity'. Maternity services are classified as non-elective services but not as emergency services (see Section 6 for further details).

2. The parties told us that, in aggregate, PH undertook less elective work than RBCH. The parties also said that within a number of the overlap specialties where they were both active they focused on different sub-specialties which meant that, even where they both appeared to undertake a significant volume of activity in a specialty, they might still not overlap across a wide range of services. On this point the parties have told us in particular that:

(a) within general surgery (including upper GI surgery) in relation to:

- (i) upper GI surgery—only PH does Endoscopic Retrograde Cholangio-Pancreatography (ERCP), pancreatic surgery (benign) and hepatobiliary surgery whereas only RBCH does upper GI cancer surgery and bariatric (obesity) surgery;
- (ii) lower GI surgery—only PH does pelvic floor surgery and endometriosis surgery;
- (iii) endocrine surgery—only RBCH does adrenal surgery;
- (iv) sarcoma surgery—only RBCH does diagnostic and resectional sarcoma surgery; and

- (v) paediatric surgery—only PH does elective minor and intermediate general paediatric surgery;
- (b) within cardiology only RBCH provides interventional cardiology and EP services;
- (c) within dermatology only RBCH provides Mohs surgery; and
- (d) within gynaecology only PH provides complex gynaecology.

3. In order to test these points we have assessed:

- (a) the extent to which each party is active within the overlap specialties identified, by looking at the volume of patient episodes each party provided in the last three years (January 2010 to December 2012) within that specialty; and
- (b) the degree of *treatment overlap* within each overlap specialty, by looking at what proportion of each merging party's activity in each overlap specialty related to procedures (measured using Finished Consultant Episode (FCE) Dominant Procedure⁵) and diagnosis (measured using Primary Diagnosis⁶) that are undertaken by the other merging party.

4. Our overlap analysis was based on internal activities or SUS data provided by the parties, which we adjusted to mitigate the problem that the parties had different specialty coding practices, particularly in relation to general medicine and general surgery.⁷
5. This adjustment consisted of reallocating FCEs within general medicine and general surgery (in both party's datasets) on the basis of information they supplied regarding whether the Dominant Procedure Codes and Primary Diagnoses were typically associated with specialties outside of general medicine and general surgery.⁸ Whilst the parties urged some caution in relation to the information they provided us to enable us to do the reallocation (because a given treatment/diagnosis can be associated with a range of specialties)⁹ they indicated that it is broadly a sensible way to proceed.^{10,11} As such, we acknowledged that there may be some error in the

⁵ An FCE is an inpatient or day-case episode where the patient has completed a period of care under a consultant/midwife/Consultant Nurse and is either transferred to another consultant/midwife/Consultant Nurse or discharged. The dominant procedure is the most significant treatment received by the patient in that FCE.

⁶ Many patients admitted by physicians have multiple diagnoses. For each admission a primary diagnosis is designated relating to the main condition treated or investigated.

⁷ For example, upper gastrointestinal surgery (106); colorectal surgery (104) and breast surgery (103) are typically recorded under general surgery and hepatology (306); endocrinology (302) and diabetic medicine (307) are typically recorded under general surgery.

⁸ The reallocation method can be described as follows:

- we reallocated general surgery episodes to paediatric surgery when patients were aged 16 or under;
- for the remaining general surgery episodes, if the FCE grouping flag is 'P' (procedure) and the dominant procedure matches one of the codes identified by the parties, we reassigned the specialty accordingly; and
- for general medicine episodes, if the FCE grouping flag is 'D' (*diagnosis*) and the primary diagnosis matches one of the codes identified by the parties, we reassigned the specialty accordingly.

The FCE grouping flag identified which element of clinical coding was primarily used to derive the relevant HRG. The parties told us that if the grouping flag 'was a diagnosis, then either there was no procedure coding or this procedure coding was not sufficiently highly ranked by the grouper to hold sway'.

Based on the dominant procedure, general surgery episodes were reallocated to the following specialties: colorectal surgery, upper GI surgery, breast surgery, vascular surgery, and thoracic surgery. Based on the primary diagnosis, general medicine episodes were reallocated: endocrinology, diabetic medicine, hepatology, rehabilitation service, respiratory service, gastroenterology and cardiology.

⁹ In particular, the parties pointed to difficulties in identifying procedures and diagnosis codes that may be associated with 'urology' and 'vascular' activity.

¹⁰ The parties told us that:

There is no correct way of retrospectively reassigning General Medicine and General Surgery activity to other specialties, given that this is not standard NHS practice and there is no one-for-one mapping between procedure/diagnosis codes and specialties. Nonetheless, we can confirm that the methodology set out above ... looks reasonable

figures below and thus the activity of either party in a given specialty may be slightly under or overstated but this methodology appeared to be the most sensible on the basis of the information we were provided with.

6. We also compared the parties' inpatient data with data provided by the Dorset CCG and West Hampshire CCG, which covered activity carried out by NHS hospitals in the relevant areas in the period April 2010 to November 2012. We identified some discrepancies between the data provided to us by the parties on their activities and data provided by the CCGs, mainly in relation to the procedures/diagnoses within spells.¹² We were told that the discrepancies arose for a number of reasons, for example the HRG grouper applied, the time when the data was extracted from SUS, etc. We replaced the internal data with the CCG data whenever we observed discrepancies so as to avoid internal inconsistencies between the two datasets.¹³
7. In evaluating the extent of overlap we considered whether it was appropriate to include activity relating to specialised services within these numbers. In our market definition we provisionally concluded that some services (ie sub-specialties) within specialties may constitute separate relevant markets because supply-side substitution is unlikely to apply to those services, and this is particularly the case for specialised services. Although these services are commissioned separately and may be subject to an additional approval process, the nature of competition is not in general different from that of any other sub-specialty that is not classified as a specialised service. Therefore, the considerations set out in the following sections as regards pre-merger competition in elective and non-elective apply also to specialised services. For this reason all the figures by specialty presented in this section include specialised services.
8. We acknowledged that supply-side substitution into specialised services may be difficult even for providers active within the relevant specialty due to the way in which they are commissioned.¹⁴ Nevertheless, we did not consider it necessary to analyse specialised services separately for the following reasons:
 - Where the parties overlapped in the provision of a specialised service, we considered that overlap within our approach.
 - Where only one party provided a specialised service but there was an overlap within the wider specialty, expansion from that specialised service into other aspects of the specialty was likely to be possible (although the reverse is not true).

as a working solution for reapportioning inpatient General Medicine and General Surgery in order to provide a rough estimate of the breakdown of activity that the CC is looking for.

¹¹ We also acknowledged that the parties tended to record differently some types of episode in their SUS data, for example in relation to A&E, obstetrics and allergy activity. This may raise some concerns over the actual comparability of the volume carried out by the parties in the affected specialties.

¹² A spell relates to the whole hospital stay of a patient, from admission to discharge. For complex patients the spell may contain many episodes of care under different consultants.

¹³ The parties submitted that that 'the limited differences between the parties' data and the data supplied by the CCG are likely to come down to the choice of grouper and issues of timing. It is not clear to us why the CCG's data should automatically supersede the parties' data where discrepancies arise.' While we accepted that there is no 'right' or 'wrong' version our reasons for preferring the CCG data in the (relatively small) number of inconsistent cases is that (a) we understand that this is the basis on which the parties were actually paid, and (b) using the appropriate grouper for each year seems to us better to reflect the way decisions would have been made at the time. We noted that the inconsistencies affected a limited number of spell representing less 10 per cent of the total spells carried out by the parties in Dorset and West Hampshire areas in the period April 2010 to November 2012.

¹⁴ ie the fact that they are commissioned by NHS England rather than CCGs, and the number of providers is often limited rather than falling under the AQP regime.

The value of this service will be captured in our ‘upper bound’ but not our ‘lower bound’, so we were able in any case to consider the effects of excluding it.¹⁵

9. We also acknowledged that the SUS data we used did not include some of the parties’ sources of income. In particular, we were told that the SUS datasets did not include: (a) radiology or pathology, tests, drugs data, devices data, genitourinary medicine attendances and any specialty specific databases like prosthetics; (b) outpatient activity that was not part of PbR contract but which may form part of the parties’ block contract with the local commissioners (for example, physiotherapy attendances and multidisciplinary teams); (c) community-based activity; and (d) ward attenders. On these activities RBCH and PH generated revenue of, respectively, £[£] million and £[£] million in FY 2011/12. The full list of the activity not captured by SUS is provided in Table 2.

TABLE 2 Parties’ revenue associated with activities not captured by the SUS data—FY 2011/12

<i>PH</i>	<i>Revenue</i> £	<i>RBCH</i>	<i>Revenue</i> £
<i>Item</i>		<i>Item</i>	
Excluded drugs—chemo	[£]	Community midwives—antenatal visits	
Excluded drugs	[£]	Community midwives—births	
Radiotherapy	[£]	Community midwives—haven births	[£]
DA Pathology	[£]	Community midwives—postnatal visits	
ITU	[£]	Community midwives—visits	
NICU/SCBU	[£]	DA pathology (biochem)	
Breast screening programme	[£]	DA pathology (haem)	[£]
OP physio	[£]	DA physio & OT	[£]
Community midwives	[£]	DA radiology	[£]
Ward attenders	[£]	Hospital at home/Early discharge schemes	[£]
DA radiology	[£]	HPA collaborating laboratory	[£]
Community paediatrics	[£]	Integrated community equipment store	[£]
Liquid based cytology	[£]	ITU/HDU	[£]
Transport	[£]	Non-face-to-face	[£]
Bowel cancer screening programme	[£]	Outpatient radiology using non-mandatory tariff	[£]
Best practice	[£]		
CF adult service	[£]	Pain management	[£]
Palliative care for adults	[£]	Parentcraft classes	[£]
DA clinical neurophysiology	[£]	Patient transport services	[£]
Non-face-to-face	[£]	Stroke TIA clinics	[£]
Epilepsy service	[£]	Daycare	[£]
Excluded devices	[£]	Yound disabled centre	[£]
Head & neck—restorative	[£]	DPC	[£]
Brachytherapy	[£]	HIV/AIDS	[£]
Physio/OT (school team)	[£]	Anti-coagulent services	[£]
Home equipment loans	[£]	Rehabilitation	[£]
Insulin pumps	[£]	CART	[£]
Hospital at home/early discharge schemes	[£]	OPAL	[£]
Children’s therapy services	[£]	CQUIN	[£]
Home oxygen service	[£]		
Lumbar back pain service	[£]		
Multi professional Op attends	[£]		
Pain management	[£]		
Cancer nurses	[£]		
MS nurse	[£]		
Parentcraft classes	[£]		
HPA collaborating laboratory	[£]		
Child review—deaths	[£]		
Domiciliary visits	[£]		
Readmissions	[£]		
Total	[£]	Total	[£]

Source: RBCH and PH.

¹⁵ That specialised service may also be affected as a corollary of the argument that patients and GPs often make choices based on something broader than a treatment, and so it is appropriate to capture this in our ‘upper bound’.

10. The parties provided us with comments on the specialties we identified as overlapping, using our approach outlined above. We considered many of the parties' comments and revised the analysis as described below. We accepted that despite the initial indication of an overlap in the following specialties, based on their SUS data, there was no overlap in activities in the following areas:
- (a) Genitourinary medicine (inpatient). This specialty is only available at RBCH and the volume we observed at PH was the result of reapportioning general medicine activity to other specialties. We therefore decided, in line with the parties' suggestion, not to reapportion general medicine episodes to genitourinary medicine, and therefore we did not find an overlap in this specialty.
 - (b) Adult cystic fibrosis (inpatient). The parties told us that RBCH did not offer this service. The very few non-elective activity episodes we observed at RBCH were the result of the reapportioning of general medicine episodes to other specialties. We therefore decided, as with genitourinary medicine above, not to reapportion adult cystic fibrosis and therefore did not find an overlap in this specialty.
 - (c) Hepatobiliary & pancreatic surgery (inpatient). The parties told us that hepatobiliary & pancreatic surgery was a specialty which entailed complex treatments while the parties performed basic hepatobiliary surgery that could be undertaken by any hospital with a general surgery department. We therefore accepted that the activity carried out by the parties should be classified under general surgery and as a consequence no overlap arose in this specialty.
 - (d) Clinical immunology and allergy (inpatient). The parties told us that neither of them had an inpatient clinical immunology or allergy service. These specialties were initially included because we understood that although these episodes were coded differently in the two merging hospitals, both parties provided the service. The parties submitted that this was not case and the episodes reported in SUS under clinical immunology and allergy must be recorded as general medicine. We carried out this recording amendment and therefore did not find an overlap in these inpatient specialties.
 - (e) Paediatric sub-specialties (surgery, neurology, respiratory medicine, medical oncology, diabetic medicine, cystic fibrosis, cardiology) (outpatient). The inclusion of these specialties in initial overlap assessment was based on the understanding that RBCH provided all types of outpatient paediatric. The parties submitted that RBCH offered a general outpatient paediatric clinic service but did not sub-specialise. We therefore found no overlap in these outpatient specialties (but an overlap in the more general specialty of paediatrics).
 - (f) Neurosurgery (outpatient): outpatient neurosurgery services were initially included on the basis of an understanding that these services were provided at both parties' hospitals. RBCH later submitted that it did not provide outpatient neurosurgery services and we therefore removed this from the overlapping specialties.
 - (g) Clinical oncology (inpatient). The parties told us that RBCH did not have a radiotherapy bunker and thus it could not provide radiotherapy services. The inpatient clinical oncology episodes reported in the SUS data related to other specialties, namely medical oncology, urology and clinical haematology. We reallocated these episodes to these three specialties based on the information provided by RBCH and therefore did not find an overlap in this specialty.

- (h) Anaesthetics (inpatient). We grouped anaesthetics with pain management as the parties told us that anaesthetics was a support service rather than a separate elective specialty and the volume associated with anaesthetics in the SUS actually related to pain management. We reapportioned anaesthetics episodes to pain management and therefore did not find an overlap in this specialty.
- (i) Medical oncology (inpatient). The parties told us that medical oncology services at RBCH were transferred to PH in November 2012 and that 'it is [X] that RBCH will [X] providing medical oncology inpatient service in the [X], since the [X]'. RBCH told us that it had had six beds for this and had moved its provision to PH on a temporary basis, [X]. To move it on a permanent basis would require public consultation. RBCH also told us that the Deaneries (which allocated junior staff) had noted to RBCH that the service would need to be restructured as it did not provide sufficient support for junior staff. Following that information, RBCH told us that it had to move quickly to transfer the service to PH and the commissioners agreed with this temporary transfer. RBCH told us that [X]. Based on the evidence submitted by the parties, we considered it unlikely that RBCH would be able to restart the service should it wish to do so, and therefore we excluded the service from the overlap areas.
- (j) Oral surgery (inpatient). The parties submitted that RBCH historically only provided some day-case activity (more than 90 per cent of this related to tooth extractions) and had recently ceased providing the service. Although RBCH had provided the tooth extraction service until recently, it stated that [X] because
 - (i) the service previously provided at RBCH was provided by PH consultants [X]; and
 - (ii) given that tooth extraction activities represented a small fraction of oral surgery activity [X].
 We considered the arguments submitted by the parties and removed oral surgery (inpatient) from the overlap specialties.
- (k) Persistent pain management (inpatient and outpatient)—subset of the pain management specialty. The parties told us that from 2013/14 the persistent pain management services (which include both outpatient and inpatient activity) would be transferred out of an acute setting and provided in the community by DHUFT, while activity relating to acute pain and some more complex patients would remain in secondary care. The parties provided information to identify in the SUS data the episodes that related to persistent pain management which we accordingly removed from the overlap. The parties submitted that in relation to outpatient activity it was not possible to clearly identify these episodes related to persistent pain activity. They suggested considering for outpatient activity a similar proportion of persistent pain services as we observed for elective activity, ie 80 to 90 per cent. We accepted the parties' argument and assumed that 90 per cent outpatient attendances currently coded as pain management will be transferred into the community and therefore will not constitute an overlap area.
- (l) Transient ischaemic attack (elective). We understand that this is an entirely non-elective (emergency) service and should not have been listed as an elective overlap (although it is a non-elective overlap, as we discuss in the following paragraph).

11. The parties also submitted that we should not consider the following specialties as specialties in which they overlapped. However, we took the view that they should be considered as overlapping in these specialties for the following reasons:
 - (a) Hepatology (inpatient). The parties submitted that hepatology episodes in SUS related to patients treated by physicians with an interest in liver disease who also had other clinical responsibilities. They suggested that hepatology should be

grouped with general medicine (this contrasts with tertiary centres that do offer dedicated hepatology services). While we accepted that hepatology activities can be carried out by clinicians with other responsibilities, we considered that as long as the services undertaken by these clinicians relate to liver diseases they should be classified under hepatology.

(b) Clinical haematology: the parties submitted that clinical haematology services could be distinguished in three distinct levels:

- Level 3 includes the most complex types of haematology services (for instance, bone marrow transplant). The parties told us that this type of service was most efficiently provided by a small number of centres and it was currently subject to UK-wide reconfiguration. They said that absent the merger the 'Level 3' service would be reconfigured.
- Level 2 includes complex inpatient care (eg intensive chemotherapy) currently provided by both parties and not the primary target for the UK-wide reconfiguration. The parties told us that in theory both parties could continue to provide these services absent the merger, but that in practice Level 2 and Level 3 were deeply interlinked in that they both required high levels of staffing, and the provision of Level 2 would be both clinically and economically unsustainable without Level 3.
- Level 1 encompasses routine (outpatient) services that both parties provide and they would continue to provide absent the merger.

The commissioner of specialised services, NHS England (Wessex), told us that both parties had recently self-assessed as meeting the relevant standards for provision of Level 3 haematology services and therefore it, as commissioner of these services, had no immediate plans to reconfigure or tender these services. As such, whilst we found that it was possible that in the counterfactual some changes might be made to Level 3 haematology services as currently offered in the wider Dorset area, the evidence on this was inconsistent. We therefore thought the most likely counterfactual outcome would be that haematology service provision would remain unchanged in the foreseeable future and the parties would continue to overlap in provision of this service.

(c) Transient ischaemic attacks (TIA) (inpatient). The parties submitted that this service was part of the stroke service, rather than being a separate specialty and they suggested reapportioning TIA to general medicine and geriatric medicine.¹⁶ Whilst we understand that from a clinical perspective this service can be grouped together with other specialties, we decided to consider it as a stand-alone specialty in line with the classification adopted in SUS. As noted by the parties, the inpatient volume of activity reported in the SUS data is negligible.

(d) Hepatobiliary & pancreatic surgery (outpatient). The parties submitted that the trusts' consultants did not provide hepatobiliary & pancreatic surgery outpatient services as these services were provided by Southampton University Hospital's consultants. As we discussed in Section 6, sharing consultants does not remove hospitals' incentives to compete and therefore we consider this specialty (in relation to outpatient services) as a further instance of overlap.

¹⁶ According to the following breakdown: at RBCH 50 per cent of TIA activity should be recorded under general medicine and 50 per cent under geriatric medicine; at PH 75 per cent of TIA activity should be recorded under general medicine and 25 per cent under geriatric medicine.

(e) Anaesthetics (outpatient). The parties told us that, as for inpatient services, anaesthetics was a support service and the ‘outpatient’ activity picked up in the SUS data likely referred to pre-operative assessment work. PH submitted that around 50 per cent of the outpatient attendances were mislabelled pain management activity (which we then reapportioned accordingly to pain management) and the remainder related to obstetrics pre-operative assessment work. RBCH told us that outpatient ‘anaesthetics’ related to pre-operative assessment work and screening to identify more complex patients that were part of a pathway leading to elective surgery. However, RBCH did not indicate how these episodes could be reallocated to other specialties. For consistency in the way we treated the parties’ SUS data we did not reallocate half of PH’s and all RBCH’s anaesthetics outpatient episodes to other specialties and on this basis we still found an overlap in this specialty. We noted nonetheless that while reapportioning anaesthetics outpatient episodes to other specialties would remove the overlap in this specialty, it would increase the extent of overlap in other specialties (as the parties overlap in a large number of outpatient specialties). Therefore, the impact on the overall overlap between the parties was likely to be marginal.

(f) Trauma & orthopaedics (outpatient). The parties told us that RBCH did not carry out any outpatient clinics related to trauma (ie non-elective services). While RBCH was the main centre for orthopaedics (ie elective services), PH also offered outpatient orthopaedic clinics which were primarily for initial consultations (ie part of the elective pathway). Patients needing an orthopaedic appointment could select PH clinics using Choose & Book or via paper referrals from GPs, tertiary & OMS (Orthopaedic Medical Service in the Community setting). Therefore we considered that the parties did overlap in relation to elective elements of outpatient trauma & orthopaedic services.

12. With respect to programmed pulmonary rehabilitation (PPR) (outpatient), the parties advised that RBCH’s activity volumes reported for this specialty should be grouped under respiratory medicine as the two specialties were clinically linked. As we explained above in relation to TIA, although we understand that from a clinical perspective PPR can be grouped with respiratory medicine, for the sake of consistency we followed the SUS classification and considered PPR as a stand-alone specialty. We acknowledged in any event that the parties did not overlap in this specialty.
13. Figure 1 summarizes,¹⁷ for each overlap specialty and distinguishing between elective and non-elective activities,¹⁸ the volume of inpatient episodes (measured according to the number of FCEs each party provided in the last three years within that specialty). Similarly, Figure 2 summarizes, for each overlap specialty, the volume of outpatient episodes (measured according to the number of attendances) each party provided in the last three years (January 2010 to December 2012).¹⁹

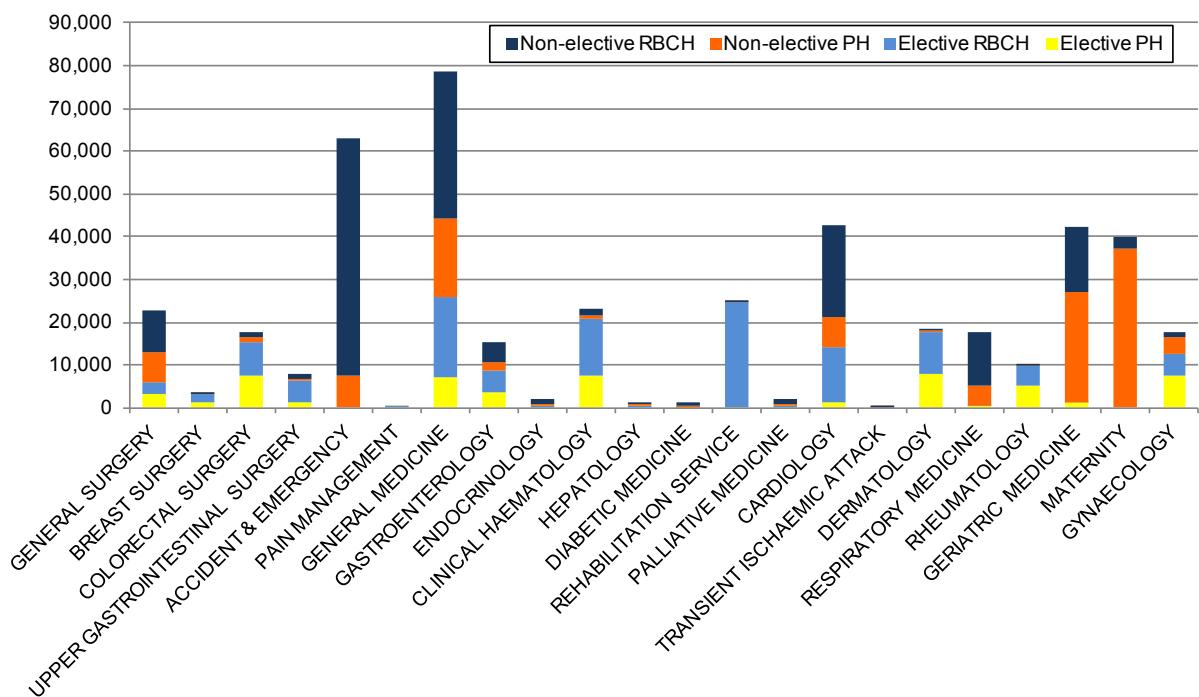
¹⁷ For the purposes of the overlap analysis we excluded the volume related to private patients since overlaps in relation to these activities are considered elsewhere.

¹⁸ We consider day-case episodes as elective inpatient activities because they are recorded as such in the SUS data. We note that this may differ from the approach followed by the parties which considers day-case episodes together with outpatient activities.

¹⁹ General surgery and general medicine attendances were reallocated according to the estimates provided by the parties in relation to the breakdown of activity presented at each general medicine and general surgery clinic.

FIGURE 1

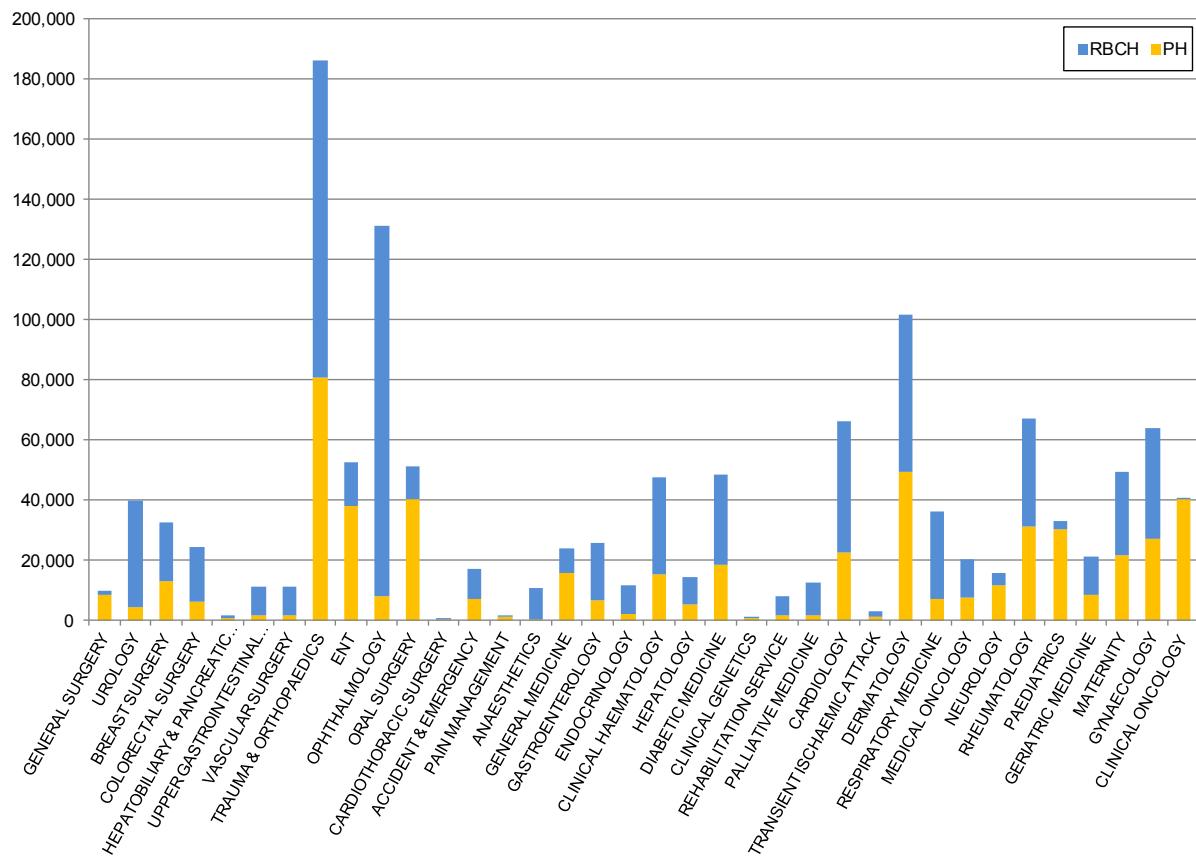
Parties' volume of inpatient activity (elective and non-elective) at specialty level—2010 to 2012



Source: RBCH and PH internal data, CC analysis.

FIGURE 2

**Parties' volume of outpatient activity for specialties where they overlap—
2010 to 2012**



Source: RBCH and PH internal data, CC analysis.

14. We have discussed the results of our overlap analysis in more detail below, distinguishing between inpatient elective and non-elective, and outpatient services.
- *Inpatient elective*: according to our estimates there are two additional overlaps compared with the parties' submission, namely clinical haematology and pain management.²⁰ Overall, we identified 20 overlaps.
 - *Inpatient non-elective*: according to our estimates there is one additional overlap compared with the parties' submission, namely clinical haematology. Overall, we identified 21 overlaps.
 - *Outpatient*: according to our estimates there are two additional overlaps compared with the parties' submission, namely A&E²¹ and anaesthetics.²² Overall, we identified 36 overlaps.

²⁰ Only in relation to activities other than persistent pain management (see paragraph 10).

²¹ In this context, we understand that 'A&E' as a specialty relates to inpatient episodes where patients came to the A&E department, or follow-up appointments to a visit to the A&E department, that did not require the presence of a consultant and therefore were not classified under any other specialty. As such, they are a small subset of all episodes arising from A&E department attendances.

²² We acknowledged that anaesthetics is a support service rather than a separate specialty. However, as we were not provided with information to reappportion the anaesthetics outpatient episodes to other specialties, we maintained this specialty as a separate overlap (see paragraph 11 for further details).

15. In summary, Table 3 shows the specialties that we are considering to be overlap specialties.

TABLE 3 Parties' overlap at specialty level—inpatient elective and non-elective, and outpatient

<i>Treatment specialty description</i>	<i>Elective</i>	<i>Non-elective</i>	<i>Outpatient</i>
General surgery	X	X	X
Urology	-	-	X
Breast surgery	X	X	X
Colorectal surgery	X	X	X
Hepatobiliary & pancreatic surgery	-	-	X
Upper gastrointestinal surgery	X	X	X
Vascular surgery	-	-	X
Trauma & orthopaedics	-	-	X
ENT	-	-	X
Ophthalmology	-	-	X
Oral surgery	-	-	X
Cardiothoracic surgery	-	-	X
A&E	-	X	X
Anaesthetics	-	-	X
Pain management	X	-	X
General medicine	X	X	X
Gastroenterology	X	X	X
Endocrinology	X	X	X
Clinical haematology	X	X	X
Hepatology	X	X	X
Diabetic medicine	X	X	X
Clinical genetics	-	-	X
Rehabilitation service	X	X	X
Palliative medicine	X	X	X
Cardiology	X	X	X
Transient ischaemic attack	-	X	X
Dermatology	X	X	X
Respiratory medicine	X	X	X
Medical oncology	-	-	X
Neurology	-	-	X
Rheumatology	X	X	X
Paediatrics	-	-	X
Geriatric medicine	X	X	X
Maternity	-	X	X
Gynaecology	X	X	X
Clinical oncology	-	-	X

Source: RBCH and PH internal data, Dorset and West Hampshire CCG data, CC analysis.

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16. Considering all the specialties listed in Table 3, the parties appeared to overlap in specialties that represented 61 and 53 per cent of, respectively, PH's and RBCH's elective activity volume. With regard to non-elective services, the overlap specialties accounted for 75 per cent and 94 per cent of, respectively, PH's and RBCH's activities.²³
17. The overlap specialties accounted for 95 and 76 per cent of, respectively, PH's and RBCH's outpatient activities. Although all outpatient services are technically classified as elective, we took the view that in most specialties they could in principle be separated into those which have proper elective characteristics (either because they were part of an inpatient elective/maternity pathway or because patients had a choice of provider using Choose & Book) and those which relate only to emergency pathways. Our understanding was that all outpatient overlap services, except A&E, transient ischaemic attack and maternity,²⁴ involved elective overlaps (this assumption is based on the fact that, with these three exceptions, there were no

²³ The proportion of SUS non-elective volume related to maternity represented 24 per cent of PH's non-elective activity and 2 per cent of RBCH's.

²⁴ The outpatient volume associated with these three specialties represents 5 per cent of PH's outpatient volume activity and 4 per cent of RBCH's outpatient activity.

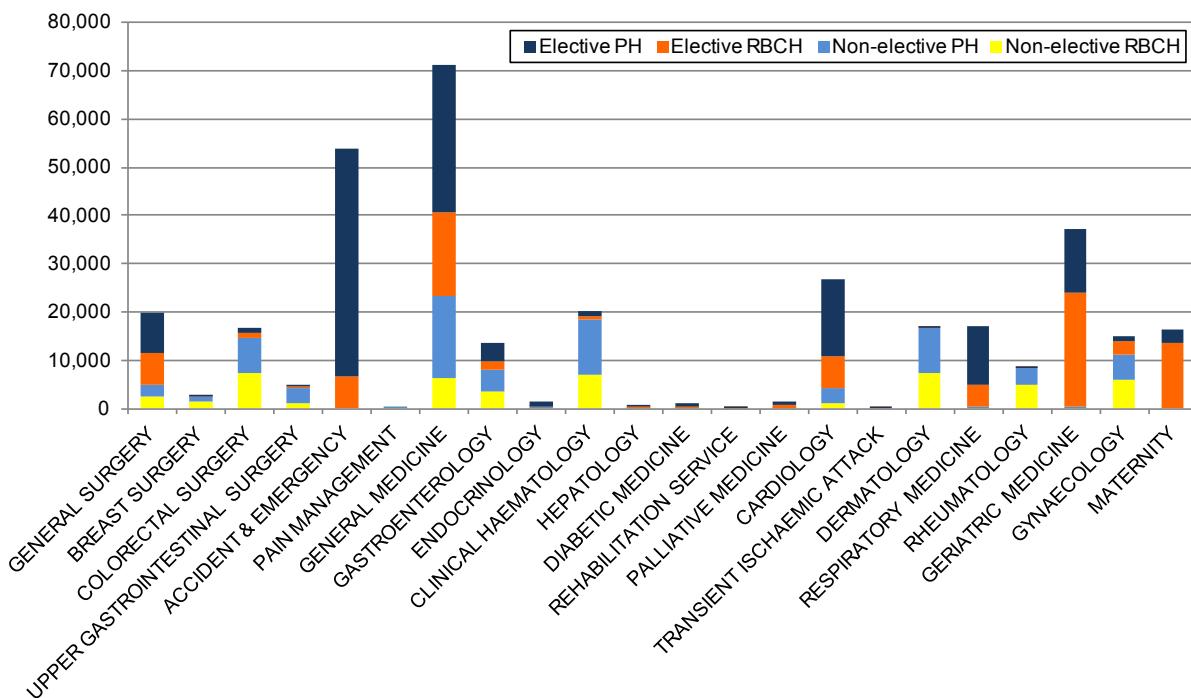
specialties with an inpatient non-elective overlap but no inpatient elective overlap). The parties were unable to provide us with data which could perfectly separate out those elements, but we understood that the ‘source of referral’ field within SUS data could be used to identify episodes which resulted from emergency treatment. Therefore we classified any episode which was ‘following an emergency admission’, ‘referral from an Accident And Emergency Department (including Minor Injuries Units and Walk In Centres)’ or ‘following an Accident And Emergency Attendance (including Minor Injuries Units and Walk In Centres)’ as being part of an emergency pathway, and assumed that all other outpatient episodes were part of an elective pathway.

18. The parties submitted that there was no or very limited scope for competition when they shared consultants between them or with other hospitals (ie University Hospital Southampton and Salisbury District Hospital). We investigated this issue and concluded that sharing consultants did not remove the incentives to compete (see paragraphs 6.132 to 6.141). We therefore included specialties in which the parties share consultants in our estimates.
19. We acknowledged that in some cases hospitals may focus on different treatments/procedures within a specialty. In cases where the parties tended to carry out different treatments/procedures within a specialty and where the scope of supply-side substitution across treatments/procedures is limited (because the specialty includes treatments/procedures that are not ‘routine’ and involve significant investment to start providing), evidence of overlap at specialty level might overstate the extent of overlap between them. We therefore analysed this issue by looking at the degree of treatment/diagnosis overlap within each overlap specialty. In particular, for each of the merging parties we calculated the volume of activities associated with the treatments/diagnosis²⁵ that both merging parties provided at least once in the last three years (2010 to 2012) (ie both do). We noted, however, that this approach may lead to understating the degree of overlap between the parties as it did not account for the overlap resulting from the ability of hospitals to supply-side substitute between treatments of a given specialty.
20. Figure 3 shows the parties’ overlap at specialty level.

²⁵ To evaluate overlap between the parties, we considered the FCE dominant procedure when this is flagged as the relevant activity within the FCE, and the primary diagnosis within the FCE otherwise. As the grouping flag is often missing in PH’s data we discussed and agreed with the parties to consider, when the flag is not provided, the FCE dominant procedure if available and the primary diagnosis otherwise.

FIGURE 3

Parties' volume of inpatient activity (elective and non-elective) related to overlapping procedures/diagnosis—2010 to 2012



Source: RBCH and PH internal data, Dorset and West Hampshire CCG data, CC analysis.

21. When only the volume related to procedures/diagnosis for which both merging trusts have recorded activities was taken into account, the extent of overlap at specialty level was lower than that discussed previously. This suggested, as indicated by the parties, that there may be a degree of differentiation within specialties and the merging trusts did not fully overlap over the entire range of procedures/diagnosis that fall under a given specialty.
22. We noted that in aggregate²⁶ the parties' overlap in relation to elective services still accounted for a significant proportion of the parties' volume of activities, ie 55 and 32 per cent, respectively, for PH and RBCH. On the non-elective side, the aggregate overlap represented 56 and 80 per cent,²⁷ respectively, of PH's and RBCH's activities.^{28,29}
23. We carried out a similar analysis for the outpatient services.^{30,31} Figure 4 shows the extent of overlap at procedure/diagnosis level.

²⁶ We only included in the estimate the 19 elective specialties listed in Table 3 above.

²⁷ The volume associated with the overlap treatments in maternity represents 9 per cent of PH's non-elective volume activity and 2 per cent of RBCH's non-elective activity.

²⁸ We only included in the estimate the 21 non-elective specialties listed in Table 3 above.

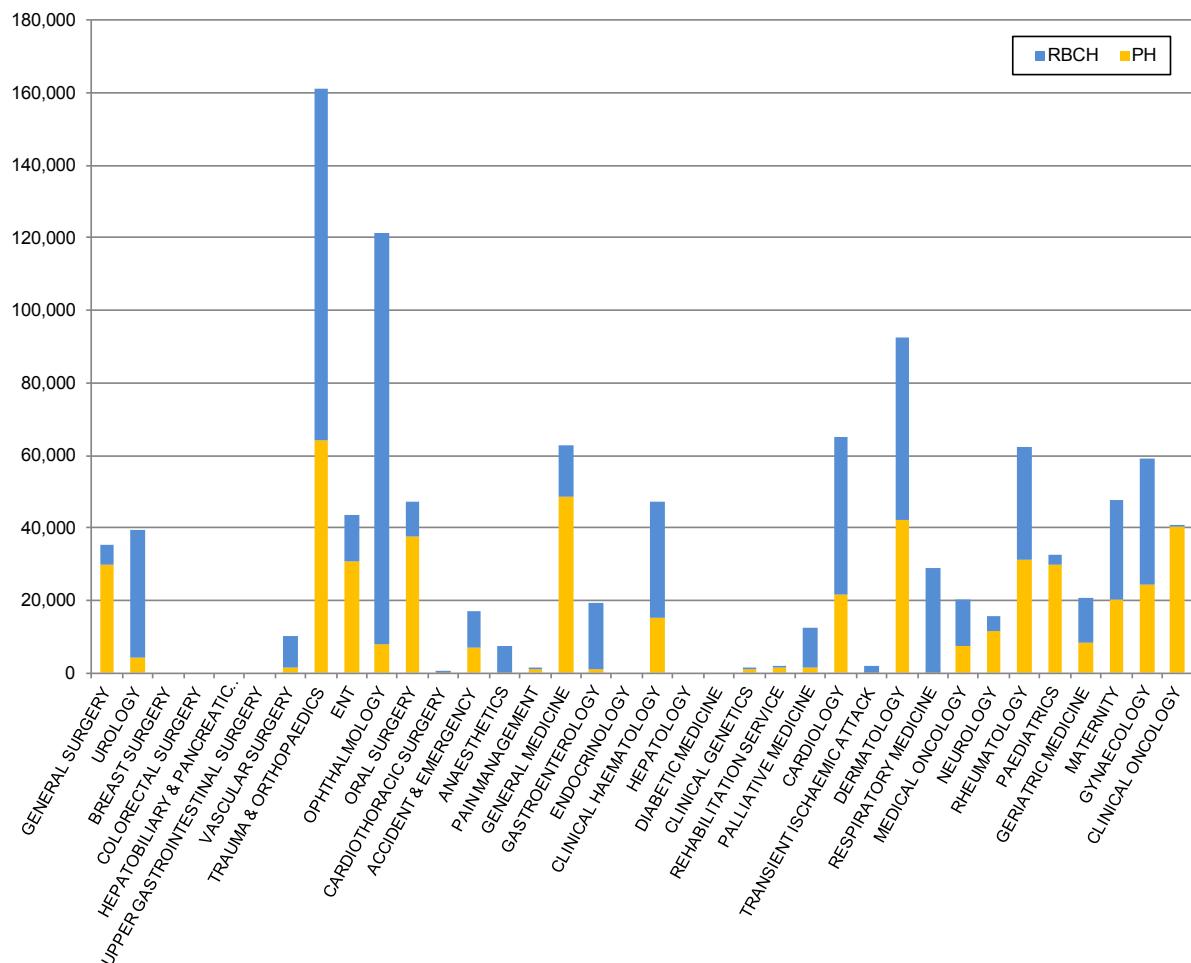
²⁹ These percentage figures were calculated as the ratio between the volume related to procedures/diagnosis for which both merging trusts have recorded activities and the total volume carried out by the parties (including those specialties where we identified no overlap and the volume related to non-overlap treatments in specialties that we considered as instances of overlap).

³⁰ The large majority of outpatient attendances had neither dominant procedure nor primary diagnosis. For these episodes we identified as instances of overlap those cases when both parties provided services that fall under the same HRG code. We acknowledged, however, that HRG codes may fail to capture some differences between the outpatient services provided by the merging trusts.

³¹ We noted that since the reallocation of general surgery and general medicine to other specialties was based on reappportioning the total volume rather than the single episodes (see footnote 19 above), we were not able to capture the extent of treatment overlap related to the reappportioned volume.

FIGURE 4

Parties' volume of outpatient activity related to overlapping procedures/diagnosis—2010 to 2012



Source: RBCH and PH internal data, Dorset and West Hampshire CCG data, CC analysis.

24. Similarly to inpatient activities (elective and non-elective), the volume related to procedures/diagnosis for which both merging trusts have recorded outpatient activities was lower than the total volume observed in each specialty. However, the aggregate³² overlap was still significant accounting for 87 and 62 per cent, respectively, of PH's and RBCH's outpatient volume.³³

Overlaps as proportion of the parties' activities, by value

25. In their joint initial submission (paragraph 251), the parties stated that the services for which there was some scope for the parties to compete

only account for a very small proportion of RBCH's and PH's clinical incomes. In 2011/12, RBCH's clinical income from these activities (excluding non-elective income, for which the parties cannot compete) summed to £[§] million, or [0–10] per cent of the Trust's total clinical

³² We only considered in the estimate the 36 outpatient overlapping specialties listed in Table 3.

³³ The volume associated with the overlap treatments in maternity and A&E represents 5 per cent of PH's outpatient volume activity and 4 per cent of RBCH's outpatient activity.

income for the year. PH's clinical income from these activities summed to £[§] million, or [0–10] per cent of the Trust's total clinical income for the year.

26. To test this statement we estimated how much the specialties in which we have identified the parties as overlapping represented in terms of revenue generated by the parties. The parties submitted value information in relation to the data recorded in their internal SUS data. Whilst PbR outpatient activities are remunerated on a per-episode basis, inpatient activities (elective and non-elective) are remunerated on the basis of the average cost incurred to treat a patient over the entire spell (which may include multiple episodes). For the scope of estimating the activity value related to each specialty, this posed the problem of apportioning value across episodes in cases of spells composed of a number of episodes which may fall under different specialties (multi-episode, multi-specialty spells).
27. The parties told us that they adopted different approaches to derive specialty-level income numbers for the purposes of SLR reporting. [§]
28. We used a reallocation methodology which in our view resembled the approach followed by PH, ie we apportioned the spell income based on the FCE HRG value but without weighting by the FCE's length of stay. While this methodology did not reflect exactly the approach adopted by the parties, we considered that overall it should result in sufficiently approximate estimates of the values by episode.
29. We applied this methodology to the financial year 2011/12 on the basis of the PbR tariff information publicly available on the Department of Health's website.³⁴ We noted that there were a (limited) number of multi-episode spells that have either (a) no FCE HRG codes associated with any of the episodes within the spell, or (b) the FCE HRG is available for some but not all the episodes within the spell.³⁵ As far as cases under (a) are concerned, we evenly apportioned the spell value to the FCEs within the spell. When one or more FCE HRG codes were missing (cases under (b) above) we applied the allocation methodology only to the FCEs with an associated HRG (ie we assigned no value to the episodes where the FCE HRG is missing).
30. Table 4 shows the SUS revenue generated in the financial year 2011/12 by the parties in the overlap specialties as identified based on the activity carried out by the parties (see Table 3 above).³⁶ PH appeared to overlap with activities of RBCH in specialties which overall generated £[§] million for it in the financial year 2011/2012 while the same figure for RBCH amounted to £[§] million.

³⁴ See <http://webarchive.nationalarchives.gov.uk/20130507170152/https://www.gov.uk/government/publications/confirmation-of-payment-by-results-pbr-arrangements-for-2011-12>.

³⁵ We estimated that only around 1,900 spells out of around 179,000 spells (1 per cent) related to the financial year 2011/12 have either of the two issues outlined in paragraph 28. The revenue associated with these spells is approximately £[§] million which represents around 2 per cent of the total SUS revenue generated by the parties in the financial year 2011/12.

³⁶ The outpatient revenues associated with general surgery and general medicine episodes were reallocated according to the same breakdown used to reapportion volume to other specialties (see footnote 19).

TABLE 4 SUS revenues generated by the parties in the overlap specialties in FY 2011/12

All overlap specialties					£
	Elective	Non-elective*	Outpatient	Total	
PH	[£]	[£]	[£]	[£]	[£]
RBCH	[£]	[£]	[£]	[£]	[£]
Total	[£]	[£]	[£]	[£]	[£]

Source: RBCH and PH internal data, CC analysis.

*The value related to non-elective maternity services amounted to approximately £[£] million for PH and £[£] million for RBCH.

31. Table 5 shows the revenue generated by the parties in the overlap specialties as a proportion of the total parties' revenue recorded in SUS data.

TABLE 5 Proportion of SUS revenues generated by the parties in the overlap specialties in FY 2011/12

All overlap specialties					per cent
	Elective	Non-elective*	Outpatient	Total	
PH	[51–60]	[61–70]	[91–100]	[61–70]	[61–70]
RBCH	[31–40]	[91–100]	[71–80]	[61–70]	[61–70]

Source: RBCH and PH internal data, CC analysis.

*The proportion of SUS non-elective revenue related to maternity was [£] per cent for PH and [£] per cent for RBCH.

32. The figures in the last column of Table 5 indicate that the parties overlap in specialties that represented a significant proportion of their SUS revenue ([61–70] per cent). As expected, the proportion of overlap revenue (over the total revenue recorded in SUS) was higher in elective and outpatient for PH than RBCH as the latter tends to carry out more elective and outpatient services, whilst the opposite holds true in relation to non-elective services.
33. Similarly to the overlap analysis in volume terms, we also considered the extent to which the parties overlapped at treatment/diagnosis level in order to account for differences in the range of treatments provided by the parties within the various specialties. Table 6 shows the SUS revenue generated by the parties in the financial year 2011/12 in relation to the treatments/diagnosis that both merging parties have provided at least once in the last three years (2010 to 2012). The parties overlapped on treatments/diagnosis from which PH generated revenue of £[£] million and RBCH generated revenue of £[£] million in the financial year 2011/12.

TABLE 6 SUS revenues generated by the parties in overlaps at treatment/diagnosis level—FY 2011/12

All overlap treatments/diagnosis					£
	Elective	Non-elective*	Outpatient	Total	
PH	[£]	[£]	[£]	[£]	[£]
RBCH	[£]	[£]	[£]	[£]	[£]
Total	[£]	[£]	[£]	[£]	[£]

Source: RBCH and PH internal data, CC analysis.

*Of this, the value related to overlap treatments in non-elective maternity services amounted to approximately £[£] million for PH and £[£] million for RBCH.

34. As a proportion of the total parties' revenue recorded in SUS data, the overlapping treatments/diagnosis represented [51–60] per cent of PH's revenue and [41–50] per cent of RBCH's revenue (see Table 7 below).

TABLE 7 Proportion of SUS revenues generated by the parties in overlaps at treatment/diagnosis level—FY 2011/12

All overlap treatments/ diagnosis	per cent			
	Elective	Non-elective*	Outpatient	Total
PH	[41–50]	[41–50]	[81–90]	[51–60]
RBCH	[21–30]	[61–70]	[61–70]	[41–50]

Source: RBCH and PH internal data, CC analysis.

*The proportion of SUS non-elective revenue related to the overlap treatments in maternity services was [☒] per cent for PH and [☒] per cent for RBCH.

Conclusion on overlaps

35. In summary, the parties overlapped in the provision of (see Table 2 above):
 - 19 elective specialties at inpatient level;
 - 21 non-elective specialties at inpatient level; and
 - 36 specialties at outpatient level.
36. The volume associated with these specialties accounted for more than 70 per cent of the SUS activities for both parties (88 per cent for PH and 74 per cent for RBCH). The revenues generated in 2011/12 in the overlapping specialties amounted to approximately £[☒] million for PH and to £[☒] million for RBCH, and represented [61–70] and [61–70] per cent of the SUS revenues for, respectively, PH and RBCH.
37. We acknowledged that the figures aggregated at specialty may not reflect differences in the activity carried out by the parties at sub-specialty level (eg in relation to specialised services that only one party provides). For this reason we assessed overlap between the parties at treatment level. This approach likely underestimated the extent of overlap as it did not capture situations when the parties overlap due to the possibility of supply-side substitution. The volume associated with the overlapping treatments accounts for 77 per cent of PH's SUS activity and 60 per cent of RBCH's. In terms of revenues the overlapping treatments generated in 2011/12 approximately £[☒] million for PH and £[☒] million for RBCH.

Drivers of choice and the role of quality

1. This appendix presents evidence on the extent to which quality influences choice. It includes analysis of the extent to which patients attend their nearest hospital; evidence from the economics literature; third party views; analysis of changes in the hospitals that GPs refer to; and evidence from the parties' internal documents.

Patients attending the nearest hospital

2. If distance/proximity were the sole driver of hospital choice, one would expect that patients would opt to a very large extent for the nearest hospital (provided that the nearest hospital offers the required treatment). The extent to which patients tend to attend the nearest hospital may therefore provide an indicator as to whether they take a decision based on factors such as quality rather than solely distance/proximity. However, we acknowledge that this analysis is only likely to identify quality effects on the referral pattern to the extent to which quality of hospitals varies. If quality across hospitals is roughly similar (ie no significant differences in quality are perceived by patients/GPs), location becomes the main or only differentiator and in such circumstances referral patterns would be largely driven by hospital location.
3. In determining whether a patient went to the nearest hospital for their treatment we took into account what treatments hospitals in the area offered. For each elective episode we took the most relevant activity within that episode (either the dominant procedure or the primary diagnosis¹) and checked which of the five major acute service providers in the area² (namely, PH, RBCH, Dorset County Hospital, Salisbury District Hospital and University Hospital Southampton)³ recorded some volume related to that activity at some point in the past three years: if they did they were deemed to provide the treatment. We then used this information to assess whether the patient travelled to the nearest hospital that actually provided the treatment.⁴
4. We acknowledged that there was likely to be some level of error around our assessment of travel times (because we used the GP practice postcode as a proxy for patients' location) and hence the classification of what constituted the nearest hospital. We therefore considered a second measure of 'having travelled to the nearest hospital', including any patients who travelled to a hospital that, according to the travel time data, was only 5 minutes further away than their nearest hospital. We considered that patients that met this criteria were broadly speaking 'equidistant'

¹ Please see Appendix G for further details on how the treatment was defined for inpatient and outpatient services.

² West Hampshire CCG provided information only in relation to two sub-local areas within West Hampshire, namely West New Forest and Totton and Waterside, as they are the sole areas from which RBCH and PH draw patients in significant numbers.

³ We did not have the internal datasets of other hospitals in the area (either acute or community hospitals) to check the range of procedures that they provided. For this reason, in our assessment we only considered episodes that were carried out at one of the five acute hospitals listed above (in other words, we implicitly assumed that patients had a choice only among these hospitals). Although other hospitals, especially community providers, may also be a credible alternative for patients in some cases, this approach is unlikely to have a significant impact on the outcome. Community hospitals tend to provide a relatively narrow set of outpatient services, and other acute service hospitals, such as Yeovil District Hospital, are located further away and cannot therefore be expected to be the nearest alternative in more than a very limited number of cases. We also note that to perform this analysis, we had to exclude those observations where the prognosis variable was missing (a relatively small number).

⁴ In other words if a patient travelled to the second nearest hospital, but this was the nearest of the hospitals that actually provided the treatment, the patient was classified as travelling to the nearest hospital.

between two hospitals and referred to the measure that includes these patients as having travelled to their nearest hospital as ‘the equidistant measure’.⁵

5. Table 1 shows the proportion of patients attending their nearest hospital split by specialty and type of treatment.⁶

⁵ This measure is always higher than the unadjusted measure because we classify more patients as having travelled to their nearest hospital under this rule.

⁶ We excluded any treatments that were provided by only one hospital in the area, since 100 per cent of these patients would by definition travel to their nearest hospital and this would not provide any information on choice and would inflate the average for the specialty (and the overall average).

TABLE 1 Proportion of patients attending the nearest hospital

Specialty code	Specialty description	Proportion of patients attending the nearest hospital			Proportion of patients attending the nearest hospital (equidistant measure)		
		Elective	Non-elective	Outpatient	Elective	Non-elective	Outpatient
100	General surgery	85.8	85.3	77.7	92.1	92.8	84.6
101	Urology	95.0	96.4	73.4	96.4	97.6	81.1
103	Breast surgery	85.2	89.0	90.2	91.8	95.5	92.6
104	Colorectal surgery	85.9	87.7	96.5	93.5	94.9	97.5
105	Hepatobiliary & pancreatic surgery	-	-	99.6	-	-	99.6
106	Upper gastrointestinal surgery	84.0	86.7	99.7	90.6	93.1	99.8
107	Vascular surgery	91.5	86.4	71.8	93.1	87.9	78.2
110	Trauma & orthopaedics	73.9	89.9	69.4	79.6	93.9	76.6
120	ENT	89.1	93.8	79.1	92.0	96.7	84.4
130	Ophthalmology	93.3	84.6	74.9	94.5	85.7	80.9
140	Oral surgery	76.0	91.8	68.4	81.6	93.6	75.2
141	Restorative dentistry	-	-	95.9	-	-	100.0
143	Orthodontics	-	-	94.0	-	-	95.8
144	Maxillo-facial surgery	95.2	96.2	98.9	99.1	97.3	99.3
150	Neurosurgery	-	-	17.8	-	-	20.1
170	Cardiothoracic surgery	-	-	83.8	-	-	93.6
171	Paediatric surgery	65.1	75.7	66.0	70.1	82.7	70.6
173	Thoracic surgery	-	-	71.5	-	-	78.3
180	A&E	-	86.8	85.1	-	93.5	92.7
190	Anaesthetics	-	-	75.8	-	-	81.5
191	Pain management	83.9	-	77.0	91.5	-	84.8
211	Paediatric urology	-	-	58.4	-	-	66.1
214	Paediatric trauma and orthopaedics	-	-	82.9	-	-	85.6
215	Paediatric ear nose and throat	-	-	93.5	-	-	97.1
216	Paediatric ophthalmology	-	-	91.0	-	-	95.3
251	Paediatric gastroenterology	-	-	70.2	-	-	74.4
252	Paediatric endocrinology	-	-	60.3	-	-	64.0
253	Paediatric clinical haematology	-	-	70.5	-	-	76.5
255	Paediatric clinical immunology and allergy service	-	-	84.0	-	-	88.2
257	Paediatric dermatology	-	-	96.9	-	-	98.8
258	Paediatric respiratory medicine	-	-	70.9	-	-	74.9
259	Paediatric nephrology	-	-	55.9	-	-	60.6
260	Paediatric medical oncology	60.1	-	94.3	60.6	-	97.9
262	Paediatric rheumatology	-	-	73.3	-	-	78.2
263	Paediatric diabetic medicine	-	-	91.0	-	-	98.9
264	Paediatric cystic fibrosis	-	-	64.0	-	-	68.6
300	General medicine	86.4	87.7	81.9	94.2	94.8	89.1
301	Gastroenterology	83.4	89.6	86.8	89.8	96.3	94.1
302	Endocrinology	87.5	88.4	92.7	94.6	95.1	96.3
303	Clinical haematology	84.0	84.7	85.2	91.6	91.0	92.3
304	Clinical physiology	-	-	98.3	-	-	99.1
306	Hepatology	78.8	90.8	92.7	79.2	96.5	94.3
307	Diabetic medicine	-	90.3	96.2	-	96.3	97.9
309	Haemophilia service	-	-	-	-	-	-
311	Clinical genetics	-	-	42.7	-	-	47.5
313	Clinical immunology and allergy service	-	-	15.9	-	-	15.9
314	Rehabilitation service	-	-	64.9	-	-	73.8
315	Palliative medicine	98.0	91.5	92.4	99.6	97.6	96.0
316	Clinical immunology	-	-	-	-	-	-
317	Allergy service	-	-	85.0	-	-	85.7
318	Intermediate care	-	-	98.5	-	-	99.0
320	Cardiology	87.8	87.2	83.0	91.2	93.5	89.9
321	Paediatric cardiology	-	-	45.2	-	-	48.8
324	Anticoagulant service	-	-	97.5	-	-	99.0
329	Transient Ischaemic attack	-	-	90.7	-	-	96.7
330	Dermatology	81.9	92.1	83.6	89.1	94.5	89.1
340	Respiratory medicine	79.9	89.0	83.1	85.0	97.1	90.7
341	Respiratory physiology	-	-	92.7	-	-	94.4
343	Adult cystic fibrosis service	-	-	54.1	-	-	57.6
361	Nephrology	62.7	78.1	62.1	68.7	82.3	67.8
370	Medical oncology	82.6	81.8	78.5	89.0	87.8	85.0
400	Neurology	88.6	78.1	67.9	91.0	79.1	75.1
401	Clinical neurophysiology	-	-	95.9	-	-	97.0
410	Rheumatology	84.6	-	81.4	90.5	-	88.2
420	Paediatrics	85.3	92.6	64.3	85.9	97.1	72.4
421	Paediatric neurology	-	-	74.5	-	-	85.2

Specialty code	Specialty description	Proportion of patients attending the nearest hospital			Proportion of patients attending the nearest hospital (equidistant measure)		
		Elective	Non-elective	Outpatient	Elective	Non-elective	Outpatient
422	Neonatology	-	85.9	97.9	-	87.1	99.9
424	Well babies	-	73.8	-	-	78.4	-
430	Geriatric medicine	95.8	86.7	87.9	97.2	94.6	95.9
501	Obstetrics	-	94.4	80.8	-	96.9	93.5
502	Gynaecology	79.4	75.1	79.9	86.8	82.4	86.8
503	Gynaecological oncology	-	-	89.4	-	-	93.8
560	Midwifery service	-	98.7	92.6	-	98.7	93.6
650	Physiotherapy	-	-	97.3	-	-	98.7
651	Occupational therapy	-	-	97.9	-	-	98.7
654	Dietetics	-	-	87.5	-	-	88.5
655	Orthoptics	-	-	94.1	-	-	97.1
656	Clinical psychology	-	-	57.4	-	-	88.9
800	Clinical oncology (previously radiotherapy)	91.8	87.8	59.4	95.1	90.9	66.6
811	Interventional radiology	84.2	86.9	83.2	85.6	89.9	84.1
812	Diagnostic imaging	-	-	97.9	-	-	99.3
822	Chemical pathology	-	-	75.9	-	-	92.3
All specialties		81.0	88.0	80.4	86.4	93.8	86.2

Source: Dorset and West Hampshire CCG data, RBCH, PH, Dorset County, Salisbury, Southampton data, CC analysis.

Note: Individual cells exclude specialties with fewer than 100 episodes since they tend to be offered at few hospitals and the small number of cases means results can be skewed. The all specialties row does include these specialties.

6. On average around 81 per cent of elective patients attended their nearest hospital. The proportion rose to approximately 86 per cent if we included those patients who we have classified as equidistant between two hospitals and therefore as having travelled to their closest hospital even if the data suggested it was 5 minutes further away. Specialties showing a proportion below the average included oral surgery, paediatric surgery, paediatric medical oncology, hepatology, respiratory medicine, nephrology, gynaecology, and trauma & orthopaedics.
7. The high proportion of patients attending the nearest hospital supported the view that proximity plays an important role in patients' decisions. However, as we noted above, if the quality is roughly similar across hospitals (we discuss quality indicators in Appendix D) we would expect a large proportion of patients to attend the nearest hospital, but this would still be consistent with the view that quality would be factored into patients' and/or GPs' choice were quality to vary.
8. Table 1 also shows that on average the proportion of patients attending the nearest hospital is higher in non-elective compared with both elective and outpatient services, although the difference is not substantial.

A&E attendees

9. In the context of non-elective services, we examined the extent to which patients had a choice of provider and might be able to exercise choice. We noted that patients making their own way to an A&E department without referral from a GP or dentist were likely to have had a choice, especially since the parties are located relatively close to each other and some potential patients will live in between the two. According to the parties, in practice, most of them go to their nearest A&E.⁷ We examined this proposition. If a significant proportion of A&E attendees chose to go to

⁷ Joint main party initial submission, paragraph 61.

a hospital that was not their nearest, it would indicate that some other factor (ie some aspect of quality) was likely to be driving their decisions.

10. First, we analysed the data on patients who were *admitted* at PH (which were only a subset of those *attending* the A&E). 64 per cent of admissions arrived by ambulance, with only 25 per cent self-referring, 5 per cent from GP referral and 4 per cent from another healthcare provider.⁸ This suggested that of patients who are admitted to have inpatient non-elective care, only around one-quarter would have been able to make a choice of hospital, while a further 5 per cent were referred by a GP who might have been able to make a choice. However, for the analysis below we could not identify those who went on to be admitted and so it covers all A&E attendees.
11. Dorset CCG provided data on all emergency department attendees at RBCH and PH in 2011/12 and 2012/13 (up to end of January 2013), which accounted for just over 200,000 attendees split approximately equally between the two trusts. At PH, 34 per cent arrived by ambulance, and at RBCH, 9 per cent arrived by ambulance.⁹ A higher proportion of A&E attendees who came by ambulance resulted in an admission than A&E attendees generally.
12. The data also showed the source of referral for A&E attendees. The majority were listed as self-referral (59 per cent at PH and 82 per cent at RBCH) and we would have expected most of these to have had some scope to choose their hospital; most of the remainder were brought by emergency services (31 per cent at PH and 10 per cent at RBCH¹⁰), and a small minority the result of GP or dental emergency referrals (3 per cent at PH and 2 per cent at RBCH).¹¹
13. For each attendee, we determined their closest A&E department, based on their GP's location.¹² 47 per cent were closest to PH and 51 per cent closest to RBCH, with 1 per cent each being closest to Dorset County and Salisbury and fewer than 1 per cent closest to Southampton or Yeovil.
14. We then analysed the tendency for patients to attend the nearest A&E. Overall, 75 per cent of attendees at PH and 79 per cent of attendees at RBCH were attending their nearest A&E department.
15. We then removed those arriving by ambulance from our data (to restrict our analysis to those who would be likely to have a choice). This made very little difference to our results: 77 per cent of these attendees at PH and 78 per cent of these attendees at RBCH were attending their nearest A&E department.
16. We separated non-ambulance attendees into those who came from home and those who did not (since for those needing to attend from outside the home, we were less confident that we were identifying the A&E department nearest to them at the time they needed to attend), but the results were not significantly different.

⁸ Based on A&E data from PH for 2011/12 and CC calculations.

⁹ We have excluded patients whose mode of arrival was not recorded. RBCH's recording of this data appeared to improve during 2011/12. The differences in the proportions arriving by ambulance between the two trusts may be partly due to ambulance protocols, and we also understand that many patients arriving by ambulance at RBCH go straight to a department rather than A&E so may be excluded from this data.

¹⁰ Again, the proportion at RBCH arriving by ambulance is likely to be lower because many patients arriving by ambulance are transferred directly to the relevant department for treatment and so do not appear in this data. Around 2 per cent of all attendees were listed as arriving by ambulance with a source other than emergency services, and around 1 per cent had a source of emergency services but not coming by ambulance, and hence the two do not match exactly.

¹¹ Other sources include police, work, social services and 'Other'.

¹² We excluded patients where the GP practice is not listed and patients attached to GP practices whose locations were not in our dataset (a small proportion of practices and likely to be out of area GPs).

17. We compared self-referral attendees with those referred by GPs or dentists¹³ (again, ignoring those transported by ambulance). We found that self-referral attendees were slightly more likely than average to go to their nearest A&E (79 per cent at PH and 80 per cent of these attendees at RBCH), but those who had been referred were much less likely to do so (58 per cent at PH and 56 per cent at RBCH). The difference between referred patients and other patients suggests that GPs and dentists are likely to be exerting influence on the patient's destination, possibly because they are more aware of, and would refer to, hospitals which are able or better suited to treat the patient's condition.
18. Finally, looking at all non-ambulance attendees, we used the equidistant measure described above (see paragraph 4) to assess the proportion of such patients attending their nearest hospital and we found that 85 per cent of equidistant patients at PH and 85 per cent at RBCH attended a 'nearest hospital'.¹⁴ We found that of the patients in this 'equidistant' group (excluding ambulance users), around 40 per cent went to PH and 60 per cent to RBCH. Table 2 summarizes the results mentioned in paragraphs 12 to 16 above, of A&E attendees to attend their nearest A&E.

TABLE 2 Proportion of A&E attendees at PH and RBCH attending their nearest A&E

A&E attended	per cent	
	PH	RBCH
All patients	75	79
Ambulance	72	88
Non-ambulance	77	78
Non-ambulance, from home	77	78
Non-ambulance, not from home	77	80
Non-ambulance, self-referral	79	80
Non-ambulance, GP/dentist	58	56
Non-ambulance, incl equidistant	85	85

Source: Dorset PCT data, CC analysis.

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19. Looking at different groups of patients and across time, we consistently found that around three-quarters went to the A&E department nearest to their home (as proxied by GP address). The only exception was for patients receiving an emergency referral from a GP or dentist, where patients are likely to have input from a healthcare practitioner which may help direct them to the most suitable provider. We would expect the theoretical maximum to be less than 100 per cent, even if location is the only driver and quality plays no role in choice, because (a) some patients will need treatment when they are not near to their 'local' A&E (although we tried to address this by looking at 'from home'); and (b) some patients will know that their nearest hospital's medical facilities are less able to treat their condition (eg if they have a recurring condition or from second-hand experience). Therefore we consider that a figure of approximately three-quarters indicates that most patients are likely to view proximity as an important, or the most important, factor in choice of provider in an emergency.
20. We also found that only around 2.5 per cent of patients living within the local area but treated by the parties' A&E departments lived closer to a third party's A&E department.

¹³ Dentist referrals made up a small proportion of these referrals and so the results for GPs alone are similar to the numbers we report.

¹⁴ We did this because there may be some patients who are going to their second-nearest A&E according to our driving-time calculations but in practice they may actually be closer to the one they attend (because we are using GP location as a proxy), or may be attending the most convenient when taking into account factors that a simple comparison of driving times does not capture.

21. Overall, we found that at least one-third of A&E attendees did not appear to have any choice of provider.¹⁵ Of those who were later admitted, this proportion was much higher—around three-quarters. And of all attendees who did have a choice, around three-quarters attended their nearest A&E. Finally, the proportion attending the nearest A&E was similar for those who did not have choice (ie who arrived in an ambulance) and those who had chosen which hospital to attend. This analysis is consistent with the view that in the Dorset area most patients are likely to view proximity as an important factor in choice of non-elective provider, although the role played by proximity might be due the fact that providers are perceived to be of similar quality (see paragraph 2).

Evidence from the economics literature on choice and competition in the NHS

22. The following paragraphs provide a high-level overview of some of the academic literature on choice and competition in the NHS in England. We set out the findings from the articles that have been published in peer-reviewed journals and the main findings from other potentially relevant papers. In doing so, we did not critique the methodologies used, but we did distinguish papers published in peer-reviewed journals from others that may not have received the same degree of academic scrutiny.

Patient choice

23. There were three main studies of patient choice in the NHS in England. The first study, published in 2012, looked at the effect of increased patient choice, following the introduction of choice in the NHS, on patient behaviours and hospital responses.¹⁶ Using data for Coronary Artery Bypass Graft (CABG), the authors estimated the extent to which patient sensitivity to two dimensions of quality of care—waiting times and mortality rate—changed following reforms in 2006 to encourage patient choice.¹⁷ They also investigated the impact of patient choice on the competitive environment faced by hospitals.
24. The authors found that there was a substantial change in patients' sensitivity with respect to one aspect of clinical care: a one percentage point increase in mortality rate leads to an approximately 7 per cent decrease in the probability of the average patient to choose the provider compared with a pre-reform decrease of approximately 3 per cent. The study also found that responsiveness with respect to waiting times did not change for the average patient. However, some groups of patients—severely ill and more informed patients—did change their behaviours following the introduction of greater choice. Another finding of this study was that greater patient choice had an impact also on hospitals' market shares: a one percentage point increase in mortality rate leads to an approximately 5 per cent decrease in market share for the average hospital relative to an approximately 0.36 per cent decrease pre-reform.
25. Another study, published by The King's Fund in 2010, looked at patient choice in four areas of England that were chosen on the basis of the number of hospitals in a 60-minute drive-time and the proportion of patients that were offered a choice by their GP according to the Department of Health National Patient Choice Survey.¹⁸ The

¹⁵ This is based on figures at PH; the corresponding figure for RBCH is lower because many emergency ambulance cases bypass the A&E and are not recorded, hence the RBCH figure of 9 per cent is likely to be understated.

¹⁶ Gaynor, Propper and Seiler. 'Free to choose? Reform and demand response in the English National Health Service', CEPR Discussion Paper number 9250, December 2012.

¹⁷ From January 2006, patients had to be offered a choice of five hospitals when referred for treatment by their GP.

¹⁸ *Patient choice: how patients choose and how providers respond*. The King's Fund 2010, Dixon, Robertson, Appleby, Burge, Devlin and Magee.

study involved 18 structured patient interviews and a survey of 2,181 patients. The survey sought to investigate recent experience of referral and to understand how patients make trade-offs between different factors when choosing a hospital.

26. The following key points arose from the survey:
 - (a) 75 per cent of respondents said that patient choice was either 'very important' or 'important' and older patients, those with no qualifications and those from a mixed and non-white background were more likely to value choice.
 - (b) 45 per cent of patients said they knew before visiting their GP that they had a right to choose a hospital. Older patients and those looking after their family at home were more likely to know about choice.
 - (c) 69 per cent of those patients who were offered choice chose their local provider.
 - (d) When thinking about hypothetical questions, nearly 20 per cent always chose their local hospital, regardless of their characteristics and 45 per cent chose a non-local hospital.
 - (e) One of the main reasons for choosing a non-local hospital was a bad experience at the local hospital.
 - (f) Patients made little use of available information on the performance of hospitals; just 4 per cent consulted the NHS Choices website and 6 per cent looked at leaflets, both of which provide comparative information on hospital performance. Instead patients relied heavily on their own experience (41 per cent), that of friends and family (10 per cent) or the advice of their GP (36 per cent).
 - (g) Patients value aspects of quality including the quality of care, cleanliness of the hospital and standard of facilities.
27. A third study reached similar conclusions regarding the factors that determine patient and GP choice of NHS hospital in England.¹⁹ The study used NHS data on GP referrals for patients requiring hip replacements in 2008. The authors used econometric techniques to compare the characteristics of the hospitals that were chosen by patients and their GPs with the characteristics of the other hospitals that they might have chosen.²⁰
28. The authors found that distance affects choice in that patients and GPs are more likely to choose a closer hospital. The research also suggested that quality mattered to patients and GPs; patients and GPs were more likely to choose a hospital the lower the mortality rate, the shorter the waiting time, the higher the CQC rate and the lower the number of MRSA infections. The study also suggested that older patients, those living in rural areas and those living in more income-deprived areas were more likely than average to choose a closer hospital. Finally, the study suggested that GP preferences mattered to patient and GP choice of hospital, in that patients are more likely to be referred to a particular hospital if the GP has referred more patients to it in the past.

¹⁹ Beckert, Christensen and Collyer, '[Choice of NHS-funded hospital services in England](#)', *The Economic Journal*, 122 (May).

²⁰ The authors estimated a conditional logit model where the patient-specific choice set was defined to be the set of the 30 nearest hospitals. Patient and GP choice was conditioned on a number of patient and hospital characteristics, including distance and quality, as well as interactions between patient and hospital characteristics.

Impact of competition on quality in the NHS in England

29. A number of studies have investigated the impact of competition on quality in the NHS in England.
30. The main empirical study of the impact of competition on quality in the NHS was published in a peer-reviewed journal in 2011.²¹ The authors hypothesized that competition was introduced in 2006 when all patients in England were formally given the ability to select their hospital. They used this as a natural experiment and compared the effect of the introduction of competition on the performance of hospitals that faced competition with those that did not. Using this ‘difference in difference’ approach, they tested whether patient outcomes in more potentially competitive markets had improved at a significantly faster rate after 2006 than in less competitive markets.
31. The authors measured the effect on quality by looking at changes in 30-day mortality rates for patients diagnosed with acute myocardial infarction (AMI). This indicator is often used in academic literature because it is easily clinically identifiable, is not subject to gaming or manipulation and for patients there is a clear link between appropriate treatment and good outcomes.
32. The general pattern of results from this analysis suggested that the trends for both sets of hospitals were similar before the introduction of competition in 2006, but diverged afterwards with hospitals in more competitive markets improving at a faster rate.
33. The authors found that hospital competition could lead to improvements in hospital quality. To illustrate their results, they found that the shift from a market with two equally sized providers to one with four equally sized providers after the reforms would have resulted in a 0.39 percentage point faster reduction in AMI mortality per year from 2006 onwards. They estimated that the 2006 reforms resulted in approximately 300 fewer AMI deaths per year. The authors noted that given that they postulated that AMI mortality was correlated with quality across hospitals, in practice, the lives saved from the reforms when estimated across the NHS and all dimensions of service provision were likely to be significantly higher.
34. The authors have extended this methodology to analyse the impact of competition on hospital efficiency. They concluded that their results suggest that competition between NHS hospitals prompted them to improve their productivity by decreasing their pre-surgery, overall and post-surgery length of stay.²²
35. This research has been criticized by a number of health academics.²³ The main criticism is that AMI patients do not choose their hospital and that there is no mechanism to explain why choice of hospital for elective treatment could affect patient outcomes from an emergency intervention. In response, the authors noted that in their article they stated that ‘while providers are not explicitly competing for AMI patients because competition in the NHS is limited to the market for elective care, we expect the market-based reforms to result in across-the-board improvements in hospital performance, which in turn will result in lower AMI death rates’.

²¹ Cooper, Gibbons, Jones and McGuire, ‘Does hospital competition save lives? Evidence from the English NHS patient choice reforms’, *The Economic Journal*, 121, August 2011.

²² ‘Does Competition Improve Public Hospitals’ Efficiency? Evidence from a Quasi-Experiment in the English National Health Service’. CEP Discussion Paper number 1125, February 2012.

²³ <http://blogs.lse.ac.uk/politicsandpolicy/archives/21185>.

36. A second working paper by other authors used a very similar methodology to estimate the impact of the introduction of competition on productivity and expenditure as well as on clinical outcomes. The authors found very similar results to the previous study and concluded that the effect of competition is to save lives without raising costs.²⁴
37. The authors found that a 10 per cent fall in the HHI is associated with a fall in the 30-day death rate following AMI admissions by 2.91 per cent, implying approximately 1,000 fewer total deaths per year over all 135 hospitals in their sample. They also found that greater concentration is associated with a longer patient stay in hospital, a common measure of efficiency. The authors concluded that, taken together, the findings for quality and resource utilization suggested that hospitals facing more competitive pressure were able to find ways to marshal resources more efficiently to produce better patient outcomes.

Impact of competition on quality of hospital management

38. A further paper looked at the impact of competition on management quality in NHS hospitals.²⁵ The study used survey techniques to measure firm productivity and management quality. The authors had applied this approach to a number of sectors including the NHS in England. The study found that management quality is strongly correlated with financial and clinical outcomes (such as survival rates from emergency heart attack admissions). It found that higher competition is positively correlated with management quality and that adding a rival hospital increases management quality by 0.4 standard deviations and increases heart attack survival rates by 9.5 per cent.

Qualitative studies of hospital responses to competition

39. There are two studies that provide some qualitative evidence and insights into hospital responses to competitive incentives.
40. The King's Fund patient choice study²⁶ included semi-structured interviews with 49 senior staff in NHS hospitals in England in the four areas of focus in the study. The King's Fund covered a number of areas including an understanding of the local market.
41. The King's Fund concluded that most hospitals operated in a defined geographical market and their main competitors were neighbouring NHS hospitals. It found that generally, hospitals competed for patients directly only at the boundaries of their catchment areas, where another hospital was equidistant. The main focus of competitive activity was securing GP referrals rather than directly competing for patients. Hospitals saw GPs as a significant barrier to developing patient choice and establishing a competitive market for healthcare services. They perceived GPs' referral patterns to be fairly stable and giving little attention to quality.
42. The King's Fund assessed whether hospitals were receiving clear signals from patient choices, which they would analyse and use to improve service quality. The

²⁴ 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.

²⁵ Bloom, Propper, Seiler and Van Reenan, [The impact of competition on management quality: evidence from public hospitals](#). Centre for Economic Performance, LSE, Discussion Paper No 983. May 2010 (revised February 2013).

²⁶ Anna Dixon, John Appleby, Ruth Robertson, Peter Burge, Nancy Devlin and Helen Magee, '[Patient choice, How patients choose and how providers respond](#)', The King's Fund, June 2010.

King's Fund concluded that choice did not act as a lever to improve quality in this structured way. However, it did find that choice appeared to be a motivation for hospitals to maintain their reputation to ensure that patients returned or influenced others by speaking highly of their experience. It also found that most hospitals focused on retaining patients rather than expanding into new markets or new areas.

43. A study by the CCP sought to shed some light on the causes of the relationship between competition and better outcomes that have been identified in academic studies.²⁷ It drew insights from a review of board and strategy documents of a large number of NHS hospitals. The CCP used documents obtained in its investigations into hospital mergers between May 2011 and May 2012.
44. The CCP found examples of hospitals responding to competitive incentives by innovating and investing to improve the quality of their services and the patient experience more generally. Hospitals had done this through investment in integration and cooperation with GPs, improved inputs and processes, better patient and GP access to services, and market research and communication strategies. Examples of behaviour it had observed included a proactive GP engagement strategy; reducing waiting times; increasing capacity utilization rates; improving infection control processes; and higher achievement against indicators that measure quality of performance.
45. In summary, the economics literature and studies of hospitals in the UK provided evidence of competition driving better outcomes and hospitals responding to competitive incentives.

Third party views

46. We received submissions from a number of parties on the role of competition and choice in the NHS.
47. The King's Fund was commissioned by the Chief Executive of RBCH to provide its own independent views and submitted a paper²⁸ making a number of points on the role of competition in the NHS.²⁹ In relation to the degree to which hospitals compete on quality The King's Fund submitted that:
 - (a) research on patient choice had found that while valued by patients, choice of provider had not acted as a particularly strong driver for service improvement. It quoted Dixon et al (2010) in this context;
 - (b) the few econometric studies (eg Cooper et al 2011, Propper et al 2004) that had been carried out in the UK and which had sought to isolate the impact of patient

²⁷ [Inside the black box: how competition between hospitals improves quality and integration of services](#). CCP, working paper series volume 1, number 5.

²⁸ Note from The King's Fund commissioned by RBCH.

²⁹ Including that: (a) healthcare comprises a complex range of services and the way in which competition functions needs to be sensitive to this; (b) an important distinction needs to be made between competition in the market and competition for the market, and each applied appropriately; (c) empirical evidence shows that competition appears to have made some contribution to improving outcomes in some services in the English NHS, although these findings have been contested on methodological and other grounds; (d) evidence illustrates the challenges faced by NHS commissioners in England in realizing the theoretical benefits of competition in practice; (e) regulators need to be alert to the risks involved in the wrong kind of competition and to the costs of extending market principles in healthcare, including delays in bringing about service changes that may benefit patients; (f) the costs and benefits of any gains or losses in competition need to be properly assessed, with the costs of any loss of competition also evaluated and not just assumed; and (g) a range of other factors and motivations have made bigger contributions to improving performance than competition. Weighing all these considerations, the view of The King's Fund is that choice and competition should be seen as one of a number of instruments used to improve performance and deliver benefits for patients. In its view, evidence shows that competition needs to be used alongside planning, and the role of collaboration and clinical networks should be fully recognized.

choice on various outcome measures (such as mortality) showed that areas of the country with more competitive markets seemed to have achieved greater quality improvements (eg reduced mortality) than areas with less competition, although these findings had been contested on methodological and other grounds (Mays 2011);

- (c) no empirical work had been done on the cost-effectiveness of this sort of competition as a way to achieve quality improvements in healthcare; and
- (d) the most comprehensive study of the health reforms of the last government (Dixon, Mays, Jones 2012) found that while some improvements had resulted from choice and competition, other approaches had had a bigger impact. Specifically many of the most significant and visible changes resulted from the use and enforcement of targets, standards and performance management supplemented by regulation and building the capabilities of staff and leaders.

48. The Foundation Trust Network told us that, while various academic studies, most notably Cooper et al,³⁰ had used statistical techniques to demonstrate a relationship between the presence of in the market competition and quality improvements in unrelated areas of provision, more work was needed for a fuller understanding of the impact of competition. It said that concerns had been raised that it was difficult to isolate the effect of competitive pressures from the impact of other government policies. In this context it cited Kelly and Tetlow³¹ who found that it was not possible to separate the effects of the two policies—increasing patient choice and the expansion of Independent Sector Treatment Centres on changes in the proportion of patients treated at different locations over time.
49. The Foundation Trust Network also said that the existence of competition in the market was not sufficient alone to ensure that competition would work effectively. It said that other measures must be in place such as effective information systems to address information asymmetries and ensure patients have the right information to make choices. Most importantly, the act of choosing must be facilitated at the point where the patient makes a decision about which healthcare provider to select. It cited a 2010 NHS patient survey which found that 49 per cent of patients recalled being offered a choice of provider by their GP, nearly four years after the choice of provider for first outpatient appointment in elective care was introduced. According to the Foundation Trust Network this suggested that other parts of the machinery of choice are not yet functioning adequately across the board.
50. The Foundation Trust Network also said that there were other mechanisms for improving quality in the NHS, for example using integration to improve services for patients. It said that, while integration and competition were not mutually exclusive concepts, the benefits of integration should not be disregarded as a consequence of too narrow a focus on competition benefits. In summary, it said that, whilst it was keen to ensure that competition drivers were used in an appropriate and evidence-based way to drive up quality in appropriate circumstances, in order for this to happen in the long term, it would be necessary to ensure that the benefits of competition were not overstated and that competition drivers were viewed as one of a series of tools available to commissioners of NHS services, rather than answers in themselves.

³⁰ 'Does hospital competition save lives? Evidence from the English NHS patient choice reforms', op cit.

³¹ Choosing the place of care: the effect of patient choice on treatment location in England, 2003–2011, Nuffield Trust 2012.

Evolution of hospital shares at GP level

51. We analysed the evolution of the parties' shares at a GP practice level (ie the share of GP referrals which the parties received in the Dorset CCG and West Hampshire CCG³² areas) in the period April 2010 to September 2012, an analysis which could provide some useful insights as to whether quality factors influence referral decisions. Should distance be the sole driver of choice, we would have expected that hospital shares at a GP practice level would be roughly stable over time. By contrast, if quality played a role in patients' choice we would have expected that hospital shares at the GP practice level would vary to reflect any relative variation in the quality of hospital providers' services over time (although we recognized that there may be other explanations for why hospital shares could vary).
52. We acknowledge that distance is a major driver of hospital choice and thus patients of GP practices for which the second nearest hospital is located significantly further away compared with the nearest one may be less prone to travel further in order to benefit from higher-quality services provided in other hospitals. For this reason we focused our analysis on the GP practices roughly equidistant between the parties' hospital (ie the difference in drive-time to the parties' sites is less than 5 minutes) and for which factors other than distance might therefore have more tangible effects. We identified 14 GP practices meeting this condition.
53. Some specialties are relatively low volume. The quarterly activity³³ related to these specialties at GP practice level may therefore be very limited and consequently hospital shares may be subject to significant 'noise' mainly driven by the limited size of the sample (in what follows we refer to it as 'undue variation') rather than by actual changes in the referral pattern. In order to mitigate this issue, we restricted the set of specialties in our analysis and selected specialties where (a) both merging parties were active in the specialty, and (b) the specialties were relatively high volume so as to have a meaningful number of episodes to calculate shares at GP practice level and on a quarterly basis. We identified ten specialties for elective inpatient services (breast surgery, clinical haematology, colorectal surgery, dermatology, gastroenterology, general medicine, general surgery, gynaecology, medical oncology and rheumatology) and ten specialties for outpatient services (cardiology, clinical haematology, dermatology, gastroenterology, general medicine, general surgery, gynaecology, medical oncology, obstetrics and rheumatology).
54. Even when they are active in the same specialties, trusts can focus on different ranges of services/procedures.³⁴ The parties' shares aggregated at specialty level can therefore suffer from a product/service mix issue, ie they may vary over time because the range of services for which GPs referred patients varied (and hospitals did not provide the same range), and not necessarily because the relative volume provided by the various operators for the same set of treatments has changed. To address this problem we initially selected for analysis the three highest-volume elective procedures³⁵ within each specialty (on the basis of total volume carried out in the Dorset and West Hampshire areas) which both parties could be expected to provide. However, for some of these procedures we observed that at least one of the parties provided no (or very small) volume. We therefore further refined our selection of procedures with the aim of finding high-volume procedures which both RBCH and PH

³² See footnote 2 to paragraph 3 above.

³³ To have a meaningful number of observations over which to calculate market shares we aggregated data at quarterly level. The data submitted by the Dorset and West Hampshire CCGs covered the period April 2010 to November 2012. The last quarter of 2012 was incomplete and was therefore excluded from the analysis.

³⁴ See also Section 5 and Appendix F.

³⁵ We considered the FCE dominant procedure, when provided in the data and when relevant for the episode (ie when the grouping method flag indicated that the procedure was the most relevant/representative activity within the episode).

provided. As a result, we selected some procedures for general surgery, medical oncology and rheumatology which were not among the three highest-volume procedures overall but were characterized by significant activity by both parties. The list of the selected inpatient procedures by specialty is shown in Table 3 below.

55. In our view, the service mix was less of an issue for outpatient services as differentiation within specialties was more limited than in inpatient services and we found that when hospitals were active in a given specialty, they tended to provide the full range of outpatient activity. Therefore, in analysing the hospital share pattern for outpatient services we considered the total volume by specialty.

TABLE 3 List of the selected (inpatient elective) procedures

Specialty	Procedure	Procedure description
General surgery	T202	Primary repair/inguinal hernia using insert/prosthetic mater
General surgery	J183	Total cholecystectomy NEC
General surgery	S069	Unspecified—other excision of lesion of skin
Breast surgery	B282	Partial excision of breast NEC
Breast surgery	B285	Wire guided partial excision of breast
Breast surgery	B274	Total mastectomy NEC
Colorectal surgery	H259	Unspecified—Diagnostic endoscopic examination of lower bowel using fibreoptic sigmoidoscope
Colorectal surgery	H229	Unspecified—Diagnostic endoscopic examination of colon
Colorectal surgery	H221	Diagnostic fibreoptic endoscopic examination of colon and biopsy of lesion of colon
General medicine	G451	Fibreoptic endoscopic examination of upper gastrointestinal
General medicine	G459	Unspecified—Diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract
General medicine	H221	Diagnostic fibreoptic endoscopic examination of colon and biopsy of lesion of colon
Gastroenterology	G451	Fibreoptic endoscopic examination of upper gastrointestinal
Gastroenterology	G459	Unspecified—Diagnostic fibreoptic endoscopic examination of upper gastrointestinal tract
Gastroenterology	H229	Unspecified—Diagnostic endoscopic examination of colon
Clinical haematology	X339	Unspecified—Other blood transfusion
Clinical haematology	X332	Intravenous blood transfusion of packed cells
Clinical haematology	X333	Intravenous blood transfusion of platelets
Dermatology	S069	Unspecified—Other excision of lesion of skin
Dermatology	S065	Excision of lesion of skin of head or neck NEC
Dermatology	E091	Excision of lesion of external nose
Medical oncology	L913	Attention to central venous catheter
Medical oncology	X332	Intravenous blood transfusion of packed cells
Medical oncology	L914	Removal of central venous catheter
Rheumatology	A522	Therapeutic sacral epidural injection
Rheumatology	V544	Injection around spinal facet of spine
Rheumatology	W903	Injection of therapeutic substance into joint
Gynaecology	Q181	Diagnostic endoscopic examination of uterus and biopsy of lesion of uterus
Gynaecology	Q171	Endoscopic resection of lesion of uterus
Gynaecology	Q074	Total abdominal hysterectomy NEC

Source: Dorset CCG data, CC analysis.

56. Figure 1 below shows the parties' (elective inpatient) shares (in terms of number of episodes) over time separately for each specialty.³⁶ Each hospital's share is calculated as the proportion of the episodes carried out by the hospital over the total inpatient episodes (related to the treatments listed in the table above) which involved patients located in the 14 equidistant GP practices.

³⁶ The data provided by the CCGs contained, for each episode, information on the hospital where the patient was treated. Several hospitals, including private providers, attracted referrals in the Dorset and West Hampshire area. However, a small number of providers covered the large majority of the activity in these areas. These providers were: RBCH, PH, Salisbury District Hospital, University Hospital Southampton, Dorset County Hospital, Yeovil District Hospital, DHUFT and Southern Health NHS Foundation Trust.

FIGURE 1

**Parties' quarterly shares (by volume)—inpatient elective services,
April 2010 to September 2012**



Source: Dorset CCG data, CC analysis.

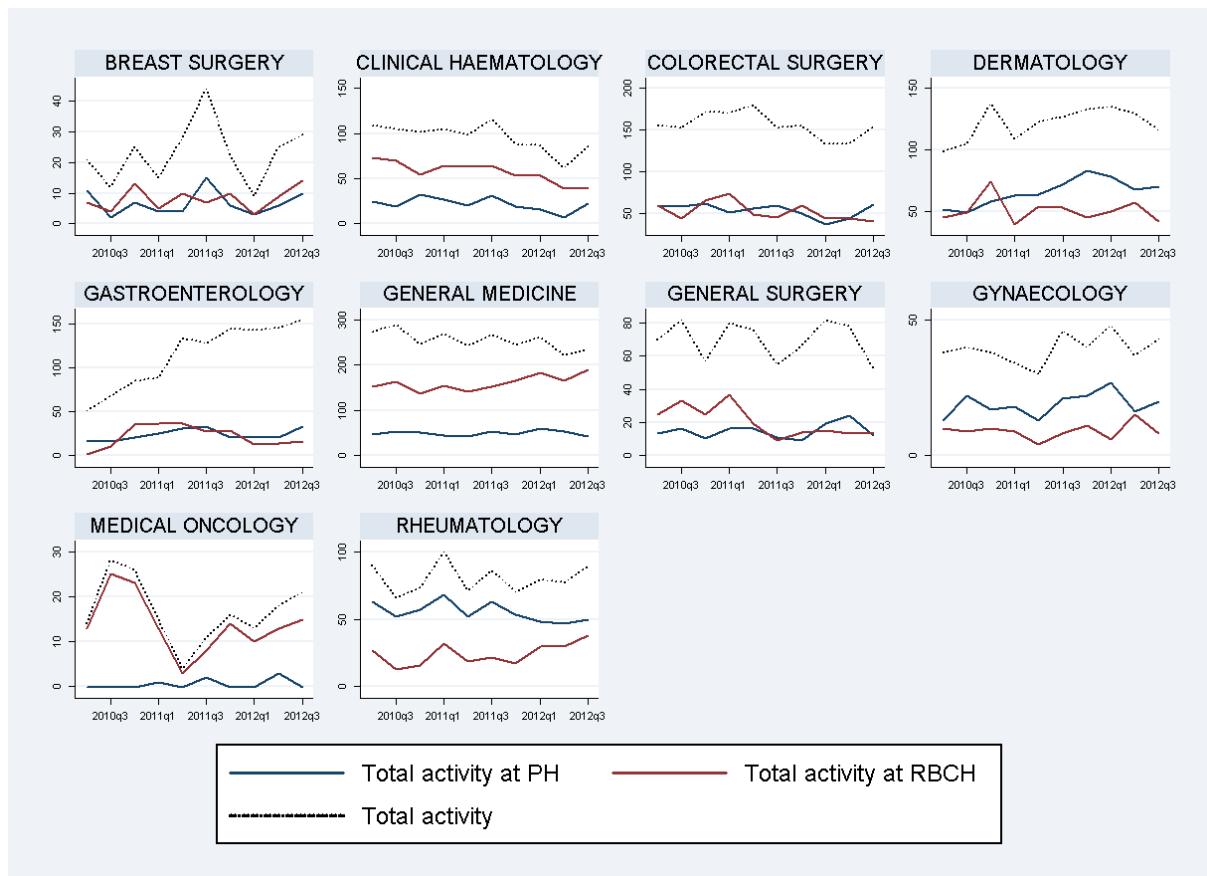
57. We saw some volatility in PH's and RBCH's shares over time, especially in general surgery, colorectal surgery, dermatology, gastroenterology and rheumatology. Breast surgery, gynaecology and medical oncology also showed some variability over time. However, these specialties were characterized by lower volumes (less than 50 episodes on a quarterly basis) and may therefore have been more exposed to undue volatility which did not necessarily reflect changes in the referral pattern (ie in the choice preference of patients and/or GPs).
58. We considered whether the variation in the shares may have been driven by a change in the overall demand rather than by a 'business winning' effect associated with a change in relative quality. We considered in particular whether increases in share for one hospital might be better explained by that hospital capturing a larger share of an increase in demand because its rival(s) were capacity constrained (as distinct from winning referrals from rivals).³⁷ To do so we calculated the quarterly activity (in terms of number of FCEs) carried out by the parties and compared it with the total volume related to the selected treatments (see Figure 2 below). If increases (decreases) in the volume of one hospital tend to be associated with decreases (increases) in the volume of the other hospital, this would suggest that the former is

³⁷ Under the assumption that the rivals are operating at close to full capacity, when the demand increases the capacity constraints bite and only the hospital with spare capacity can accommodate additional volume (thereby leading the latter to expand its share vis-à-vis the rivals).

winning referrals at the expense of the latter, possibly due to fluctuations in quality, and it is this that is explaining hospital share fluctuations. If, on the other hand, we see a hospital increase volume but not at the expense of the other, this may suggest that capacity constraints explain in whole or in part the variations we observe.

FIGURE 2

**Parties' quarterly volume—inpatient elective services,
April 2010 to September 2012**

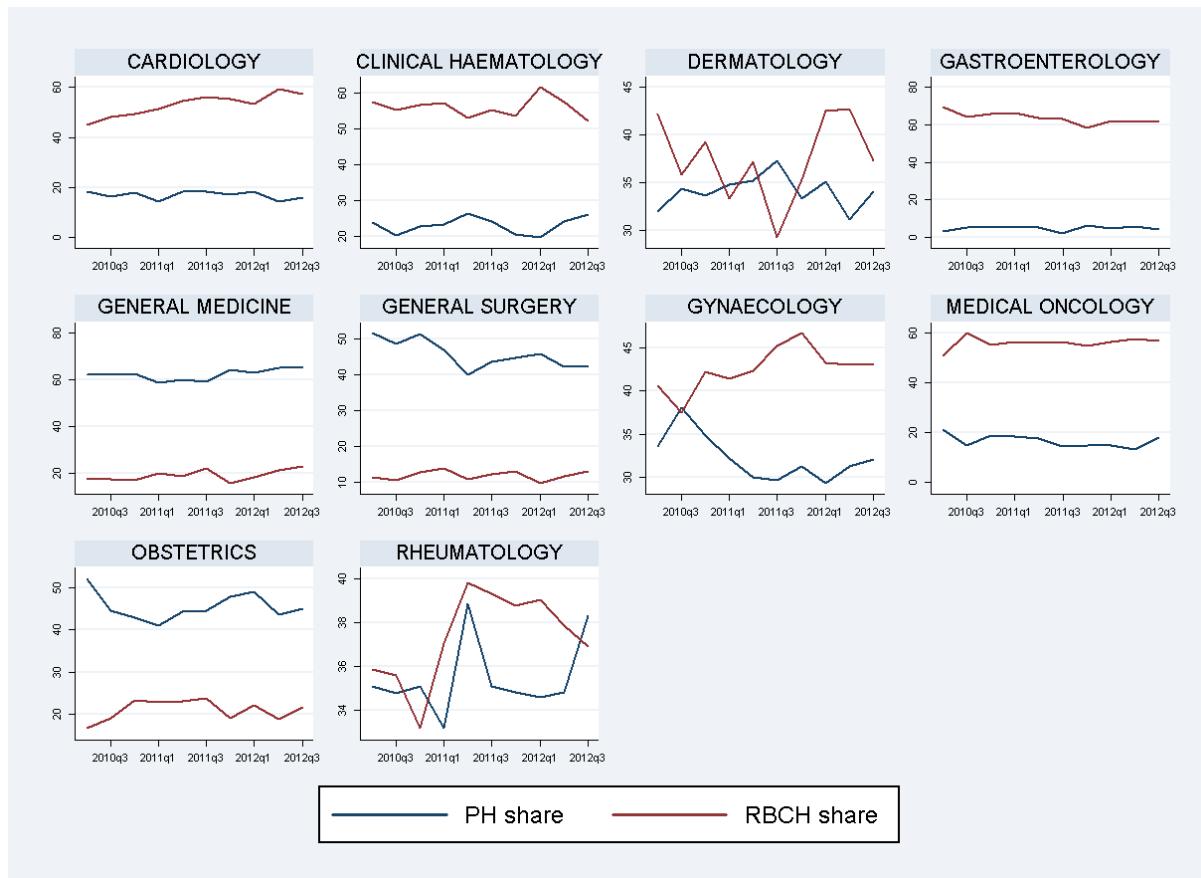


Source: Dorset CCG data, CC analysis.

59. We focused on the four specialties for which we observed significant fluctuations in hospital shares (colorectal surgery, dermatology, gastroenterology and rheumatology), and we observed cases where the parties' changes in volume appeared in part to be at the expense of one another (see, for instance, in Figure 2 the volume pattern in colorectal surgery and rheumatology in the period between the first quarter of 2011 and the first quarter of 2012 and dermatology in the period between the first quarter in 2010 and the second quarter of 2012). These changes could not be accounted for by capacity constraints and hence they indicated some other reason for the observed variation in shares.
60. Figure 3 shows the parties' hospital shares over time for outpatient services.

FIGURE 3

**Parties' quarterly shares (by volume)—Outpatient elective services,
April 2010 to September 2012**



Source: Dorset CCG data, CC analysis.

61. The volatility in outpatient shares appeared more limited than in inpatient services, though we still observed some non-negligible variability within certain specialties, for example clinical haematology, dermatology, rheumatology, obstetrics and to a lesser extent in PH's share for general surgery. This was consistent with the notion that patients' responsiveness to quality factors in relation to outpatient services is lower compared with inpatient services because quality is more likely to affect provider choice when patients and/or GPs face more severe healthcare conditions that require hospital admissions and inpatient procedures, although other factors may explain this.³⁸
62. In summary, we found that some variation in GPs' referral patterns had occurred over time which was unlikely to be caused by capacity constraints. In our view the analysis pointed to quality playing some role, at least at the margin, in referral patterns.

Evidence from the parties' marketing strategy and internal documents

63. We reviewed (a) the parties' internal documents and (b) information they provided on their approaches to marketing, with a view to establishing whether these were

³⁸ Outpatient shares are likely to be less affected by undue variation due to the larger sample of episodes (attendances) in outpatient services compared with inpatient services.

consistent with the parties competing on quality in the past and, if so, what quality measures were relevant.³⁹ We asked the parties for any market or advertising strategy documents or promotional materials. The parties told us that, whilst communications campaigns had been undertaken to support national initiatives such as 18-week waiting time targets and patient choice, no specific marketing campaigns had been undertaken. We reviewed a range of materials that they had produced to communicate with GPs and patients (see paragraphs 72 to 89 below).

Evidence from the parties' internal documents/board minutes

64. We reviewed the internal documents and board minutes submitted by the parties with a view to understanding:
 - (a) what quality measures they focused upon and whether they did so for regulatory or competition reasons; and
 - (b) whether they appeared to take strategic decisions in response to competition.
65. The parties monitored a number of key performance and quality indicators (KPIs) used to define and measure progress towards organizational goals. These indicators focused on a range of areas, some of which were used to monitor performance towards CQUIN goals and Monitor's requirements. RBCH's KPIs included, among others, patient safety incidents, 'never events', patient falls, medication AIRS, pressure ulcers, safety thermometer (CQUIN standards), mortality, patient experience, CQUIN questions and complaints. PH reported various indicators mandated by Monitor (eg cancer standards, A&E metrics) but it also counted additional information among its KPIs that was not directly related to quality (eg theatre utilization, bed occupancy). See further Appendix D for some quality information which the parties report.
66. We understand that these KPIs are indicators used to measure and evaluate clinical and management performance against set internal targets. However, these indicators are increasingly used to assess performance across the NHS and show the relative achievements of individual providers. PH reported to its board of directors how it had performed compared with the NHS South and South-West against some key indicators, for example the proportion of patients treated in less than 18 weeks from referral to treatment. This shows that it monitored quality, but not that it related to competition.
67. Certain documents showed that RBCH has, at least in the past, engaged in activity to attract patients away from other hospitals. We also read a marketing plan from November 2007⁴⁰ which said 'Marketing plan must proactively engage GPs as [REDACTED] most [REDACTED] area of our portfolio' and discussed segmenting and targeting GP practices according to the proportion of their patients that were referred to RBCH. Again, this suggests an ability and incentive to compete for patients. RBCH's 'GP Engagement Plan', produced in November 2009, said:

The approach we previously took toward GP practices was to encourage them to refer patients to us on the basis that we would be paid at PBR rates and that generally we made a surplus on the work we undertake. We particularly focused on what we called the marginal practices —those practices that send significant amount of work to us and to

³⁹ If the parties compete on quality we would expect quality of services to be an aspect of marketing.

⁴⁰ 'Marketing & Communications Plan—Putting Patients First'.

neighbouring Trusts. This was on the basis that they would be more likely to flex their referral patterns than practices that were already strongly wedded to us or one of our competitors.

68. This showed that RBCH had the ability and incentive to attract patients in the past. However, the plan went on to note that changes to NHS funding and PCT behaviour, in particular the introduction of a managed contract, had caused it to reconsider this plan ‘and move away from [§] and move towards [§]’. It is therefore consistent with RBCH having an ability and incentive to attract patients (subject to being paid at PbR rates) but either not acting on it, or removing emphasis on it, because of its relationship with commissioners (which we discuss in more detail in paragraphs 6.154 to 6.177 and Appendix J).
69. We also reviewed RBCH’s Strategic Plan 2013–14, and specifically the section titled ‘Market Share and Competition’. This presents RBCH’s share of secondary care activity at each GP practice in the region (similar to our analysis in Section 5 of our report), noting that ‘Maintaining or growing share in these practices remains a constant watching brief, and one that a strengthened IT support will most successfully support’. It also notes that ‘There is not considered to be any competition for emergency care, as this is both growing rapidly and not something any other providers wish to take on’, which implies that it believes there is competition for non-emergency care.
70. The parties prepared a Clinical Challenge Presentation Pack to motivate a discussion on post-merger quality and cost improvements. In this they made a number of references to competition including:
 - (a) The current status in relation to surgical specialties was described as ‘Facing sustainability challenge as Commissioners withdraw services, competition from Acute and Private providers.⁴¹ There is pressure on services to meet waiting times. Challenging CIP of £[§] million over 3 years’.
 - (b) The vision for both anaesthetics and cardiology was described as ‘Maintain market share for services by delivering on wait times and becoming provider of choice of high quality and reputation. Providing 7 day service to support early discharge’.⁴²
71. We also reviewed the parties’ detailed plans for post-integration,⁴³ which included many references to market shares, being a provider of choice, attracting and retaining patients, and the importance of quality in this. It lays out plans by directorate, where a directorate may contain more than one specialty. We include these as examples of the parties’ awareness of the role of competition, in various forms, in the NHS, and note that since they are post-merger plans they necessarily involve competing with third parties rather than each other. For example, the plans contain the following text:
 - (a) The vision for Anaesthetic Services is to ... Maintain market share for services by delivering on wait times and maintain position as a provider of choice of high quality and reputation delivering 7 day service to support early discharge ... By ensuring that we attract

⁴¹ PH told us that this related to the concern in the NHS about private providers ‘cherry picking’ cases leaving the NHS more exposed to more complex cases which were often less profitable.

⁴² PH told us that in cardiology the risks to RBCH came from Southampton (the tertiary provider in the region) and not PH (which did not provide interventional cardiology or EP services); and that in anaesthetics this related to pain services which were being moved out of an acute setting and into the community.

⁴³ Integration plans and CIP review, papers prepared for meetings on 1 and 2 July 2013.

and retain market share by delivering the highest standard of care; and implementing best practice guidance for delivery of patient outcomes ... By holding a leading place on indices measuring the patient experience and clinical outcomes.

- (b) Cardiology ... becoming a Provider of Choice of high quality and reputation; maintaining market share for services, delivering on wait times, providing a 7 day service to support admission avoidance and early discharge.
- (c) PPT (pathology) ... becoming a Provider of Choice of high quality and reputation; maintaining market share for services, delivering on turn around times, providing a 7 day service to support admission avoidance and early discharge ... Actively pursue greater market share ... Develop a strategy to market pathology services to potential users of the service Identify what the competitive advantages are in the new Trust. Identify areas of potential gaps in the market and how the market may develop. Develop business cases and submit to execs for approval as required. ... Market existing users e.g. GP newsletter ... Identify with marketing a means by which the service can engage with current and potential service users to expand market share. ... Risks: ... Unable to attract activity due to competitiveness or unwillingness of market. ... Positively market repertoire. Ensure competitiveness in terms of finance and quality where ever possible, negotiate with providers and CCGs.
- (d) PPT (Therapies) Directorate Vision—To become the provider of choice of high quality Therapy Services across East Dorset. This will be achieved by the delivery of reputable high quality clinical services; maintaining and, where possible, increasing the market share for services. ... Whilst some core business components of Therapy Services such as Primary Care Physiotherapy may in the future be impacted upon by Any Qualified Provider (AQP) commissioning processes this also presents an opportunity to increase market share in other areas. The department must be alert to such opportunities and position themselves to take advantage of these if they arise. ... To increase market share through the implementation of MSK Outpatient Physiotherapy Services to Hampshire patients with Neck & Back Pain following provider qualification under the AQP process.
- (e) PPT (Outpatients) Directorate: Across all locations we aim to increase market share for all outpatient services by becoming the Provider of Choice of high quality and reputation, delivering innovative models of care across the Trust and region. ... Main risk associated with the ability to attract activity due to competitiveness or unwillingness of market. Need to engage comms for support.
- (f) Maternity: Market the facility ... Contact communications re press release/on maternity website ... Design/print leaflet for inclusion in booking packs for pregnant women ... Ensure both Poole booked and Bournemouth booked women are aware of the facility ... Ensure staff are aware of the facility and market it to women.
- (g) Paediatrics: Maximise future opportunities for increased market share through extended paediatric expertise and enhanced service

provision ... Improved patient experience and outcomes through compliance with BPT's and NICE guidance. Improved quality of service to influence market share opportunities ... to maximise upon any opportunity for expanding its market share. ... Determining the [§] of the Paediatric Unit will also require a detailed assessment and understanding of the impact on potential market share, patient experience and subsequent choice of provider ... Undertake assessment of current market share and develop emerging plan to influence commissioners and increase share. ... Work with clinicians to develop strategy for both sub-specialisation and increase of market share.

- (h) Surgical Specialities Directorate [Ophthalmology/ENT]: Our vision is to maintain and expand market share for services by delivering on wait times and becoming a Provider of Choice of high quality and reputation ...
- (i) Radiology: Maintaining market share for services and delivering on wait times ... Instigate a marketing strategy for patients and clinicians ... RBH is soon to be centre of a hub and spoke vascular network in line with national recommendations. This opens up the potential to [§] with new work from patients in the catchment of [§] and [§]. [§] have Best Practice PBR tariff (£7100 per case and the stent is an excluded device). Profit share with surgery. Aim to attract [§] cases per year from [§] and [§] cases per year from [§]. ... Improve facilities to attract patients.
- (j) Cancer Care Directorate: Repatriation, marketing of services, reputation building ... Undertake assessment of current market share and develop plan to influence commissioners and increase share.

Evidence from the parties' approach to marketing

PH

72. PH told us that it did not devote a great deal of effort, time and resource to marketing in its pure sense. When PH submitted its application for foundation trust status in 2007, it set out its strategy which included: promoting its services, particularly the quality of care, and low waiting times in order to make the hospital the preferred provider of choice for patients and referring GPs, in line with the guidelines set out for Practice Based Commissioning; engaging in a series of one-to-one meetings with GP practices and with the trust's consultant bodies to develop services; and maintaining a diary of forthcoming events to help plan proactive publicity around national and local awareness campaigns. When asked how PH had developed these strategies since 2007, PH told us that, whilst there had been ongoing engagement with GP practices, there had been no coordinated marketing strategy for the following reasons:
- (a) The trust already had an excellent clinical reputation with its local GP practices and was already receiving the majority, if not all, appropriate referrals.
 - (b) The trust's best way of promoting its services was through maintaining a consistently high quality of care and working to keep waiting times low. This was already well understood by local GP practices, which were well placed to advise patients on these considerations.

- (c) The trust was in significant breach in 2010 and 2011 and was focused on financial recovery and since being released from significant breach the primary focus had been on delivering a successful merger with RBCH.
- (d) The trust did not have the resources to develop and implement a marketing strategy: it had not had a Director of Strategy for significant periods; had no marketing department and no contracting department.
- (e) The trust had had block contracts with its commissioners in 2010/11 and 2011/12 and had been working closely with commissioners to reduce activity rather than increase it, and this related to all activity although the primary focus had been on emergency activity (where the 30 per cent marginal tariff applied).

73. PH told us that marketing activities had only a very marginal impact on referrals (less than half a per cent), and that the level of investment, time and energy that went into promoting services rarely delivered any shifts in referrals. More generally, PH told us that it did not think that there was any real evidence to suggest that patients made decisions on the basis of reasons other than clinical care and indeed were often directed by GPs on this.⁴⁴ PH said it was very difficult to change historical referral patterns because patients went to their local hospitals unless there were extreme reasons for changing (see paragraph 42 above). PH said that some changes in referral patterns might be based on temporary factors, for example the other hospital could offer shorter waiting times, but these tended to be short-term changes and were unlikely to make significant differences to the trust's income generation, particularly if reducing waiting times further required additional resource/costs.
74. PH also told us that it constantly monitored the referrals of its local GPs—ie its 'natural referral market'—to make sure that it received the referrals it was expecting. PH also told us that in the past, when Choose and Book was first launched, it tried to attract more patients by ensuring that the right services were listed online. PH said that 'it is getting the right clinics that would catch the eye of the patient who is trying to find the right clinic'. It said that this was done to ensure patients using the system would see the appropriate specialist, rather than attending a more general clinic which would waste the patient's and doctor's time; but it seemed to us that this would also help PH to attract referrals when Choose and Book displayed services at other local hospitals.
75. Regarding its communication campaigns, PH told us that it sent a regular newsletter to GP practices within the area. We reviewed examples of this newsletter from 1 January 2013 to 1 June 2013 and 1 April 2009 to 31 March 2010. PH promoted several educational events for GPs, which we would expect to lead to increased referrals. Some (though not all) aspects of this newsletter also seemed to us to be promotional, in the sense of implying that PH was a better hospital than others, presumably with the aim of encouraging referrals. For example:
- (a) in April 2009 PH reported that it was named the winner of the CHKS Patient Safety Award 2009 as the safest hospital in the UK;
 - (b) in July/August 2009 PH reported that the National Patient Safety Agency (NPSA) rated PH's quality, choice and availability of food as 'excellent';

⁴⁴ PH said that it did release 'good news story' press releases (for instance to inform the public about the installation of a new MRI scanner, or staff awards); but these were primarily about providing information and assurance to the public about the range and quality of services on offer at PH, and were not aimed at attracting more patients to the hospital.

- (c) in October/November 2009 PH reported that it received a double 'excellence' rating by the CQC for the quality of its services and managing its finances. It also reported that the double 'excellence' rating was awarded to only 37 other acute hospitals in the country;
- (d) in July/August 2009 PH was reported as having been given another clean bill of health for hygiene standards following an unannounced inspection by the CQC;
- (e) every GP Newsletter published by PH provided a monthly update on the number of hospital-acquired MRSA bacteraemia and, in October/November 2009, gave an overall count of the infections during the year;
- (f) in April 2009 PH promoted the fact that patients who required minor op procedures in its dermatology department were now admitted as day-cases and stressed how this change allowed a better management of the waiting list and the ability to agree dates directly with patients;
- (g) in January 2010 PH promoted a new model of maternity care and stressed how the pilot highlighted improved outcomes for women and improved continuity of care; and
- (h) in March 2010 PH promoted a new echocardiograph machine and stressed how the new equipment boosted PH's capacity and, ultimately, shortened waiting times and improved diagnostic accuracy.

76. PH said it did not accept that informing patients of its high-quality standards should be regarded as promotional 'with the aim of encouraging referrals'. It said that it would publicize 'good news' stories for a number of reasons (including inspiring local confidence in NHS services and promoting staff morale) and that it cost little to do so. We accept that this kind of activity may have more than one motivation but one interpretation for this material was that it promoted competition, and one likely effect of it would be a positive impact on referrals to PH.

RBCH

77. RBCH also told us that it was difficult to persuade patients to change their choice of hospital as the vast majority of patients chose to go to their nearest hospital. RBCH said that the likelihood of attracting patients from other hospitals was very remote as it was necessary to motivate patients to go to a different centre, travel further and establish new relationships with new consultants. It said that major problems with its services would result in patients moving to another hospital, but there were no such examples of problematic services currently. RBCH said that it struggled to attract patients who lived in Poole even though its waiting times were currently shorter for endoscopies. RBCH also said that there was a 10 per cent difference in the five-year survival rates from colorectal cancer between RBCH and PH and other hospitals in the South-East of England and yet this had not resulted in a massive influx of patients to RBCH or PH. RBCH also said that the funnel plot data on 30-day surgical mortality showed that RBCH was number 4 out of 167 trusts in the country and yet this had not resulted in a massive influx of patients either.
78. In contrast, we noted that RBCH told us that it had competed in relation to interventional cardiology services: RBCH developed these services from scratch with

commissioner support and was able to win business from Southampton Hospital over a number of years.⁴⁵

79. RBCH told us that, if PH attempted to increase its elective provision in an area where it already had a significant service, it would [X]. RBCH said that in these circumstances it would look at [X]. In summary, RBCH told us that it would not be [X] in the face of competition from PH: it would [X]. However, as part of service development in the NHS there are examples where RBCH has supported development of services at neighbouring trusts. For example, RBCH supported PH in training its own consultants to develop a cardiac pacemaker implantation service, which took Poole catchment patients away from RBCH. Likewise it supported Salisbury hospital cardiologists in gaining the skills to open a 'rival' cardiac intervention unit.
80. Like PH, RBCH told us that it did very little marketing in the sense of promoting services to attract new referrals and that its communication efforts were predominantly aimed at information for patients about their conditions and helping them manage them. It said this was part of the responsibility to ensure public confidence in the NHS, as well as best use of scarce resources. RBCH said that it did monitor market share and count GP referrals but it did not do marketing campaigns. RBCH indicated that the main discussions it had with the PCTs were around managing the increase in referrals (eg cancer) because [X].
81. RBCH said it had a list of 71 GPs mainly in and around the Bournemouth-Poole area that it regularly communicated with, although it also made communication materials available to a broader set of GPs in and around the wider Dorset area.
82. In terms of specific communication activities RBCH told us that it carried out various activities to engage with GPs. RBCH:
 - (a) runs evening and educational events for GPs where they talk about changes in provision and advances in clinical practice;
 - (b) collects feedback from GPs to understand in which areas the hospital could improve; and
 - (c) circulates leaflets to GP practices where it provides a range of information including the portfolio of services it offers and consultant waiting times. On this, RBCH said that it sent the leaflets to its existing catchment population so that it could inform them of the current services, because its main concern was that patients should use the services appropriately.
83. RBCH also said that the last time it circulated any promotional materials was about five years ago (after RBCH became a foundation trust) when it distributed a brochure of services en masse, via a leaflet drop. RBCH said that it carried out the following activities to engage with patients:
 - Circulating patient information leaflets about conditions and how to manage them, eg emergency telephone numbers to contact.
 - Providing patient information via its website. For example, it provided videos where a consultant talked about a specific treatment and patients could watch how the procedure looked in advance. It told us that these videos circulated on the Internet and it had won awards for engaging with the population in this way.

⁴⁵ See paragraph 6.122.

- Bringing in patients to try crutches in advance of a knee or hip replacement surgery. RBCH told us that this activity made a significant difference in terms of rehabilitation and was therefore provided as patient education benefits and quality benefits.
- Hosting talks where groups of 200 patients came into the hospital to hear about a given service. RBCH told us that with this strategy it aimed to put the condition and the service in patients' minds for a number of years.
- RBCH organized an annual open day event where it engaged with members of the public and gave more information on its new services and treatments. In addition, it organized conferences on specific diseases and related treatments throughout the year.

84. RBCH said that it had until recently bought a regular column in the *Echo* newspaper primarily for public education purposes. RBCH said that it carried out this strategy when it was starting to expand its services and was looking to develop market share, although it had become more focused on patient education, ie raising awareness and education, rather than advertising. It told us that as of about three months ago it started to take a different approach and replaced the column with advertorial pieces to explain the merger and its benefits, among other things. It told us that it did not use these articles as a vehicle for encouraging patients to switch away from PH.
85. We reviewed examples of RBCH's *Echo* columns and noted that RBCH included information of public interest on new services/units recently opened, post-surgery care, new equipment and timely diagnosis which, on the face of it, suggested that it was stressing aspects of the quality of its clinical care to patients and GPs. RBCH told us that these articles were not 'a vehicle for encouraging patients to switch away from PH', noting that two recent examples promoting new or improved services were about the new Acute Medical Unit at RBCH, which was not (in its view) an area where patients exercised choice;⁴⁶ and a new eye unit at RBCH, emphasizing the improvement in patient experience, with ophthalmology services not being available at PH.⁴⁷
86. Not all of the columns related to promoting its services, but we still considered that the columns went beyond information provision and acted to some extent as a promotional tool (even if not every example is aimed at PH, RBCH will still compete with other hospitals, albeit that their greater distance may make them weaker competitors than PH would be).
87. We also noted that:
- (a) On the front page of RBCH's website is a section titled 'Reasons to choose us' (which includes reference to its award of 'Acute Organisation of the Year' in 2009 by the *Health Service Journal*, and a link to select patient feedback).⁴⁸
 - (b) RBCH discussed ensuring that comments received through NHS Choices are responded to on a number of occasions in the Marketing and Communications Committee meetings.

⁴⁶ *Echo column*, 13 June 2012. We do not accept that there is no scope for choice in emergency care. This article says: 'The ability of the AMU to take direct referrals from the local GPs means that patients receive high quality care from a team of experienced healthcare professionals in an appropriate environment—so they get the right decision about their care at the right time.' GPs sometimes have a choice as to where they refer patients in an emergency (although in other cases there may be protocols in place that direct them), and may also take patients' preferences into account.

⁴⁷ *Echo column*, 12 August 2012.

⁴⁸ www.rbch.nhs.uk/, accessed 24 September 2013.

- (c) Reviewing KPIs such as market share and trends as well as patient satisfaction reports was suggested when discussing revised terms of reference for this committee in July 2008 (although RBCH told us that subsequent years' papers show this no longer occurs, we note RBCH's 2013/14 Annual Plan described in paragraph 69 includes a section on market share information).
- (d) At a Marketing and Communications Committee meeting on GP activity in September 2008 it was noted that RBCH was arranging for consultants to give lectures in various GP practices [§]. Separately at this time it appeared that RBCH was trying to increase referrals to the hospital through those practices although there had been no significant impact to date: on this it was agreed that someone would investigate whether they might acquire software to monitor the communication that is sent out via email and perform a post-campaign analysis. However, after review this was not implemented. Subsequently, when updating the committee on the trend of GP referrals in October 2009 it was noted that 'when seeing GPs the message is that we still want to be the provider of choice but we need to work within available resources and with the PCT in managing demand'.⁴⁹
- (e) At a Marketing and Communications Committee meeting discussing the development of the website in May 2009 it was noted that 'there should be a marketing section, and applying the objectives giving reassurance to patients and preparing the patients stay in hospital'. When discussing the website in November 2009 it was noted that the system must enable RBCH to do campaign analysis so RBCH could see what the impact is from what it does on the website, for example the feedback from the maternity DVD. When discussing the development of the website in January 2010 someone asked whether information on GPs could be stored in the members' database so that it can be used to target different communities as well as how powerful its marketing capabilities would be. RBCH told us that subsequent minutes showed that website visits had been monitored, but the information on targeted groups was not available.
- (f) At a Marketing and Communications Committee meeting in November 2009, when discussing its communications plan RBCH noted that as part of the communications plan a series of case studies had been put together to demonstrate how the trust was achieving better care and that these case studies would be used in various ways to promote RBCH's successes to GPs, the public and staff, ie at poster points within the trust and in the column RBCH has in the *Echo*; and
- (g) When discussing patient information in June 2010, the committee noted that the quality of the letters sent out by RBCH needed to be reviewed and that the letters should also be a facility to promote the hospital. RBCH told us that letters were sent to patients already attending the trust and this was about reassurance rather than attracting new patients.
88. We also observed recent examples (while the merger has been in contemplation) of RBCH and PH working jointly, rather than competitively, on engagement with GPs. In January 2012 it was noted that 'it has been agreed in principle to start working jointly with PH on GP engagement and a meeting has been arranged with their consultant lead to co-ordinate on this'. Similarly in September 2012 it was noted that 'The CCG

⁴⁹ It was reported in the Marketing and Communications Committee in November 2009 that '[§]'. RBCH told us that the context for this was the financial crash of 2008, and the clear expectation that public finances would constrict, and the 6 to 8 per cent annual growth that the NHS had been receiving would end, and hence the expansion of services would end. In this context the committee's focus since 2009 had been on serving the local population well.

will be in place formally from April 2013 and replace the PCT. The Trust needs to have a better understanding of the GP views. It would be more productive to do this work with PH' and the committee agreed that RBCH would progress this work with PH. However, in May 2013 it was noted that RBCH would have liked to meet with the local medical committee team with PH,⁵⁰ but this was not possible because of the merger.

89. In summary, whilst the parties told us that they did not engage in much marketing activity to attract new market share because it was difficult to affect patient referral patterns, we found that:
- (a) When PH applied for foundation trust status it outlined a marketing strategy and continues to understand the importance of maintaining high quality standards in order to attract patient referrals. PH also appeared to have marketed its services to GPs through its newsletter.
 - (b) Prior to the decision to merge, RBCH does appear to have engaged in marketing and promotional activities in relation to the quality and range of its services. We also noted that RBCH actively monitored GP referrals and told us that it would [REDACTED], which suggests that it believes it has tools at its disposal to retain patient referrals.
 - (c) We also reviewed the parties' detailed plans for post-integration,⁵¹ which included many references to market shares, being a provider of choice, attracting and retaining patients, and the importance of quality in this and that this included detailed references to marketing and increasing market share.

⁵⁰ The local medical committee is akin to a trade body for local GPs, and has no formal role for commissioning. RBCH said the meeting was at the local medical committee's request.

⁵¹ Integration plans and CIP review, papers prepared for meetings on 1 and 2 July 2013.

GfK. Growth from Knowledge



**Royal Bournemouth and Christchurch Hospitals NHS
Foundation Trust and Poole Hospital NHS
Foundation Trust Merger Inquiry**

**A research report prepared for
The Competition Commission
April 2013**

Provided by: GfK Consumer Services

Your contact:

David Rodgers

Phone: +44 (0)20 7890 9779, Fax: +44 (0)20 7890 9744
e-mail: david.rodgers@gfk.com



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4.2	Drivers of choice
4.3	Diversion
5.	GP Survey Findings
5.1	GP Profile
5.2	Dialogue with patient
5.3	Diversion
5.4	Views on the Merger

Appendix

A - Patient questionnaire

B - GP questionnaire

C – GP Notification Letter

D – Practice Manager Letter



1 Executive Summary

Background

1. The Competition Commission (CC) has been investigating the anticipated merger between the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (hereafter referred to as RBCH) and the Poole Hospital NHS Foundation Trust (hereafter referred to as PH). As part of this inquiry, the CC sought quantitative market research with GPs who refer patients to the merging hospitals, and with patients who have been referred to the merging hospitals. The purpose of the research was to understand how the choice set offered in the local area for elective treatments (those planned in advance) might be affected by the merger.

2. The surveying was undertaken in two parts. For patients, face-to-face interviewing was conducted at each of the hospitals among those who were undergoing treatment for one of the specialties of interest to the CC. The list of specialties was drawn up by the CC and was designed to cover those specialties where provision was available from both RBCH and PH. 456 patient interviews were conducted in total across the two hospitals. For GPs, telephone interviews were carried out among GPs who had made a referral to one or other of the merging hospitals in the last three months for one of the specialties of interest. 36 GP interviews were conducted in total.

Patient Survey

3. About one in two patients were aware they had a choice of hospitals they could go to for their treatment (46% at RBCH and 54% at PH). Most of these patients knew about their right to choose before they first visited the GP for the referral; just 5% of patients had been unaware before but had been told by the GP that they had a choice of hospitals they could attend.

4. About one in four patients knew they had a choice and knew which hospital they wanted to attend before they saw the referring GP. About one in ten were aware of choice and had a recommendation from the GP, and this split roughly equally between those who said the recommendation was essential or very important in their choice of hospital to attend, and those who said otherwise. The remainder of those who were aware of choice did not know in advance where they wanted to go, and had no discussion with or recommendation from the GP. There was little difference in the pattern of response by hospital attended.

5. Patients were asked about their personal or family experience of hospitals in the local area. Nearly all had some previous experience of one or other of the merging hospitals, and just over one in two had experience of both. In comparison, experience of other hospitals in the local area was at a relatively low level.
6. All patients were asked how important it was to them that they were offered a choice of hospitals. About one in two thought that having a choice was essential or very important.
7. One in four (24%) had a discussion with the GP about which hospital to attend, and mostly the discussion was about one or two hospitals. Nearly all of those who discussed a hospital with the GP talked about the hospital they attended. In about one in three cases they discussed the other merging hospital, whilst discussion about other hospitals was at a lower level. The most frequently discussed topic was the waiting times for appointments.
8. Patients were asked whether the GP had either recommended a hospital, or told them where to go for their condition. In only a minority of cases did this happen (about three in ten). In the great majority of these cases the recommendation was for the hospital they attended.
9. Patients at both hospitals identified the clinical expertise of consultants and other healthcare professionals as the most important feature when thinking about which hospital to attend. Availability of specialist medical equipment was considered the next most important feature. The features identified as relatively less important were the patients' previous experience of the hospital, and comfort of the waiting rooms. The ease of getting to the hospital or parking at the hospital was also one of the features considered relatively less important.
10. Patients were asked how many weeks they had to wait before their first appointment at the hospital following their referral from the GP. They were then asked how much longer they would have been prepared to wait for their first appointment before going to another hospital that provided their treatment. This provided a measure of their tolerance to increased wait times at the hospital they attended. They were then asked which other hospital they would have gone to instead, if the wait time at the hospital they attended had been longer than the maximum they were prepared to wait. Those patients that could not give a maximum wait time or would not have gone to another hospital even with a longer wait time, were asked which



other hospital they would have gone to instead if they had not been able to get an appointment at the hospital they attended.

11. About one in two patients would have gone to the other merging hospital (51% of patients at RBCH and 56% at PH), with about one in five saying they would have asked the GP or did not know, and nearly all the remainder indicating they would have gone to another NHS hospital.

12. All who would have gone to the other merging hospital as their second choice were asked where they would have gone if this hospital did not offer their treatment. About one in two patients (57% at RBCH and 43% at PH) named a third choice hospital. The most frequently mentioned third choice hospitals were DHUFT Wimbourne/Victoria hospital and Southampton General hospital, this being true of both RBCH and PH patients.



GP Survey

13. The results from the GP survey should be treated with caution due to the relatively low sample size (36 interviews).
14. GPs were asked a series of questions about their most recent referral to one or other of the merging hospitals for one of the specialties of interest to the CC. It should be noted that only a small minority of GPs (one in six) thought the most recent referral was atypical of the way they discussed hospital choices with patients.
15. In about half of cases the GP indicated the patient already knew which hospital he or she wanted to attend when discussing the referral. In two in three cases the GP had a discussion with the patient about the hospitals they could be referred to, although this varied according to whether the patient already knew which hospital they wanted to go to or not. Where the patient did know, a discussion was held in about half of all cases, but where the patient did not know or was open to considering other options, a discussion was held in almost all cases.
16. Those GPs who said they had a discussion with the patient (23 GPs) were asked how many and which hospitals they had discussed. Most claimed to have discussed two or three hospitals with the patient, and the majority had discussed both RBCH and PH. Among those GPs who had a discussion with the patient, the three topics most often discussed (by the majority) were waiting times for appointments, the ease of getting to the hospital and the clinical expertise of consultants or other healthcare professionals.
17. One in three GPs recommended a hospital to the patient. A recommendation was generally not made with patients who already knew which hospital they wanted to attend (only one GP did so). However, with patients who did not know which hospital they wanted to attend, a recommendation was nearly always made. Where the GP made a recommendation (11 cases), it was always to one of the merging hospitals.
18. Those GPs who had made a recommendation to the patient were asked a series of questions to establish which other hospital they would have recommended if clinical outcomes at their recommended hospital had deteriorated. They were asked to rate their recommended hospital on the overall level of clinical outcomes for the specialty under consideration, and then how

much lower the clinical outcomes would have to be before they would change their recommendation, and if this happened which other hospital they would have recommended instead.

19. Five out of the eleven GPs answering this question said they would have recommended the other merging hospital, four said Dorset County Hospital (three of whom had originally recommended PH and one RBCH), one said Southampton General Hospital and one said DHUFT Wimbourne/Victoria Hospital.
20. GPs were asked for their views on the planned merger; whether they thought it would improve the quality of patient care in the local area, worsen the quality of patient care, or make no difference. Opinion was split, with one in three saying patient care would improve and the same proportion that it would worsen. Negative opinion was slightly more prevalent among those GPs whose most recent referral had been to PH.
21. Four key themes emerged as reasons why it was thought the merger would improve patient care. Some GPs thought a merger would allow the sharing of *resources and expertise*, which would improve patient care. There were also comments about the merger providing opportunities to specialise, to create *centres of excellence* for particular specialties. Some GPs emphasised the *financial benefit* of the planned merger, which they thought would save costs and ensure that money is spent on patient care. *Removing duplication* was mentioned as another benefit, with some GPs saying that the merger would help rationalise service provision and ensure that there was no duplication of services across the two hospitals.
22. Looking at responses from those GPs who thought that patient care would deteriorate with the merger, four themes emerged. Some thought the *quality of care* would worsen, with concerns about cuts in service, and specific mentions of services deteriorating at PH. *Financial issues* were mentioned by some GPs with particular concerns about the level of charges from RBCH. Some GPs thought the quality of patient care would deteriorate because of the *reduction in choice*. They thought that less competition would reduce the level of service. The *accessibility of services* was an issue for some, with specific concerns about the difficulty of getting to RBCH for some patients.



Survey Comparisons

23. Looking at the findings of the two surveys in combination, there are some common themes that emerge:
- A sizeable proportion of patients knew which hospital they wanted to attend before they visited the GP. One in four from the patients survey indicated they knew beforehand, and one in two GPs indicated that this was the case with their most recent patient referral.
 - Waiting times for appointments and the clinical expertise of consultants were the topics most often discussed between the GP and patient.
 - Outcome focused features such as the clinical expertise of consultants, and availability of specialist medical equipment, were considered the most important factors in assessing a hospital.
 - Where GPs discussed hospitals or made recommendations, it tended to be about one or other of the merging hospitals, or both.
24. However, there are some interesting points of comparison between the two surveys:
- GPs claimed to have discussed options with the patient in more cases than was evident in the patients' survey.
 - One in two patients claimed to be unaware that they had a choice of hospitals that they could have attended for their treatment, a higher figure than is indicated by the results of the GP survey.



2 Background and Research Objectives

25. The CC has been investigating the anticipated merger between the RBCH and PH. As part of this inquiry, the CC sought quantitative market research with GPs who refer patients to the merging hospitals, and with patients who have been referred to the merging hospitals, to understand how the choice set offered in the local area for elective treatments (those planned in advance) might be affected by the merger.
26. In particular the survey sought to establish:

FOR PATIENTS:

- Choice, if any, of hospital offered by their GP
- Choice of hospital made
- Reasons for making choice
- What the patient would have done if the hospital s/he chose was not available
- Condition referred for
- Demographic details

FOR GP's:

- Hospitals available for referrals, in general
- Key factors in deciding choices to offer/ recommendations to make
- For the last referral:
 - i. Overall choices available
 - ii. Choices offered to the patient
 - iii. Whether made a recommendation, and if so reasons for making a recommendation
 - iv. Action would take if hospital referred to not available
 - v. Patient details (including condition referred for)
- Demographic details of the GP

3 Research Design

3.1 Patients

27. Interviewing was conducted face-to-face among patients who were undergoing an elective treatment for one of the specialties of interest to the CC (see table below) at RBCH and PH. Patients were screened to ensure they were seeing a consultant, hospital doctor or specialist nurse on that day, for one of the specialties of interest. The list of specialties was drawn up by the CC and was designed to cover those specialties where provision was available from both RBCH and PH. In order to facilitate the screening process, the hospitals provided a list of the consultants (and doctors/specialist nurses) for the relevant specialties who were working on each day of the fieldwork period, and patients were asked whether they were visiting the hospital on that day to see one of the named individuals, and only those so doing were eligible for the interview. As a second check, patients were asked to identify the reason they were visiting the hospital on that day (from a showcard list of the specialties of interest), and only those visiting for one of the relevant specialties were invited to take part in the survey. Patients were also required to have been initially referred to the hospital by the GP (or dentist if for Oral Surgery) within the previous four months to qualify for interview.

Table 1: List of specialties

	Speciality
1	Breast Surgery
2	Cardiology involving MRI, CT, and ECHO scans (not ECHO stress)
3	Dermatology (skin)
4	Diabetic medicine
5	Endocrine Surgery (glands)
6	Endocrinology (glands)
7	Gastroenterology (stomach, digestion)
8	Gastro-intestinal Surgery – upper (stomach, digestion)
9	Gastro-intestinal Surgery – lower (colorectal)
10	Geriatric medicine (older people)
11	Gynaecology
12	Haematology (blood)
13	Hepatology (liver)
14	Oral Surgery (mouth, teeth, gum) but not Maxillofacial
15	Pain Management
16	Rehabilitation
17	Rheumatology (joints, arthritis, rheumatism)

28. A pilot fieldwork shift was conducted at RBCH in advance of the main fieldwork to test the questionnaire, and a few minor amends were made as a result. The average questionnaire length was 10 minutes.
29. Survey fieldwork was conducted from 14 February - 8 March 2013.
30. A total of 2,116 patients were approached, and of these just 11% refused to participate. One in four (24%) of those who participated were eligible and completed the interview, this amounting to 456 completed interviews in total. The sample breakdown is shown in the table below.

Table 2: Patient Sample

Total Number of Patients Approached at the hospital	2,116
Patients who did not refuse interview	1,877
Patients who were seeing a GP, consultant or specialist nurse	1,709
Patients who were seeing one of the named GPs/consultants/ specialist nurses	1,325
Patients visiting hospital for one of the specialties listed	1,203
Patients who had initially been referred by GP	1,063
Patients who had been referred within last 4 months (interviews completed)	456



3.2 GPs

31. The survey was conducted among GPs who had made a referral to either RBCH or PH in the last three months for one of the specialties of interest to the CC. As with the patient survey, these specialties were those where provision was available from both RBCH and PH.
32. The sample was provided by the CC and comprised all GPs who had made a referral to one of the hospitals in the last year. For sampling purposes only GPs who had made five or more such referrals were contacted, to establish whether or not they were eligible to complete the survey.
33. A notification letter was sent out to all GPs, informing them of the Inquiry and that they may be contacted by GfK. It also provided an option for opting out of participation of the survey. Interviews were conducted by telephone, in most cases the first point of contact was the Practice Manager who was asked to help make appointments with all the GPs in the practice on the sample list. The assistance provided by Practice Managers was uneven, and therefore a notification letter was also sent half way during the fieldwork period to all Practice Managers informing them directly of the survey to try to encourage their help in the conduct of the survey.
34. GPs were asked to give responses with regards to their most referral to RBCH or PH for one of the specialties of interest. The survey therefore represents a sample of referrals. However, it should be noted that at the end of the survey the GPs were asked whether or not their most recent referral was typical of how they discussed hospital choices with patients, and three in four indicated that it was typical, and only one in six saying it was atypical (the rest indicating it was too difficult to say).
35. Two pilot interviews were conducted in advance of the main fieldwork to test the questionnaire and ensure it was fit for purpose. The interviews lasted twelve minutes on average.
36. Fieldwork was conducted from 12 February – 12 March, 2013.



37. 535 GP contacts were available from 111 GP practices (excluding those GPs who were no longer working at the practice). From this 36 interviews were achieved with GPs across 23 practices, this representing a 7% response rate. One of the main fieldwork challenges was trying to obtain multiple GP interviews at the same practice, as Practice Managers were generally reluctant to make multiple appointments for interviewers.
38. The sample breakdown is shown in the table below.

Table 3: GP Sample

Sample provided	1,099
Sample with doctor names	1,009
Made >=5 referrals to either hospital	598
Available sample after Pilot (removed; pilot respondents and unusable sample)	570 (111 GP practices)
Usable sample (removed; Moved, Retired, Long Term Sick, Deceased)	535
Did not refuse	309
Completed Interviews	36 (23 GP Practices)

39. The majority of the practices represented in the survey were within the Bournemouth (BH) postcode, with a few in the Dorchester (DH) postcode area. Looking at the proximity of practices to the merging hospitals, about half of the practices were closer to RBCH and half to PH.
40. Some care is required when interpreting the results from the survey. The results should not be viewed as precise representations of GP views, as the sample size is relatively small (36 interviews) and the views may or may not be totally representative of all GPs who could have taken part in the survey.

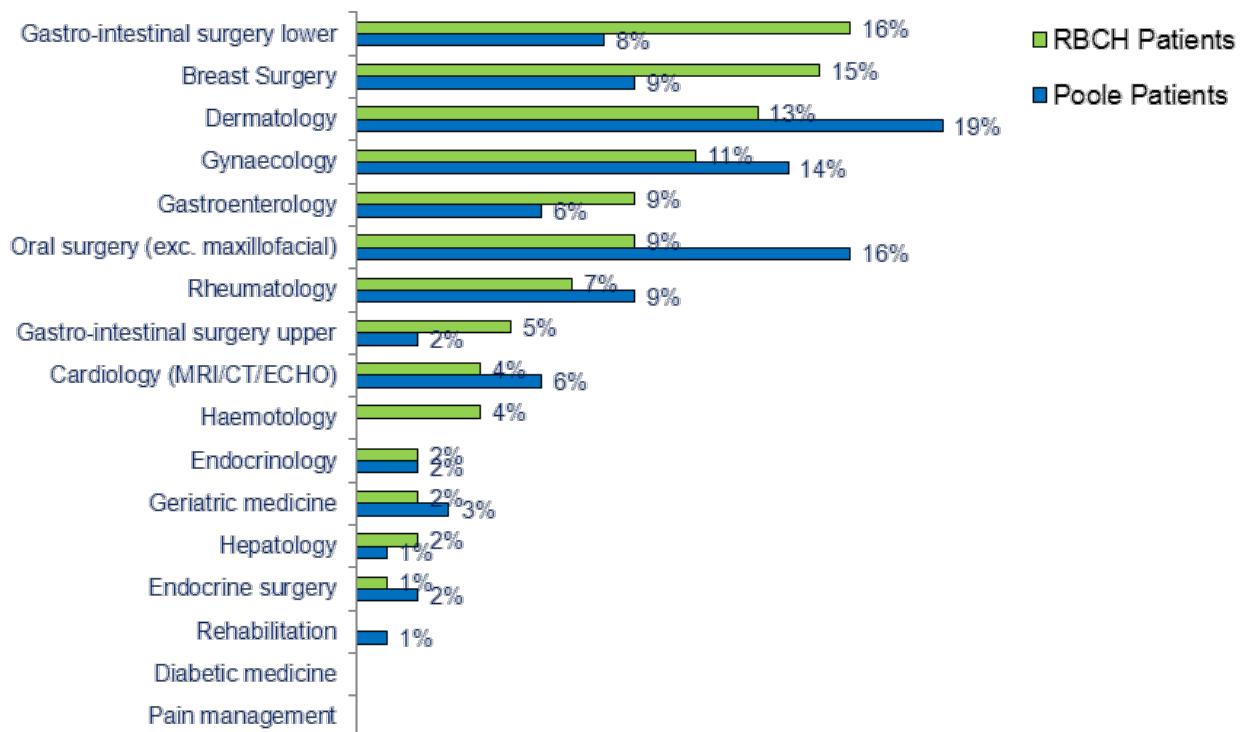
4 Patient Survey Findings

4.1 Patient profile

41. Patients were visiting the hospitals for a wide range of the relevant specialties. At RBCH Gastro-intestinal Surgery (lower) and Breast Surgery were the most frequently mentioned reasons; at PH the most frequent were Dermatology and Oral Surgery patients.

Figure 1: Patient survey - Specialty

A3. For which if any of these reasons are you visiting the hospital today?

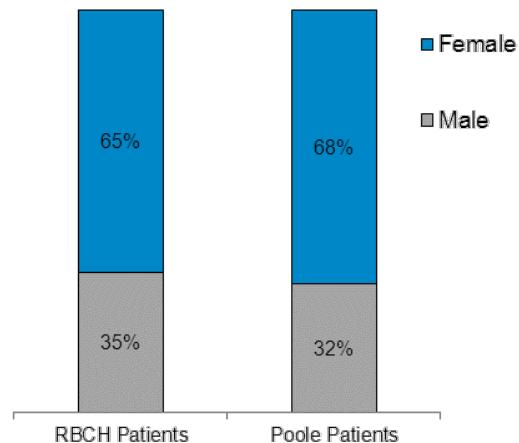


Base: All RBCH: 254/ All Poole:202

42. About two in three patients were female, and over half were aged 55 years or over. The profile of patients at each hospital was similar.

Figure 2: Demographics

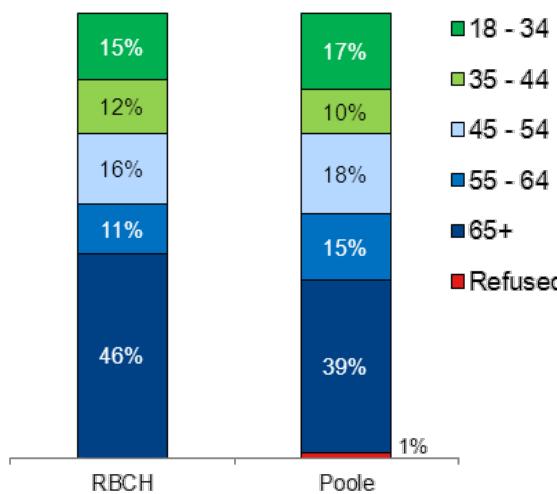
C4. Gender



Base: All RBCH: 254/ All Poole:202

Figure 3: Demographics

C5. Age

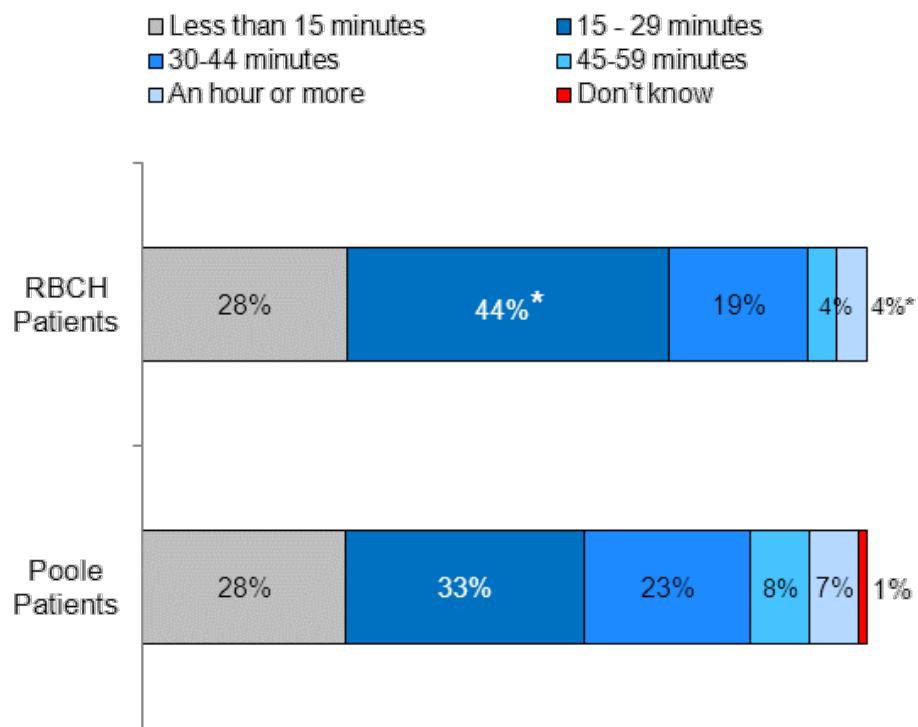


Base: All RBCH: 254/ All Poole:202

43. The majority of patients at each hospital travelled less than 30 minutes to get to the hospital. However, the proportion travelling more than 30 minutes to get to PH was higher than did the same to get to RBCH.

Figure 4: Patient Profile - Travel to the hospital

C1. How long did it take you to travel to the hospital today?

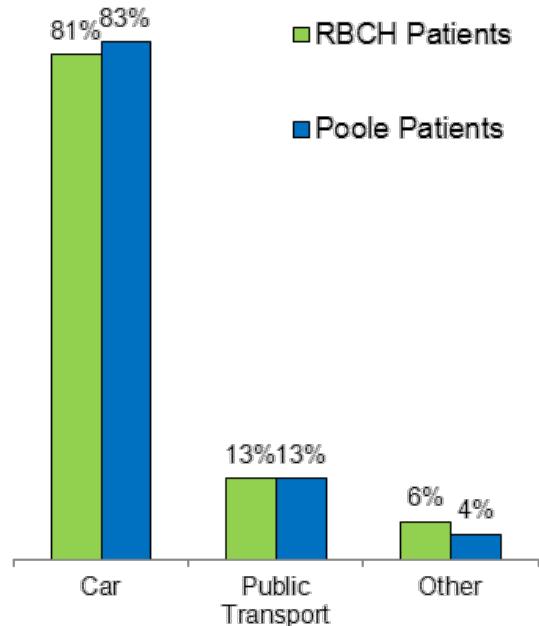


Base: All RBCH: 254/ All Poole:202/ * Significant difference between RBCH and Poole patients

44. Most patients travelled to the hospital by car, and there was no difference by hospital attended.

Figure 5: Patient Profile - Travel to the hospital

C2. How did you travel here today?

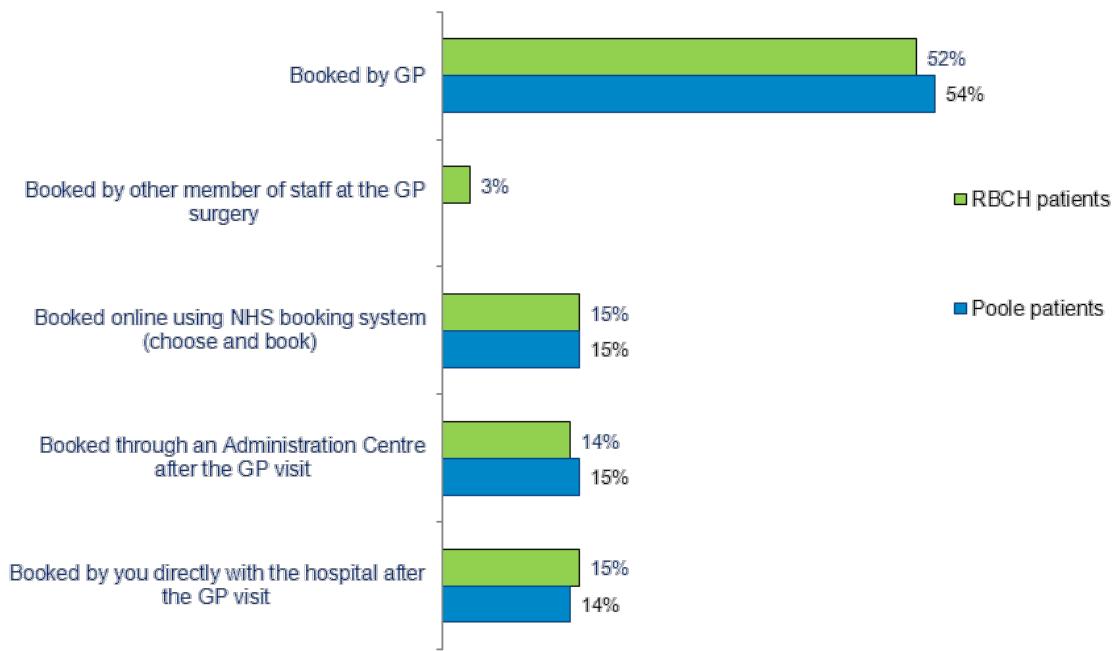


Base: All RBCH: 254/ All Poole:202/

45. About half the appointments were booked by the GP. Use of other booking methods was split equally between the online Choose and Book system, bookings through an Administration Centre and cases where the patient made the booking directly with the hospital.

Figure 6: Appointment booking method

B6. How did you book your first appointment to the hospital?

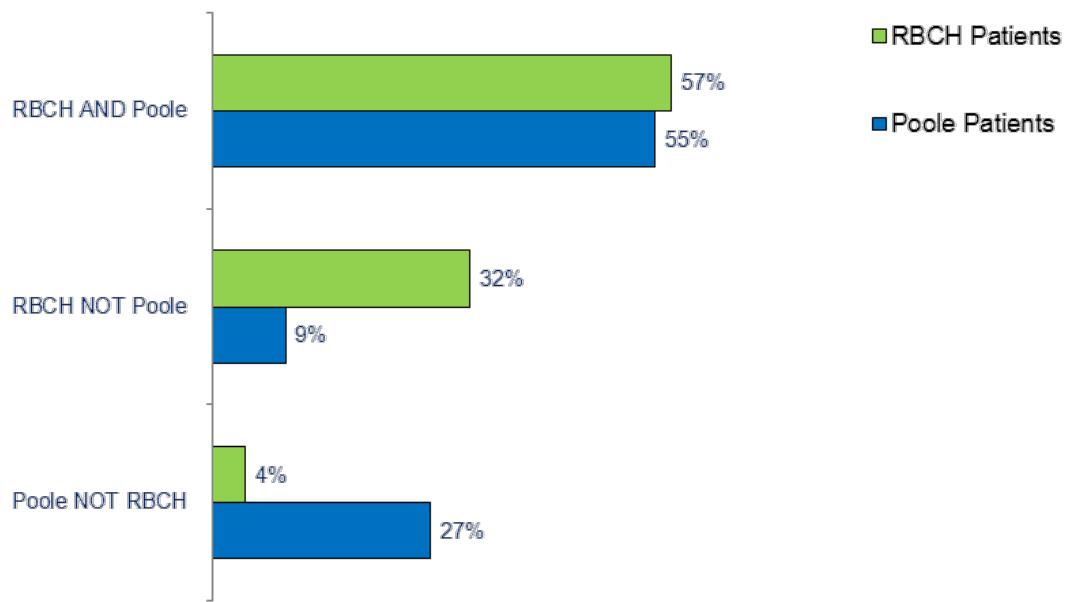


Base: All: RBCH 254, Poole 202

46. Patients were asked about their personal or family experience of hospitals in the local area. Nearly all had some previous experience of one or other of the merging hospitals, and just over one in two had experience of both.

Figure 7: Local hospital knowledge – RBCH and PH

C3. Which hospitals have you or your family been referred to before in the local area?

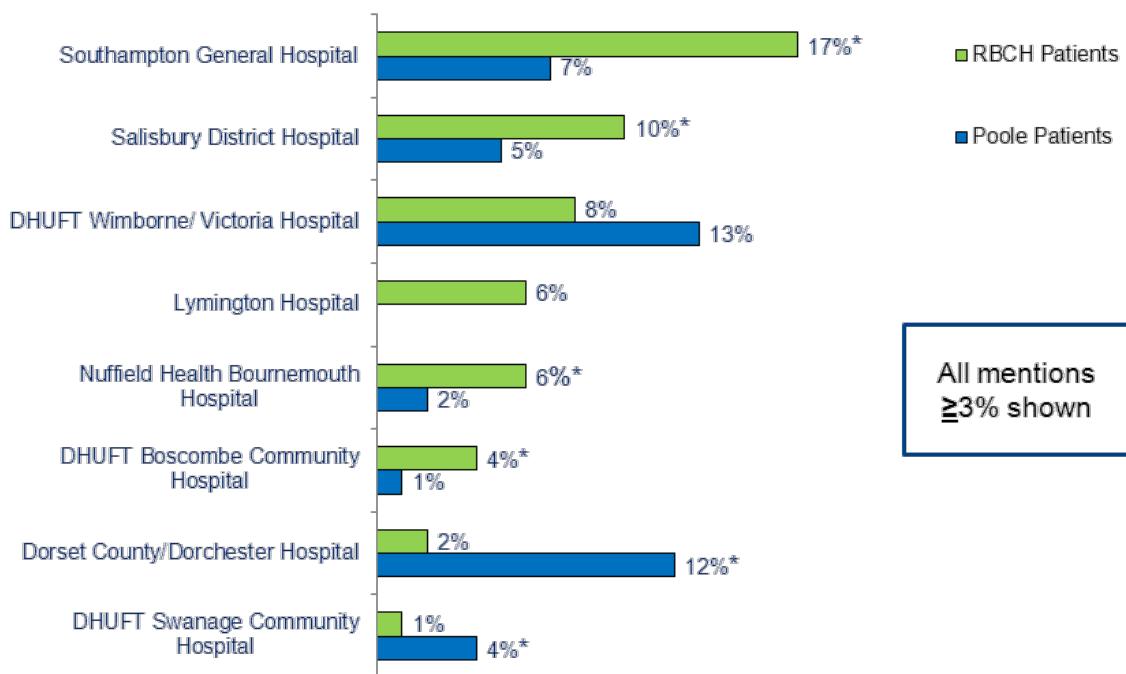


Base: All RBCH: 254/ All Poole:202.

47. In comparison, experience of other hospitals in the local area was at a relatively low level, with some differences by hospital attended. Southampton General was the most frequently mentioned hospital among RBCH patients (17% had experience of this hospital), with the next most frequent being Salisbury District hospital (10%). On the other hand, PH patients were more likely to have experience of DHUFT Victoria Hospital (13%) and Dorset County Hospital (12%).

Figure 8: Local hospital knowledge – other local hospitals

C3. Which hospitals have you or your family been referred to before in the local area?

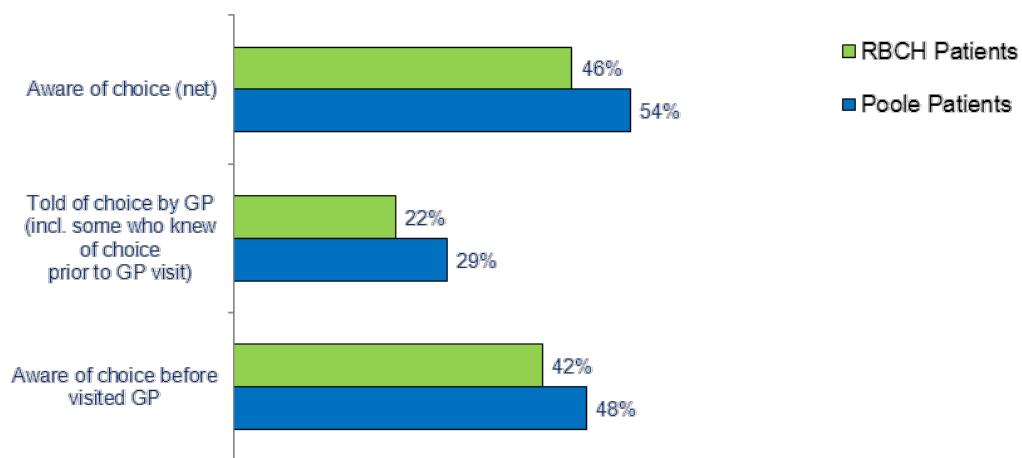


48. Patients were asked if they had been aware that they had a choice of hospital before first visiting the GP for their condition, and whether they had been told by the GP that they had a choice. About one in two knew they had a choice of hospitals, most of these being aware before they saw the GP. About a quarter of patients (22% at RBCH and 29% at PH) had been told by the GP that they had a choice, but only a few (5% across both hospitals) had not been aware before their first visit and had been told by the GP.

Figure 9: Awareness of Choice

A7. Before you first visited the GP for this condition, did you know that you had a choice of hospitals that you could have gone to, or not?

A8. At the time of your referral, did the GP tell you that you had a choice of hospitals that you could have gone to, or not?



Base: All RBCH: 254/ All Poole: 202

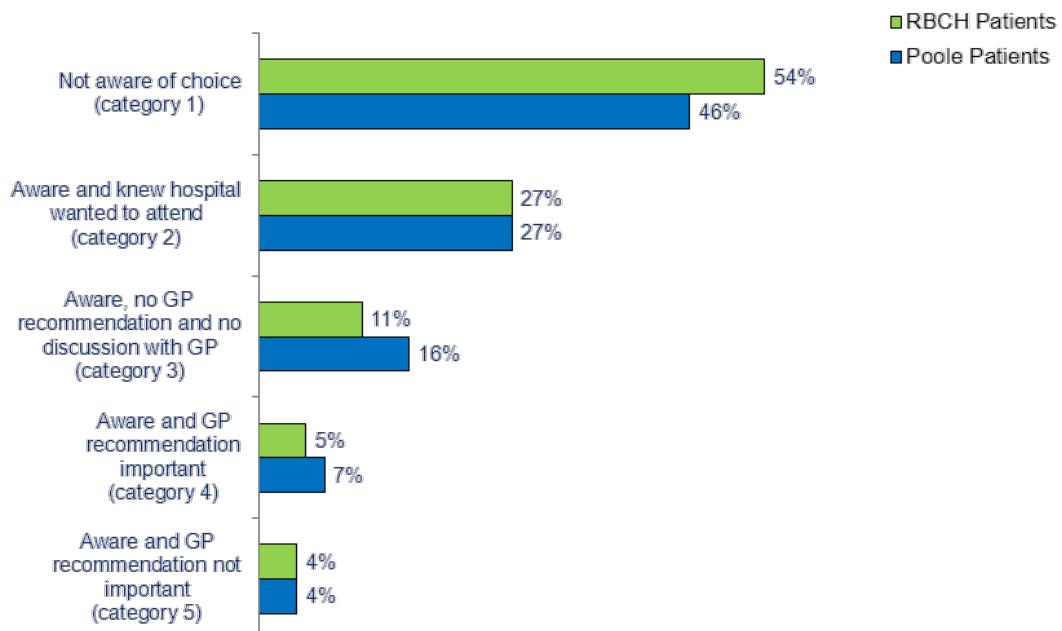
49. Patients were classified into one of five types depending upon their awareness of choice, prior knowledge of the hospital they wanted to attend, any recommendation they had from their GP and the importance of this recommendation on their choice of hospital, and the extent of any discussion they had with the GP. The table below describes the criteria for assigning patients to the five types.

Table 4: GP Sample

Category	Criteria
Not aware of choice	Not aware had choice of hospital prior to GP visit Not made aware of choice by GP
Aware and knew hospital wanted to attend	Aware had choice of hospital Knew which hospital wanted to attend before visit to GP
Aware, no recommendation and no discussion	Aware had choice of hospital Did not know which hospital wanted to attend before visit to GP Did not get a recommendation of which hospital to attend from the GP Did not have a discussion about which hospital to attend with the GP
Aware and GP recommendation important	Aware had choice of hospital Did not know which hospital wanted to attend before visit to GP Had a recommendation from the GP or told where to go by GP Thought recommendation was important
Aware and GP recommendation not important	Aware had choice of hospital Did not know which hospital wanted to attend before visit to GP Had a recommendation from the GP or a discussion with the GP Thought recommendation was unimportant

50. About one in two patients were unaware they had a choice of hospitals. About one in four patients knew they had a choice and knew which hospital they wanted to attend before they saw the referring GP. About one in ten were aware of choice and had a recommendation from the GP, and this split roughly equally between those who said the recommendation was essential or very important in their choice of hospital to attend, and those who said otherwise. The remainder were aware of choice, but did not know in advance where they wanted to go, and had no discussion with or recommendation from the GP. There was little difference in the pattern of response between patients by hospital attended.

Figure 10: Patient Profile

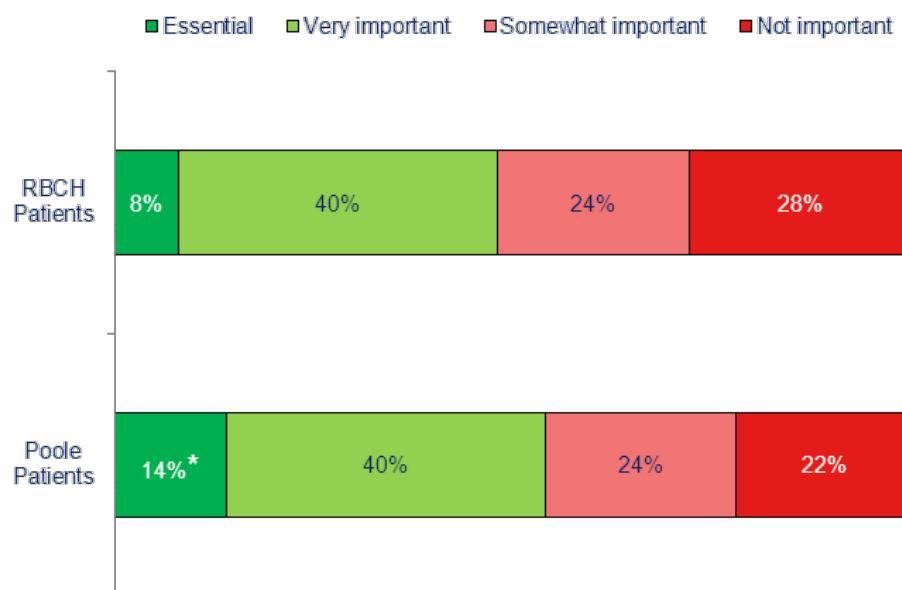


Base: All RBCH: 254/ All Poole: 202

51. All patients were asked how important it was to them that they were offered a choice of hospitals. About half thought that having choice was essential or very important, the proportion thinking it essential being higher at PH. Those who were unaware they had a choice tended to think it less important (42% said choice was essential/ very important).

Figure 11: Importance of Choice

B18. How important is it to you that you are offered a choice of hospitals?



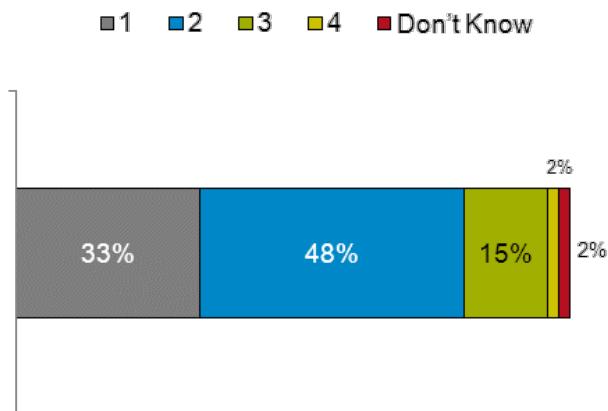
Base: All RBCH: 254/ All Poole:202 * Significant difference between RBCH and Poole patients

4.2 Drivers of choice

52. This section looks at how patients chose which hospital they attended; any discussion they had with the GP, the importance of various factors in their choice, and any recommendation they had received from the GP. The results for this section are based on those patients who were aware they had a choice of hospitals they could attend.
53. One in four (24%) had a discussion with the GP about which hospital to attend, and mostly the discussion was about one or two hospitals. Nearly all of those who discussed a hospital with the GP talked about the hospital they attended. In about one in three cases they discussed the other merging hospital, whilst discussion about other hospitals was at a lower level. One in four RBCH patients who discussed hospitals with the GP talked about Southampton General Hospital and one in ten (11%) Salisbury District Hospital. The most frequently discussed hospitals among PH patients (apart from the merging hospitals) were Dorset County Hospital, Yeovil District Hospital and DHUFT Wimbourne/ Victoria Hospital.

Figure 12: GP Discussion

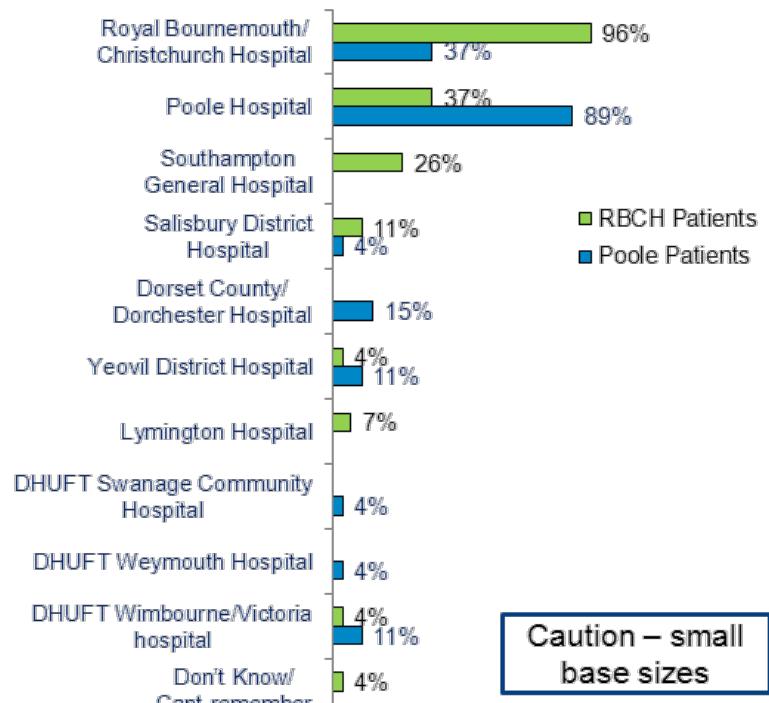
B3. How many hospitals did you discuss with the GP?



Base: All aware of choice and discussed hospitals: 54

Figure 13: GP Discussion

B4. Which hospitals did you discuss with the GP?

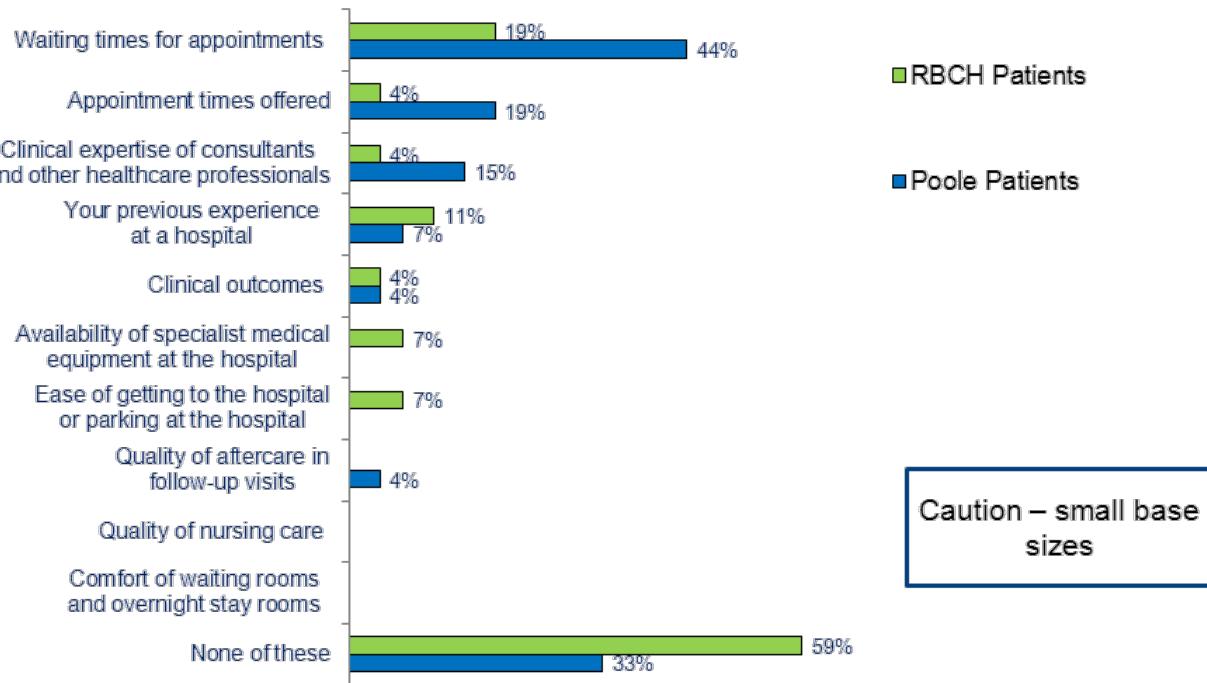


Base: All aware of choice and discussed hospitals: RBCH; 27/ Poole; 27

53. Patients were prompted with a list of topics and asked which if any they had discussed with the GP. The most frequently mentioned topic was the waiting times for appointments. A high proportion indicated that they did not discuss any of the topics, particularly among RBCH patients.

Figure 14: Aspects discussed with GP

B5. Did the GP discuss any of these things with you about the hospital you could go to?

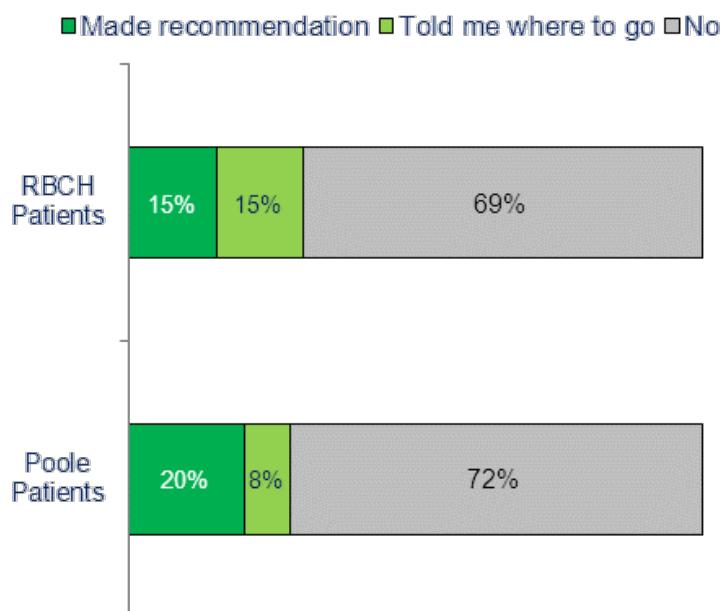


Base: All aware of choice and discussed hospitals: RBCH: 27/ Poole: 27

55. Patients were asked whether the GP had either recommended a hospital, or told them where to go for their condition. In only a minority of cases did this happen (about three in ten). All those who received a recommendation or were told where to go were asked which hospital(s) the GP had recommended to them or told them where to go. In the great majority of cases it was the hospital they attended. (It should be noted that a minority of patients were recommended more than one hospital). Apart from the two merging hospitals recommendation of other hospitals was at a relatively low level.

Figure 15: Recommendation

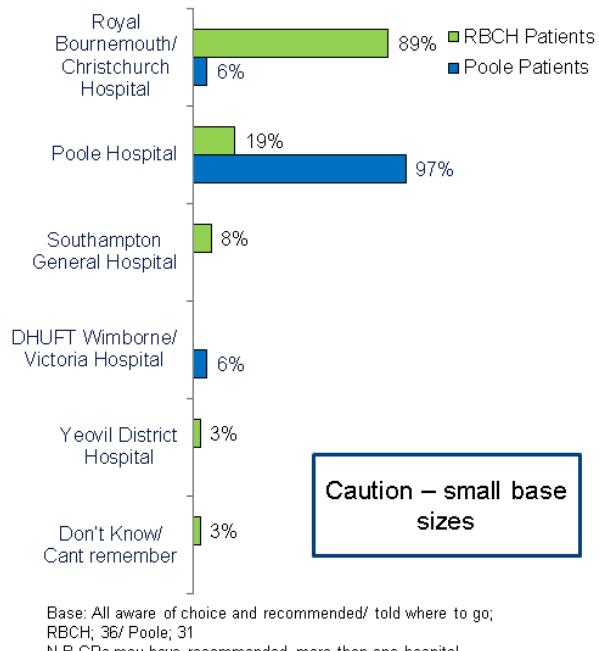
B7. Did the GP recommend a hospital, or tell you where to go, or not?



Base: All aware of choice RBCH 117 Poole 109

Figure 16: Recommendation

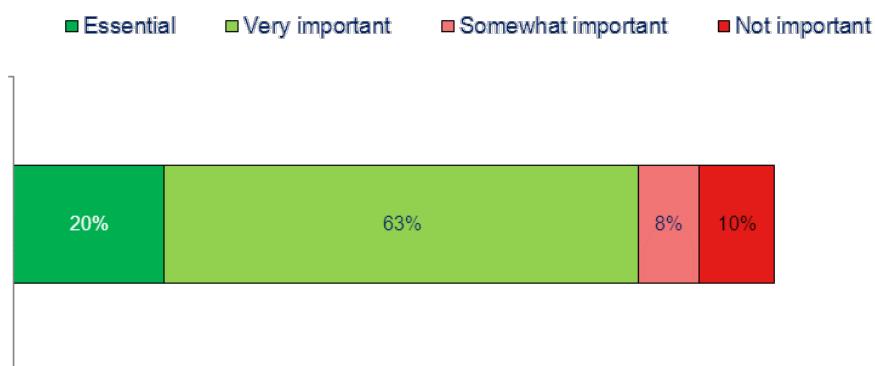
B8. Which hospital did the GP recommend/tell you to go to?



56. All patients who had been given a recommendation by the GP (40 patients) were asked how important it was in their decision about which hospital to go to. One in five (20%) said it was essential, a further two in three (63%) that it was very important, 8% that it was somewhat important, and 10% that it was not at all important. There was no marked difference in response by hospital attended.

Figure 17: Importance of GP recommendation

B9. How important was the GP recommendation in the decision to come to this (LOCATION) for your condition?

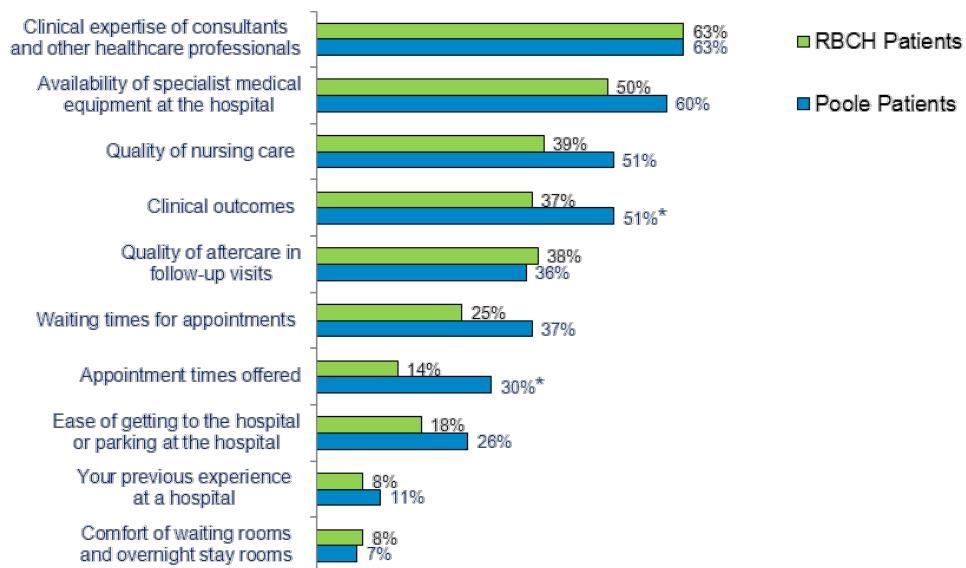


Base: All aware of choice and recommended a hospital; 40/* Caution: small base size

57. Patients were then asked to rate the importance of various features in assessing which hospital to attend for their condition, using the same four-point 'Essential' to 'Not important' scale. The charts below show the aspects which were considered essential (figure 18) and essential/very important (figure 19). Patients at both hospitals identified the clinical expertise of consultants and other healthcare professionals as the most important feature. Availability of specialist medical equipment was considered the next most important feature. The features identified as relatively less important were the patients' previous experience of the hospital, and comfort of the waiting rooms. The ease of getting to the hospital or parking at the hospital was also one of the features considered relatively less important. PH patients were more likely to say that clinical outcomes and appointment times offered were essential.

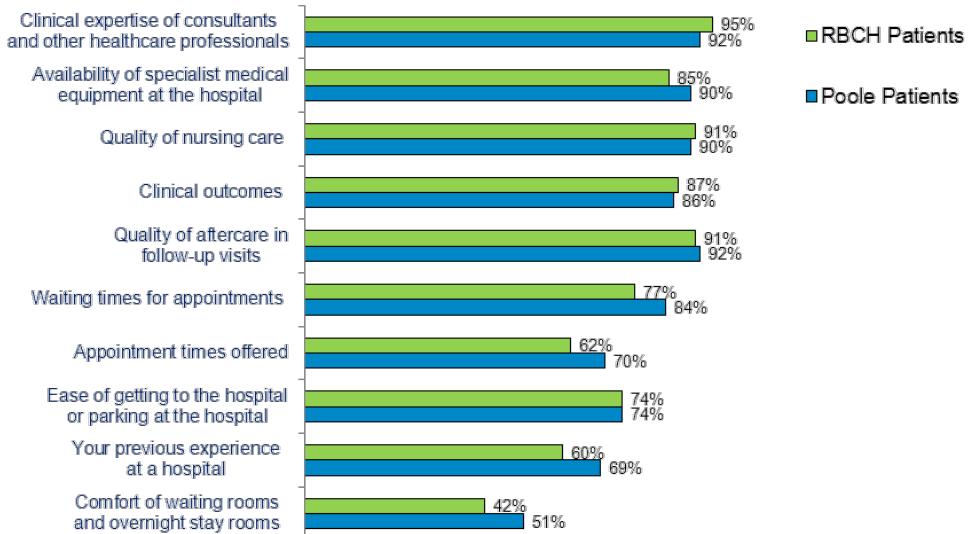
Figure 18: Aspects considered "Essential" when assessing a hospital for condition

B6. I am going to read out a list of features. For each one I'd like you to tell me how important it was when assessing a hospital for your condition.



Base: All aware of choice RBCH 117 Poole 109/ * Significant difference between RBCH and Poole patients

Figure 19: Aspects considered “Essential/ Very important” when assessing a hospital for your condition



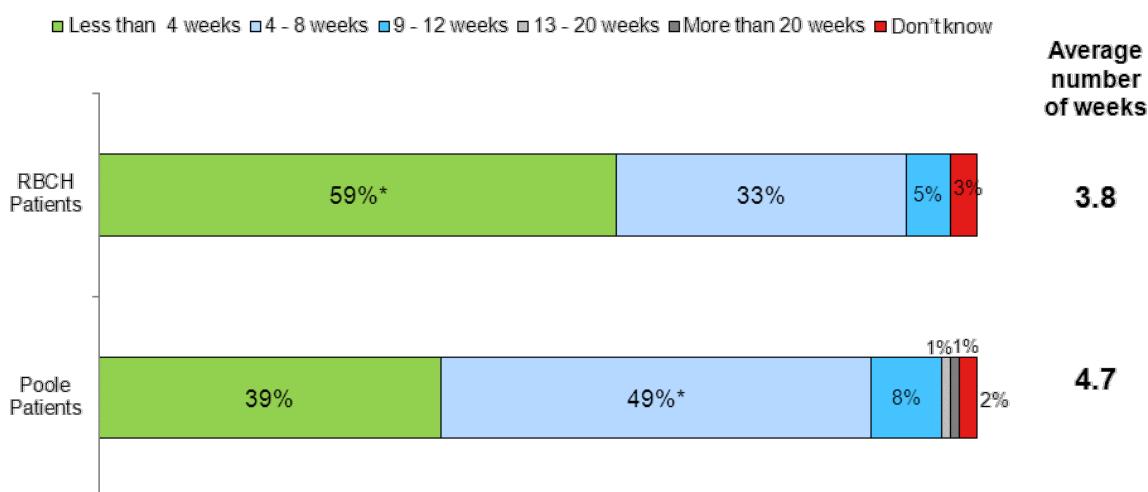
Base: All aware of choice RBCH 117 Poole 109

4.3 Diversion

58. Patients were asked how many weeks they had to wait before their first appointment at the hospital following their referral from the GP. They were then asked how much longer they would have been prepared to wait for their first appointment before going to another hospital that provided their treatment. This provided a measure of their tolerance to increased wait times at the hospital they attended. They were then asked which other hospital they would have gone to instead, if the wait time at the hospital they attended had been longer than the maximum they were prepared to wait. Those patients that could not give a maximum wait time or would not have gone to another hospital even with a longer wait time, were asked which other hospital they would have gone to instead if they had not been able to get an appointment at the hospital they attended.
59. On average RBCH patients waited just under four weeks for their first appointment and PH patients just under five weeks. The proportion of patients seen in less than four weeks was significantly higher at RBCH hospital (59% c.f. 39% at PH).

Figure 20: How long had to wait for first appointment

B10. Thinking back to when you were first referred by the GP, approximately how many weeks did you have to wait before you had your first appointment at the hospital?

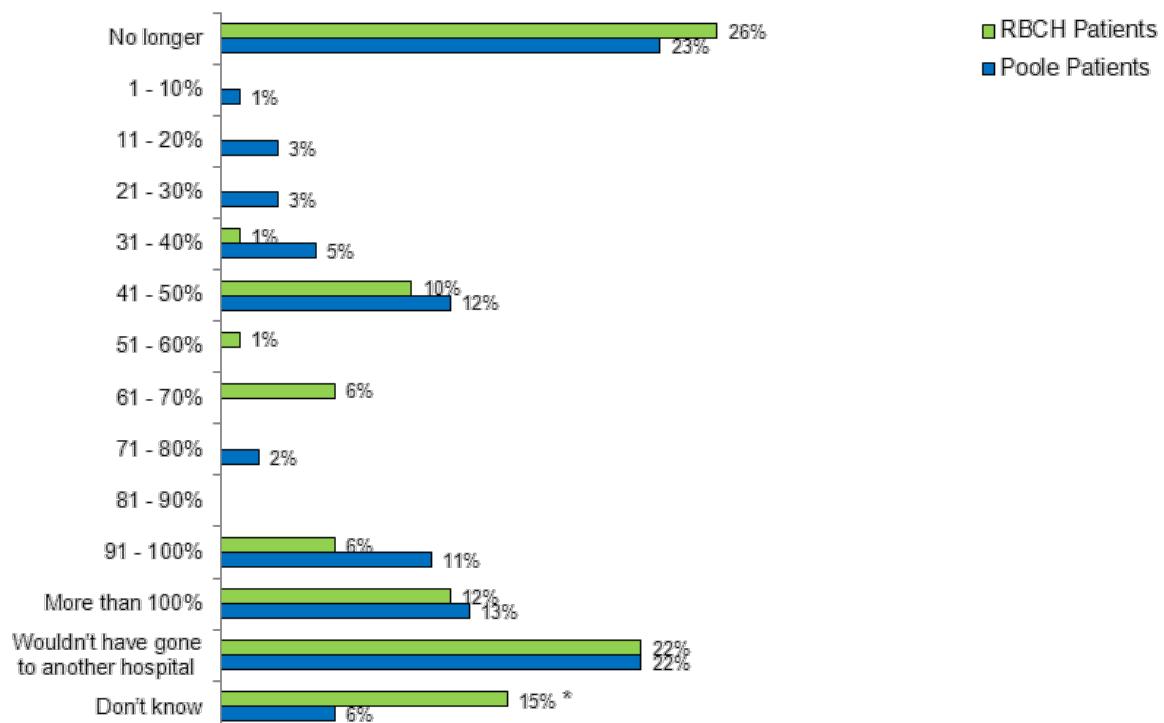


All aware of choice: RBCH:117/ Poole: 109/ * Significant difference between RBCH and Poole patients

60. About one in four patients would not have been willing to wait any longer for their first appointment. On the other hand, just over one in five would not have gone to another hospital no matter how much longer they would have needed to wait. About one in ten patients would have been willing to wait 41% - 50% longer, whilst about one in ten would have been prepared to wait over 100% longer.

Figure 21: How much longer prepared to wait before switching hospital

B10/11 How much longer would have waited for an appointment (% of original wait time)

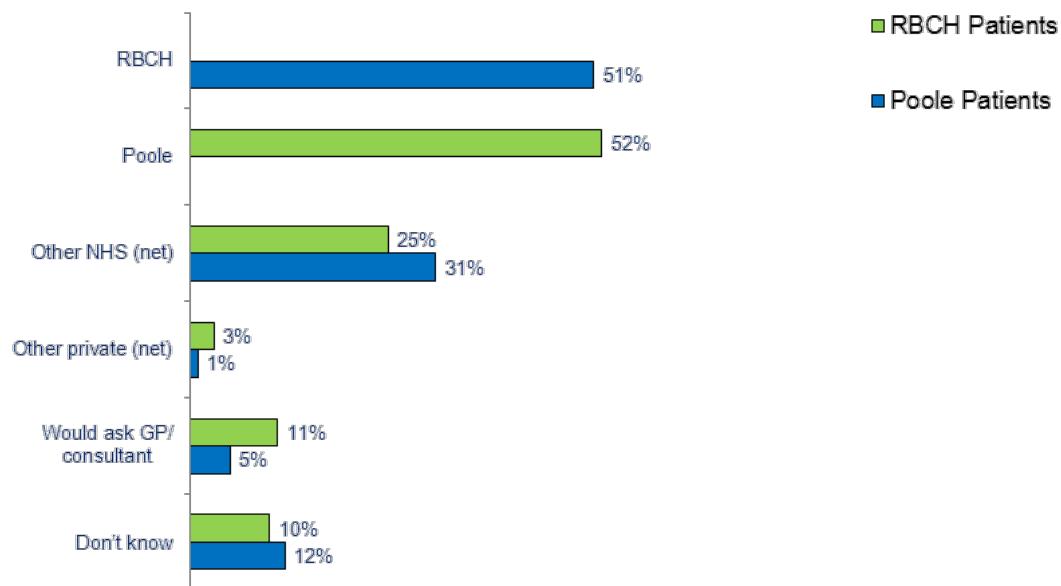


All aware of choice: RBCH:117/ Poole: 109. * Significant difference between RBCH and Poole patients

61. Looking at responses from those who indicated a maximum time they would have been prepared to wait to get an appointment at the hospital they attended, one in two would have gone to the other merging hospital if the wait time had exceeded this maximum. This was true at both RBCH and PH. One in four patients at RBCH would have gone to another NHS hospital (Southampton General and Salisbury District most frequently mentioned), and one in three patients at PH (DHUFT Wimbourne/Victoria and Dorset County/Dorchester most frequently mentioned). Most other patients would either have asked the GP or did not know where they would have gone, the proportion mentioning a private hospital being very low.

Figure 22: Hospital would have gone to instead (Second Choice Hospital) – Gave increase in wait time

B13 Suppose the wait time was longer than maximum willing to wait which other hospital would you have gone to instead?

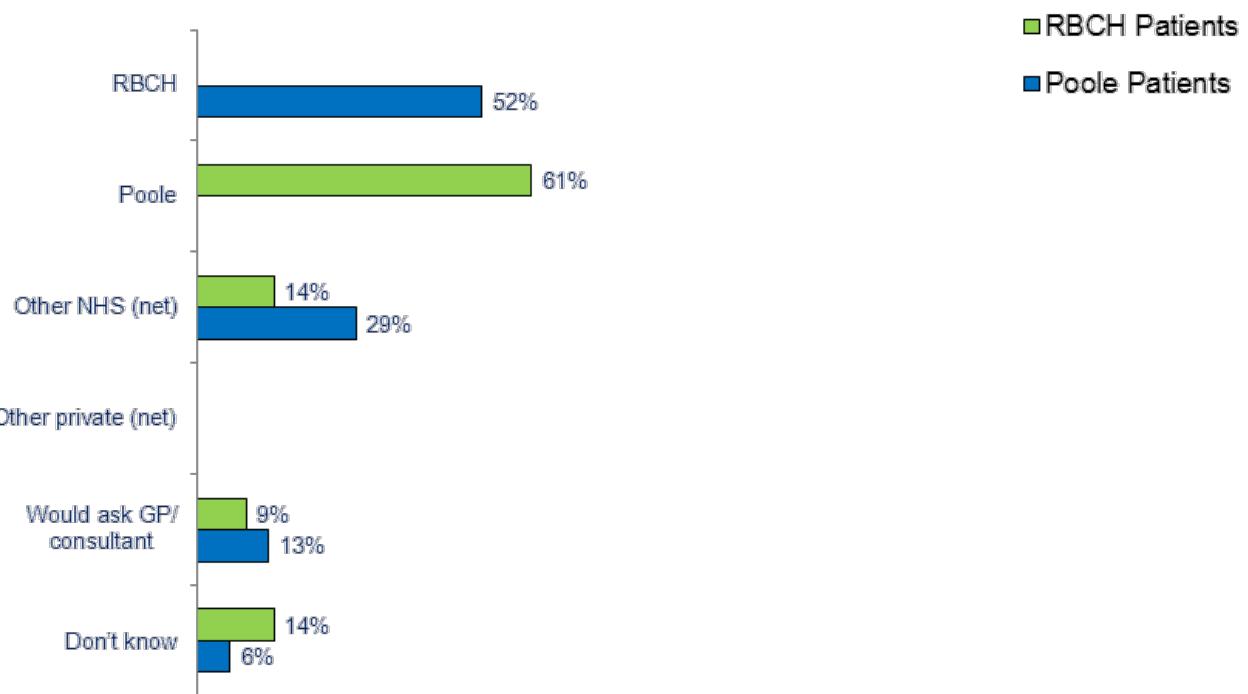


All aware of choice and gave increase in wait time; RBCH:73 / Poole: 78

62. Looking at responses from patients who could not give a maximum wait time or who would not have gone to another hospital even if the wait time was longer, the pattern was very similar.

Figure 23: Hospital would have gone to instead (Second Choice Hospital) – Did not give increase in wait time

B14 Suppose could not get an appointment at location hospital, which other hospital would you have gone to instead?

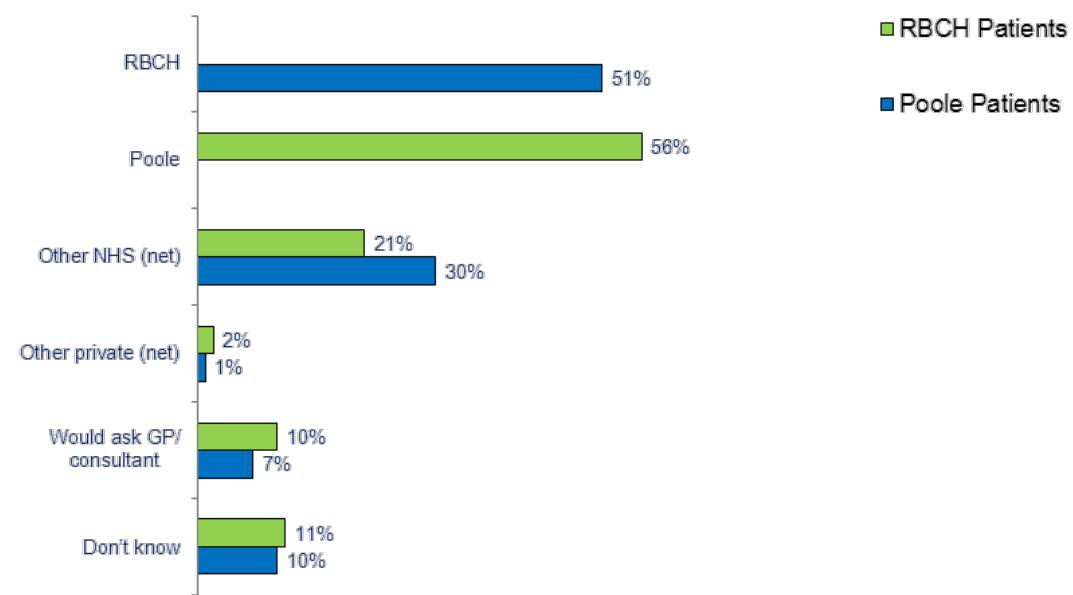


All aware of choice and did not give increase in wait time: RBCH:44/ Poole: 31

63. The chart below shows the combined responses from all patients, with just over half saying they would have gone to the other merging hospital (56% at RBCH and 51% at PH), about one in five saying they would have asked the GP or did not know, and nearly all the remainder indicating they would have gone to another NHS hospital.

Figure 24: Hospital would have gone to instead (Second Choice Hospital) – Gave increase in wait time and did not give an increase in wait time

B13/B14. Suppose the wait time was longer than maximum willing to wait/ suppose could not get an appointment at location hospital, which other hospital would you have gone to instead?

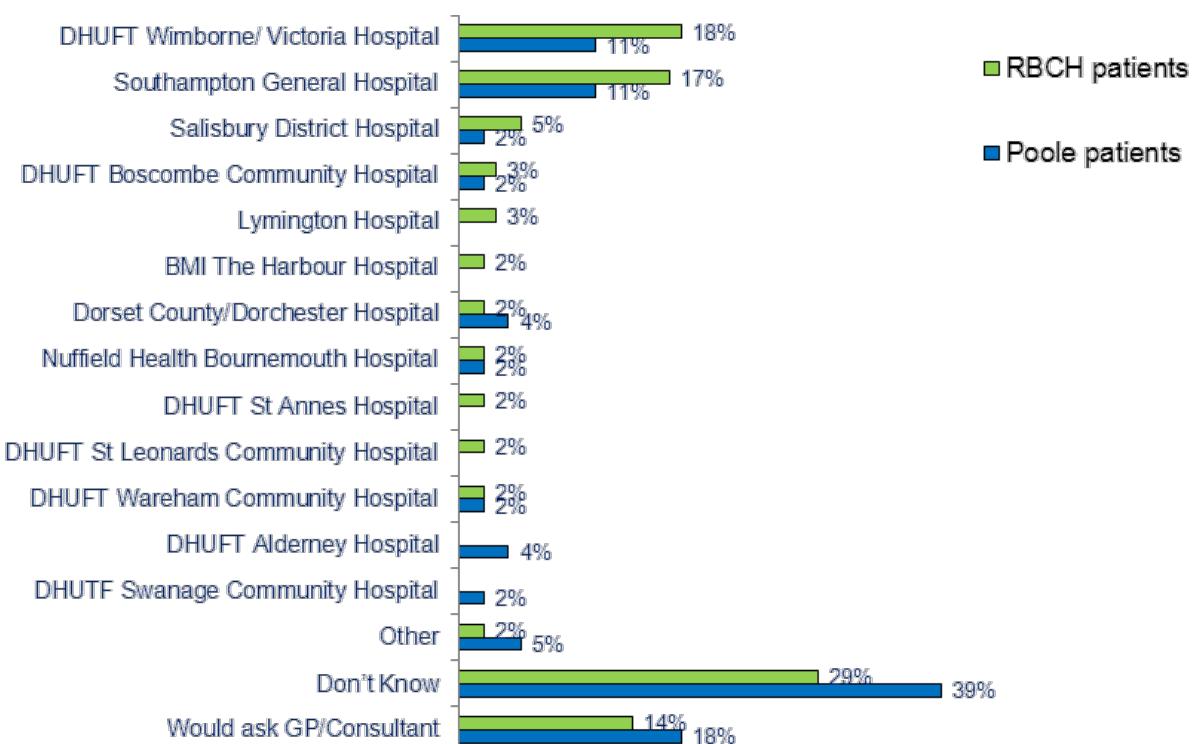


All aware of choice: RBCH:117/ Poole: 109

64. All who would have gone to the other merging hospital as their second choice were asked where they would have gone if this hospital did not offer their treatment. About one in two patients (57% at RBCH and 43% at PH) named a third choice hospital. The most frequently mentioned third choice hospitals were DHUFT Wimborne/Victoria hospital and Southampton General hospital, this being true of both RBCH and PH patients.

Figure 25: Hospital would have gone to instead (Third Choice Hospital)

B16. If (OTHER MERGING HOSPITAL) did not offer your treatment, which other hospital would you have gone to instead?



Base: All aware and would divert to other merging hospital; RBCH: 65/ All Poole: 56

65. The small number of patients who said their second choice was the other merging hospital and who named a third choice hospital (61 patients) were asked how strongly they would have preferred to go the other merging hospital rather than go to their third choice. Opinion was split with about half saying they strongly preferred the idea of going to the other merging hospital, whilst most of the remainder said it would have made no difference.

Figure 26: Extent of preference for merging party hospital instead of third choice hospital
B17. Would you have strongly preferred to go to (OTHER MERGING HOSPITAL) hospital instead of (THIRD CHOICE HOSPITAL WOULD DIVERT TO), slightly preferred, or would it have made no difference to you?



Base: All aware of choice and would have gone to another named hospital if could not go to other merging hospital RBCH: 37/ All Poole:24

5. GP Survey Findings

5.1 GP Profile

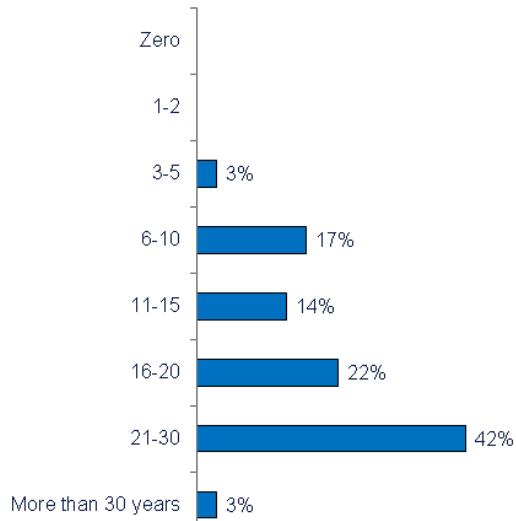
66. Many of those interviewed had worked as a GP for a long time, about three in four for over 10 years as a GP in the local area.

Figure 27: Length of time worked as a GP

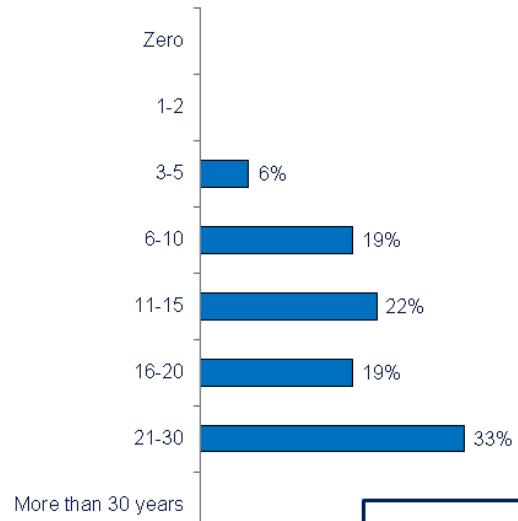
C1. For how many years have you worked as a GP?

C2. For how many years have you been working as a GP in the local area?

Years worked as GP



Years worked as GP in local area

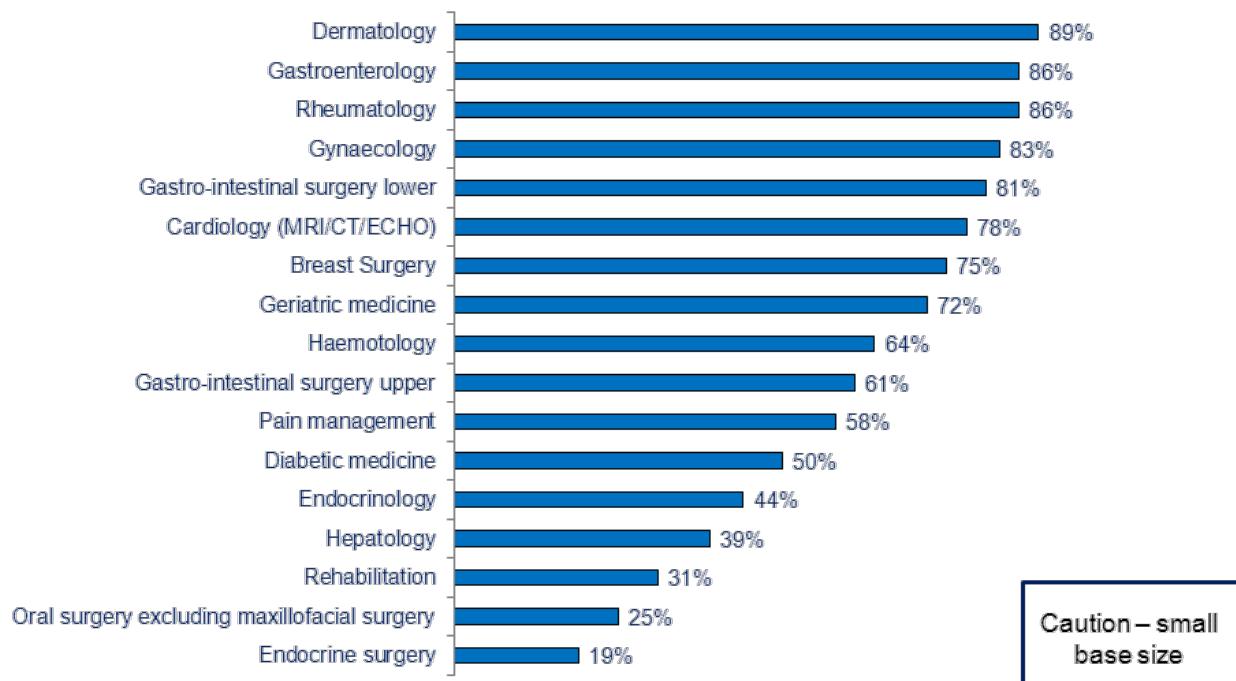


Base: All GPs: 36

67. GPs were asked whether they had been involved in a referral to RBCH or PH in the last three months where the patient could have gone to one or other of the hospitals, for any of the specialties of interest. The GPs surveyed tended to have made referrals to many of the specialties of interest, as indicated in the chart below.

Figure 28: Specialties referred in the last three months to one of the merging hospitals

A1. Have you been involved in a referral to one of these hospitals in the last three months, where the patient could have gone to either hospital, for any of the following specialties?

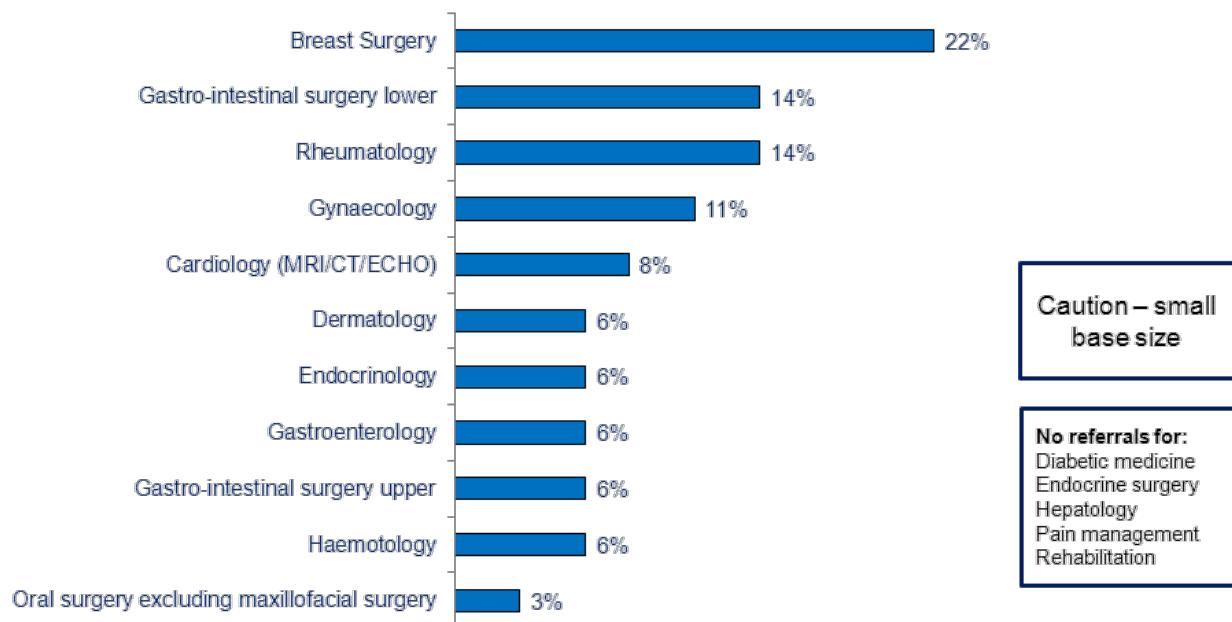


Base: All GPs: 36

68. GPs were then asked to say which of the specialties of interest they had most recently referred (and for the remainder of the interview to focus responses on this particular referral). The most commonly cited was a referral for Breast Surgery, but there was a range of specialties mentioned. A marginally greater number of referrals to PH were found among those interviewed (six in ten).

Figure 29: Specialty most recently referred

B1. Thinking about the last time you were involved in such a referral, which specialty was it for?

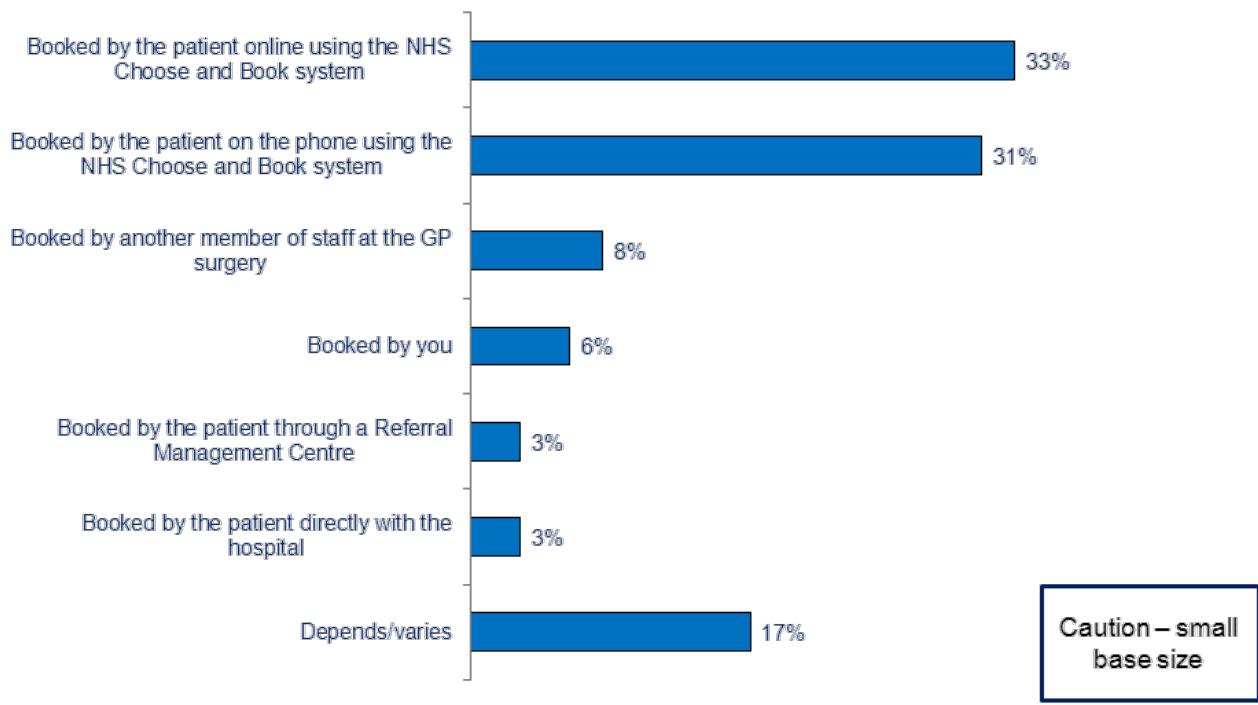


Base: All GPs: 36

69. When asked how their patients typically made hospital appointments, about two in three GPs indicated that the patient used the NHS Choose and Book system, with an equal split between bookings made by telephone and online. In only a minority of cases were bookings typically made by either the GP or another member of staff at the surgery.

Figure 30: Appointment booking method

B21. How do your patients typically make hospital appointments?



Base: All GPs: 36

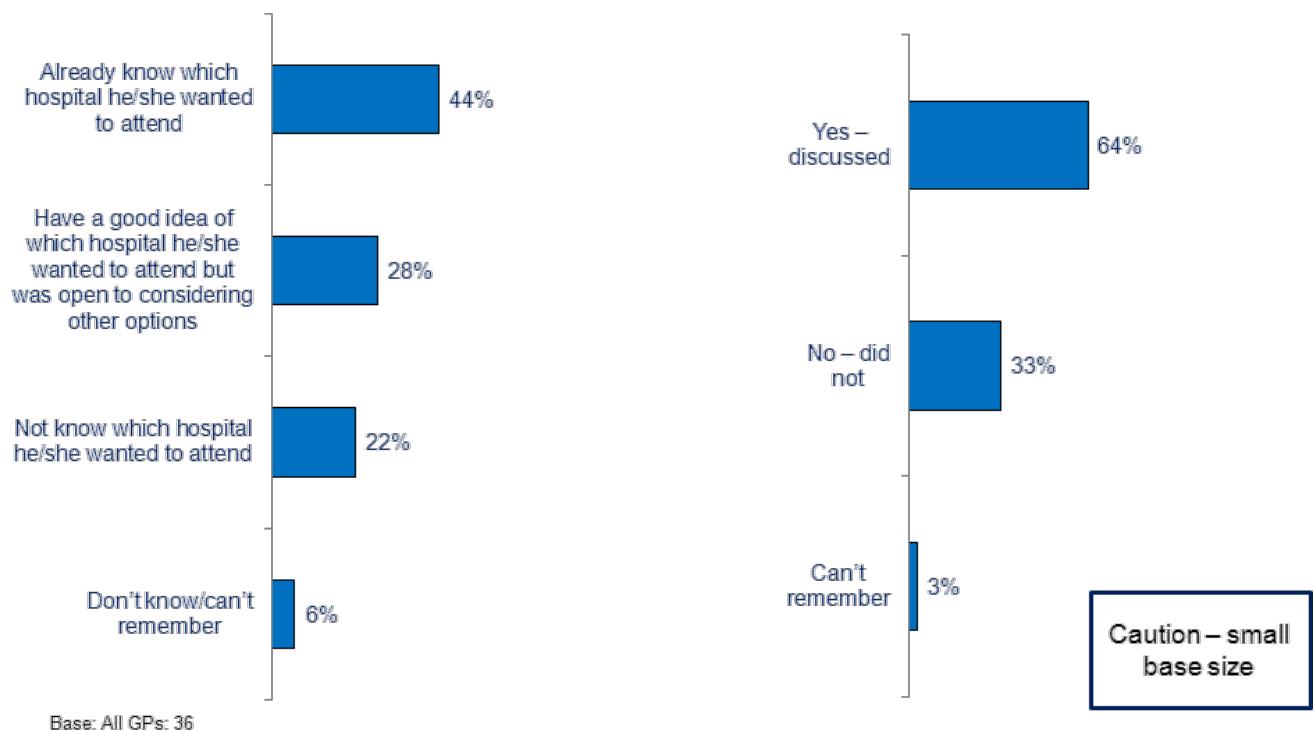
5.2 Dialogue with patient

70. In about half of cases the GP indicated that the patient already knew which hospital he or she wanted to attend when discussing the referral. In two-thirds of cases the GP had a discussion with the patient about the hospitals they could be referred to, although this varied according to whether the patient already knew which hospital they wanted to go to or not. Where the patient did know, a discussion was held in about half of all cases, but where the patient did not know or was open to considering other options, a discussion was held in almost all cases.

Figure 31: Whether had a discussion with the patient

B3. When you discussed the referral, did the patient ...?

B4. Did you have a discussion with the patient about the hospital or hospitals they could be referred to, or not?

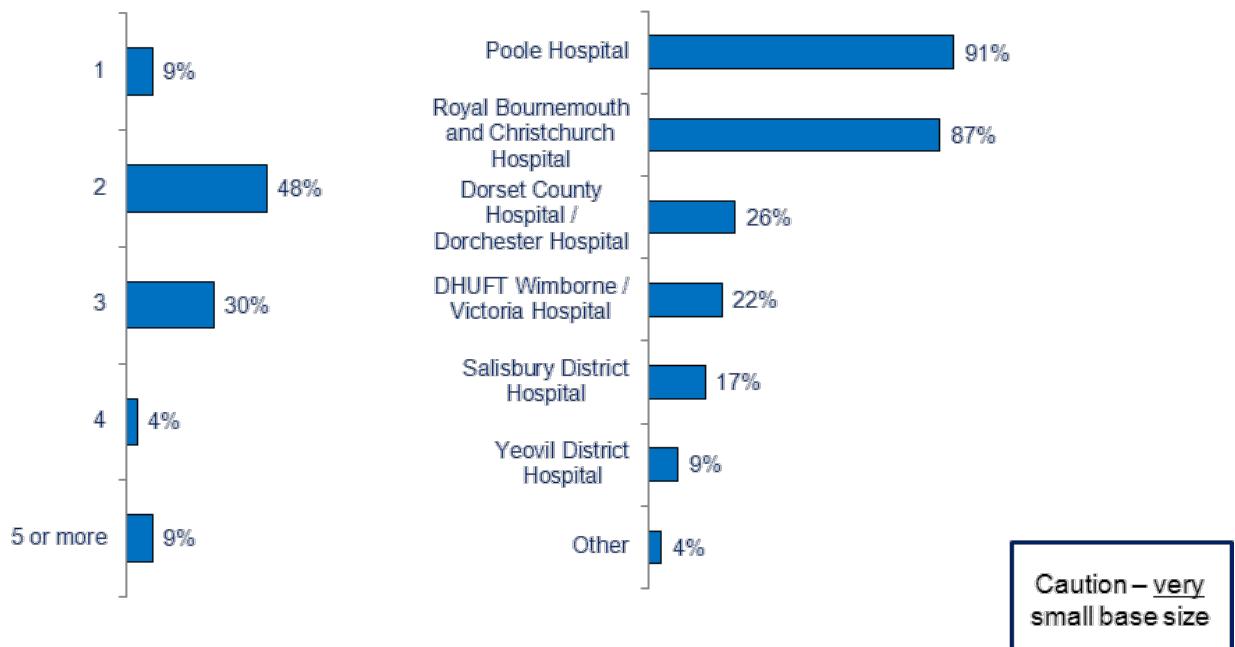


71. Those GPs who said they did not have a discussion with the patient were asked why this was the case. The reasons varied, with some mentioning that they wanted the patient to go to the closest hospital.
72. Those GPs who said they had a discussion with the patient (23 GPs) were then asked how many and which hospitals they had discussed. Most claimed to have discussed two or three hospitals and the majority had discussed both RBCH and PH. Two GPs had discussed RBCH but not PH, and three GPs PH but not RBCH.

Figure 32: Hospitals discussed with the patient

B5. How many named hospitals did you discuss with the patient?

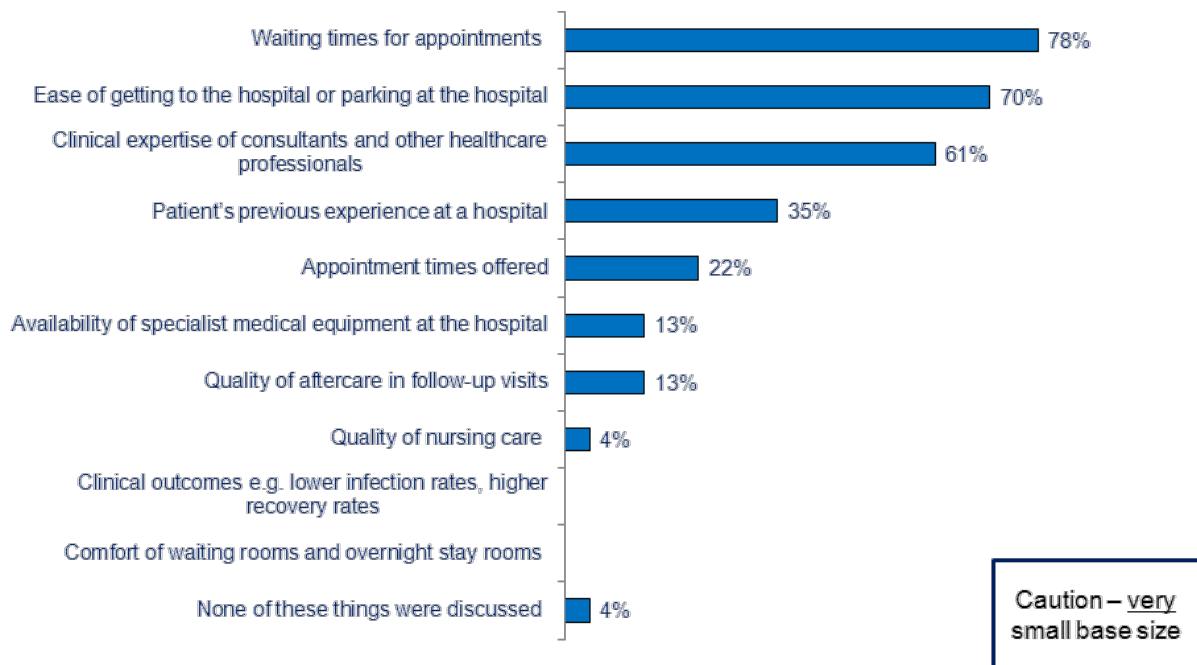
B6. Which hospitals did you discuss with the patient?



73. A list of different features was read out and GPs asked which if any they had discussed with the patient. Among those GPs who had a discussion with the patient, most had discussed waiting times for appointments, the ease of getting to the hospital and the clinical expertise of consultants or other healthcare professionals. Other topics of conversation were in the minority.

Figure 33: Topics discussed with the patient

B8. Did you discuss any of these things with the patient about the hospital/hospitals they could go to?

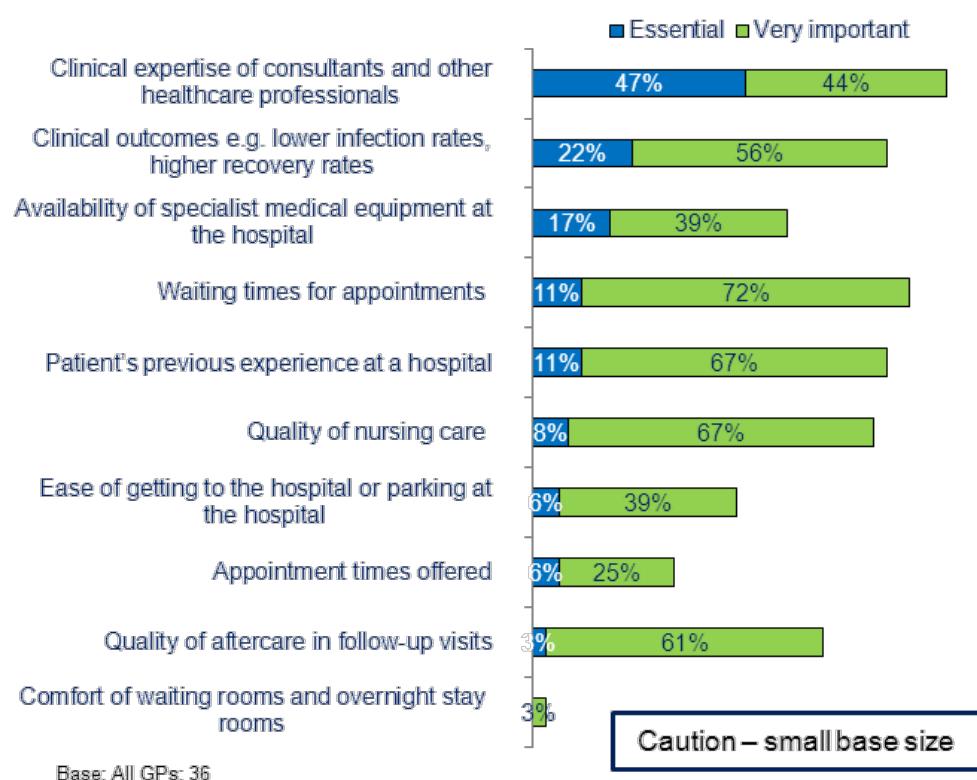


Base: All GPs who discussed with patient: 23

74. GPs were then asked how important different features were for them when assessing a hospital, using the same list, on a four-point Essential/Very important/Quite important/Not important scale. Outcome and expertise related features tended to be considered the most important by GPs, as indicated in the chart below.

Figure 34: Choice of hospital

B11. I am going to read out a list of features, and for each one I'd like you to tell me how important it is when assessing a hospital for this specialty



75. One in three GPs recommended a hospital to the patient. With patients who already knew which hospital they wanted to attend, a recommendation was generally not made (only one GP did so). However, with patients who did not know which hospital they wanted to attend, a recommendation was nearly always made. Where the GP made a recommendation, it was always to one or both of the merging hospitals: five GPs recommended RBCH, five PH, and one GP recommended both PH and Dorset County hospital.



5.3 Diversion

76. Those GPs who had made a recommendation to the patient were asked a series of questions to establish which other hospital they would have recommended if clinical outcomes at their recommended hospital had deteriorated. Five out of the eleven GPs answering this section said they would have recommended the other merging hospital, four said Dorset County Hospital (three of whom had originally recommended PH and one RBCH), one said Southampton General Hospital and one said DHUFT Wimbourne/Victoria Hospital.¹ The second choice hospital was generally one of the closest to the GP surgery.

¹ An attempt was made to quantify how much worse clinical outcomes would need to be before GPs changed their recommendation, but the results have not been reported given the very low sample size.



5.4 Views on the Merger

77. GPs were asked for their views on the planned merger; whether they thought it would improve the quality of patient care in the local area, worsen the quality of patient care, or make no difference. Opinion was split, with one in three saying patient care would improve and the same proportion that it would worsen. Negative opinion was slightly more prevalent among those GPs whose most recent referral had been to PH.
78. Four key themes emerged as reasons why it was thought the merger would improve patient care. Some GPs thought a merger would allow the sharing of **resources and expertise**, which would improve patient care.

"There are a number of departments where amalgamation will lead to a bigger consultant body...The patients will have access to a range of expertise in the same hospital. I think having one management will lead to better services."

"You can use more resources and I think it also frees up resources for other services it would improve care across the community generally."

"There will be greater expertise in one centre and availability of services...and probably equipment as well, in specialist services."

"The units will be concentrated and have a higher level of expertise."

"There will be a sharing of expertise and the ability to concentrate expertise in some areas which will improve quality of care...Sharing out of hours access across two trusts, will mean that we can have more senior cover at extended hours."

79. There were also comments about the merger providing opportunities to specialise, to create **centres of excellence** for particular specialties.

"We can focus on two centre of excellences. Each dealing with certain specialties...I think we can have more focus on specialties which are based in each and try and improve those specialties, so we can improve the quality of service."



"I would rather see a wider range of services with specialists in one hospital or the other."

"It would be complementary. Some things are better in Bournemouth Hospital and some things are better in Poole Hospital."

80. Some GPs emphasised the **financial benefit** of the planned merger, which they thought would save costs and ensure that money is spent on patient care.

"They will be able to ...create financial savings that we can invest in healthcare and other areas of need."

"At the moment, the two hospitals are in competition with each other and I think that money is spent on the wrong things."

"The financial risk is shared between the two, which will improve the security and the long term future of both hospitals. It will enable them to provide a joined up service with provision for the whole area being taken into account without competing with each other and it will enable them to share management costs."

"Cost wise, I see a lot of benefit in a merger because then it will be like rather than two departments of the same speciality, there will be one department and the collaboration of specialties would be much better."

81. **Removing duplication** was mentioned as another benefit, with some GPs saying that the merger would help rationalise service provision and ensure that there was no duplication of services across the two hospitals.

"[They are] duplicating some services by having two very good hospitals close to each other and by having a manager will mean not duplicating those services...Patients [will benefit] from two very good, high quality centres rather than both duplicating each other and competing."

"If you have a duplication of services, you do not build up the expertise."

"They will be able to rationalise the services that they offer across the two trusts and hopefully improve access for patients."

"There is a lot of synergy that could be used off the two sites and rationalising the services and concentrate on their core jobs."

"The combined resources will better and there will be less duplication."

82. Looking at responses from those GPs who thought that patient care would deteriorate with the merger, four themes emerged. Some thought the **quality of care** would worsen, with concerns about cuts in service, and specific mentions of services deteriorating at PH.

"The care at Poole hospital is excellent, it does not need any interference from Bournemouth."

"Poole Hospital will lose some of its excellent services... When I have patients who have been to both, most patients prefer Poole... I think it is friendlier; I think the care is still better at Poole."

"[Poole] is smaller and I think it is more personal. I mean, my impression is that Poole offers a better standard of care... Departments will be rationalised and we will lose some departments in Poole that are offering an excellent standard of care... I think patients like going to Poole; I think it has got a very good reputation."

"There are certain specialties that have problems and I have a feeling that the problems may be compounded by the amalgamation of the two hospitals."

"I have actually always preferred Poole Hospital. I think the treatment is better; the infection rates are better; the nursing levels are better... If you ask Poole patients, they will say they do not want to go to Bournemouth."

"There are bound to be cuts in services if they are merged... things are only just enough as it is... There will be a decrease in the work force and that can only reduce the number of services."

"Poole hospital will deteriorate because they will have their staff slashed."

"I personally see the ethos of one hospital [as] fairly aggressive and the other one less so. I would not like to see them both becoming aggressive, i.e. in a merger... I have always been pro Poole, as I say, I work there and it is very local to me."

83. **Financial issues** were mentioned by some GPs with particular concerns about the level of charges from RBCH.

"Bournemouth Hospital is very money-grabbing and it is going to cost us, as GPs, a lot more, because they code a lot more aggressively and they will put a lot more things down on coding, so they will draw more money out of primary care and they will make the hospital care, secondary care, much more expensive...I think the Bournemouth management is very business-orientated, which has its positives, I can see, from the point of view of the Government wanting to save money - but it is not patient-focused."

"Bournemouth is the most expensive hospital for tariffs and it will cost us a lot more...Because of the increased costs, there will be less money in the system, so you will have to cut other referrals."

"Bournemouth has got far too powerful...It is all to do with charging for patient care and their overcharging for patient care. My concern is that Poole would then start using this questionable charging system that even more money would be taken out of primary care and we would have even less money for health visitors and district nurses."

84. Some GPs thought the quality of patient care would deteriorate because of the **reduction in choice**. They thought that less competition would reduce the level of service.

"I think that the element of competition helps maintain standards. I worry that this merging is not merging but a take-over really."

"I just think it is offering less variety, you know, less options for the patients, then they will get less preferences."

"It might lead to less competition and less patient choice."

"I think it is good to have a choice of services."



"There will be less choice and I think a merger means...less nurses, doctors and beds so appointment times and waits might go up...Choice of where they go, for one thing and where some specialties are both at Poole and Bournemouth...if they merge, then that is lost."

85. The **accessibility** of services was an issue for some, with specific concerns about the difficulty of getting to RBCH for some patients.

"Partly because of location - Poole Hospital, most patients prefer it."

"There are poor transport links to Bournemouth hospital for us. 99% of my patients will go to Poole but if they have to go to Bournemouth because that is the only hospital that will be of detriment to my patients."

"Poole is more convenient than Bournemouth...Bournemouth is incredibly difficult to get to if you have not got your own transport and, even if you have got your own transport, it is difficult to park. Having to get to Bournemouth on public transport is nigh-on impossible."



Appendix A – Patient Questionnaire

A Introduction and screener

Good morning/afternoon. My name isfrom GfK NOP, the market research company. We are carrying out an important survey on behalf of an independent Government body about health services in the local area. Could you spare a few minutes to answer some questions?

REASSURANCES, ONLY READ OUT IF NECESSARY:

- The interview will take about 5-10 minutes, depending on your answers
- All your answers will be treated in strict confidence according to the Market Research Society Code of Conduct
- Everything you say is confidential and any responses will not be attributed to you
- There will be no attempt to sell you anything, either during or as a result of this survey
- This research is being used as part of an inquiry by the Competition Commission, which is an independent government body, and your views are important

CODE HOSPITAL LOCATION

Royal Bournemouth and Christchurch Hospitals
Poole Hospital



A 1 Are you seeing a consultant, hospital doctor, or specialist nurse today?

1. Yes
2. No
3. Don't know

CLOSE IF NOT SEEING CONSULTANT/ HOSPITAL DOCTOR/ SPECIALIST NURSE

A 2 Are you seeing any of the consultants, hospital doctors, or specialist nurses from this list?

SHOW LIST OF NAMES. IF YES: Who are you seeing?

INTERVIEWER: WRITE IN NAME OR CODE NONE OF THESE

CLOSE IF NOT SEEING ANYONE FROM THE LIST

A 3 For which if any of these reasons are you visiting the hospital today? SHOW CARD A. Please just tell me the number on the showcard.

1. Breast surgery
2. Cardiology involving MRI, CT, and ECHO scans (not ECHO stress) (heart)
3. Dermatology (skin)
4. Diabetic medicine
5. Endocrine surgery (glands)
6. Endocrinology (glands)
7. Gastroenterology (stomach, digestion)
8. Gastro-intestinal surgery – upper (stomach, digestion)
9. Gastro-intestinal surgery – lower (colorectal)
10. Geriatric medicine (older people)
11. Gynaecology
12. Haematology (blood)
13. Hepatology (liver)
14. Oral surgery (mouth, teeth, gum) but not Maxillofacial
15. Pain Management
16. Rehabilitation
17. Rheumatology (joints, arthritis, rheumatism)
18. None of these
19. Don't know/not sure

CLOSE IF NOT VISITING FOR ANY OF THESE REASONS (CODE 1- 17 AT A3)

A 4 Did a GP / dentist (**ONLY ASK IF ORAL SURGERY A3**) initially refer you to this hospital, or were you referred by a consultant?

1. GP
2. Dentist (**ONLY ASK IF ORAL SURGERY AT A3**)
3. Consultant
4. Don't know/can't remember

CLOSE IF NOT INITIALLY REFERRED BY A GP OR DENTIST

A 5 When did the GP first refer you?

1. Less than a month ago



- 2. 1-2 months ago
- 3. 3-4 months ago
- 4. More than 4 months ago
- 5. Don't know/can't remember

CLOSE IF MORE THAN FOUR MONTHS AGO, OR CAN'T REMEMBER.

A 6 How did you book your first appointment to the hospital?

SHOW CARD B. SINGLE CODE ONLY

- Booked by the GP
- Booked by other member of staff at the GP surgery
- Booked online using NHS booking system (choose and book)
- Booked through an Administration Centre after the GP visit
- Booked by you directly with the hospital after the GP visit

A 7 Before you first visited the GP for this condition, did you know that you had a choice of hospitals that you could have gone to, or not?

- 1. Yes - aware
- 2. No – not aware
- 3. Don't know/can't remember

A 8 At the time of your referral, did the GP tell you that you had a choice of hospitals that you could have gone to, or not?

- 1. Yes – told by GP
- 2. No – not told
- 3. Don't know/can't remember

IF NOT AWARE BEFORE AND NOT TOLD BY GP (CODE 2/3 AT A7 AND CODE 2/3 AT A8), GO TO B18.

IF AWARE OF CHOICE, GO TO B1

B Main Interview

The questions in this survey are about the condition you are visiting the hospital for today.

B 1 When you were told by the GP that you needed to go to hospital, did you ...?

INTERVIEWER READ OUT. SINGLE CODE ONLY

- 1. Already know that you wanted to attend this hospital
- 2. Have a good idea of which hospital you wanted to attend but were open to considering other options
- 3. Not know which hospital you wanted to attend
- 4. Don't know/can't remember (DO NOT READ OUT)

B 2 Did you discuss which hospital you might go to for your condition with the GP who referred you, or not?

- 1. Yes - discussed



2. No – did not
3. Don't know/can't remember

ASK B3 IF DISCUSSED HOSPITALS WITH GP (CODE 1 AT B2). REST GO TO B6

B 3 How many hospitals did you discuss with the GP? Please could you give me a number, including any hospitals that you personally had in mind already.

1. 1
2. 2
3. 3
4. 4
5. 5
6. Six or more
7. Don't know/can't remember

B 4 Which hospitals did you discuss with the GP?

DO NOT READ OUT. PROMPT TO THE NUMBER OF HOSPITALS MENTIONED AT B3

1. Royal Bournemouth and Christchurch Hospital
2. Poole Hospital
3. Alderney Hospital
4. Blandford Community Hospital
5. BMI The Harbour Hospital
6. BMI Sarum Road Hospital
7. BMI The Winterbourne Hospital
8. Boscombe Community Hospital
9. Bridport Community Hospital
10. Dorset County Hospital / Dorchester Hospital
11. Lymington New Forest Hospital
12. Nuffield Health Bournemouth Hospital
13. Portland Hospital
14. Royal Hampshire County Hospital
15. Salisbury District Hospital
16. Southampton General Hospital
17. Southampton Spire Hospital
18. St Anne's Hospital
19. St Leonards Community Hospital
20. Swanage Community Hospital
21. Wareham Community Hospital
22. Westhaven Hospital
23. Westminster Memorial Hospital
24. Weymouth Community Hospital
25. Wimborne Hospital/ Victoria Hospital
26. Yeatman Hospital
27. Yeovil District Hospital
28. Other (Write In)
29. Don't know/can't remember

NOTE TO SCRIPTWRITER ALLOW SAME NUMBER OF RESPONSES AS INDICATED AT B3, UP TO A MAXIMUM OF SIX



B 5 Did the GP discuss any of these things with you about the hospital you could go to?

READ OUT AND CODE ALL THAT APPLY. ROTATE BETWEEN INTERVIEWS

1. Clinical outcomes e.g. lower infection rates, higher recovery rates
2. Availability of specialist medical equipment at the hospital
3. Quality of nursing care
4. Quality of aftercare in follow-up visits
5. Comfort of waiting rooms and overnight stay rooms
6. Waiting times for appointments
7. Appointment times offered
8. Ease of getting to the hospital or parking at the hospital
9. Clinical expertise of consultants and other healthcare professionals
10. Your previous experience at a hospital

ALWAYS AT THE END

11. None of these things were discussed (DO NOT READ OUT)
12. Don't know/can't remember (DO NOT READ OUT)

B 6 I am going to read out a list of features. For each one I'd like you to tell me how important it was when assessing a hospital for your condition. Please use one of the phrases on this card to describe your answer.

SHOW CARD C

INTERVIEWER: READ OUT EACH STATEMENT IN TURN

SCALE

ESSENTIAL

VERY IMPORTANT

SOMEWHAT IMPORTANT

NOT IMPORTANT

DON'T KNOW (NOT ON SHOWCARD)

NOTE TO SCRIPTWRITER: ROTATE ORDER BETWEEN INTERVIEWS

1. Clinical outcomes e.g. lower infection rates, higher recovery rates
2. Availability of specialist medical equipment at the hospital
3. Quality of nursing care
4. Quality of aftercare in follow-up visits
5. Comfort of waiting rooms and overnight stay rooms
6. Waiting times for appointments
7. Appointment times offered
8. Ease of getting to the hospital or parking at the hospital
9. Clinical expertise of consultants and other healthcare professionals
10. Your previous experience of the hospital



B 7 Did the GP recommend a hospital, or tell you where to go, or not?

PROMPT TO PRECODES. SINGLE CODE ONLY

1. Yes – recommended hospital
2. Yes – told me where to go
3. No

ASK B8 IF GP RECOMMENDED HOSPITAL OR TOLD PATIENT WHERE TO GO (CODE 1 OR 2 AT B7). REST GO TO B10

B 8 Which hospital did the GP recommend/tell you to go to?

PROMPT: WHICH OTHERS? (IF RECOMMENDED) MULTI-CODE

1. Royal Bournemouth and Christchurch Hospital
2. Poole Hospital
3. Alderney Hospital
4. Blandford Community Hospital
5. BMI The Harbour Hospital
6. BMI Sarum Road Hospital
7. BMI The Winterbourne Hospital
8. Boscombe Community Hospital
9. Bridport Community Hospital
10. Dorset County Hospital / Dorchester Hospital
11. Lymington New Forest Hospital
12. Nuffield Health Bournemouth Hospital
13. Portland Hospital
14. Royal Hampshire County Hospital
15. Salisbury District Hospital
16. Southampton General Hospital
17. Southampton Spire Hospital
18. St Anne's Hospital
19. St Leonards Community Hospital
20. Swanage Community Hospital
21. Wareham Community Hospital
22. Westhaven Hospital
23. Westminster Memorial Hospital
24. Weymouth Community Hospital
25. Wimborne Hospital/ Victoria Hospital
26. Yeatman Hospital
27. Yeovil District Hospital
28. Other (Write In)
29. Don't know/can't remember



ASK B9 IF GP RECOMMENDED A HOSPITAL (CODE 1 AT B7). REST GO TO B10

B 9 How important was the GP recommendation in the decision to come to ... (LOCATION) for your condition? SHOW CARD C

1. Essential
2. Very important
3. Somewhat important
4. Not important
5. Don't know (NOT ON SHOWCARD)

B 10 Thinking back to when you were first referred by the GP, approximately how many weeks did you have to wait before you had your first appointment at the <LOCATION> hospital?
CODE NUMBER OF WEEKS OR DON'T KNOW

ASK B11 IF NUMBER OF WEEKS MENTIONED. REST SKIP TO B14.

B 11 Assuming your treatment was available anywhere, how many weeks longer would you have been prepared to wait for your first appointment, before you decided to go to another hospital?

CODE NUMBER OF WEEKS "WOULD NOT HAVE GONE TO ANOTHER HOSPITAL" OR "DON'T KNOW". CODE ZERO IF WOULD NOT HAVE BEEN PREPARED TO WAIT ANY LONGER

ASK B12 IF EXTRA NUMBER OF WEEKS SPECIFIED. IF ZERO GO STRAIGHT TO B13. REST GO TO B14.

B 12 Can I just check, that means you would have been prepared to wait (ANSWER AT B10 + ANSWER AT B11) weeks in total before you decided to go to another hospital, is that correct?

1. Yes
2. No

GO BACK TO B11 IF NOT CORRECT. REST GO TO B13



ASK B13 IF GAVE INCREASE IN WAIT TIME OR ZERO AT B11. REST GO TO B14

- B 13 Suppose the wait time at <LOCATION> hospital was longer than <WEEKS AT B12 OR WEEKS AT B10 IF NOT PREPARED TO WAIT ANY LONGER>, which other hospital would you have gone to instead?

DO NOT READ OUT. SINGLE CODE ONLY. NOTE TO SCRIPTWRITER: DO NOT INCLUDE LOCATION HOSPITAL IN PRECODE LIST

1. Royal Bournemouth and Christchurch Hospital
2. Poole Hospital
3. Alderney Hospital
4. Blandford Community Hospital
5. BMI The Harbour Hospital
6. BMI Sarum Road Hospital
7. BMI The Winterbourne Hospital
8. Boscombe Community Hospital
9. Bridport Community Hospital
10. Dorset County Hospital/ Dorchester Hospital
11. Lymington New Forest Hospital
12. Nuffield Health Bournemouth Hospital
13. Portland Hospital
14. Royal Hampshire County Hospital
15. Salisbury District Hospital
16. Southampton General Hospital
17. Southampton Spire Hospital
18. St Anne's Hospital
19. St Leonards Community Hospital
20. Swanage Community Hospital
21. Wareham Community Hospital
22. Westhaven Hospital
23. Westminster Memorial Hospital
24. Weymouth Community Hospital
25. Wimborne Hospital/ Victoria Hospital
26. Yeatman Hospital
27. Yeovil District Hospital
28. Other (Write In)
29. Would ask my GP/consultant
30. Don't know



ASK B14 IF ANSWERED DON'T KNOW OR WOULD NOT HAVE GONE TO ANOTHER HOSPITAL AT B11, OR DON'T KNOW AT B10. REST GO TO INSTRUCTION BEFORE B16

- B 14 Suppose you could not get an appointment at this hospital, which other hospital would you have gone to instead?

DO NOT READ OUT. SINGLE CODE ONLY. NOTE TO SCRIPTWRITER: DO NOT INCLUDE LOCATION HOSPITAL IN PRECODE LIST

1. Royal Bournemouth and Christchurch Hospital
2. Poole Hospital
3. Alderney Hospital
4. Blandford Community Hospital
5. BMI The Harbour Hospital
6. BMI Sarum Road Hospital
7. BMI The Winterbourne Hospital
8. Boscombe Community Hospital
9. Bridport Community Hospital
10. Dorset County Hospital/ Dorchester Hospital
11. Lymington New Forest Hospital
12. Nuffield Health Bournemouth Hospital
13. Portland Hospital
14. Royal Hampshire County Hospital
15. Salisbury District Hospital
16. Southampton General Hospital
17. Southampton Spire Hospital
18. St Anne's Hospital
19. St Leonards Community Hospital
20. Swanage Community Hospital
21. Wareham Community Hospital
22. Westhaven Hospital
23. Westminster Memorial Hospital
24. Weymouth Community Hospital
25. Wimborne Hospital/ Victoria Hospital
26. Yeatman Hospital
27. Yeovil District Hospital
28. Other (Write In)
29. Would ask my GP/consultant
30. Don't know

INTERVIEWER NOTE: IF INTERVIEWING AT ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITAL, AND RESPONDENT MENTIONS "ROYAL BOURNEMOUTH" OR "CHRISTCHURCH" HOSPITAL AS ALTERNATIVE, SAY:

For this survey we would like you to consider Royal Bournemouth and Christchurch as the same hospital, so please tell me which other hospital you would have gone to instead.

ASK B15 IF ANSWER AT B14 IS ANOTHER NAMED HOSPITAL. REST GO TO B18

- B 15 Would you have strongly preferred to go to <LOCATION> hospital instead of <ANSWER AT B14>, slightly preferred, or would it have made no difference to you?

1. Strongly preferred
2. Slightly preferred



3. No difference

ASK B16 IF ANSWER AT B13/B14 IS OTHER MERGING HOSPITAL TRUST. REST GO TO B18

B 16 If <OTHER MERGING HOSPITAL> did not offer your treatment, which other hospital would you have gone to instead?

DO NOT READ OUT. SINGLE CODE ONLY. PLEASE NOTE THE LIST EXCLUDES BOTH MERGING HOSPITALS

1. Alderney Hospital
2. Blandford Community Hospital
3. BMI The Harbour Hospital
4. BMI Sarum Road Hospital
5. BMI The Winterbourne Hospital
6. Boscombe Community Hospital
7. Bridport Community Hospital
8. Dorset County Hospital/ Dorchester Hospital
9. Lymington New Forest Hospital
10. Nuffield Health Bournemouth Hospital
11. Portland Hospital
12. Royal Hampshire County Hospital
13. Salisbury District Hospital
14. Southampton General Hospital
15. Southampton Spire Hospital
16. St Anne's Hospital
17. St Leonards Community Hospital
18. Swanage Community Hospital
19. Wareham Community Hospital
20. Westhaven Hospital
21. Westminster Memorial Hospital
22. Weymouth Community Hospital
23. Wimborne Hospital/ Victoria Hospital
24. Yeatman Hospital
25. Yeovil District Hospital
26. Other (Write In)
27. Would ask my GP/consultant
28. Don't know



ASK B17 IF ANSWER AT B16 IS ANOTHER NAMED HOSPITAL. REST GO TO B18

B 17 Would you have strongly preferred to go to <OTHER MERGING HOSPITAL> hospital instead of <ANSWER AT B16>, slightly preferred, or would it have made no difference to you?

1. Strongly preferred
2. Slightly preferred
3. No difference

ASK ALL

B 18 How important is it to you that you are offered a choice of hospitals?

SHOW CARD C

1. Essential
2. Very important
3. Somewhat important
4. Not important
5. Don't know (NOT ON SHOWCARD)



C PATIENT PROFILE

C 1 These last few questions are for classification purposes only. How long did it take you to travel to the hospital today?

INTERVIEWER: WRITE IN NUMBER OF MINUTES AND CODE TO RANGE.

1. Less than 15 minutes
2. 15 – 29 minutes
3. 30-44 minutes
4. 45-59 minutes
5. An hour or more
6. Don't know

C 2 How did you travel here today?

1. Car
2. Bus
3. Train
4. Taxi
5. Walked
6. Other

C 3 Which hospitals have you or your family been referred to before in the local area? PROMPT:
Which others?

1. Royal Bournemouth and Christchurch Hospital
2. Poole Hospital
3. Alderney Hospital
4. Blandford Community Hospital
5. BMI The Harbour Hospital
6. BMI Sarum Road Hospital
7. BMI The Winterbourne Hospital
8. Boscombe Community Hospital
9. Bridport Community Hospital
10. Dorset County Hospital/ Dorchester Hospital
11. Lymington New Forest Hospital
12. Nuffield Health Bournemouth Hospital
13. Portland Hospital
14. Royal Hampshire County Hospital
15. Salisbury District Hospital
16. Southampton General Hospital
17. Southampton Spire Hospital
18. St Anne's Hospital
19. St Leonards Community Hospital
20. Swanage Community Hospital
21. Wareham Community Hospital
22. Westhaven Hospital
23. Westminster Memorial Hospital
24. Weymouth Community Hospital
25. Wimborne Hospital/ Victoria Hospital
26. Yeatman Hospital
27. Yeovil District Hospital



28. Other (Write In)
29. Don't know/can't remember

C 4 RECORD GENDER

1. Male
2. Female

C 5 Into which of these age bands do you fall? Please give me the number from this card.

SHOW CARD D

1. 18-24
2. 25-34
3. 35-44
4. 45-54
5. 55-64
6. 65-74
7. 75+

C 6 Which of these describes you? Again please give me the number from this card.

SHOW CARD E

1. Employed full time (30+ hours per week)
2. Employed part-time (less than 30 hours per week)
3. Self-employed full time (30+ hours per week)
4. Self-employed part-time (less than 30 hours per week)
5. In full time higher education
6. Retired
7. Not able to work
8. Unemployed and seeking work
9. Not working for other reason

C 7 Thank you very much for your help. Would you be willing to be contacted again about this subject, if necessary?

1. Yes
2. No



D Back-checking details

Name

Address

Telephone Details

Postcode Details

Permissions

D 1 Would be willing for us to pass on your first half postcode details to the Competition Commission, which is the Government body that is carrying out this survey. These details will only be used for analysis purposes, for example to look at which hospitals are near to you?

Yes – willing
No – not willing



Appendix B – GP Questionnaire

Receptionist Introduction

Good morning/afternoon. My name is from GfK NOP the market research company. We are carrying out an important survey on behalf of the Competition Commission about hospital services in the local area. One or more of the doctors at your practice should have received a notification letter about this survey already.

You may have already spoken to us, as we are looking to speak to a number of doctors at each practice. Please could I speak to Dr <INSERT LAST NAME FROM SAMPLE>.

E Introduction and screener

Good morning/afternoon. My name is from GfK NOP the market research company. We are carrying out an important survey on behalf of the Competition Commission about hospital services in the local area. You should have received a notification letter about this survey already. As an appreciation of your time, we would like to offer you £50 or a donation of £50 to charity.

Do you have 10 minutes to complete this important survey?

All the work we carry out is governed by the Market Research Society's Code of Conduct, which means that everything you say will be treated in the strictest confidence, and neither you nor your practice will be identified in any way, without your permission. The interview will be recorded but this is for our own quality assurance purposes and will not be kept.

ADD REASSURANCES AS NECESSARY

- Everything you say is confidential and any responses will not be attributed to you
- There will be no attempt to sell you anything, either during or as a result of the survey
- This is a genuine market research survey being conducted on behalf of the Competition Commission
- Charitable donations will go to Macmillan and Diabetes UK



E 1 This survey is about NHS patient referrals to the Royal Bournemouth and Christchurch hospital and Poole hospital. By referral I mean the process of making a hospital appointment, whether it is booked by you or the patient. Have you been involved in a referral to one of these hospitals in the last three months, where the patient could have gone to either hospital, for any of the following specialties?

READ OUT SPECIALTIES FROM LIST BELOW. CODE THOSE WHERE GP HAS BEEN INVOLVED IN A REFERRAL

- 20. Breast surgery
- 21. Cardiology involving MRI, CT and ECHO scans (but not ECHO Stress test)
- 22. Dermatology
- 23. Diabetic medicine
- 24. Endocrine surgery
- 25. Endocrinology
- 26. Gastroenterology
- 27. Gastro-intestinal surgery – lower (i.e. colorectal)
- 28. Gastro-intestinal surgery – upper (i.e. stomach, digestion)
- 29. Geriatric medicine
- 30. Gynaecology
- 31. Haematology
- 32. Hepatology
- 33. Oral surgery excluding maxillofacial surgery
- 34. Pain management
- 35. Rehabilitation
- 36. Rheumatology
- 37. None of these (DO NOT READ OUT)
- 38. Don't know/not sure (DO NOT READ OUT)

CLOSE IF NOT BEEN INVOLVED IN ANY SUCH REFERRALS TO RBCH OR POOLE HOSPITAL IN LAST THREE MONTHS.



F Main Interview

F 1 Thinking about the last time you were involved in such a referral, which specialty was it for?

INTERVIEWER: IF NECESSARY READ OUT LIST AGAIN

LIST AS CODED AT A1, APART FROM 'NONE OF THESE' - REMOVED

CLOSE IF DON'T KNOW/NOT SURE

F 2 Was the patient referred to the Royal Bournemouth and Christchurch hospitals or to the Poole hospital?

1. Royal Bournemouth and Christchurch
2. Poole

F 3 When you discussed the referral, did the patient ...?

INTERVIEWER READ OUT AND SINGLE CODE

5. Already know which hospital he/she wanted to attend
6. Have a good idea of which hospital he/she wanted to attend but was open to considering other options
7. Not know which hospital he/she wanted to attend
8. Don't know/can't remember

F 4 Did you have a discussion with the patient about the hospital or hospitals they could be referred to, or not?

1. Yes – discussed
2. No – did not
3. Can't remember

ASK B4X IF DID NOT DISCUSS WITH PATIENT (CODE 2 AT B4). REST GO TO B5.

B4x Why did you not have that discussion with the patient?

DO NOT READ OUT BUT CODE TO PRECODES. MULTI-CODING ALLOWED

1. Patients expect me to make the choice
2. I know what is best for my patients
3. Only one hospital patient wanted to go to
4. Wanted patient to go to closest hospital
5. Only local hospital for that specialty
6. Other (Write in)



ASK B5 IF DISCUSSED HOSPITALS WITH PATIENT (CODE 1 AT B4). REST GO TO B9

F 5 How many named hospitals did you discuss with the patient? Please could you give me a number, including any hospitals that the patient had in mind already.

- 8. 1
- 9. 2
- 10. 3
- 11. 4

12. 5 or more

13. Don't know/can't remember

F 6 Which hospitals did you discuss with the patient?

DO NOT READ OUT. PROMPT TO THE NUMBER OF HOSPITALS MENTIONED AT B5.

NUMBER MUST BE LESS THAN OR EQUAL TO NUMBER MENTIONED AT B5.

1. Royal Bournemouth and Christchurch Hospital
2. Poole Hospital
3. Alderney Hospital
4. Blandford Community Hospital
5. BMI The Harbour Hospital
6. BMI Sarum Road Hospital
7. BMI The Winterbourne Hospital
8. Boscombe Community Hospital
9. Bridport Community Hospital
10. Dorset County Hospital / Dorchester Hospital
11. Lymington New Forest Hospital
12. Nuffield Health Bournemouth Hospital
13. Portland Hospital
14. Royal Hampshire County Hospital
15. Salisbury District Hospital
16. Southampton General Hospital
17. Southampton Spire Hospital
18. St Anne's Hospital
19. St Leonards Community Hospital
20. Swanage Community Hospital
21. Wareham Community Hospital
22. Westhaven Hospital
23. Westminster Memorial Hospital
24. Weymouth Community Hospital
25. Wimborne Hospital / Victoria Hospital
26. Yeatman Hospital
27. Yeovil District Hospital
28. Other (Write In)
29. Don't know/can't remember



ASK B7 IF ONLY DISCUSSED ONE HOSPITAL (CODE 1 AT B5). REST GO TO B8

F 7 Why did you discuss just the one hospital with the patient?

DO NOT READ OUT BUT CODE TO PRECODES. MULTI-CODING ALLOWED

1. Easiest to get to/closest
2. Best local hospital
3. Good local hospital
4. Patients expect me to make the choice
5. I know what is best for my patients
6. Only local hospital for that specialty
7. This is the one the patient wanted to go to
8. Other (Write in)

F 8 Did you discuss any of these things with the patient about the hospital/hospitals they could go to?

READ OUT AND CODE ALL THAT APPLY. ROTATE BETWEEN INTERVIEWS

13. Clinical outcomes e.g. lower infection rates, higher recovery rates
14. Availability of specialist medical equipment at the hospital
15. Quality of nursing care
16. Quality of aftercare in follow-up visits
17. Comfort of waiting rooms and overnight stay rooms
18. Waiting times for appointments
19. Appointment times offered
20. Ease of getting to the hospital or parking at the hospital
21. Clinical expertise of consultants and other healthcare professionals
22. Patient's previous experience at a hospital

ALWAYS AT THE END

23. None of these things were discussed (DO NOT READ OUT)
24. Don't know/can't remember (DO NOT READ OUT)



ASK ALL

F 9 Did you recommend a hospital to the patient, or not?

- 1. Yes
- 2. No

ASK B10 IF RECOMMENDED A HOSPITAL (CODE 1 AT B9). REST GO TO B11

F 10 Which hospitals did you recommend? PROMPT: Which others?

DO NOT READ OUT, CODE ALL THAT APPLY

1. Royal Bournemouth and Christchurch Hospital
2. Poole Hospital
3. Alderney Hospital
4. Blandford Community Hospital
5. BMI The Harbour Hospital
6. BMI Sarum Road Hospital
7. BMI The Winterbourne Hospital
8. Boscombe Community Hospital
9. Bridport Community Hospital
10. Dorset County Hospital / Dorchester Hospital
11. Lymington New Forest Hospital
12. Nuffield Health Bournemouth Hospital
13. Portland Hospital
14. Royal Hampshire County Hospital
15. Salisbury District Hospital
16. Southampton General Hospital
17. Southampton Spire Hospital
18. St Anne's Hospital
19. St Leonards Community Hospital
20. Swanage Community Hospital
21. Wareham Community Hospital
22. Westhaven Hospital
23. Westminster Memorial Hospital
24. Weymouth Community Hospital
25. Wimborne Hospital / Victoria Hospital
26. Yeatman Hospital
27. Yeovil District Hospital
28. Other (Write In)
29. Don't know/can't remember



F 11 I am going to read out a list of features, and for each one I'd like you to tell me how important it is when assessing a hospital for <SPECIALTY AT B1>. Please use the following scale when giving your answer.

INTERVIEWER: READ OUT SCALE, THEN READ OUT EACH STATEMENT IN TURN

SCALE

ESSENTIAL

VERY IMPORTANT

SOMEWHAT IMPORTANT

NOT IMPORTANT

DON'T KNOW (DO NOT READ OUT)

NOTE TO SCRIPTWRITER: ROTATE ORDER BETWEEN INTERVIEWS

1. Clinical outcomes e.g. lower infection rates, higher recovery rates
2. Availability of specialist medical equipment at the hospital
3. Quality of nursing care
4. Quality of aftercare in follow-up visits
5. Comfort of waiting rooms and overnight stay rooms
6. Waiting times for appointments
7. Appointment times offered
8. Ease of getting to the hospital or parking at the hospital
9. Clinical expertise of consultants and other healthcare professionals
10. Patient's previous experience at a hospital



ASK B12 IF RECOMMENDED AT B10 LOCATION HOSPITAL (AT B2) OR OTHER MERGING HOSPITAL (IF DID NOT RECOMMEND LOCATION HOSPITAL). REST GO TO B19.

- F 12 You mentioned earlier that you recommended that the patient went to <HOSPITAL AT B2/OTHER MERGING HOSPITAL> (IF RECOMMENDED MERGING HOSPITAL AND DID NOT RECOMMEND LOCATION HOSPITAL AT B2>. On a scale of 1-10, where 10 means Excellent and 1 means Very Poor, how would you assess the overall level of clinical outcomes for this condition at this hospital?

1
2
3
4
5
6
7
8
9
10

Don't know

ASK B13 IF GAVE A 1-10 RESPONSE AT B12. REST GO TO B15

- F 13 Suppose you had concerns that clinical outcomes were deteriorating. How much worse could they get, on that same scale of 1 to 10, before you would recommend another hospital?

CLARIFY IF NECESSARY – How much lower on the scale would the level of clinical outcomes need to get before you would recommend another hospital?

ONCE NUMBER HAS BEEN ENTERED, CHECK MESSAGE APPEARS: Could I just check, is that <ANSWER AT B13> points worse, or <ANSWER AT B13> on the scale? CHANGE ANSWER BELOW IF NECESSARY

1
2
3
4
5
6
7
8
9
10

Don't know

NOTE TO SCRIPTWRITER – RESPONSE AT B13 MUST BE LESS THAN OR EQUAL TO RESPONSE AT B12



ASK B14 IF GAVE A 1-10 RESPONSE AT B13. REST GO TO B15

F14 Which other hospital would you have recommended instead?

DO NOT READ OUT. SINGLE CODE ONLY. NOTE TO SCRIPTWRITER:

DO NOT INCLUDE LOCATION/MERGING HOSPITAL IN PRECODE LIST (AS APPLICABLE)

1. Royal Bournemouth and Christchurch Hospital
2. Poole Hospital
3. Alderney Hospital
4. Blandford Community Hospital
5. BMI The Harbour Hospital
6. BMI Sarum Road Hospital
7. BMI The Winterbourne Hospital
8. Boscombe Community Hospital
9. Bridport Community Hospital
10. Dorset County Hospital / Dorchester Hospital
11. Lymington New Forest Hospital
12. Nuffield Health Bournemouth Hospital
13. Portland Hospital
14. Royal Hampshire County Hospital
15. Salisbury District Hospital
16. Southampton General Hospital
17. Southampton Spire Hospital
18. St Anne's Hospital
19. St Leonards Community Hospital
20. Swanage Community Hospital
21. Wareham Community Hospital
22. Westhaven Hospital
23. Westminster Memorial Hospital
24. Weymouth Community Hospital
25. Wimborne Hospital / Victoria Hospital
26. Yeatman Hospital
27. Yeovil District Hospital
28. Other (Write In)
29. Would ask my GP/consultant
30. Don't know



ASK B15 IF DON'T KNOW AT B12 OR B13. REST GO TO INSTRUCTION BEFORE B17

- F 15 Suppose the patient could not get an appointment at <HOSPITAL AT B2/OTHER MERGING HOSPITAL>, which other hospital would you have recommended instead?

DO NOT INCLUDE LOCATION/MERGING HOSPITAL IN PRECODE LIST (AS APPLICABLE)

1. Royal Bournemouth and Christchurch Hospital
2. Poole Hospital
3. Alderney Hospital
4. Blandford Community Hospital
5. BMI The Harbour Hospital
6. BMI Sarum Road Hospital
7. BMI The Winterbourne Hospital
8. Boscombe Community Hospital
9. Bridport Community Hospital
10. Dorset County Hospital / Dorchester Hospital
11. Lymington New Forest Hospital
12. Nuffield Health Bournemouth Hospital
13. Portland Hospital
14. Royal Hampshire County Hospital
15. Salisbury District Hospital
16. Southampton General Hospital
17. Southampton Spire Hospital
18. St Anne's Hospital
19. St Leonards Community Hospital
20. Swanage Community Hospital
21. Wareham Community Hospital
22. Westhaven Hospital
23. Westminster Memorial Hospital
24. Weymouth Community Hospital
25. Wimborne Hospital / Victoria Hospital
26. Yeatman Hospital
27. Yeovil District Hospital
28. Other (Write In)
29. Would ask my GP/consultant
30. Don't know

ASK B16 IF NAMED A HOSPITAL AT B15. REST GO TO INSTRUCTION BEFORE B17.

- F 16 Would you have strongly preferred the patient to go to <HOSPITAL AT B2/OTHER MERGING HOSPITAL instead of <ANSWER AT B15>, slightly preferred, or would it have made no difference to you?

4. Strongly preferred
5. Slightly preferred
6. No difference



ASK B17 IF ANSWER AT B14/B15 IS OTHER MERGING HOSPITAL. REST GO TO B19

- F 17 If <OTHER MERGING HOSPITAL> did not offer the treatment, which other hospital would you have recommended instead?

DO NOT READ OUT. SINGLE CODE ONLY.

1. Alderney Hospital
2. Blandford Community Hospital
3. BMI The Harbour Hospital
4. BMI Sarum Road Hospital
5. BMI The Winterbourne Hospital
6. Boscombe Community Hospital
7. Bridport Community Hospital
8. Dorset County Hospital / Dorchester Hospital
9. Lymington New Forest Hospital
10. Nuffield Health Bournemouth Hospital
11. Portland Hospital
12. Royal Hampshire County Hospital
13. Salisbury District Hospital
14. Southampton General Hospital
15. Southampton Spire Hospital
16. St Anne's Hospital
17. St Leonards Community Hospital
18. Swanage Community Hospital
19. Wareham Community Hospital
20. Westhaven Hospital
21. Westminster Memorial Hospital
22. Weymouth Community Hospital
23. Wimborne Hospital / Victoria Hospital
24. Yeatman Hospital
25. Yeovil District Hospital
26. Other (Write In)
27. Would ask my GP/consultant
28. Don't know

ASK B18 IF ANSWER AT B17 IS ANOTHER NAMED HOSPITAL. REST GO TO B19

- F 18 Would you have strongly preferred the patient to go to <OTHER PARTY> hospital instead of <ANSWER AT B17>, slightly preferred, or would it have made no difference to you?

1. Strongly preferred
2. Slightly preferred
3. No difference

ASK ALL

- F 19 Would you say that the case we have just discussed is typical of the way you discuss hospital choices with a patient, or not?

1. Yes – typical
2. No – not typical
3. DK/too difficult to say



ASK B20 IF NOT TYPICAL (CODE 2 AT B19). REST GO TO B21

F 20 In what way is it not typical?

CAPTURE VERBATIM RESPONSE

PROMPT: Do you refer in different ways for different specialties, or patients? IF YES: How does this vary?

F 21 How do your patients typically make hospital appointments? Are they normally

READ OUT, SINGLE CODE ONLY

Booked by you

Booked by another member of staff at the GP surgery

Booked by the patient online using the NHS Choose and Book system

Booked by the patient on the phone using the NHS Choose and Book system

Booked by the patient through a Referral Management Centre

Booked by the patient directly with the hospital

Depends/varies (DO NOT READ OUT)

Don't know (DO NOT READ OUT)

F 22 As you may know the Royal Bournemouth and Christchurch hospitals NHS Foundation Trust and the Poole Hospital NHS Foundation Trust are planning to merge. Do you think this will improve the quality of patient care in the local area, worsen the quality of patient care, or will it make no difference?

Improve care quality

No difference

Worsen care quality

Don't know

ASK B23 IF GP THINKS MERGER WILL IMPROVE OR WORSEN CARE QUALITY. REST GO TO C1.

F 23 Why do you say that?

CAPTURE VERBATIM RESPONSE

G GP PROFILE/VIEWS ON MERGER

G 1 Finally, I'd like to ask you a few questions for classification purposes only. For how many years have you worked as a GP?

INTERVIEWER: WRITE IN NUMBER AND CODE TO RANGE. IF LESS THAN ONE YEAR CODE AS ZERO

3. Zero

4. 1-2

5. 3-5

6. 6-10

7. 11-15

8. 16-20

9. 21-30

10. More than 30 years



G 2 For how many years have you been working as a GP in the local area?

INTERVIEWER: WRITE IN NUMBER AND CODE TO RANGE. IF LESS THAN ONE YEAR CODE AS ZERO

NOTE TO SCRIPTWRITER: ANSWER MUST BE EQUAL TO OR LESS THAN RESPONSE AT C1

1. Zero
2. 1-2
3. 3-5
4. 6-10
5. 11-15
6. 16-20
7. 21-30
8. More than 30 years

G 3 Would you be willing for us to pass on your postcode details to the Competition Commission?

This will only be used for analysis purposes, not to identify you in any way.

1. Yes – willing
2. No – not willing

ASK C6 IF WILLING TO PASS ON DETAILS, REST GO TO C4

G 4 Please could you tell me your postcode?

INTERVIEWER TYPE IN

ASK ALL

G 5 Thank you very much for your help. Would you be willing to be contacted again about this subject, if necessary?

3. Yes
4. No

G 6 Please could you let me know whether you would prefer to receive the £50 as a thank you for your time yourself, or whether you would prefer to donate the money to charity? Charitable donations will go to Macmillan and Diabetes UK.

Incentive to respondent
Charitable Donation

ASK C7 IF WOULD PREFER TO RECEIVE INCENTIVE

G 7 Can I just confirm who the cheque should be made payable to, and your address?

INTERVIEWER WRITE IN CHEQUE PAYEE DETAILS, AND CONFIRM ADDRESS DETAILS FROM SAMPLE.

Thank you. Your cheque will be posted in the week commencing 4th March.

Thank you for participating in this survey. We really appreciate your time.



Appendix C – GP Notification Letter

Dear XXXXXXXXX

ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST/POOLE HOSPITAL NHS FOUNDATION TRUST MERGER INQUIRY

I am writing to ask for your assistance. The Competition Commission (CC) is currently conducting research to provide evidence for the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust / Poole Hospital NHS Foundation Trust merger inquiry.

As part of the inquiry, we have asked an independent research company, GfK NOP, to undertake some research on our behalf. GfK NOP may contact you in the next few weeks to ask whether you would be willing to talk to them about your views.

If you have recently made a referral for one of the specialties on the back of this letter you will be invited to take part in a short questionnaire regarding the process of your most recent referral. To thank you for your time we will be offering £50 or a £50 charity donation.

Please be assured that this is genuine market research commissioned by the CC to help with our inquiry and your responses will be strictly confidential. No information that could link responses with details of you will be passed back to the CC or to anyone else, without your permission. All research conducted by GfK NOP adheres to the Market Research Society Code of Conduct and the Data Protection Act.

I hope that you will take part in this important research study, which is important for our inquiry.

However, if you do not want to take part, please telephone GfK NOP within the next 2 days on 020 7890 9969. If you do call, please leave your name, practice name, email address and telephone number, and quote the following reference number: {INSERT REF} and you will not be contacted by GfK NOP.

If you have any questions regarding the survey please contact Alice Wainwright at GfK NOP on 020 7890 9741. If you have any questions regarding the inquiry you can email me at RBCH.PH@cc.gsi.gov.uk or visit the CC website: <http://www.competition-commission.org.uk/our-work/royal-bournemouth-and-christchurch-poole>.

Many thanks for your time.

Yours sincerely

Matthew Weighill

Inquiry Manager



Appendix D – Practice Manager Notification Letter

Dear XXXXXXXXX

ROYAL BOURNEMOUTH AND CHRISTCHURCH HOSPITALS NHS FOUNDATION TRUST/POOLE HOSPITAL NHS FOUNDATION TRUST MERGER INQUIRY

The Competition Commission (CC) is currently conducting research to provide evidence for the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust / Poole Hospital NHS Foundation Trust merger inquiry.

As you may know, GfK NOP has been commissioned to undertake some research on behalf of the CC. We have written to the relevant GPs at your practice to tell them about the survey and what it involves.

If you have not had the opportunity to do so already, please could you help our interviewer when he or she phones to request an interview time with one or more of your GPs. We wish to conduct a 10-minute telephone interview at a time that is convenient to them, and are providing an incentive or donation to charity as a thank you for their time.

Please be assured that this is genuine market research commissioned by the CC to help with their inquiry and that responses will be strictly confidential. No information that could link responses with details of the GPs will be passed back to the CC or to anyone else, without their permission. All research conducted by GfK NOP adheres to the Market Research Society Code of Conduct and the Data Protection Act.

We hope that the GPs at your practice will take part in this important research study, which is an essential part of the CC Inquiry.

If you have any questions regarding the survey or you wish to suggest suitable interview times please leave a message on 0207 890 9982.

Many thanks for your time.

Yours sincerely

David Rodgers

Divisional Director, GfK NOP

Supporting information for incentives analysis

1. This appendix provides supporting information for our analysis of the parties' incentives to compete for patients. The first part (paragraphs 2 to 34) of this appendix describes how we assessed the parties' submission that they are currently operating at close to full capacity and that this removes their incentives to compete to attract patients. The second part (paragraphs 35 to 46) sets out our methodology for investigating the profitability of the parties' services and describes the breakdown of costs by type. The third part (paragraphs 47 to 73) sets out further factual background to RBCH and PH's relationships with commissioners.

Capacity

2. Paragraphs 3 to 34 of this appendix describe how we assessed the parties' submission that they were currently operating at close to full capacity and that this removed their incentives to compete to attract patients.
3. The parties told us¹ that they were currently operating at close to full capacity. They submitted utilization statistics for the period 2009 to 2012 showing that bed day occupancy² was a consistent annual average of around 90 per cent at both merging trusts and the theatre utilization rates were around 90 per cent at PH³ and approximately 85 per cent at RBCH. Table 1 summarizes the capacity utilization for each trust.

TABLE 1 Utilization at PH and RBCH, 2009 to 2012

	per cent		
	2009/10	2010/11	2011/12
<i>PH</i>			
Occupied bed days	87	88	88
Theatre utilization	91	88	87
<i>RBCH</i>			
Occupied bed days	[X]	[X]	[X]
Theatre utilization	[X]	[X]	[X]

Source: RBCH and PH.

-
4. The parties submitted that these statistics might appear to suggest that the merging trusts had some spare capacity while in reality they did not. This was because these statistics did not capture a number of relevant aspects. With particular regard to bed occupancy, the parties stated that:⁴
 - (a) Occupancy bed rates were measured at night, and therefore they did not account for inpatients who occupied beds during the daytime only.

¹ Joint main party initial submission, paragraph 242.

² Bed occupancy rate was defined by the parties as 'the percentage of available beds which have been occupied over a given period. It is calculated by dividing the number of occupied beds for the period by the number of available bed days for the period, and expressing the result as a percentage'.

³ PH told us that 'Over the course of the last quarter PH have been seeing occupancy rates of 100 per cent with the need more recently to cancel elective operations to give priority to non elective emergency admissions'. It also added that 'Recently we have had more patients needing beds than beds available at certain times'.

⁴ RBCH also submitted that the numbers in Table 1 were 'averages, and therefore there are frequently periods where bed capacity is at 100 per cent'.

(b) Demand was seasonal (higher from November to March and lower in the summer months).

(c) Beds allocated to elective services tended to be occupied less at weekends 'predominantly due to the level of relevant consultant coverage'.

(d) Due to service-specific requirements, beds were not always substitutable across specialties and services⁵ and where they were, this may lead to a suboptimal patient experience and poorer outcomes.

5. PH also submitted that it did not have spare bed capacity and that it 'would take a significant step change in costs to achieve greater capacity at the trust and even then the challenges currently being faced in recruiting nursing staff could still remain a barrier'.

6. However, the parties' submission to us on the subject of bed closures indicated that they were planning to close a number of beds, and that many of these were not merger-dependent (ie would be expected to happen absent the merger). The non-merger-dependent closures included [☒] beds across the two sites within acute surgery, cardiology, maternity & gynaecology, trauma and general medicine. This suggested that if these beds were no longer needed to provide existing services, they could be used as extra capacity to expand the volume of elective services. The parties told us that the closures depended on changes in patient pathways and improvements in the length of stay which cannot be guaranteed, and assumed a major increase in out-of-hospital provision (mainly community provision but also social care). RBCH also told us that it could not use the freed space to generate additional elective activity as it would need the space to respond to peaks in non-elective activity, and PH said that it would need the spare capacity to achieve an acceptable level of bed occupancy in time of pressure. PH also said that the closures would be certain beds on particular wards, rather than clearing entire wards. Given that the possible [☒] beds represent around [11–20] per cent of the trusts' current beds, we were sceptical that all of those would be needed to respond to peaks, especially given the scale of RBCH's non-elective activity. We thought that there was at least a possibility of bed capacity being freed up in the near future, absent the merger, which would allow some degree of expansion.

7. We also considered whether these utilization statistics might have understated capacity because a measure of 100 per cent is not a true maximum. First, extra beds were available (although they may not be optimally placed and bedhead services may not be available). In connection with this, PH told us that it had in the recent past reduced its official number of beds and converted ward space to other activities which could be converted back (and sometimes was when needed). In relation to this, PH told us that it would be unable readily or sustainably to convert office or other space into clinical space to create additional capacity. In theory it could convert such space but it estimated that this would cost £1 million. It said that the space it had previously converted from inpatient space into day-care space and space for additional patients was heavily utilized and could not, in PH's view, be reconverted without investing in additional capacity.

8. Second, theatres could be utilized above 100 per cent by operating for longer hours (and PH identified '[increasing] the use of day theatres to maximise patient benefit and throughput' as a targeted area of improvement in its 2012/13 Annual Report).

⁵ The parties mentioned, as an example, paediatric beds, which could not be filled with obstetrics patients.

9. In relation to the theatre utilization, the parties told us that as out-of-hours activity was significantly more expensive ([§] per cent more for consultant time; and [§] to [§] per cent more for staff time), elective activity would therefore be unprofitable (however, we note an alternative view in paragraph 33 below). In addition, theatre time was only useful, in their view, if there were beds for the patients to go into and PH's were already full for much of the year.
10. Against this background we considered the inpatient volumes (measured in terms of episodes) of all SUS activity carried out by the parties in recent years. Table 2 shows the total SUS elective and non-elective activities of the merging trusts in FY 2010/11 and 2011/12.⁶

TABLE 2 **Volume of activity (number of FCEs) of elective and non-elective services at PH and RBCH, 2010/11 to 2011/2012**

			<i>% variation</i>
	2010/11	2011/12	2010/11–2011/12
PH	82,953	82,174	-1
RBCH	128,947	133,969	4

Source: RBCH and PH—SUS data.

11. The figures in Table 2 showed that PH slightly reduced its volumes of inpatient activity between years (-1 per cent) whilst RBCH increased its activity by 4 per cent.
12. We also looked at the annual volume variation at a specialty level. Table 3 reports the variation in activity⁷ (only for inpatient elective and non-elective services) between FY 2010/11 and FY 2011/12.⁸ As the volume carried out in many specialties was very small, limited changes in the number of activities may produce large percentage variations. As such, the table only shows the specialties for which the total volume of activities over the two financial years considered was above 1,000 episodes.

⁶ These figures covered all the activities recorded in SUS, ie PbR and non-PbR, routine and specialised services, NHS and private patients.

⁷ The volume is measured in terms of Finished Consultant Episodes.

⁸ The figures in Table 3 cover all the activities recorded in SUS, ie PbR and non-PbR, routine and specialised services, NHS and private patients.

TABLE 3 Annual volume variation at specialty level (for elective and non-elective services) at PH and RBCH, 2010 to 2012

Specialty code	Specialty description	<i>per cent</i>	
		PH	RBCN
100	General surgery	9	-12
101	Urology	N/A	6
103	Breast surgery	N/P	2
104	Colorectal surgery	1	-4
106	Upper gastrointestinal surgery	N/P	14
107	Vascular surgery	N/P	-18
110	Trauma and orthopaedics	0	0
120	ENT	-2	N/A
130	Ophthalmology	N/P	-4
140	Oral surgery	-5	N/P
171	Paediatric surgery	6	N/P
180	A&E	-55	19
191	Pain management	N/P	-8
300	General medicine	-3	3
301	Gastroenterology	15	18
302	Endocrinology	N/P	11
303	Clinical haematology	5	6
314	Rehabilitation service	N/P	-11
320	Cardiology	14	9
330	Dermatology	17	4
340	Respiratory medicine	-5	4
370	Medical oncology	17	2
400	Neurology	12	N/P
410	Rheumatology	2	7
420	Paediatrics	8	N/A
424	Well babies	N/A	6
430	Geriatric medicine	4	11
501	Obstetrics	-8	N/A
502	Gynaecology	-3	-5
560	Midwifery service	N/A	2
800	Clinical oncology (previously radiotherapy)	7	N/P

Source: RBCH and PH—SUS data.

Notes:

N/A = no activity undertaken in either or both the two financial years considered.

N/P = not provided because the total volume over the two financial years considered was below 1,000 episodes.

13. The figures in Table 3 indicated that the parties experienced significant variations in the annual volume of activity at specialty level. In some specialties (such as, for instance, gastroenterology at both PH and RBCH, cardiology, dermatology and medical oncology at PH, or upper gastrointestinal surgery, geriatric medicine and endocrinology at RBCH) the volume of episodes treated at the merging trusts' hospitals increased more than 10 per cent from 2010/11 to 2011/12. Considering that the utilization rates (see Table 1) have been rather stable over the same period, this evidence suggested that the merging hospitals had some flexibility in adjusting capacity to accommodate volume changes at specialty level.⁹
14. The parties told us that both trusts operated at average rates that were above a recommended maximum average level of around 85 per cent, which would allow some headroom to deal with fluctuations in demand and, in fact, the bed capacity and occupancy exceeded 90 per cent at night and was almost at 100 per cent during the day. RBCH regularly enacted escalation policies [☒]. PH has a 'decanting ward' which it uses to cope with additional patient volumes at times of high demand. The parties suggested that it would not be prudent for them to expand their services

⁹ We noted that as the total activity across all specialties had fallen, capacity increases may be, at least to some extent, the result of switching capacity between specialties. We also acknowledged that volume changes at specialty level may have been partially due to the variations in the scope of the SUS data (ie the way treatments are recorded and/or remunerated).

without investment in additional ward and/or theatre capacity. They said that this was because to do so would involve compromising clinical quality or patient safety in other areas, as it would risk facilities not being available when demand for services peaked.

15. The parties also suggested that it was important to distinguish between two different types of capacity:
 - (a) the capacity that trusts should have to deal with short-term peaks in demand, particularly non-elective demand, by using their resources flexibly to accommodate additional patients; and
 - (b) genuine spare capacity that would enable the expansion of existing services or the launch of new services.
16. The parties noted that our capacity analysis (see paragraphs 10 to 13 above) related to the first type of capacity, which in the parties' view all trusts should have spare. At the same time, they suggested that not all trusts had 'genuine' spare capacity of the second type.¹⁰
17. We considered that our analysis was likely to reflect both types of capacity. We considered the variation in the annual volume of activities carried out by the parties from FY 2010/11 to FY 2011/12. We would have expected any seasonal peak in demand to affect the volume in both financial years and therefore the annual increase in activity would reflect changes in volume that go beyond short-term seasonal peaks.
18. We nonetheless investigated the extent to which the annual activity increase was caused by short-term peaks. Table 4 below reports the volume variation for each month in FY 2010/11 compared with the volume undertaken in the same month of the following FY 2011/12. We focused on the specialties that we previously identified as showing a considerable variation on an annual basis (see paragraph 13).

TABLE 4 Annual volume per cent variation (FY 2010/11 vs FY 2011/12) by month for some specialties—inpatient (elective and non-elective services)

	PH				RBCH			
	Gastro-enterology	Cardiology	Dermatology	Medical oncology	Upper gastro-intestinal surgery	Gastro-enterology	Endocrinology	Geriatric medicine
April	41	11	56	-2	4	69	-2	24
May	30	8	35	52	23	34	117	15
June	58	22	-5	35	34	60	44	37
July	26	8	24	36	66	15	8	18
August	21	56	35	5	7	64	-26	36
September	57	24	12	21	21	34	3	15
October	7	23	14	18	24	8	-41	-18
November	-24	33	11	28	-16	-17	-10	-10
December	26	14	10	24	21	19	-11	6
January	-20	-14	31	4	-5	18	127	25
February	-15	-7	7	6	-2	10	-2	4
March	-9	4	-2	-8	25	-26	33	-2
Annual variation	15	14	17	17	14	18	11	11

Source: RBCH and PH—SUS data, CCG data.

¹⁰ Furthermore, the parties emphasized that in addition to limitations on physical capacity, trusts also needed to consider access to the necessary clinical staff when contemplating an expansion of their services, which raised a number of issues to overcome.

19. The fluctuation in monthly volumes from 2010/11 to 2011/12 was positive in the large majority of cases, suggesting that the annual variation was the result of an increase in activity that was spread over the year and was not exclusively driven by short-term/seasonal peaks in demand. We also noted that when there was seasonal variation it was spread across specialties (there was no uniform pattern of increases in particular months). While we acknowledged that at least part of the increments in demand could be accommodated through escalation policies which involved temporary measures (especially during demand peaks), it seemed unlikely that the parties did not rely on any 'genuine' spare capacity to cope with the marginal but not necessarily short-term increases in volumes that we observed.
20. Capacity available within a given specialty or for a given service may be increased either through expanding or making better use of existing facilities (notably beds, theatres and/or consultants/other staff) or by diverting capacity from other services.

Other capacity issues

21. The parties submitted that there might be obstacles in moving capacity across services or specialties due to different service-specific requirements which meant that resources used for different services were not readily substitutable.¹¹ RBCH also submitted that: 'it is recognised that the right patient in the right speciality bed is clinically more effective and efficient. Having a headline occupancy rate above 85–92 per cent risks periods where this is not possible to achieve, leading to patients being unable to get to the correct speciality beds, and therefore lower quality care.'
22. Similarly, Dorset County Hospital told us that it was not easy just to transfer capacity across services and that if the local commissioner were to stop purchasing some services from its hospitals, it would be more likely to seek to reduce its capacity rather than transfer it to other services.
23. Hospitals, however, seem to have some degree of flexibility when it comes to adjusting capacity within a given specialty or for a service. University Hospital Southampton, for example, told us that 'we open and close capacity all the time ... It is the way that we work; so, no two days will we have the same number of beds open.' It went on to say that 'the trust would need estate changes or new facilities to significantly expand and dependant [sic] upon the type of capacity would determine the time and investment required but circa 18 to 24 months'. However, 'operational capacity flexes due to a range of factors; seasonality, time of day, time of week hence for small volume service changes investment may not be required'.
24. Dorset County Hospital stated that if it had an increase in activity: 'we have to flex our capacity but we don't usually see such rapid increases that we can't adjust capacity accordingly'. Large capacity expansion needs, however, to be planned in advance and Dorset County Hospital told us that it would 'ensure there is commissioner support for this continuing amount of work'.
25. Salisbury District Hospital told the OFT that it 'can be flexible in expanding its capacity and can bring on short-term increases in capacity relatively quickly. Longer term, and major capacity increases, requires a longer lead in time'. Yet it also stated that expanding capacity was not always a viable option as:

¹¹ RBCH added that the barriers in transposing services between sites included, among other things, 'physical requirements, equipment, clinical interdependencies, the need for an appropriate junior medical staff structure agreed with the Deaneries and independent from the other services, funding, and commissioner support'.

the additional costs of increasing capacity to satisfy demand can be disproportionate. For example, the cost of developing capacity to perform more surgical procedures which require an inpatient admission would involve theatre capacity (either an additional theatre, or flexible staffing to increase usage of current facilities), increasing bed capacity with the associated staffing requirements in addition to the indirect impact on supporting services (like catering, radiology, pathology, porters). It is possible that the income generated from performing the additional activity will be insufficient to cover the step costs of providing the required capacity.

26. We understand that marginal capacity expansion does not need to be discussed and agreed in advance with the local commissioners. Salisbury District Hospital told us that some commissioners (eg Wiltshire CCG) may request that it is consulted prior to new consultant appointments being made but that ‘using capacity flexibly and increasing the number of wards and beds available for a temporary period does not require commissioner approval’. Dorset County Hospital confirmed that ‘increasing capacity does not require commissioner approval’.
27. Whilst formal approval is not required, hospitals may seek commissioners’ support for capacity expansion (especially when it involves significant investment, which small increases in activity may not) in order to ensure that commissioners will pay for the extra activity. Dorset County Hospital stated that ‘we would need commissioner support for them to commission an increasing amount of activity’. Hampshire Hospital told the OFT that ‘all capacity expansion proposals are tested against a return on investment assessment, for which a key factor is the commissioner’s (PCT/CCG) willingness and ability to pay for the expanded service’. We discuss the extent to which commissioners can be expected to pay for extra activity in paragraphs 47 to 73 below, where we concluded that commissioners could generally be expected to pay for genuine activity that is clinically appropriate (as opposed to, for example, activity generated by reducing intervention levels or aimed at reducing waiting times beyond agreed activity plans).
28. Past experience suggested that hospitals frequently engaged in capacity reconfiguration with the aim of either expanding or reducing capacity. The parties provided us with examples of changes in the scope of services at PH and RBCH in recent years in relation to various specialties (including oncology, radiology, emergency care, cardiology, radiotherapy, etc). We also noted that RBCH told us that if the merger did not proceed, it was likely to invest in [§] on the Bournemouth site and also in an additional [§].¹² We also note that both RBCH and PH’s financial forecasts assume activity growth in the coming years (see Appendix B).
29. Salisbury District Hospital mentioned to us a number of instances when it expanded its capacity in the last five years. These include:
 - (a) Acute Medical Unit (AMU): Reconfiguration of the unit to provide more assessment bays enabling the ambulatory model of care to be expanded.

¹² RBCH told us that it would only invest in such infrastructure for services where it would have a financial incentive to invest and its analysis suggested that it would be incrementally loss-making to invest in services where the parties overlapped. It noted that the [§] would only be used for [§], which was not available at PH. As noted in paragraph 6.128ff, it was unclear to us how the parties have carried out their profitability calculations and we relied on the detailed service line reporting data for our profitability analysis.

- (b) Children's Unit: Relocation to a completely refurbished facility saw children's services housed in a more spacious facility. Whilst the number of inpatient beds was not increased, outpatient facilities and the day assessment unit were expanded to meet the evolving needs of the service.
- (c) Interventional Cardiology: A second interventional cardiac suite has allowed the trust to increase the number of patients treated [§], enabling patients to be treated closer to home.
- (d) Endoscopy Unit: Reconfiguration of the department has enabled the trust to treat more patients. This was necessary to respond to the reduction in diagnostic waiting times and an increase in activity as a result of the bowel cancer screening programme.
- (e) Emergency Department: The department was refurbished and reconfigured to help improved patient flow. Additional capacity was created in the resuscitation area of the department.
30. The parties submitted that neither of them would have the financial incentives to invest in additional capacity 'since it is likely that this incremental activity would prove to be loss-making'. In support of this argument the parties compared, in relation to seven specialties,¹³ estimates of the incremental revenues that RBCH would generate from a [§] per cent uplift in elective, day-case and outpatient activity with the incremental costs of additional staffing resources to accommodate the increase in activity. According to their estimates, the parties would [§]. As we discuss in paragraph 6.128ff, we would not expect any of these factors to change the conclusion that the supply of most elective services could profitably be expanded, at least at the margin.
31. We also noted that hospitals have other levers to respond to volume variation. In their response to the OFT's questionnaire, RBCH and PH said that 'reductions in length of stay and greater efficiency and productivity' (eg ward rounds, inpatient tests, pharmacy flexed capacity and weekend working) had allowed the trusts to cope with the bed numbers reduction policy driven by the Department of Health. Also, in the minutes of a meeting held on Friday 12 October 2012, RBCH's board of directors discussed a number of measures proposed to be implemented 'to deal with the unprecedented demand: an increase in emergency activity of 30 per cent over the past three years and 20 per cent in the current year'. While some of the measures entailed identifying with the local commissioner and other hospitals ways to alleviate the pressure on RBCH, other measures, such as anticipating the implementation of the Winter Plan, adding a consultant in the Emergency Department, strengthening the Clinical Site Team overnight, and adding appointments across dementia, pharmacy and therapy services,¹⁴ indicated to us that the trust has some flexibility also to address unexpected demand increases. PH told us that it had reduced its number of beds by 20 per cent in recent years and had turned wards into, for example, a day-case medical investigation unit where patients could be treated while seated in a chair, in this way increasing the capacity to accommodate day-case activities. PH told us that it could not revert to having more beds because the day-case medical investigation unit was well utilized and could not be shut down.

¹³ [§]

¹⁴ RBCH pointed out that 'the steps outlined to increase infrastructure relate to people, not beds. Where there is no immediate excess physical capacity, the additional appointments would in large measure be only temporary and funded by non-recurrent monies. By definition winter pressures measures are temporary measures to alleviate short-term pressures'.

32. Salisbury District Hospital also told us that it had reduced its bed stock over past years. This was mainly the result of service improvements which had led to reductions in length of stay which in turn enabled the trust ‘to have a number of “escalation” beds which can be used when capacity needs to be increased at short notice, for example, to respond to winter pressures’.
33. In this regard, we also noted that Dr Foster said in its the Hospital Guide 2013¹⁵ that:

Moving to seven-day working can bring efficiencies if it means operating theatres and scanners are used more frequently. Currently, much of the expensive equipment that the NHS has invested in lies unused at the weekend. Few hospitals offer many elective services at weekends currently and many of those that do are doing so in order to clear waiting lists. These short-term initiatives are often costly. However, planned activity at weekends can, if properly organised, save money. The proportion of a basket of common elective operations performed in hospital at weekends varies from close to zero to 16 per cent. We also looked at how frequently emergency patients who needed an MRI scan had it on their day of admission. In some hospitals, this was more likely to happen at weekends than on weekdays. But in some hospitals, no patients received scans over the weekend.

34. Furthermore, we understood that the local commissioners’ policy of promoting activity transfer from acute hospitals to community hospitals and/or independent treatment centres for less complex procedures was freeing up capacity at acute hospitals which can to some extent be utilized on other services. University Hospital Southampton, for example, told us that when:

the Independent Southampton Treatment Centre was opened in 2008/09 work transferred to the centre from University Hospital Southampton but capacity was backfilled with planned service developments including growth of tertiary work. This means the flow of capacity, staff and facilities continue to be utilised.

It added that ‘there is a plan to improve discharge of elderly patients into the community capacity to cope with the demand. Any capacity released will be used to absorb other growth or planned service change’.

Profitability

35. Paragraphs 36 to 46 of this appendix set out our methodology for investigating the profitability of the parties’ services and describe the breakdown of costs by type.

Methodology

36. We analysed the costs and revenues of RBCH and PH by specialty for the year 2011/12. We could only examine specialties as they were recorded at the ‘service line’ level and so to the extent that, for example, PH coded certain patients under general medicine or general surgery as a service line when another hospital would code them under a different specialty, we were not able to reflect this.¹⁶ Nevertheless, in our view our conclusions were sufficiently general that this issue should not

¹⁵ <http://drfosterintelligence.co.uk/thought-leadership/hospital-guide/>.

¹⁶ In our analysis of overlapping services we were able to reassign treatments by specialty, but could not do so here because we did not have the appropriate cost information.

significantly affect them. Similarly, our ability to analyse costs was limited to the way the parties recorded them and the way they allocated shared costs.

37. Our methodology was to look at the income earned from inpatient treatments by each trust and set it against different measures of cost.¹⁷ PH supplied the following definitions of cost, taken from the latest HFMA costing guidance:
 - (a) Fixed costs will not change as activity changes over a 12-month period (although they may change if a contracted service is removed or added).
 - (b) Variable costs will be directly affected by the number of patients treated or seen. The nature of patient-level costing means that this cost may vary from patient to patient, but the nature of the cost is that it is triggered by the quantity of patients (eg cost of drugs).
 - (c) Semi-fixed costs do not move with activity changes on a small scale, but ‘jump’ or ‘step up’ when a certain threshold is reached.
38. The parties told us that in principle, there was no difference between the costing for elective and non-elective patients. If two patients were treated for the same time in the same theatre and in the same ward and at the same time, they would be allocated the same cost whether they were elective or non-elective. However, in practice, there would be differences between costs allocated to elective and non-elective patients. This was because not all theatres and wards had the same charge cost per minute or per day, and (for example) some theatres were exclusively non-elective care sessions, and had a higher cost per minute because the theatres had a lower utilization as there might not always be an emergency case to be operated on, but the theatre would remain fully staffed. It seemed to us that their allocation of costs was broadly consistent with cost causation principles and would allow us to conduct meaningful separate analyses of elective and non-elective services.
39. We noted that PH’s and RBCH’s accounting methods differed: RBCH’s costs included depreciation, impairment, dividend etc, whereas PH accounted for capital costs separately and we excluded them from our analysis. Therefore the analysis below is likely to underestimate the economic profitability of services at RBCH.
40. We assessed whether attracting extra patients would be profitable. By profitable, in this instance, we meant that the payment received for treatment exceeded the incremental cost of treating the patient; in other words, the payment made a contribution to overheads. There may be a difference between profitability at the margin (for an individual patient) and profitability for the volume of extra patients that would be attracted by an increase in quality, due to quasi-fixed costs that would be incurred. For example, if a hospital department was running close to but below its capacity, the costs of treating an extra patient might be small, but treating 20 extra patients might require extra beds, staff etc.
41. All of the analysis below assumed that RBCH and PH were recompensed based on the volume of services they provided, subject to PbR guidelines (taking into account the 30 per cent marginal tariff on emergency services). We considered separately in paragraphs 47 to 73 below whether the parties could expect to be recompensed by commissioners for the activity they carry out.

¹⁷ We summarize the breakdown of costs in paragraphs 42–46.

Breakdown of costs

42. Below, we provide a high-level breakdown of costs between fixed, semi-fixed and variable costs for each trust, for elective and non-elective inpatient services.

Elective—RBCH

43. Across service lines (looking at elective services and day cases combined), fixed costs were typically around [X] per cent but ranged from [X] to [X] per cent of total elective costs; variable costs generally ranged from [X] to [X] per cent, with the exception of two large specialties ([X]) where they were higher ([X] per cent) and two smaller specialties that were lower. As a weighted average across service lines, fixed costs made up [X] per cent of total costs, with semi-fixed costs [X] per cent and variable costs [X] per cent.

Elective—PH

44. Across service lines, fixed costs ranged from [X] to [X] per cent of total elective costs; variable costs ranged from [X] to [X] per cent (with one outlier in both measures). As a weighted average across service lines, fixed costs made up [X] per cent of total costs, with semi-fixed costs [X] per cent and variable costs [X] per cent.

Non-elective—RBCH

45. Across service lines, fixed costs ranged from [X] to [X] per cent of total costs; variable costs ranged from [X] to [X] per cent (with a couple of outliers). As a weighted average across service lines, fixed costs made up [X] per cent of total costs, with semi-fixed costs [X] per cent and variable costs [X] per cent.

Non-elective—PH

46. Across service lines, fixed costs ranged from [X] to [X] per cent of total costs; variable costs ranged from [X] to [X] per cent (with a few outliers in both measures). As a weighted average across service lines, fixed costs made up [X] per cent of total costs, with semi-fixed costs [X] per cent and variable costs [X] per cent.

Relationships with commissioners

47. Paragraphs 48 to 73 set out further factual background to our assessment of the manner in which RBCH and PH's relationships with commissioners, particularly the manner in which they are reimbursed, may affect their incentives to compete.
48. By way of background we noted that:
- (a) RBCH had contracts with the following commissioners, which paid it the following amounts in 2011/12 according to its annual accounts:¹⁸
- (i) Bournemouth & Poole PCT: £114,632,000 (53 per cent);
- (ii) Dorset PCT: £65,698,000 (30 per cent);

¹⁸ www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/our_publications/annual_report/annualreport_2012.pdf.

- ((i) and (ii) were together the Dorset PCT cluster)
- (iii) Hampshire PCT: £27,149,000 (13 per cent);
- (iv) Bristol PCT (South West SCG): £6,125,000 (3 per cent);
- (v) Wiltshire PCT: £1,722,000 (1 per cent); and
- (vi) Department of Health: £1,222,000 (1 per cent).

(b) PH had contracts with the following commissioners, which paid it the following amounts in 2011/12 according to its annual accounts:

- (i) Bournemouth and Poole PCT: £119,375,000 (65 per cent);
- (ii) Dorset PCT: £45,955,000 (25 per cent);
- ((i) and (ii) were together the Dorset PCT cluster)
- (iii) South West SHA: £5,618,000 (3 per cent);
- (iv) Bristol PCT: £4,887,000 (3 per cent);
- (v) Hampshire PCT: £3,685,000 (2 per cent);
- (vi) Other NHS bodies: £3,333,000 (2 per cent); and
- (vii) Department of Health (including Prescription Pricing Authority): £1,778,000 (1 per cent).

49. In both cases, the two major sources of revenue were the Bournemouth & Poole PCT and the Dorset PCT (together the Dorset PCT cluster). These PCTs have been replaced by Dorset CCG from April 2013. RBCH also obtained approximately 13 per cent of its revenues from Hampshire PCT (much of whose commissioning responsibility in terms of services provided by RBCH now lies with West Hampshire CCG). We focused on the parties' contracts with Dorset CCG (and its predecessor entities) and we also reviewed RBCH's contract with West Hampshire CCG (and its predecessor entities).

CC analysis

50. We considered the extent to which the contractual arrangements under which the parties were remunerated for their elective and non-elective activities¹⁹ affected their incentives to compete.
51. We reviewed both parties' contracts with the Dorset PCT cluster and noted that they were along similar lines to the NHS Standard Contract, in that they provide for an activity plan to be agreed with local commissioners and payments to be made in accordance with the level of activity actually provided. [☒]
52. When asked about these arrangements, the parties told us that:

¹⁹ We understand that the prices were set for some services according to varied or local tariff arrangements rather than national PbR.

These arrangements are therefore referred to as ‘risk-share agreements’ and they determine a fixed payment for each of PH and RBCH, irrespective of the activity each carries out. There is no cap on the amount of activity that each Party is allowed to undertake and the SHA has been historically involved in permitting such arrangements to be put in place.

RBCH had a similar managed contract with Hampshire PCT and, from April 2013, West Hampshire CCG.

53. To understand how the risk-share arrangements had operated, we asked the parties to provide details of their contracts with the Dorset PCT cluster for the past three years, including:
 - (a) ‘contract agreed’, ie the Indicative Activity Plan agreed under contract with the Dorset PCT cluster for a particular year;
 - (b) ‘actual activity’, ie the volume of services provided in the financial year for which the contract applied and the revenue associated with that volume (based on relevant tariffs/managed contracts); and
 - (c) ‘total payment’, ie the value of the total payment made by the Dorset PCT cluster for that contract year.
54. We also asked the parties to tell us about any other payments that had been made and what these were for. Our findings are set out below.

RBCH’s remuneration

55. As set out in Table 5, in each of the last three years, RBCH exceeded the agreed activity level, and the Dorset PCT cluster paid RBCH more than the amount agreed at the beginning of the contractual year. However, the total payment was less than the total activity. In other words, RBCH was not fully remunerated for the actual activity that it undertook. RBCH’s contracts with Hampshire PCT showed a similar pattern.

TABLE 5 Payments from Dorset PCT cluster to RBCH for total activities, year on year

	Contract 2010/11	Contract 2011/12	Contract 2012/13
Contract agreed (£)	[☒]	[☒]	[☒]
Actual activity (£)	[☒]	[☒]	[☒]
Total payment (£)	[☒]	[☒]	[☒]
Proportion of difference paid (%)	[☒]	[☒]	[☒]

Source: RBCH data, CC calculations.

Note: The total for the Dorset PCT cluster in 2012/13 included additional funding from the Strategic Health Authority (passed through the PCTs) in relation to Winter Pressures funding (£1 million) and merger support (£2 million).

56. RBCH told us that the difference between total payment and total actual activity was due to ‘the locally agreed marginal payment for activity over plan, and the cap in place at Hampshire [PCT]’. RBCH also said that the total payment could vary from the actual activity for a variety of reasons, including: local contractual arrangements such as the 30 per cent marginal rate emergency tariff above the 2008/09 threshold; fines and penalties set out in the standard form contract such as those relating to readmissions; withheld payments and contested activity; calculations of work in pro-

gress at year end; non-recurrent funding such as for winter pressures; capital and grants; and a variety of differing mechanisms to risk share among the parties involved. RBCH told us that examples of risk-share could include marginal rates for activities varying from plan (above and below the contracted amounts) through to full managed contracts whereby the healthcare provider received a fixed amount and took on the risk and potential reward for over- or underperforming. RBCH said that there could also be challenges from commissioners regarding coding, activity levels, compliance with policies and other reasons to dispute activity levels. According to RBCH, the total amount agreed upon therefore resulted from a complex mix of reasons and negotiation between the commissioner and provider.

57. When asked about any other payments made above the total payment, RBCH said that there might be some examples where a [☒] but that in effect this was a marginal variance given that the agreed figure was usually agreed around the end of month 12.
58. We compared RBCH's planned and actual activities with the amount paid by commissioners for elective and non-elective services separately to understand to what extent it was reimbursed for particular activities. As Table 6 below shows, RBCH consistently met or exceeded its planned activity in both elective and non-elective services (apart from a very small shortfall in elective services in 2010/11) and was paid for less than its actual activities as a result.²⁰

TABLE 6 Payments from Dorset PCT cluster to RBCH for elective and non-elective activities, year on year

	Contract 2010/11		Contract 2011/12		Contract 2012/13	
	Elective	Non-elective	Elective	Non-elective	Elective	Non-elective
Contract agreed (£)	[☒]	[☒]	[☒]	[☒]	[☒]	[☒]
Actual activity (£)	[☒]	[☒]	[☒]	[☒]	[☒]	[☒]
Total payment (£)	[☒]	[☒]	[☒]	[☒]	[☒]	[☒]
Proportion of difference paid* (%)	[☒]	[☒]	[☒]	[☒]	[☒]	[☒]

Source: RBCH data, CC calculations.

*Where percentages appear in parentheses, this indicates that actual activity was lower than the agreed contract level.
Note: RBCH told us that emergency (non-elective) spells were counted in the table at full value so that all activity was fully represented with the exception of the final row for total payment; here, the 30 per cent marginal rate for work over the baseline level plus any relevant other adjustments have been applied before arriving at the final billed amount.

59. We understood from commissioners that they aimed to apply national and marginal tariffs when a provider's activities went beyond the levels agreed at the beginning of the contractual year. However, we also understand from Dorset CCG that it felt under more pressure to remunerate providers for non-elective activities than for elective because providers had less ability to control their non-elective activities. In theory, since RBCH exceeded its baseline for non-elective (emergency) services in each year, it should have been reimbursed at approximately 30 per cent for marginal activity above that baseline,²¹ and so any deviations from the agreed level should also have been paid at 30 per cent. We see that, in practice, it was reimbursed between [☒] and [☒] per cent for non-elective (which was largely emergency) activity above its agreed level. This does not suggest that it has been reimbursed less than it would expect to be under the marginal rate tariff. We were told that although remuneration was assigned to different types of activity (such as non-elective), the main negotiation was over the total payment.

²⁰ We also reviewed outpatient activity but found that there was relatively little variation between agreed and actual activity.

²¹ Since non-elective activity includes a small amount of non-emergency activity which is not subject to the marginal rate tariff, we would strictly expect it to have been reimbursed at slightly above 30 per cent.

60. Dorset CCG told us that, in the case of RBCH, settlement payments were only for activity above the planned amount. It said that it tried not to make additional payments unless totally justified but it was effectively a negotiation. It gave three examples of activity that it had disputed in the past:
- (a) In Cardiology, Dorset CCG said that RBCH's level of intervention was [☒], and therefore it [☒]; RBCH said that it was [☒] and that it had [☒].
 - (b) Dorset CCG said that sometimes it disputed coding of procedures that would, in its view, lead to payments that trusts were not entitled to (and that this was a larger issue [☒]).
 - (c) In 2009/10, both parties expanded their elective output as part of a regional initiative to reduce waiting times beyond the national targets. We understand that [☒] since the regional waiting time targets, whilst a priority, could not overrule maintaining the financial stability of the commissioner, and as a result it [☒].
61. RBCH told us that it had negotiated a similar managed contract with Dorset CCG for the year to March 2014.

PH's remuneration

62. Table 7 presents the total payments from Dorset PCT cluster to PH in the past three years, which showed that Dorset PCT cluster paid PH more than the amount agreed at the beginning of the year when PH had higher than planned activity in 2011/12 and 2012/13 and in fact more than the value of the actual activity. When PH had lower than planned activity in 2010/11, the Dorset PCT cluster paid [☒] the initially agreed amount, and this appeared to have been driven primarily by payments to reflect [☒] non-PbR contracts.

TABLE 7 Payments from Dorset PCT cluster to PH for total activities, year on year

	Contract 2010/11	Contract 2011/12	Contract 2012/13
Contract agreed (£)	[☒]	[☒]	[☒]
Actual activity (£)	[☒]	[☒]	[☒]
Total payment (£)	[☒]	[☒]	[☒]†
Proportion of difference paid* (%)	[☒]	[☒]	[☒]†

Source: PH data, CC calculations.

*Where percentages appear in parentheses, this indicates that actual activity was lower than the agreed contract level.

†Includes £[☒] of winter pressure funding and £[☒] of non-recurring support.

63. PH told us that 'the actual payment in 10/11 and 11/12 was [☒] than the [agreed contract payment] because the PCT agreed to [☒] the amount paid for non-PbR services'. On this, PH told us that:
- (a) The additional contract income of £[☒] million was agreed in March 2012 as a net increase in the agreed 2010/11 contract to reflect a general underfunding of non-PbR services and that the gross increase in non-PbR funding was £[☒] on PbR elements of the contract.
 - (b) The additional payment of £[☒] million in 2011/12 was made up of (i) £[☒] increase in work-in-progress; (ii) £[☒] national funding to improve access; (iii) £[☒] increase to reflect underfunding in year of non-PbR services; and (iv) £[☒] other contract variation.

- (c) The adjusted contract in 2012/13 included £[§] million of positive contract variations reflecting increased activity, additional funding for [§] and others; and the original contract had also been reduced by £[§], reflecting the transfer of services to specialised commissioners (who would pay this amount instead of Dorset CCG).
64. More generally, PH told us that it would work with commissioners to agree the most accurate estimate of activity for the coming year's contract, based on actual activity during an agreed 12-month base period, eg November to October in the current year. This is adjusted for current trends, anticipated changes in demand and demand management initiatives. This produces an expected level of activity for the coming year which can be priced at national and local tariffs. PH told us that the size of the 'financial envelope' was agreed by negotiation: the commissioner wanted a figure that it knew it could afford and PH, similarly, wanted a total that would enable it to make a [§] and maintain its financial rating. PH told us that payments above the financial envelope might be made and had been made in 2012/13 but the trust had [§] to these payments. PH told us that payments may be made in the following circumstances: where national monies were made available and passed to providers by the commissioners; where the PH could demonstrate that the agreed contract did not adequately fund the cost of non-PbR services and where the CCG was willing to agree additional funding; and where activity had increased significantly and the CCG was willing to agree payment. This may happen where a provider was struggling to maintain access times; had agreed with the commissioner to provide new services; or where it could be demonstrated that readmission rates were lower than the figure reflected in the contract.
65. PH also said that the value for non-elective activity included in Table 8 was based on the full nominal activity-based amount as PH had, in each year, been below the 2008/09 baseline and therefore the 30 per cent marginal rate emergency tariff had not applied.
66. Table 8 shows the payments made for elective and non-elective activity.²² These showed that PH was paid [§] for provision of elective services when it was above the agreed level. For non-elective services, [§] agreed activity level and in 2012/13 [§]. The Dorset PCT cluster's reimbursement for non-elective services was based on actual activity in 2010/11 and 2011/12; [§].

TABLE 8 Payments from Dorset PCT cluster to PH for elective and non-elective activities, year on year

	Contract Elective	2010/11 Non-elective	Contract Elective	2011/12 Non-elective	Contract Elective	2012/13 Non-elective
Contract agreed (£)	[§]	[§]	[§]	[§]	[§]	[§]
Actual activity (£)	[§]	[§]	[§]	[§]	[§]	[§]
Total payment (£)	[§]	[§]	[§]	[§]	[§]	[§]
Proportion of difference paid* (%)	[§]	[§]	[§]	[§]	[§]	[§]

Source: PH data, CC calculations.

*Parentheses indicate that actual activity was lower than the agreed contract level.

67. PH further told us that the financial framework for the 2013/14 contract included the following assumptions:

- (a) that contract income in 2013/14 would be £[§] million higher than 2012/13; and

²² We also reviewed outpatient activity but found that there was relatively little variation between agreed and actual activity.

(b) that contract income in 2014/15 and 2015/16 would [☒].

68. PH said that this agreement, including a £3.3 million subsidy, was reached in order to help it achieve [☒] but was not directly dependent on the merger and that no repayment was required if the merger did not proceed.
69. In relation to 2013/14, PH told us that the basis of the agreement was an estimate it provided of the level of income it required to achieve a [☒]. Separately PH told us that the £[☒] million was the increase in the contract value over 2012/13 and represented 'additional funding to fund services already provided as part of the non-PbR contract and PbR contract' and that the assumption was that this level of income would continue under the [☒] arrangements agreed in principle as part of the [☒] for PH.
70. In relation to 2014/15 and 2015/16, PH told us that a forecast additional payment of £[☒] million ([☒]) was based on the assumption that contract income in 2014/15 and 2015/16 would remain at [☒]. PH told us that the additional revenue was not guaranteed but regarded by both sides as a reasonable planning assumption. PH said that it assumed that the net effect of the following changes in contract income would be neutral in terms of total contract income:
- (a) reduction in tariff—currently projected at [☒] per cent;
 - (b) loss of services/activity through competition; and
 - (c) growth in activity.
71. Finally, PH noted that as the level of income in 2013/14 would include an element of subsidy (of £3.3 million), it would be unlikely to achieve any further increases in income in 2014/15 or 2015/16 even if there were significant growth in activity. PH also said that any growth in emergency activity in excess of £[☒] million would only be paid at 30 per cent of the tariff as the trust was now close to its 2008/09 baseline.
72. We asked Dorset CCG about the circumstances in which it might make extra payments (above actual activity) to providers. Dorset CCG told us that it could give extra payments above tariff to help when providers could genuinely not provide a service within the tariff amount, but it would have fewer available funds for the next year. Dorset CCG said that the funds came from the pot of savings made by driving down costs elsewhere and from headroom risk reserves. More specifically, Dorset CCG said that its agreements with providers were for a set level of activity, and it would pay more than that only if:
- (a) a provider had done a lot more activity than its plan—Dorset CCG would challenge this to make sure it was genuine and not miscoding, or inappropriate interventions aimed at driving down waiting times without prior agreement; or
 - (b) a trust was in financial difficulty.
73. [☒] When asked what it would do in the event that the merger did not proceed, Dorset CCG said that it did not know whether it would seek to 'prop up' PH for longer or whether it would let PH fail and see what would happen in the context of the failure regime.

Closeness of competition analysis

1. In addition to the survey material discussed in the main document (see paragraphs 6.89 to 6.98) and included in Appendix I which demonstrated that RBCH and PH tended to be each other's next best alternatives, we looked at what GP referral patterns showed regarding closeness of competition between the parties.

Analysis of GP referral patterns

2. To assess the closeness of competition between acute services providers in the Dorset area, we looked at the share of referrals (related to inpatient elective and outpatient services) for each provider from GP practices in the wider Dorset area and ranked acute services providers according to their share. Considering the ranking as a reasonable indicator of patients' and/or GPs' preferences, this analysis provided insights as to which alternative hospital a GP practice would be likely to refer patients to in response to a change in the quality of services at either of the parties.
3. This approach only provided a static picture of patients' and/or GPs' behaviour because it does not capture changes over time and does not necessarily reflect closely the way in which patients would divert to other hospitals if the quality at one of the merging trusts' hospitals was reduced following the merger. We therefore considered the results of this analysis in conjunction with the evidence resulting from our survey and evidence we have from national studies on hospital choice (see Section 6 and Appendix H).
4. We considered 132 GP surgeries: all GP surgeries in the Dorset CCG area and also those GP surgeries in West Hampshire CCG area from which the parties drew patients.¹ For each of them we calculated the share provided by each acute services provider over the entire range of elective and outpatient services commissioned by the two CCGs.²
5. We then considered how frequently the best alternative option for either of the parties is the merging partner. In doing that, we assumed that the highest ranked hospital (apart from the party under consideration) would be the favoured alternative for a GP practice if it decided to switch away patients from a hospital. To clarify, if a party supplied the highest share of acute services to a GP practice, we assumed that the best alternative option is the hospital which supplied the second highest share. When a party does not have the highest share of supply to a GP practice, the best alternative option is the highest share hospital for that GP practice. We considered this assumption reasonable. First, hospital care is an experience good—in other words, both GPs and patients learn about the quality of a hospital when they have had experience with it. It seemed likely that GPs would switch to hospitals to which they have previously referred and for which they have gained some experience (as long as that experience has not been negative). Second, we expected that past choices of patients/GPs are likely to reflect (although imperfectly) their preferences over the best alternatives available.

¹ West Hampshire CCG provided information only in relation to two sub-local areas within west Hampshire, namely West New Forest and Totton and Waterside. These are the primary areas within west Hampshire from which the parties receive patients.

² We considered the period April 2010–November 2012 for which the CCGs provided data.

6. Table 1 below shows how many times other hospitals ranked as the best alternative option for PH. RBCH was the best ranked alternative for 68 GP practices (54 per cent) followed by Dorset County Hospital with 34 practices (27 per cent) and University Hospital Southampton with 12 practices (10 per cent). Salisbury District Hospital and Yeovil District Hospital were the next best option to PH for a small number of GP practices (four).

TABLE 1 Ranking of alternative providers to PH by share with Dorset area GPs

<i>Best alternative to PH</i>	<i>Number of GP practices</i>	<i>Share %</i>
RBCH	68	54.0
Dorset County Hospital	34	27.0
Salisbury District Hospital	4	3.2
University Hospital Southampton	12	9.5
Yeovil District Hospital	4	3.2
Others	4	3.2
Total	126*	100

Source: CCG data, CC calculations.

*The total is lower than 132 because we observed only non-elective services in two GP practices and also because PH did not receive any referrals from four GP practices and therefore we did not include them in our calculation.

7. We also considered how much of PH's total activity, by volume (measured in terms of inpatient elective and outpatient episodes), these GP practices referred. In other words, the first row of Table 2 below shows how much activity PH drew from the 68 GP practices where RBCH was the best alternative option (expressed as a proportion of PH's total activities drawn from all GP surgeries in the wider Dorset area). The GP practices for which RBCH was the best alternative option to PH accounted for the large majority of PH's activities (88 per cent). This implied that, in general, the more referrals PH drew from a practice (ie the greater its importance to PH), the more likely RBCH was to be the best alternative at that practice. The practices where Dorset County Hospital was the best alternative option accounted for a small percentage of the activities carried out at PH (8 per cent).

TABLE 2 Proportion of PH's activity drawn from GP practices, categorized by next best provider option to PH at these practices

<i>Best alternative provider option to PH at these GP practices</i>	<i>Proportion of PH's total activity drawn from these GP practices %</i>
RBCH	88.4
Dorset County Hospital	7.6
Salisbury District Hospital	0.4
University Hospital Southampton	0.1
Yeovil District Hospital	0.1
Others	3.5

Source: CCG data, CC calculations.

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8. Next we considered the relative competitive constraints upon RBCH using the same methodology. Table 3 shows the results. PH appeared to be RBCH's closest competitor as it was the best alternative option to RBCH in 64 out of 126 GP practices³ (52 per cent), followed by Dorset County Hospital (33 practices) and University Hospital Southampton (12 practices).

³ RBCH did not receive any referrals from four GP practices which were therefore excluded from the analysis.

TABLE 3 Ranking of alternative providers to RBCH by share with Dorset area GPs

Best alternative option to RBCH	Number of GP practices	Share %
PH	64	50.8
Dorset County Hospital	33	26.2
Salisbury District Hospital	7	5.6
University Hospital Southampton	12	9.5
Yeovil District Hospital	4	3.2
Others	6	4.8
Total	126	100

Source: CCG data, CC calculations.

9. When weighted by the activities, by volume, that RBCH drew from these GP practices, PH appeared to be by far the closest competitor to RBCH (85 per cent). The practices for which Salisbury District Hospital was the next best option represented 7 per cent of the activity carried out at RBCH. The other hospitals appeared to be the best alternative for a very limited amount of the activities undertaken at RBCH.

TABLE 4 Proportion of RBCH's activity drawn from GP practices, categorized by next best provider option to RBCH at these practices

Best alternative provider option to RBCH at these GP practices	Proportion of RBCH's total activities drawn from these GP practices %
PH	84.8
Dorset County Hospital	1.3
Salisbury District Hospital	7.1
University Hospital Southampton	1.6
Yeovil District Hospital	0.04
Others	5.2

Source: CCG data, CC calculations.

10. The parties submitted that our analysis failed to recognize that providers may supply different services and that, given the parties' contention that they tend to provide complementary services, they may both appear to have a high share in a GP practice even if their respective referrals related to specialties/services for which they do not compete.
11. To address this concern we performed a number of checks based on restricted sets of specialties/services that both parties provide. More specifically, we estimated the hospitals' shares at GP practice level for (i) only the overlapping specialties (as identified in Section 6), (ii) considering all specialties but only the treatments that all five major acute hospitals in the area (including the parties)⁴ provide, and (iii) within the overlapping specialties, only the treatments provided by all five major acute hospitals in the area (including the parties).
12. The results from all of these checks are consistent with those presented above based on all elective and outpatient services. PH appeared to be RBCH's best alternative option in 53 to 54 per cent of the GP practices from which it received referrals. Similarly RBCH appeared to be PH's best alternative option in 53 to 54 per cent of the GP practices from which it received referrals. Even when weighted by the volume that hospitals drew from these GP practices, the parties appeared to be the closest competitor to each other. The GP practices for which RBCH was the best alternative option to PH accounted for 88 to 90 per cent of PH's activities; and the GP practices

⁴ RBCH, PH, Dorset County Hospital, Salisbury District Hospital and University Hospital Southampton.

for which PH was the best alternative option to RBCH accounted for 87 to 90 per cent of RBCH's activities.

Exposure to competition

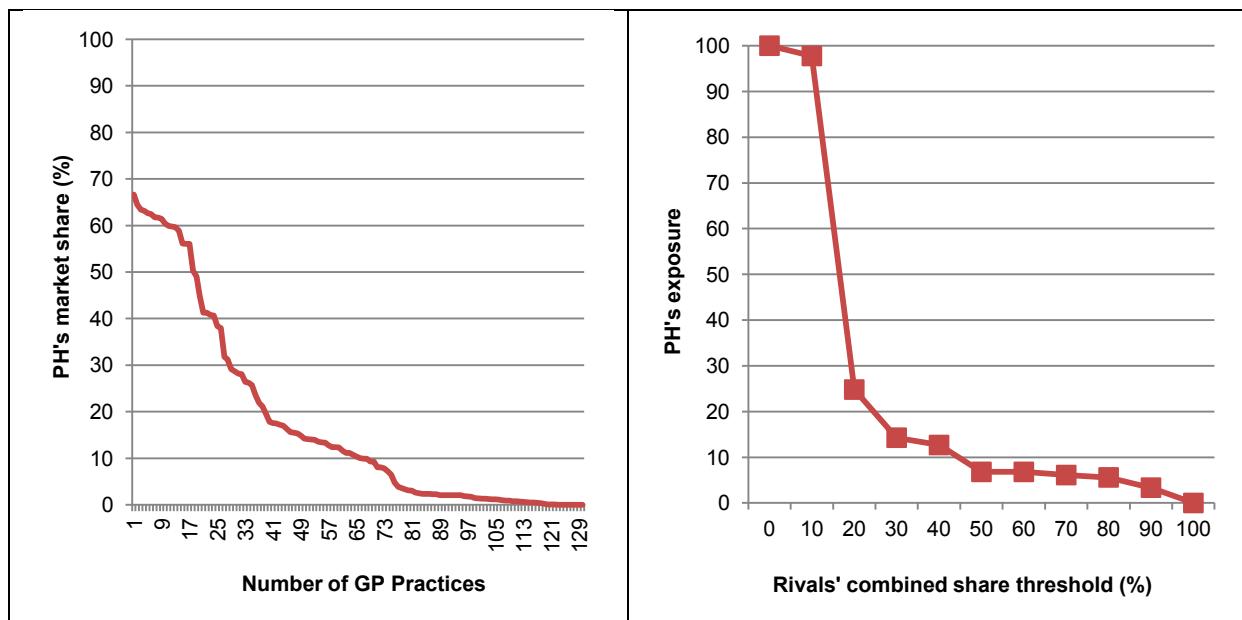
13. As a further assessment of the substitutability between hospitals, we considered the extent to which hospitals overlap (or are 'exposed' to one another) in the GP practices from which they draw their patients. This analysis helped to identify the extent to which a GP practice and its patients are likely to be marginal (or contestable). The underlying assumption is that if every patient of a given practice uses one hospital exclusively, it is probable that these patients will be less likely to switch in response to a quality change than if large proportions of the patients in that area make use of another hospital, ie if the hospital is 'exposed' to another hospital in that area. This approach implicitly assumes that the current shares of providers (by volume drawn from GP practice) are a good proxy of patients' sensitivity to changes in the competitive conditions in a given area. We acknowledged the limits of this approach that can lead to understating or overstating the willingness of patients/GPs to switch: current shares of supply are based on past referrals and do not necessarily reflect how patients would switch.
14. In analysing the exposure of RBCH and PH to other hospitals, we assumed that, if other hospitals accounted for a large percentage of patients from a particular GP practice, all patients from that GP practice were potentially contestable by those hospitals. However, it is not obvious what level of exposure ('threshold') is required in a given GP practice to conclude that the parties are subject to a competitive constraint from other hospitals. For this reason, we started by considering GP practices where rivals supply a combined share of 50 per cent or more of activity referred by the GP practice to acute service hospitals. We then flexed the 50 per cent threshold to assess how much the outcome is sensitive to this assumption.
15. For 60 out of 130⁵ GP practices, the combined share of rivals⁶ was above 50 per cent. Less than 7 per cent of PH's referrals were drawn from GP practices where the rivals' combined share was above 50 per cent. The same figure for RBCH was less than 8 per cent. This suggested that a relatively small proportion of the referrals received by the parties might be exposed to competition from other hospitals.
16. Figure 1 below shows how the exposure of each of the parties to other hospitals changed with assumptions relating to the threshold. The left-hand figure shows PH's share of referrals at each GP practice, in descending order, showing that there are 18 practices where it has a share of 50 per cent or more. The right-hand figure plots the percentage of PH's activity, by volume, that came from GP practices in which a potentially substitutable hospital (or group of potentially substitutable hospitals) to the merged entity had a share of referrals at least as high as the given threshold.

⁵ We observed some inpatient elective and/or outpatient activity in GP 130 practices.

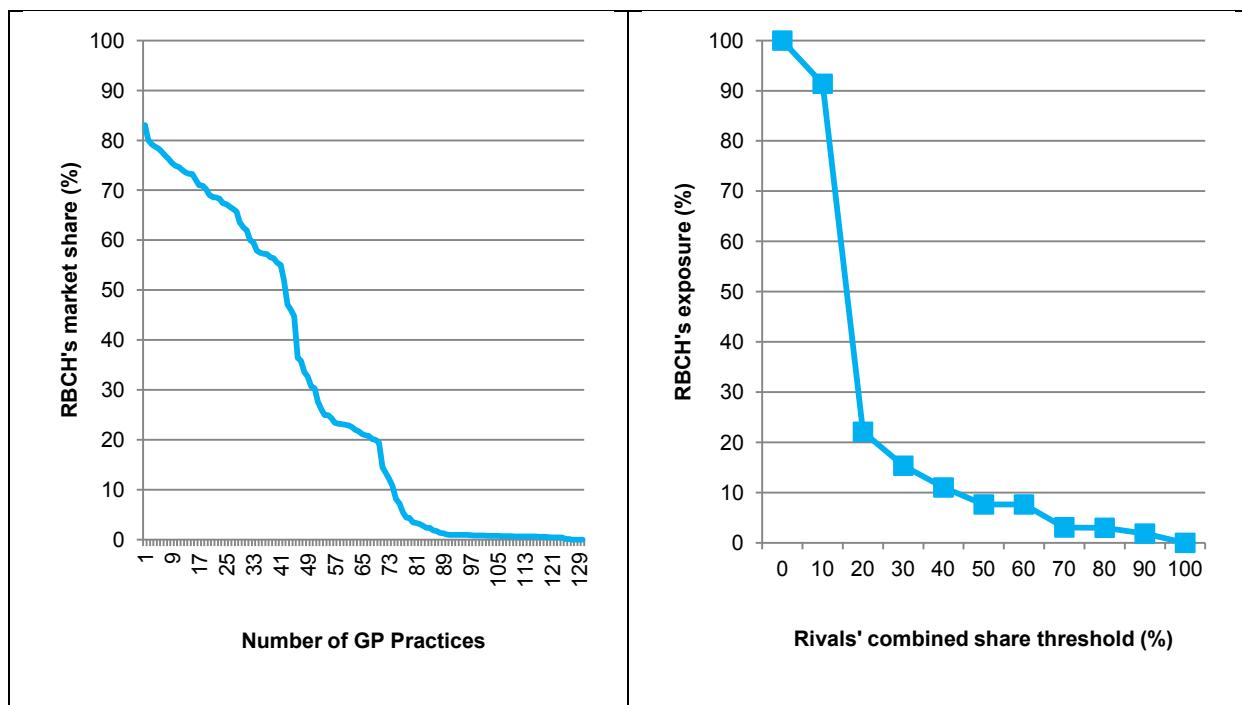
⁶ The share was calculated as a proportion of the total number of elective inpatient and outpatient episodes.

FIGURE 1

(a) PH's share of referrals (left) and exposure (right)



(b) RBCH's share of referrals (left) and exposure (right)



Source: CCGs data, CC analysis.

17. PH's exposure to other hospitals was limited: it was greater than 10 per cent only if the threshold was set at a level lower than 40 per cent. Put another way, PH drew 75 per cent of its activities from GP practices where rivals had a combined share lower than 20 per cent and appeared therefore less likely to provide a significant constraint on PH in relation to these practices. RBCH's pattern of referrals was slightly different—it had a share of above 50 per cent at 42 practices—but in terms of volume it showed a very similar picture with the large majority of referrals coming from GP

practices where the share of rivals was limited (78 per cent of its referrals came from practices where rivals have a combined share lower than 20 per cent).

Marginal GP practices

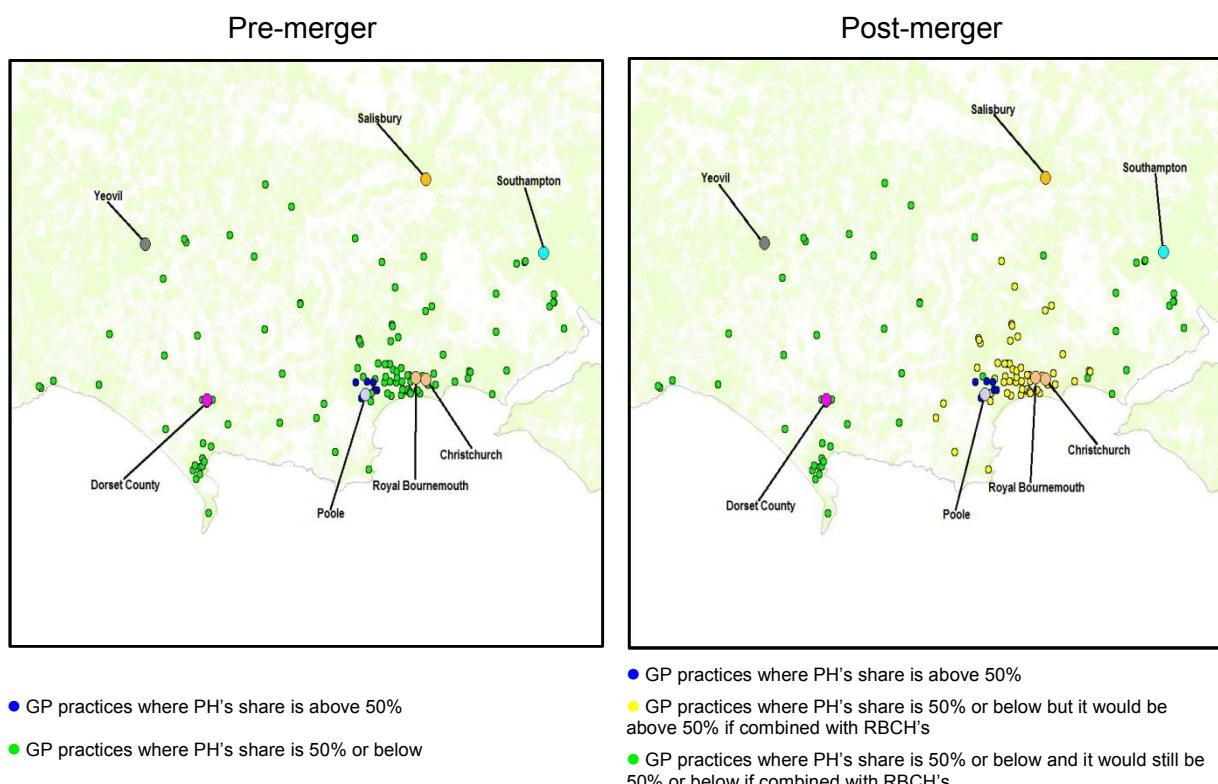
18. Building on the exposure analysis, we carried out an analysis of the extent to which the merger might internalize competition between the parties (ie the extent of the parties' revenue that would not be subject—or would to a lesser extent be subject—to competitive pressure after the merger). A merger resulting in a high internalization of competition might be more likely to result in the merged entity having the incentives post-merger to worsen the quality of their offer.
19. We defined contestable, that is, marginal GP practices on the basis of hospital value shares at the GP practice level (see paragraph 14). In particular, we assumed that a GP practice was marginal (ie liable to change its referral patterns in response to changes in quality) where rival hospitals' combined share exceeded 50 per cent.
20. We applied this assumption to each of the parties in order to identify the GP practices that each party might consider marginal on a pre-merger basis (taking into account the constraint exerted by the merging partner as well as others). We then applied the criterion to the parties' combined hospital share with the intent of identifying the GP practices that would be marginal for the merged entity should the transaction proceed. The analysis can be summarized as follows:
 - (a) We defined as *PH's pre-merger marginal GPs* those GP practices for which the combined share (measured in terms of the revenue generated by elective inpatient and outpatient services in the FY 2011/12) of all rivals of PH, including RBCH, was above 50 per cent. We then estimated the proportion of revenue that each party generated from the pre-merger marginal GP practices. We carried out a similar analysis for RBCH.
 - (b) We defined as *post-merger marginal GPs* those GP practices for which the combined share of the parties' rivals was greater than 50 per cent. We then estimated the proportion of revenue that each party generated from the post-merger marginal GP practices in the period April 2011 to March 2012.
21. The difference between the revenue generated from the marginal GP practices pre- and post-merger may provide an indication of the extent of the internalization effect (ie the parties' revenue that would not be subject—or would to a lesser extent be subject—to competitive pressure any longer after the merger).
22. Based on the data provided by the Dorset and West Hampshire CCGs,⁷ and focusing on the revenue related to elective inpatient and outpatient services, we found that:
 - PH's share was 50 per cent or lower (ie the rivals' combined share is above 50 per cent) in 120 out of the 130 GP practices from which it drew (inpatient elective and outpatient) referrals in the Dorset and west Hampshire area (PH's pre-merger marginal GP practices).

⁷ The Dorset and West Hampshire CCG data did not cover all referrals, and thereby all the sources of revenue of the parties. We acknowledged that the GP practices not covered by the CCGs' data were likely to be marginal as they were not located close to the merging parties' hospitals. However, because of that, our results may have understated the proportion of the parties' revenue 'exposed to competition' both pre- and post-merger.

- RBCH's share was 50 per cent or lower in 84 out of 130 GP practices from which it drew referrals in the Dorset and west Hampshire area (RBCH's pre-merger marginal GP practices).
23. PH generated approximately 69 per cent of its revenue in the pre-merger marginal practices, while the equivalent figure for RBCH was significantly lower (around 29 per cent).
24. The parties' combined share was 50 per cent or below in 58 GP practices (post-merger marginal GP practices). From PH's perspective this would imply a net reduction in the number of marginal GP practices of 62 GP practices, and of 26 GP practices from RBCH's perspective.
25. Figures 2 and 3 show graphically the potential impact of the merger on the number of marginal GP practices for PH and RBCH, respectively. The left-hand map of Figure 2 shows the pre-merger situation with PH's pre-merger marginal GP practices identified in green. In the post-merger map (on the right-hand side), we highlighted in yellow the GP practices that would be internalized (ie they would be no longer be marginal) post-merger. Figure 3 pictures the pre- and post-merger situation for RBCH (RBCH's pre-marginal GP practices are coloured in red).

FIGURE 2

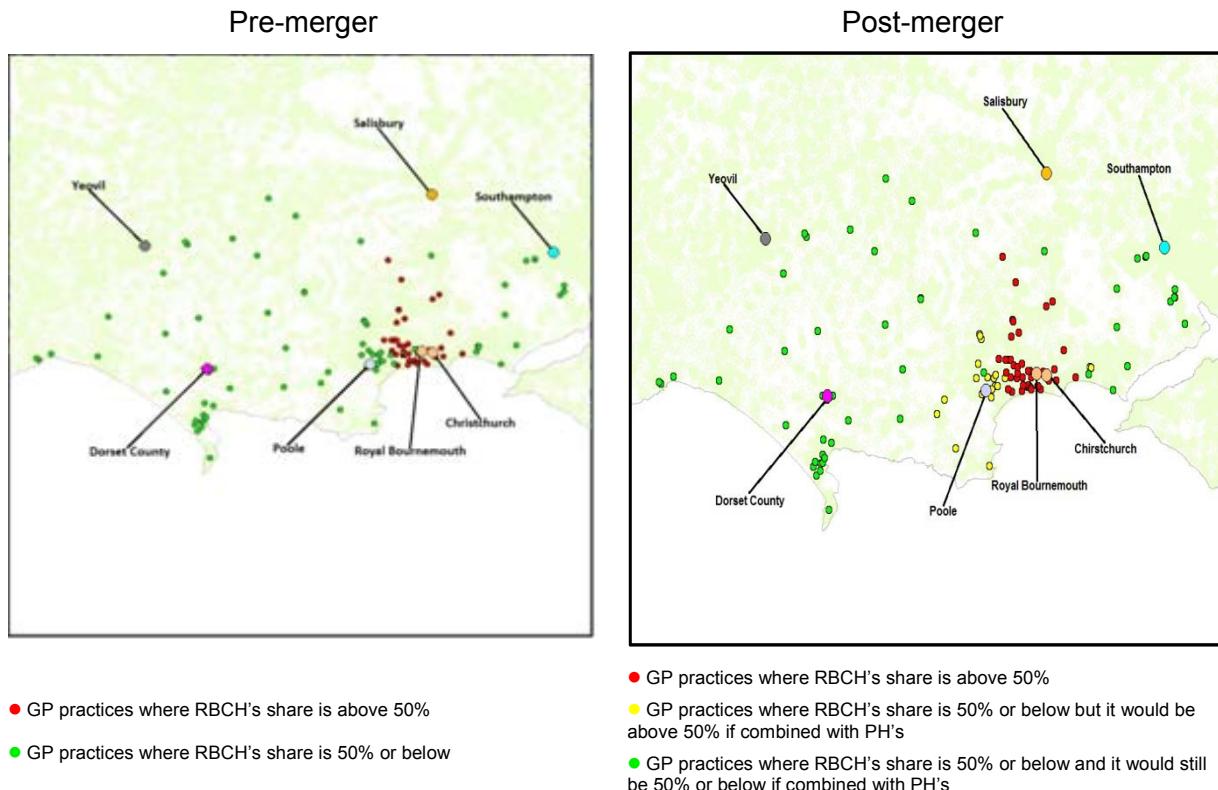
PH's marginal GP practices pre- and post-merger—elective and outpatient services



Source: CCGs data, CC analysis.

FIGURE 3

RBCH's marginal GP practices pre and post-merger—elective and outpatient services



Source: CCGs data, CC analysis.

26. Post-merger the proportion of revenue generated by PH in the marginal GP practices would be around 7 per cent, implying a reduction in the 'exposed to competition' revenue (the internalization effect) of more than 62 percentage points. The proportion of RBCH's revenue generated in the post-merger marginal GP practices would be around 6 per cent with reduction in the 'exposed to competition' revenue of 23 percentage points compared with the pre-merger scenario.
27. We acknowledged that the 50 per cent threshold may be too conservative and this may lead to an underestimate of the actual constraint exerted by rivals. To assess the sensitivity of the results to less stringent assumptions on the 'level of exposure', we considered a lower threshold, ie 20 per cent (a GP practice is identified as marginal when the combined share of rivals is greater than 20 per cent). Based on this threshold, we find that:
 - PH's pre-merger marginal GP practices are 130 (out of 130) and consequently all revenue generated by PH is the result of referrals from these GP practices; and
 - RBCH's pre-merger marginal GP practices are 113 (out of 130) and RBCH generated 68 per cent of its revenue from these GP practices.
28. Post-merger the marginal GP practices for the combined entity would be 71, with a reduction of 59 units for PH and 42 units for RBCH compared with the pre-merger scenario. The proportion of revenue generated by PH in the post-merger marginal GP practices would be around 21 per cent, implying a reduction in the 'exposed to

competition' revenue (the internalization effect) of around 79 percentage points. For RBCH this proportion would amount to 20 per cent, corresponding to a reduction in the 'exposed to competition' revenue of 48 percentage points relatively to the pre-merger scenario.

29. Compared with the results obtained using a 50 per cent threshold, the potential internalization effect would be stronger, but a higher proportion of the merged entity's revenue (around 20 per cent) would remain exposed to competition post-merger.
30. In its 'Marketing & Communication Plan—Putting Patients First (2007–2008)', RBCH also identified marginal GP practices on the basis of its share of referrals. In particular, RBCH defined as marginal the GP practices 'who send us between [21–30] per cent and [61–70] per cent of activity'. RBCH considered that the marketing and communication strategies could have the biggest impact in these GP practices 'because they are regular users of our services and so we have some relationship, and they are not geographically far away'. This seemed to suggest that GP practices in which RBCH had a high share (higher than [61–70] per cent) do not need to be actively targeted by marketing campaigns as they already referred the large majority of their patients to RBCH and appeared therefore, consistently with our approach, less exposed to competition.
31. RBCH told us that this plan was over five years old and had been superseded by a new communications strategy. RBCH told us that it found that targeted marketing strategies of this kind had little impact on patient referral patterns. As such, it no longer targets just those marginal GPs mentioned in the 2007/08 plan but instead focuses on communicating to all GPs in the local area, allowing it to provide clinical information to the majority of its patients in a cost-effective manner. We noted that a number of internal documents showed that RBCH's behaviour appeared to change in recent years (see paragraphs 6.114 to 6.116) and we explore the reasons for this in paragraphs 6.154 to 6.177 and 6.223.
32. All of the 17 GP practices⁸ identified by RBCH as marginal in 2007/08 would also be marginal according to our definition (see paragraph 17) based on RBCH's share recorded (ie in all of them RBCH had a share lower than [61–70] per cent in the period April 2010 to November 2012). Post-merger, 12 of these GP practices would become non-marginal, ie the combined share of the merged entity would be higher than [61–70] per cent. The proportion of RBCH's revenue generated from these 12 GP practices (ie the potential internalization effect) was approximately [11–20] per cent.
33. Our analysis indicated that the parties are each other's closest competitor. It indicated that the merger would significantly reduce the proportion of the parties' revenue earned from referrals by GP practices where they face competition, and therefore we expect that the merger would significantly alter their competitive incentives.

⁸ [§§]

Competition for the market

Introduction

1. We considered whether the merger would be likely to lead to reduced competition in relation to services which commissioners may procure using competitive processes, because the merger will, in principle, reduce the number of providers. We considered, in turn, elective services, non-elective services, community services and specialised services. The first three types of service are procured by CCGs (primarily Dorset CCG in this case) and the fourth by NHS England (Wessex). When we refer to competition for services as a ‘competitive tender’, we include any competitive process by which providers will be determined, which may or may not be a formal tender process.¹
2. Monitor’s draft guidance on the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 states that there will be circumstances when it is appropriate not to publish a contract notice and/or competitively tender: for example, when there is only one capable provider (eg due to co-location with other services, due to infrastructure or capacity, due to the requirement to meet an immediate interim clinical need); when the commissioner carries out a detailed review of provision and as part of that review identifies the most capable provider; when benefits of competitive tendering would be outweighed by the cost of doing so; and when there is AQP for the service.²
3. Regulations 2 and 3 of the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations 2013³ provide, among other things, that commissioners must procure NHS services from those most capable of securing the needs of service users, improving the quality and efficiency with which they are provided and provide best value for money. Monitor and the Government have both confirmed that it will be up to CCGs to decide when to use competition as a quality lever. Monitor’s consultation document dated 20 May 2013 on its substantive guidance on the NHS (Procurement, Patient Choice and Competition) (No.2) Regulations stated: ‘It is for commissioners to decide what services to procure and how best to secure them in the interests of health care service users. The regulations adopt a principles-based approach that is intended to give commissioners flexibility.’ Health Minister Norman Lamb said recently: ‘We will make it absolutely clear that the power rests with CCGs, not Monitor, not ministers but with CCGs … There is a need for a clarification to be absolutely clear that CCGs will not be forced into tendering.’⁴
4. We interpreted this as providing quite a broad discretion to the commissioner to decide not to hold a competitive tender.
5. NHS England (Wessex) told us that if there are issues with current provision it would address this first via the contract. If that would not solve the issues—or if the NHS

¹ By ‘competitive processes’ we include both situations where commissioners set out to change provider or a new contract is being awarded, and situations where commissioners consider a new provider (eg because an existing contract has ended) but are open to keeping the existing provider.

² Monitor noted that the existence of patient choice does not exclude the possibility of competition for the market.

³ Monitor, *Substantive guidance on the Procurement, Patient Choice and Competition Regulations*, 20 May 2013.

⁴ See www.bbc.co.uk/news/health-21672962 and www.hsj.co.uk/news/policy/government-to-amend-controversial-competition-rules/5055778.article?blocktitle=Headlines&contentID=7838.

England (Wessex) wanted to agree a ‘new contract’,⁵ then the priority would be to act in a transparent, proportionate and non-discriminatory way to procure services from those most capable of delivering safe, high-quality services, whilst at the same time delivering best value for money.

6. We also noted Dorset CCG’s view that it was very difficult for it to unilaterally carry out reconfigurations⁶ that were not supported by healthcare providers. We noted that such reconfigurations may be carried out using competitive processes, as described in paragraph 1 above.

Competition for the market—elective and non-elective acute services

7. We considered whether the merger might lead to reduced competition in relation to acute elective or non-elective services (including maternity services) which commissioners may change or reconfigure, because commissioners would, in principle, have less choice of provider for services. In practice, the scope for a lessening of competition, leading to worse outcomes, will depend on a number of factors, including:
 - (a) commissioners’ scope and intentions for reconfiguring services; and
 - (b) closeness of competition between the parties pre-merger relative to other competitors.
8. Below, we first assess the first factor, then assess the extent of past competition between the parties, and finally consider separately the likelihood of reduced competition for services provided by both parties and for services with no overlap.

Commissioners’ scope and appetite for reconfiguring services

9. We obtained views from Monitor and from relevant local commissioners on the extent to which they considered that there would be competition for the market generally and in the area affected by the merger.
10. We asked Monitor whether there could be competition for the market in respect of any *elective* service where the AQP model operates. Monitor told us:

Regulation 7(2)(a) of the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 provides that a relevant body must establish and apply transparent, proportionate and non-discriminatory criteria for the purpose of determining which providers qualify to be included on a list from which a patient is offered a choice of provider in respect of first outpatient appointment with a consultant or a member of a consultant’s team. Under Regulation 7(3), a relevant body must not refuse to include a provider on that list where it has satisfied the criteria established by the relevant body. We understand that this would normally preclude competition for the market in relation to these decisions.

⁵ ie a new service, or an existing service delivered in a completely different way, eg integrated care or possibly a single provider rather than more than one provider; renewal of a contract is not a new contract.

⁶ We note that in this context the term ‘reconfiguration’ is used to refer to any significant change in the manner in which a service is supplied to a commissioner where the commissioner can take a decision as to how to configure services across a set of potentially competing or competing providers (whether by amendment to their contract terms, informal tender, tender or other means). In this context ‘reconfiguration’ does not therefore only refer to service reconfigurations which require public consultation, although it may include such reconfigurations.

11. Therefore we understand that normally⁷ the only elective services that may be subject to competition for the market are those outside the AQP framework (which are in general non-PbR services).⁸ We looked at the range of non-PbR services supplied by the parties. Some relate to specialised services or community services and each of those is covered in the relevant parts of this report below. Of the remainder, only some are elective, and many are effectively add-ons as part of the care pathway (for example, payments at cost for drugs or top-up payments for patients receiving critical care) which are not services that could easily be separated from services within the AQP framework or separately tendered. Therefore the scope for competition for the market in elective services is limited.
12. We asked local commissioners about their plans with regard to reconfiguring services.⁹ Dorset CCG told us that it was unrealistic to undertake competitive tenders on a regular basis due to the scale and complexity involved. It said that providers invested heavily in specialist facilities and staff, and regular tendering could destabilize providers and in consequence lead to gaps in essential services. It said that services might be put out for tender if:
 - they were new services not currently provided but with an identified need;
 - there was a wish to change the setting of the service (eg from hospital based to community based);
 - there was a need to expand capacity; and
 - an existing provider had served notice on a particular service.

We noted that none of these reasons appear to be directly related to quality, price or value for money, consistent with our view that commissioners were unlikely to put services out to tender as a way of disciplining current providers.

13. We asked Dorset CCG which services it might consider reconfiguring in the next five years. It told us that it was too early in the life of the CCG to provide a list of services. It said that there were no services for which it was currently considering, or expected to actively consider, changing existing providers or restricting the number of providers, either with or without the merger.
14. Taking all these factors into account, below we assessed the likelihood of the merger causing a lessening of competition within non-AQP elective services or non-elective services (including outpatient services) for, first, overlap services (those supplied by both parties) and then, non-overlap services.

⁷ The [AQP FAQs](#) published by the Department of Health states that there are two circumstances where limiting the number of providers might be necessary and in the best interests of patients:

- to maintain safe clinical volumes—if a commissioner decided that the benefits of patient choice of AQP were high, but clinical competence and quality might be affected if patient volumes per provider were too low; and
- as a short-term approach to building a new AQP market—a commissioner could limit the number of providers initially to encourage new providers to enter.

SHAs would need to agree to such a decision, and any cap would need to be time limited and set prior to issuing the advertisement. Before setting a limit on the number of providers, commissioners should assess whether AQP is the right route for that particular service or whether, for example, competitive tendering might be more appropriate.

⁸ Monitor's [Substantive guidance on the Procurement, Patient Choice and Competition Regulations](#) (20 May 2013) also gives a clear statement that there is no need to run a competitive tender process where there is AQP (p23).

⁹ We discuss specialised services separately in their own section (see paragraphs 36–61), since a different commissioner is involved.

Extent of past competition between the parties in competitive processes

15. We asked commissioners for details of the tenders they had carried out over recent years. The Dorset CCG provided details of 37 tenders the Dorset PCT cluster had carried out between 2009 and 2012, many of which were for non-acute services (including community services, patient transfer services, and police custody health-care and forensic services); few were for acute elective or non-elective services. RBCH and PH both returned tenders for spinal surgery services in 2012 (which included both elective and non-elective services), for which Dorset County Hospital had been the incumbent, but PH subsequently withdrew and no bidder was successful (a temporary contract was awarded to Ramsey New Hall). There were no other tenders (aside from community services, which we discuss separately below) where both RBCH and PH submitted either an expression of interest or a bid. West Hampshire CCG told us that neither party had participated in any of tenders relating to its area in the last three years.
16. On the face of it, this evidence suggested to us that the parties would be unlikely to bid against each other, and that they would not be strong competitive constraints on each other in the event of a tender. However, we noted that this may be partly related to the fact that the merger has been in contemplation for some time; therefore the evidence relating to behaviour in the past may not be indicative of the likely extent of competition between the parties in future (absent the merger), and so we also considered the evidence more specifically.

Overlap services (supplied by both parties)

17. For elective and non-elective services currently supplied by both trusts, where local commissioners want to reduce the number of providers, there would be fewer potential bidders post-merger. Economic theory indicates that this is likely to lead to worse outcomes for commissioners in terms of price, quality or value for money. However, outcomes are unlikely to be materially worse if there are other credible bidders capable of meeting commissioners' requirements.
18. Services supplied by both trusts may be available in many cases from a range of other actual (and potential) providers in the region. We noted in this context that, although we found that distance was an important factor for patients and catchment areas were relatively small, commissioners would be expected to take a broader geographic view when configuring services. This is supported by the evidence we have seen on historical tenders, which tended to draw bidders from larger geographical areas than the catchment areas we defined and attracted bids from across the wider Dorset area.¹⁰ Therefore although the merger may reduce choice for patients in the Bournemouth and Poole area, the effects on competition from the commissioners' broader geographic point of view are likely to be smaller.
19. Our analysis of data supported this view. For non-elective services provided by both parties, we found that there were other providers in the region that we considered would be likely to be credible bidders in the event of a competitive tender for these services because they were likely to be sufficiently close geographically, would not face start-up costs and would have previous experience of providing the service.¹¹

¹⁰ See paragraph 16 above.

¹¹ The majority were provided by all of Dorset County Hospital, University Hospital Southampton and Salisbury District Hospital. Palliative medicine and rheumatology were provided by two of these hospitals; and two small specialties, transient ischaemic attack and rehabilitation service, were provided by just University Hospital Southampton.

20. We understood that the main category of non-PbR elective services where competition for the market is in theory possible is direct access services (which are worth approximately £5 million to RBCH and PH annually), which are effectively walk-in services where patients can be sent by their GP for a test (eg a blood test or an X-ray) and the test results are sent to the GP, rather than passed to a hospital consultant. We therefore asked Dorset CCG about its reconfiguration plans for this set of services specifically. It told us that it had a number of providers (including non-NHS providers such as Alliance Medical) of direct access services which it was happy with and had no plans to reconfigure existing services in the foreseeable future.
21. In summary, we found that reconfigurations have been relatively rare and the parties have, in recent years, rarely bid against each other, and there are likely to be several other credible bidders in the wider area. Whilst commissioners may be more likely to consider using competitive processes going forward, we were not aware of any specific services for which reconfiguration is likely such that a loss of competition would be likely. We therefore concluded that we did not expect that the merger would create unilateral effects in the context of competition for the market in respect of elective and non-elective services that are provided by both parties.

Services with no overlap (supplied by one or neither party)

22. For services currently supplied by only one of the parties, or neither of them, we considered the manner in which the merger could affect competition for the market for elective or non-elective services. This could happen only if commissioners were to reconfigure such a service and both parties would, absent the merger, have been likely bidders.
23. The amount of competition remaining post-merger will depend on how many other providers there are in the relevant region, compared with the number that commissioners want to have (and for low-volume services, commissioners may only want one provider in the region). If this is the case, then a reasonable choice of hospitals remains, especially for West Hampshire CCG. We also noted that Dorset CCG was apparently unconcerned about this issue.
24. There are also practical considerations as to whether a trust not currently offering a service could be a credible bidder to start offering it. At the specialty level, we note that (a) elective services are typically AQP and so would not be tendered, and (b) we understand that a trust is unlikely to start offering a non-elective service in a specialty where it does not already offer a corresponding elective service.¹² This would limit the list of specialties where a problem of this type could occur. The only specialties where RBCH offers an elective service but not a non-elective service are oral surgery and podiatry; for PH, the only such specialty is currently pain management (major aspects of which will no longer be supplied by PH in the future¹³). This suggests that there is little potential for either trust to start entering a major service that it does not currently supply.
25. Secondly, there may be high sunk costs of entry and minimum scale issues. This would affect both the likelihood of commissioners putting a service out to tender (since they will be reluctant to 'strand' assets at the existing provider) and the likelihood of potential providers entering a tender.

¹² For example, Dorset County Hospital told us that 'Consultants need to provide services on an elective basis to maintain skill and competency to provide non-elective services'.

¹³ Paragraph 4.66.

26. Thirdly, with respect to non-elective services, since both of the parties are at or near their baselines for the marginal rate emergency tariff, they may have little incentive to expand their non-elective services by offering a new service, since even if they can reach a scale that would be profitable when prices reflect costs, the necessary scale would be far higher when paid only 30 per cent of prices. This would depend on whether the baseline would be increased to reflect the new service.¹⁴ An increase seems possible but may be subject to some uncertainty.
27. It appeared unlikely to us that either trust would be a strong competitor in any specialty where it is not currently active, and therefore the merger would not lead to a lessening of competition in non-overlap areas.

Competition for the market—community services

28. As we noted in the section on community services (paragraph 6.304ff), the only overlaps between the parties in the provision of community services are midwifery services (which we considered separately in paragraph 6.272ff) and a general dermatology outpatient service (which is captured within the scope of our outpatient analysis). Therefore there is little scope for the parties to compete ‘for the market’ for community services that both already provide.
29. A number of community services have been put out to tender by the Dorset PCT cluster and its constituent PCTs since 2009.¹⁵ The parties bid independently and jointly for some of these services:
- A community skin cancer service was tendered in 2009 for the first time. PH and RBCH both bid independently, along with three other bidders. RBCH was the successful bidder.
 - Transforming community services was tendered in 2010 by both Bournemouth & Poole PCT and Dorset PCT separately. In each case RBCH bid, but DHUFT won both services. The parties told us that PH made an expression of interest but withdrew because, at the time, the trust was facing financial and governance problems and decided that it did not have the management capacity to submit a successful bid when it was going to be in breach of its licence.
 - Community persistent pain was tendered in 2012 by the Dorset PCT cluster. RBCH bid, but DHUFT won the service. RBCH, PH and Dorset County Hospital were the incumbents before the tender but the latter two did not bid.
 - Community dermatology (AQP) was tendered in 2012 by the Dorset PCT cluster. Neither RBCH nor PH bid.
 - Community endoscopy (AQP) was tendered in 2012 by the Dorset PCT cluster. Neither RBCH nor PH bid.

¹⁴ An amendment to the baseline may be made if there has been a significant service redesign which would make the 2008/09 activity unrepresentative of future patterns of activity (for example, more emergency admissions to one provider as a result of an A&E department at a second provider moving location), or if there is evidence of or planned changes to service patterns (Payment by Results Guidance for 2013–14, paragraph 103ff). However, there was no provision to adjust the baseline based directly on changes in local population or demographics. Dorset CCG told us that in general limited changes to the baseline had been made so far because there had not been material service reconfiguration. It would be likely to adjust the baseline if a provider started or stopped offering a specialty only if it was of the view that this was a material change.

¹⁵ West Hampshire CCG told us that neither party had participated in any of its tenders in the same time period.

- Community ultrasound was tendered in 2009 by Bournemouth & Poole PCT. PH and RBCH made a joint bid, along with two other bidders. They won the service alongside Alliance Medical.
 - Weight management AQP was tendered in 2010 by the Dorset PCT cluster. RBCH was one of a number of successful bidders.
30. We note that many services were tendered on an AQP basis where providers only have to fulfil a minimum set of standards, and we did not consider that the merger would reduce competition or quality in relation to such services (since commissioners are not seeking to restrict the number of providers and so the parties would not be bidding to displace each other and would not be competing on standards or value for money).
31. In relation to services where the parties did not overlap, we have considered whether the merger would reduce competition for the market. Both parties have shown that they can and do compete for tendered community services. These tenders are relatively infrequent and so there is a limited direct evidence base. We also noted that tenders appeared to be heterogeneous and therefore evidence of bidding in one tender was not informative as to strength of constraint in another tender. However, there generally appeared to be a number of bidders participating in each tender (ie there was no indication that RBCH and PH would be the only bidders for any tender); there was relatively little overlap between the parties' bids: of the tenders listed in paragraph 29 above, there was only one in which both parties bid separately, and a second where they might both have bid, had PH's circumstances been different. In both cases there were other bidders. There was one joint bid from the parties, but we did not expect the merger to affect the level of competition where the parties would have bid jointly in the counterfactual.
32. We considered whether RBCH and PH might, absent the merger, compete to supply any services which might move into the community in the future. Dorset CCG told us that this process affected a number of specialties, but predominantly outpatient and day-case activity. It told us that so far, RBCH and PH had either not applied or were not successful in these tenders, as noted above. This included the tender for persistent pain, where both parties had been incumbents. Dorset CCG said that it was moving services like this in a phased way out of an acute setting and into the community, to avoid large sudden changes to trusts' incomes.
33. We asked Dorset CCG, as the largest potential customer for these services, if it had any concerns about the effect of the merger on community services. It told us that entry was reasonably easy and that it had had reasonable responses to past community service tenders, especially from DHUFT and various private and charitable organizations.¹⁶
34. Therefore, based on our evidence on past tenders which shows a range of bidders and that PH and RBCH have not been close competitors, we did not find that the merger would be likely to create unilateral effects in competition for the market for community services.

¹⁶ It told us that it had tendered AQP contracts in dermatology, endoscopy and psychological therapy and received a good response even though neither party had bid. It also noted that many community contracts were AQP and awarded to all providers that met the criteria to provide the service, so a single AQP service could be awarded to several providers and would be paid on an activity basis. We note that in the case of AQP contracts there is no competition for the market per se, only a requirement to meet minimum criteria, and therefore having an extra bidder would not be expected to produce better outcomes (in terms of price or quality in the tenders; it could lead to more competition in the market).

Competition for the market—specialised services

35. We considered whether the merger would be likely to lead to a lessening of competition for the market in relation to any specialised services. We assessed how likely reconfiguration would be in the case of the specialised services provided by both parties. In relation to some specialised services, where we considered that reconfiguration would be likely or possible, we assessed whether or not both parties would be credible bidders in the context of a competitive process in the event of reconfiguration.
36. The parties told us that there was no scope for them to compete for the specialised services that they provided as:
- it would be clinically inappropriate—particularly in a relatively low population area such as Dorset—to have multiple competing providers, since it is clinical best practice to care for patients in regional centres of excellence that achieve a minimum clinical scale; such designations are well established via Specialised Commissioning and the ‘minimum take’ requirement which will from April 2013 be controlled by the National Commissioning Board; and the specialised services provided by the Parties involve significant sunk cost investments in specialised equipment and training—this means that once a provider of a specialised service has been established in a region there is no realistic prospect of inviting competition ‘for the market’ for this service (since awarding the service to a rival provider would involve stranding assets at significant taxpayer expense).¹⁷
37. Given the parties’ submission, our starting point for analysis was that where there were overlaps between the parties in provision of specialised services we could likely expect reconfiguration in the future. We therefore took a different approach to our analysis of the likely effects of competition for the market for specialised services to that taken above in relation to elective and non-elective services.
38. For services currently supplied by only one of the parties, or neither of them, we considered whether the merger could impact on competition for the market. This could happen only if commissioners were to reconfigure such a service and both parties would, absent the merger, have been likely bidders. Our understanding is that this is likely to be rare for services since the current configuration of them is the result of previous tenders and commissioner decisions, and in most cases a reconfiguration will be aimed at reducing the number of providers (in order to increase volume and improve outcomes at remaining providers) rather than encouraging new ones to bid.
39. First, we assessed the views of the NHS England (Wessex) and the history of tendering specialised services in the region (paragraphs 41 to 46). Secondly, we considered whether it was likely that services would be reconfigured (paragraphs 47 to 57). The parties told us that there were minimum standards associated with specialised services that made it unlikely that there would be multiple providers in an area¹⁸ so we will assess whether in practice having multiple providers appears to be sustainable. Here we focused on services offered by both parties since they are the most likely candidates for competition ‘for the market’ between the providers.
40. Thirdly, we considered whether either party would be likely to bid to supply a specialised service that it did not currently supply (ie whether we would only ever expect

¹⁷ Joint main party initial submission, paragraph 14.

¹⁸ Paragraph 48.

consolidation of existing providers, in which case the only competition for the market would be in reconfiguration of overlap services, or whether new entry would also be possible; paragraphs 59 to 61).

Views of commissioners and historical evidence of tenders

41. We asked the NHS England (Wessex) if it had any plans to reconfigure particular services. It said that it did not have any reconfiguration plans that would take effect before 2015, in terms of moving services from one site to another. Providers would be asked to self-assess whether or not they complied with the new national service specifications work that was already under way as part of a national programme. Providers would then agree with the relevant Local Area Team of NHS England what needed to be done to ensure compliance. Initially this would be the focus of the work of the Local Area Teams. Any reconfiguration would focus on improving patient safety and quality; they would focus on getting providers to work together to ensure compliance (for example, to get teaching hospitals to support smaller hospitals), and on the provision of specialised services on a networked basis to ensure that quality standards were met (for example, surgery provided at a specialist centre and pre- and aftercare provided at local level).
42. NHS England (Wessex) had to check that all providers met the service specification either on their own or as part of a centrally managed service, eg if RBCH treated small volumes it might do so as part of a network where University Hospital Southampton was the hub. NHS England (Wessex) would then either commission from RBCH which would pay University Hospital Southampton for the visiting consultant or commission from University Hospital Southampton which would be charged by RBCH for use of its clinics/nurses/clerical staff etc.
43. When we asked about specific services, it told us that it did not have any clear plans for any reconfigurations before 2015 as long as it had clinical confidence in providers. We asked it about reconfiguration of specialised services with very small volumes at RBCH and PH, such as HIV, and whether they could sustainably be provided at both hospitals. NHS England (Wessex) replied that for HIV it was primarily oversight of outpatients and regular access to medication, both of which might mean that local access was important.
44. NHS England (Wessex) said that if two providers in a local area were both providing a low-volume specialised service of satisfactory quality, and both providers met the national service specification, there would be no immediate ‘commissioner driven’ need for change. However, there might be a view where there would still be advantages associated with a single provider model—for example, benefits associated with having a larger clinical team, greater service stability/sustainability, more opportunities for specialisation and/or simply the opportunity to achieve even better outcomes (that is, achieving better results by undertaking work more frequently). In such a situation, NHS England (Wessex) would consider whether there was an obvious situation of ‘first among equals’ or whether there was an opportunity for negotiation/bargaining between the two providers to achieve the change—for example, by moving one service to Provider X and another service to Provider Y. NHS England (Wessex) pointed out that it was always difficult politically to stop commissioning services from a provider. The challenge would be to make the case for change among local stakeholders—that is, the local authority, the local Health and Wellbeing Boards, voluntary groups, patients and members of the public—so that any such proposal would be accepted. The public was understandably very keen on local services and as always, there had to be a balance achieved between the quality of the service and the ‘localness’ of provision. If the service was straightforward and there was a clear tariff, NHS England (Wessex) could go down the competitive tendering route.

The priority would be to ensure ongoing high quality and value for money rather than to ‘choose’ between providers.

45. We also considered how often the parties competed in practice. They told us that in the case of Dorset, none of the specialised services provided by RBCH or PH under the old definitions had been put out to competitive tender since service provision patterns were established by the commissioner-led Acute Services Review over 20 years ago.¹⁹ They said that the exception was bariatric surgery (morbid obesity), which was tendered by the South West Specialised Commissioning Group as a new service (starting during 2009/10). They said that only RBCH bid locally, to their knowledge, and PH did not bid.
46. The South West Specialised Commissioning Group also told us that there was only one specialised service for which either party had competed in the last ten years: bariatric surgery in 2009. It said that 11 providers (including RBCH) bid and six (including RBCH) across the South-West were designated as providers. PH did not participate in this tender.

Likelihood of reconfiguration of overlap services

47. The parties told us²⁰ that:

Alongside these specialised services, there are a range of services that, although not commissioned by Specialist Commissioning Groups, still require a high level of clinical expertise and experience. Hospitals must perform a minimum number of these complex procedures per year in order to maintain the skills and practice necessary to provide these services safely and to a high standard of care. This is one of the considerations driving the strong national policy-driven trend towards the creation of regional ‘centres of excellence’ in the provision of a range of services. This trend is most advanced in relation to cardiology, haematology, oncology and stroke services, amongst others. Guidance from the Royal Colleges now stipulates that:

- the provision of comprehensive elective surgical care on a stand-alone basis by a district general hospital is not sustainable and should be replaced by a network of hospitals serving populations of 500–600,000; and
 - the ideal unit for fully comprehensive medicine and surgery is a hospital or group of hospitals serving a population of 450–500,000.
48. We asked the parties to give us information on the overlap specialised services. We asked them to supply all quantifiable minimum standards (such as minimum number of procedures to be performed by each provider or by each consultant at that provider) and the number of procedures actually performed. We also asked if there were any other requirements that they were not currently meeting, for example requirements to have specific staff and co-located facilities. On the basis of this, we categorized the services according to the likelihood of reconfiguration.

¹⁹ Joint main party initial submission, paragraph 60.

²⁰ ibid.

No genuine overlap

49. In this category we included services which the parties essentially operate as out-patient clinics for a referral service and therefore would have no incumbency position if tendering to provide the full service specification. These services would therefore fall under the scope of our analysis of services which are not currently provided by both parties. We considered that NCBPS29r Other Respiratory; NCBPS29e Management of Central Airway Obstruction; NCBPS38s Sickle Cell Anaemia; NCBPS23b Paediatric Cardiac Surgery fell in this category:
- NCBPS29r Other Respiratory—the parties told us that this service specification varied significantly from the Identification Rules, which picked up larger amounts of activity. They said that local clinicians agreed that the specialised service would never be provided locally due to the highly specialised nature of the work. They said that a general hospital respiratory service, as part of a larger medical service (to which the sunk costs referred), was required to triage and identify patients that would benefit from this service, and refer them on. Hence, their services were primarily referral services (to specialist centres at Royal Brompton and Papworth) and they did not have the appropriate infrastructure to support this type of specialised activity.
 - NCBPS29e Management of Central Airway Obstruction—the parties told us that they were both part of a respiratory network and only acted as a referral service.
 - NCBPS38s Sickle Cell Anaemia—the parties told us that this activity related to the provision of drug administration and assessment and hence this was essentially only a financial overlap (drug costs were passed through and the providers should not earn a profit on them).
 - NCBPS23b Paediatric Cardiac Surgery—the parties told us that PH did not provide cardiac surgery (including interventions) but ran outpatient clinics for this service. As a result, activity was likely to be a transfer to RBCH for an intervention for patients aged 16 and over, or to Southampton or London for younger patients.
50. For this category of services, we considered that there was unlikely to be a reconfiguration of services which could lead to competition for the market involving RBCH and PH.

Reconfiguration unlikely

51. We included in this category the following services where, based on the evidence we received, reconfiguration would be unlikely: NCBPS01t Teenage and Young adult Cancers; NCBPS01y Rare Cancers (adult) and NCBPS01c:
- NCBPS01t Teenage and Young adult Cancers and NCBPS01y Rare Cancers (adult)—both are provided as part of a cancer network service for Dorset.
 - NCBPS01c Chemotherapy—provided as part of a cancer network service for Dorset, and the parties told us that RBCH could not provide the service without the infrastructure offered by PH.
52. Where reconfiguration was not likely, we considered that the merger would be unlikely to give rise to unilateral effects in relation to competition for the market in provision of specialised services.

Reconfiguration likely or possible in the medium term

53. We received some evidence, based on detail provided by the parties or by NHS England (Wessex), that reconfiguration might be needed in the medium term in relation to the following services: NCBPS13k Cardiac Other; NCBPS13x Congenital Heart Disease (adult); NCBPS02z BMT; NCBPS33c Transanal Endoscopic Microsurgery; due to the need to meet certain minimum volume requirements, failure to fulfil complete specifications or financial viability:
- NCBPS13k Cardiac Other—the parties told us that '[☒]'. However, PH told us that if reconfiguration were to take place, the [☒] for this service would be [☒] due to [☒].
 - NCBPS13x Congenital Heart Disease (adult)—this service was predominantly provided at RBCH and volumes at PH were very small. The parties told us that '[☒]'.
 - NCBPS02z BMT (Bone Marrow Transplants)—the parties told us that it was not sustainable for [☒]. However, NHS England (Wessex) told us that both parties had recently self-assessed as meeting the relevant standards for provision of Level 3 haematology services and therefore it, as commissioner of these services, had no immediate plans to reconfigure or tender these services. As such, whilst we found that it was possible that in the counterfactual some changes may be made to Level 3 haematology services as currently offered in the wider Dorset area, the evidence on this was inconsistent. We therefore thought the most likely counterfactual outcome would be that haematology service provision would remain unchanged in the foreseeable future.
 - NCBPS33c Transanal Endoscopic Microsurgery—procedures are provided as part of the Dorset Cancer Network. Consultants are provided by PH and shared across both sites. PH provided specialised transanal endoscopic microsurgery on a regular basis. This is a service that is part of the 'Early Rectal Cancer' service at PH. Transanal endoscopic microsurgery procedures provided at RBCH are lesser procedures with baseline service provision and [☒]. Therefore it seemed likely that commissioners would have to consider RBCH's position as a provider of this service at some point.
54. We also considered services where one party appears to have small volumes, which might indicate that reconfiguration is desirable, but we have no evidence that it is necessary. Overall we therefore concluded that reconfiguration in respect of these services would be a possibility. In this category were: NCBPS23n Paediatric Ophthalmology; NCBPS13c Inherited Heart Disorders; NCBPS23f Paediatric Gastroenterology, Hepatology and Nutrition; NCBPS23w Paediatric Rheumatology; NCBPS23x; Paediatric Surgery; NCBPS23a Paediatric Cancer; NCBPS34a Orthopaedics Surgery; NCBPS14Z HIV. In relation to these services, we found that one party had a small level of activity in the area. We therefore questioned the clinical and financial viability of these services in the medium term, although if they were tendered we generally thought that the smaller provider might be a weak bidder:
- NCBPS23n Paediatric Ophthalmology—the parties told us that this service was predominately run at RBCH with very little activity at PH.
 - NCBPS13c Inherited Heart Disorders—this service is predominantly provided at RBCH and volumes at PH are small. The parties told us that the ability for RBCH to provide this service was enhanced by its baseline cardiac services which were already in situ, and its clinical networks with University Hospital Southampton; and

that RBCH had the infrastructure to support the various treatment pathways connected with delivery of this service (such as echocardiograms and MRI facilities, its specialist cardiac clinicians, and co-dependencies with other services such as the vascular service).

- NCBPS23f Paediatric Gastroenterology, Hepatology and Nutrition; NCBPS23w Paediatric Rheumatology; NCBPS23x; Paediatric Surgery; NCBPS23a Paediatric Cancer—the parties told us that RBCH did not provide services for under-16s (and would not be able to since they had no paediatric services), and the only overlap was in the 16–19 age group. Therefore although some volumes are relatively small, if there were to be a reconfiguration of each service as a whole it would, in our view, be unlikely that RBCH would be a realistic bidder. In the case of NCBPS23f, the parties told us that this specialised service was provided as part of a network with University Hospital Southampton being the main provider.
 - NCBPS34a Orthopaedics Surgery—the parties told us that the service provision across PH and RBCH was split predominantly by elective and non-elective activity. The majority of activity at RBCH was elective surgery (planned admissions), whereas PH had the majority of non-elective activity in relation to emergency non-trauma and follow-up procedures. Therefore, although activity at RBCH is small and we questioned whether it is sustainable in the long run (suggesting that reconfiguration was a possibility), for the same reason we did not expect RBCH to be in a strong position to bid to provide the non-elective aspects of this service.²¹
 - NCBPs14Z HIV—the parties told us that PH provided a small amount of short-stay emergency care but did not provide a complete HIV service (its forecast activity in the current year related to only [REDACTED] patients, and had been on a similar scale in the past). Therefore, although activity at PH was small and we questioned whether it would be sustainable in the long run (suggesting that reconfiguration was a possibility), for the same reason we did not expect PH to be in a strong position to tender for this service. The parties also told us that the main costs and revenues of this service were drugs (which were provided on a cost pass-through basis).
55. We identified several services where there was a genuine overlap between the parties' activities but one (or both) appeared to either not be fulfilling the minimum service requirements or not financially viable at the volumes currently provided (see paragraphs 53 and 54 above. It seemed to us that, on balance, if there are no changes to the current definition of these services, some form of reconfiguration would be likely in the medium term.
56. However, we noted that the definitions of specialised services are evolving and commissioners had indicated that they were not yet in a good position to make judgements on the appropriate long-run configuration of services. We also took into account that NHS England (Wessex) told us it had no plans for major service reconfiguration before 2015 and that, even if it had, there was no certainty that a competitive approach to reconfiguration would be appropriate (and in the case of BMTs it told us that there would not be a competitive tendering process).
57. Based on the evidence described above in paragraphs 54 to 56, we found that unilateral effects would also be unlikely to arise post-merger in relation to these specialised services.

²¹ See paragraph 5.47.

Likelihood of bidding for a specialised service by a non-incumbent

58. We also considered whether the merger might affect specialised services where one party is not active. The parties told us²² that ‘... because of the significant sunk costs involved in providing complex and specialised services, commissioners are very unlikely periodically to put such services out to competitive tender where there is already a single established local provider’, and that:

the specialised services provided by the parties involve significant sunk cost investments in specialised equipment and training—this means that once a provider of a specialised service has been established in a region there is no realistic prospect of inviting competition ‘for the market’ for this service (since awarding the service to a rival provider would involve stranding assets at significant taxpayer expense).

59. We asked the parties for sunk cost information to assist with this assessment but they were unable to supply appropriate information to support this as a general claim.
60. However, given that (a) we had no evidence that reconfigurations were likely to be clinically appropriate for specialised services provided by only one party, (b) NHS England (Wessex) did not give any indication that it was considering any such reconfigurations or would do so in the near future, and (c) we had no evidence to suggest that the party not currently offering the service would tender to supply it in the event of such a reconfiguration, we concluded that the merger would be unlikely to create unilateral effects in relation to competition for the market for any specialised service where only one of the parties was active.

Conclusions on specialised services

61. Based on the stated position of the relevant specialised commissioner that it has no plans for reconfigurations, and the uncertainty about the way in which any reconfigurations would take place, we did not find that the merger would be likely to give rise to unilateral effects on the basis of a reduction in competition *for* the market in the supply of any specialised service.

²² Joint main party initial submission.

Relevant customer benefits

1. This appendix contains our analysis of the specific patient benefits proposed by the parties and the potential effect of consultation requirements on RCBs.

Consideration of specific patient benefits proposed

2. For each of the areas submitted by the parties as possible RCBs we have set out the benefit proposed by the parties and considered evidence from the parties, commissioners, experts and other third parties, as relevant. As noted in paragraph 3.12, the parties noted that many of the steps described in their benefits proposals would be subject to any and all necessary legally compliant clinical, stakeholder and public engagement and consultation on service change and that the below proposals should be considered in that context. We have also considered Monitor's view, as set out in its advice to the OFT. The parties told us that they had revised their benefits case, taking into account both Monitor's and the OFT's comments and further knowledge of the potential benefits that the merger could deliver, and there are some aspects of the parties' proposals that have altered since Monitor undertook its review.
3. We have set out our assessment of the evidence and considered whether the proposal could give rise to a benefit to patients and then assessed whether the proposal meets the statutory test to be considered an RCB. In addition to considering our guidance on remedies, we also considered Monitor's consultation document on merger benefits.¹

Maternity

4. RBCH currently provides a midwife-led maternity service with 500 to 600 births each year.² The parties told us that RBCH had a large number of midwives who were not fully utilized and the service was loss making. RBCH does not offer high-risk obstetrics which results in a third of mothers being transferred to PH due to complications.³
5. PH currently provides a midwife-led maternity unit co-located with a consultant-led high-risk obstetric service and neonatal intensive care. PH's maternity unit has a high average level of occupancy of 95 per cent and 4,500 mothers give birth there each year.⁴
6. The majority of maternity services at RBCH and PH are commissioned by Dorset CCG.
7. The parties told us that PH's existing maternity unit was no longer fit for purpose and was in urgent need of refurbishment.⁵ PH is planning an interim refurbishment, on a stand-alone basis (ie absent the merger), which will increase its capacity (from 42 to

¹ www.monitor-nhsft.gov.uk/home/news-events-publications/consultations/closed-consultations/2013/substantive-guidance-the-proc.

² Relevant customer benefits submission, 12 February 2013.

³ Benefits of the merger, 26 July 2013.

⁴ Relevant customer benefits submission, 12 February 2013.

⁵ Relevant customer benefits submission, 12 February 2013 and Benefits of the merger, 26 July 2013.

55 beds) to reduce occupancy levels and cope with additional births. This refurbishment is expected to cost approximately £4 million and be completed in April 2014.⁶

8. The parties told us that this investment would only allow for a temporary improvement, not a permanent solution. They said that independent estates consultants had suggested that, even with repairs, the building could not provide more than five years of acceptable care.⁷ In the longer term, the parties believed that PH would need to build a new maternity unit at a cost of approximately [£31–£40] million.⁸

Benefit proposed by the parties—maternity

9. In their initial submission to us on RCBs, the parties stated that post-merger they would:
 - (a) [X] maternity services at [X]; and
 - (b) construct a new maternity unit at PH.⁹
10. In August 2013, the parties stated that [X] of maternity services should no longer be considered part of the proposed maternity benefit because the decision as to whether to [X] would need to be taken by the board of the merged entity.
11. Since the response hearing, the parties told us that post-merger, in addition to building a new maternity unit, they intended to operate a single managed maternity service (without consolidation of services on a single site).
12. The parties said that the new maternity unit would improve the patient environment through en-suite delivery rooms, more single/double patient accommodation (as opposed to nightingale ward/4+ bed rooms), adequate heating in cold weather and improved security for mothers and babies.
13. Dorset CCG told us that patients would see the following quality improvements and benefits from the merger:
 - (a) significantly improved environment with new unit;
 - (b) consultant-led maternity service, and increased midwife cover (from combining current workforce)—the new unit, coupled with single service, would improve ability to recruit; and
 - (c) combining the midwifery workforce would enable increased cover through all rotas, thus supporting choice of home birth in low-risk mothers.
14. We noted that benefits (b) and (c) identified by Dorset CCG in the preceding paragraph may require the consolidation of maternity services on a single site. As set out in paragraph 10 above, consolidation of maternity services on a single site is no longer part of the benefit case submitted by the parties.

⁶ [Relevant customer benefits submission, 12 February 2013.](#)

⁷ [Benefits of the merger](#), 26 July 2013. The parties provided *NIFES Consulting Group Property Appraisal of St Mary's Maternity Hospital* dated 14 March 2011 which stated that 'the existing maternity block is not fit for purpose and should be considered for long term replacement'.

⁸ [Relevant customer benefits submission](#), 12 February 2013.

⁹ *ibid.*

15. The parties told us that the benefits of a single managed maternity service (without consolidation of services on a single site) would include:
- sharing of staff and professional links, single policies and procedures;
 - a shared and enhanced home birth service with a single home birth midwifery on-call team; and
 - improved midwifery to birth ratio, although the parties stipulated that this could only be accurately confirmed by commissioning a formal Birthrate Plus¹⁰ assessment of the joint service.
16. The Chief Executive of RBCH (who has been appointed Chief Executive of the merged entity, in the event the merger proceeds) told us that he 'could not conceive of the situation where the maternity unit, if we are a merged organisation, is not established' and that the most likely site for the new maternity unit was PH. The parties told us that PH was their preferred location for the new maternity unit as the strongest opportunity to attract activity appeared to be from [§]. The parties said that new maternity unit was 'practically feasible on several locations of the PH main site'.
17. The parties told us that no analysis of building the new unit at RBCH had been carried out as it had not been considered sufficiently plausible.
18. The parties said that, based on a merger in April 2014, the build would commence in 2016/17 with the new unit open in April 2018.
19. The parties prepared an Integrated Estate Strategy which was discussed at the JPB meeting on 19 December 2012. We reviewed updated versions of this strategy from April and June 2013 (which the parties told us had not been considered by the relevant boards). This document evaluates a number of different service and estate configuration options for the merged entity, including four different options for maternity services: new build at PH; new build at RBCH; refurbishment of existing maternity unit at PH; and refurbishment in space created in the main PH building. [§], the strategy describes the strategic estate solution for maternity as a 'key variable' and notes that there would be clinical opposition to splitting gynaecology, maternity and paediatrics on to separate sites [§]. The strategy also notes that some clinicians had suggested the option of a new build at [§]. The strategy states that 'further work is required to assess the relative pros and cons of different mixes of services on different sites'.
20. [§]
21. PH told us that it would not be able to afford investment in a new maternity hospital as a stand-alone trust. The parties said that PH had made several attempts to find funds to rebuild its maternity hospital since the 1990s, including considering funding options from the Regional Health Authority (or equivalent), the Foundation Trust Financing Facility and PFI, but had never succeeded in doing so.¹¹
22. The parties told us that a new maternity unit funded by operating cash was included in PH's foundation trust application in 2007 but the project was delayed as PH's financial position had deteriorated and it did not have sufficient funding.

¹⁰ A workforce planning system for maternity services.

¹¹ Benefits of the merger, 26 July 2013.

23. Absent the merger, PH forecast that it would be in deficit by 2014/15. The parties said that, given PH's weak financial position, it would not be able to raise the funds through taking on additional debt. Monitor told us that the ongoing investigation at PH¹² did not preclude PH from borrowing but it was possible that it might affect the willingness of lenders to lend funds to PH.
24. RBCH told us that, in general, it would not lend money to another trust to develop a service for which that trust was unable to raise independent financing, since this would suggest that the trust could not guarantee a good return or repay the loan.
25. RBCH told us that, in the case of PH, it would not be prepared to lend it money given that PH was in such serious financial difficulties and unlikely to repay the loan. RBCH said that, in any case, the governance arrangements for foundation trusts (as well as the terms of its licence and compliance with Monitor requirements) prevented this from occurring.¹³ However, Monitor told us that the NHS Act 2006 stated that 'an NHS foundation trust may give financial assistance (whether by way of loan, guarantee or otherwise) to any person for the purposes of or in connection with its function'.¹⁴ Monitor noted that the NHS Act 2006 did not appear to prevent lending between foundation trusts. However, such transactions might impact Monitor's risk assessment of the trusts, or might constitute a significant transaction¹⁵ and require assessment by Monitor. Dorset CCG told us that:

it could be seen as anti-competitive for commissioners to fund an individual provider for its capital build whilst not funding other providers for their capital schemes. PH would not be able to secure funding of this scale ([£31–£40 million]) for any capital development, due to its financial constraints. As a separate entity RBCH would not 'gift' capital to a 'rival' trust. Dorset CCG does not have this level of spare resource to fund such a capital scheme.

26. The parties told us that the new maternity unit was expected to cost approximately [£31–£40] million and would be part of the merged entity's capital programme totalling £156 million over seven years. The parties intended to fund this significant programme through a combination of existing cash reserves and cash generated through normal trading.
27. The parties said that they had not prioritized the proposed capital projects of the merged entity as all capital expenditure plans were expected to be affordable if the merger proceeded. The parties noted that Dorset CCG's support for the merger was conditional on the parties' commitment to build the new maternity unit.
28. Dorset CCG told us a new maternity unit was a high priority for the CCG but that the CCG was still in the process of developing its clinical service strategy to finalize its commissioning priorities and inform future contract negotiations with the parties.
29. The availability of funds for the merged entity's capital programme will be significantly dependent on the trust's delivery of CIPs to generate surpluses. The parties told us that the proposed changes to maternity services post-merger were expected to allow delivery of savings of £[~~XX~~] million. It is not clear how much of this saving is dependent on the new maternity unit and how much of the total saving can be realized

¹² The investigation at PH is detailed on Monitor's website at www.monitor-nhsft.gov.uk/about-your-local-nhs-foundation-trust/nhs-foundation-trust-directory-and-register/licence-holders/po.

¹³ Benefits of the merger, 26 July 2013.

¹⁴ Section 46(6).

¹⁵ As defined in Monitor's Risk Assessment Framework, Diagram 18.

through the single managed maternity service without the need for a new maternity unit.

30. Monitor publishes regular reports detailing performance of the foundation trust sector as a whole. It noted in its report on the performance of foundation trusts in 2012/13 that the sector's delivery of CIPs was 14.8 per cent lower than plan at £1.3 billion (3.4 per cent of operating costs). It stated that there had been a gradual widening between actual and planned delivery, which was probably a reflection of the nature of schemes being harder to deliver, together with ongoing activity pressures, making it harder to deliver planned cost reduction projects.¹⁶
31. Monitor also found that aggregate actual capital expenditure was 33 per cent (£841 million) below plan, continuing the trend of recent years. It stated that the foundation trust sector needed to improve significantly the robustness of its capital planning. It noted that foundation trusts in financial difficulty had significantly cut back on capital expenditure in comparison with those trusts that were performing well financially.¹⁷
32. Dorset CCG highlighted the risks of:
 - (a) consultation not supportive of the reconfiguration, particularly if one site was to close;
 - (b) planning permission for new facility not being granted; and
 - (c) costs of new build continuing to rise.
33. We noted that the parties do not expect risk (a) identified by Dorset CCG in the paragraph above to materialize, as the parties told us that public consultation would not be required to build a new maternity unit at PH.¹⁸ Further details of the requirements for public consultation are set out in paragraphs 326 to 339.
34. We noted that an assessment of the transaction by Monitor could potentially be required. Monitor assesses significant transactions¹⁹ undertaken by foundation trusts to determine whether they are likely to represent a risk to compliance with the continuity of services or governance conditions for foundation trusts (see Appendix C for further details of these conditions). If the investment in the maternity unit meets Monitor's definition of a significant transaction, it may be subject to a review by Monitor to consider the transaction's impact on the foundation trust's risk ratings. Where, in Monitor's view, a transaction represented a substantial level of risk to compliance with the trust's continuity of services or governance conditions, Monitor would consider whether the use of its powers were necessary to mitigate that risk.²⁰

Monitor assessment of benefit—maternity

35. At the time Monitor provided its advice to the OFT, the parties were proposing to:
 - (a) undertake a refurbishment of PH's maternity unit and [☒] within the second year following the merger; and

¹⁶ www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/reports-nhs-foundation-trusts/nhs-fou-0.

¹⁷ *ibid.*

¹⁸ [☒]

¹⁹ A transaction is defined as significant by Monitor if it meets any one of these criteria: >25 per cent income, >25 per cent assets, >25 per cent capital ([Risk assessment framework](#), Diagram 18, p69).

²⁰ [Risk assessment framework](#), 27 August 2013, p67.

- (b) redevelop or relocate [X] maternity unit within the fourth or fifth year following the merger.
36. The parties submitted to Monitor that the merger would deliver the following benefits to patients: eliminate patient transfers [X], reducing the risks to mortality and morbidity of both mother and baby that were associated with transfer; and enable the parties to combine their midwife rota to provide increased cover in accordance with Royal College guidance. The parties said that these benefits would be delivered by [X], and refurbishing and expanding [X]'s maternity unit. Monitor considered the likelihood of this refurbishment and expansion occurring as part of its assessment of whether the submitted benefits were likely to accrue. It did not separately assess investment in [X]'s maternity unit as a potential benefit.
 37. Monitor's view was that the merger was likely to deliver RCBs for some patients in the form of higher-quality maternity services, specifically eliminating transfers [X] (approximately 200 mothers a year) and increasing midwife cover at [X].²¹
 38. Monitor noted that there might be a [X].

CC assessment of benefit to patients—maternity

39. As noted in paragraph 10 above, [X] is no longer part of the case proposed by the parties, therefore the benefit identified by Monitor no longer forms part of the benefits case proposed by the parties to the CC.
40. We found that the new maternity unit proposed by the parties would be a benefit to patients in the form of higher quality of services. We consider that the new maternity unit would increase the quality of maternity services by providing improved facilities to the mothers using the unit.
41. The parties did not explain how a single managed maternity rota would be a benefit to patients and did not provide an implementation plan to support this reconfiguration. We therefore did not find that a single managed maternity rota would be a benefit to patients.

CC assessment of whether the statutory test is met—maternity

42. Based on the evidence set out in paragraph 17 above, we do not consider that it is likely that a new maternity unit would be built at RBCH. We concluded that although RBCH would have the financial resources to build such a unit, the existence of a consultant-led maternity service at PH means that RBCH would not have the incentive to invest significantly in order to provide what would essentially be a duplicate service.
43. We have therefore considered whether the benefit of a new maternity unit at PH may be expected to accrue within a reasonable period as a result of the merger and whether that benefit is unlikely to accrue absent the merger.
44. Given the level of capital expenditure required and the time that it would take to plan for and build a new maternity unit, we considered that a five-year period would in these circumstances be a reasonable period as defined by the Enterprise Act.

²¹ Monitor's advice to the OFT under section 79(5) of the Health and Social Care Act 2012, 11 February 2013.

45. Given PH's financial position (as discussed in Section 4 of the main report and paragraphs 14 to 34 of Appendix B), we do not consider that, absent the merger, PH would obtain the amount of money required to finance the new unit. We therefore find that this benefit would be unlikely to accrue absent the merger.
46. There is a commitment by the current management of both hospitals to build a new maternity unit.²² This has been expressed to us and to other interested parties. We also note the support of clinicians at the hospitals for the new unit,²³ although the parties told us that some clinicians had suggested that the new unit be built at [☒] (see paragraph 19).
47. However, the parties' description of the likely maternity benefit has changed during the course of Monitor's and our investigations: the new maternity unit was not initially proposed as a benefit to Monitor; and the [☒] was withdrawn as a benefit during the course of our inquiry.
48. The parties have not, at this stage, prepared their analysis of the proposed investment setting out the supporting financial projections of how the project would be implemented, including consideration of the capital expenditure required and planning requirements and clinical interdependencies and any services that will need to be co-located with the new unit. The parties have also not yet decided which of the possible sites this new unit would be built on—see paragraphs 16 and 19 above. Had this analysis already been undertaken, the board of the merged entity would be able to take a decision whether to commit to the investment soon after completion of the proposed merger.
49. As noted in paragraph 18, the parties told us that based on a merger in April 2014, the building of a new maternity unit would commence in 2016/17 with the new unit open in 2018. The board of the merged entity would be unable to consider the investment decision properly until the analysis we describe above has been undertaken. Moreover, PH is currently investing in its existing maternity unit so that it will be fit for purpose for the next five years, ie until 2018/19.
50. Overall, we consider that the required investment decision will not need to be taken immediately by the board of the merged entity. Following the merger, the board and management of the merged entity will initially be focused on the challenges of successfully integrating two separate organizations; the lack of developed planning to date means that there is a significant lead time before a full investment proposal could be considered by the board of the merged entity; and the current refurbishment at PH means that there is no immediate urgency for the investment decision in any event.
51. We expect that any decision by the merged entity to proceed with the new investment will be impacted by the need to consider the configuration of maternity services across the whole area. This is a decision that will also require careful consideration, and public consultation will be required if a decision is taken to consolidate maternity services at PH.
52. When the board of the merged entity comes to make a decision as to whether or not to build a new maternity unit, the following considerations are likely to be relevant:
- (a) The merged entity will be the only option for women in the area choosing a consultant-led service. We found that RBCH was the only provider other than PH

²² [☒]

²³ For example, the letter we received from Dr Angus Wood on behalf of senior clinical staff at PH.

providing maternity services for a substantial number of births in the parties' catchment areas and therefore the merger could be expected to lead to unilateral effects in maternity services (see paragraph 6.303). This may impact on financial incentives because it means that the merged entity is unlikely to lose many patients if it does not build a new maternity unit.

- (b) The board of the merged entity may wish to consider the practicability and, if so, the costs and benefits of further refurbishment of the existing maternity unit(s) instead of investing in a new unit.
- (c) The board will have to consider any investment proposals in the context of its financial position and forecasts at that point in time. We recognize the inherent uncertainty of longer-term financial forecasts and the increasing financial challenges facing the NHS. [§§] The merged entity may find that it has a lower capital budget than originally anticipated (for example, if the merged entity does not achieve planned surpluses which will be dependent on a significant level of CIPs—see Appendix B, paragraph 41) and as a result some of its planned capital expenditure may no longer be affordable. We note that PH included building a new maternity unit in its application for foundation trust status in 2007 (and this had been discussed by PH for several years prior to that application) but this did not occur for reasons that were outside its control and unforeseen at the time its foundation trust application was prepared. We asked for five-year forecasts of the merged entity (as Monitor would require as part of its risk assessment of the merger²⁴), but the parties told us that at this stage they had not forecast performance beyond FY 2015/16. We note that the merged entity is currently forecasting a [§§] in 2014/15 and a [§§] in 2015/16 (see further Appendix B). As noted in Appendix B, paragraphs 32 to 34 in relation to PH's forecasts, forecasts are highly sensitive to the underlying assumptions and small changes in assumptions can alter the forecast deficits.
- (d) The new unit is currently predicted to cost approximately [£31–£40] million (which represents approximately [21–26] per cent of the merged entity's total planned capital expenditure over five years). This figure is a high-level estimate and could prove to be an underestimate. We note that at the time of Monitor's review of the benefits case the estimated cost of investing in the maternity unit to allow the consolidation of the PH and RBCH units was £15–£30 million.
- (e) The level of savings that the parties told us would be delivered through changes to maternity services (£[§§] million—see paragraph 29) is relatively low compared with the significant capital investment required in a new maternity unit (approximately [£31–£40] million). We understand that the associated savings will not be a key incentive for the merged entity to proceed with the project. However, the level of savings may be increasingly relevant to the merged entity should the board need to consider the best use of resources in a cash-constrained environment.
- (f) The financial case also depends on the revenue effects of the proposal. The parties told us that they would expect to see more mothers attracted to the new maternity unit—which presumably increases the financial attractiveness of the new unit. However, in the absence of a draft business case we are unable to place significant weight on this. See paragraph 6.303 for our competitive assessment for maternity.

²⁴ As noted in paragraph 3.4, footnote 46, the parties are required to provide a business case (noting any reconfiguration of services) and a long-term financial model, exhibiting financial forecasts for the combined entity for a period of five years, as part of their application to Monitor regarding the merger.

53. Our conclusion on whether it was likely that, in the event that the merger proceeds, the new maternity unit would be built within a reasonable period is based on the following key considerations (set out in detail above):
- The challenging financial environment is likely to put a strain on the revenue budget of the merged entity with a knock-on effect on the capital budget (see paragraph 52(c) above). In such an environment the board of the merged entity is likely to focus on capital investments which deliver not only quality improvements, but also net revenue benefits.
 - The parties do not at this stage have a clear plan for the new maternity unit and have not prepared their analysis of the proposed investment, so the issues of where clinically interdependent services should be located have not yet been resolved (see paragraph 48 above). We would expect the plans to consider the configuration of maternity services across the whole area (see paragraph 51 above).
 - The maternity unit investment is not currently anticipated to deliver a significant level of savings and we have seen limited detail of the revenue effects as the plan has not yet been fully developed (see paragraph 52(e) and 52(f) above).
 - The current investment in the refurbishment of the existing maternity unit at PH (see paragraph 7 above) means that a new maternity unit is not required immediately and, as noted above, the required planning has not yet taken place. It will take time to undertake this analysis which will be required in order for the board of the merged entity to take a decision whether to commit to the investment.
54. Given all of these factors, we therefore did not find that, in the event that the merger proceeds, it was likely that the new maternity unit would be built within a reasonable period.

Finding on possible RCB—maternity

55. As set out in paragraph 40, we found that the new maternity unit proposed by the parties would be a benefit to patients in the form of higher quality of maternity services. We did not find that a single managed maternity rota would be a benefit to patients (see paragraph 41).
56. As noted in paragraph 45, we did not consider that, absent the merger, PH would find and invest the amount of money required to finance the new unit; nor did we consider it likely that a new unit would be built at RBCH; we therefore concluded (see paragraph 42) that this benefit is unlikely to accrue absent the merger.
57. However, we did not find that, in the event that the merger proceeds, this benefit could be expected to accrue within a reasonable period (despite the fact that a five-year period would be a reasonable period within which to realize a project of this scale).
58. We have therefore concluded that the maternity benefit is not a relevant customer benefit.

Cardiology

59. Cardiology is one of the parties' largest services, treating 33,000 patients each year, 9,000 of which are inpatients.²⁵ Cardiology services at RBCH and PH are primarily commissioned by Dorset CCG.
60. RBCH has four cardiac catheter laboratories which enable it to carry out urgent and planned interventional cardiology such as primary percutaneous coronary intervention (PPCI). Patients at PH requiring PPCI are transferred to RBCH. PH has two stress echo specialists²⁶ and some patients are sent from RBCH to have (outpatient) stress echo at PH. Patients with acute cardiac problems are currently admitted to both PH and RBCH (with the exception of patients who require PPCI who are admitted only to RBCH).²⁷
61. RBCH has two dedicated cardiology rotas: one rota provides general cardiology care while the other rota specialises in PPCI. These rotas are made up of a total of ten cardiology consultants and provide an emergency cardiology service 24 hours a day, seven days a week (on-call 'out of hours', ie in the evenings and at the weekends).²⁸
62. PH does not have a dedicated cardiology rota and instead employs four cardiologists who are part of the general medical rota. There is no consultant cardiology cover for [70–75] per cent of out-of-hours time.²⁹

Benefit proposed by the parties—cardiology

63. The parties told us that, following the merger, cardiology services would continue to be provided from both sites³⁰ but (a) a single dedicated rota of cardiologists would span the two sites,³¹ and (b) acute cardiac inpatient admissions would be consolidated at RBCH.
64. The parties said that the creation of a single cardiology rota would allow out-of-hours cardiology cover to be extended to the PH site including consultant ward rounds at the weekend.³²
65. The parties told us that general medical rotas across the merged entity would be re-organized to allow the PH cardiologists to be released from the general medical rota which would ensure out-of-hours cardiology cover from Monday to Friday between 18.00 and 8.00. The parties said that the weekend cardiology cover (ie from Friday 18.00 to Monday 8.00) would be provided by the four PH cardiologists on two weekends out of three and that RBCH cardiologists would provide remote cover and undertake ward rounds at both PH and RBCH on one week out of three. The RBCH PPCI rota would remain unchanged.
66. The parties told us that a single cardiology rota would be achieved by changing the working times of a total of 50 medical staff across the merged entity.³³ RBCH said that this would be possible as RBCH physicians currently did significantly less 'out of hours' on-call than PH physicians.

²⁵ Benefits of the merger, 26 July 2013.

²⁶ Relevant customer benefits submission, 12 February 2013.

²⁷ Benefits of the merger, 26 July 2013.

²⁸ Relevant customer benefits submission, 12 February 2013.

²⁹ ibid.

³⁰ Benefits of the merger, 26 July 2013.

³¹ Relevant customer benefits submission, 12 February 2013.

³² Benefits of the merger, 26 July 2013.

³³ ibid.

67. The parties told us that a single cardiology rota would result in more rapid access to cardiology expertise, investigation and procedures for out-of-hours patients currently presenting at PH.
68. The parties cited national evidence which supported the argument that patients treated by cardiology teams, as opposed to general medical teams, had lower mortality rates and better follow-up care. The parties told us that evidence showed that admission of acute coronary syndromes (ACS) patients directly to the care of a cardiologist compared with admission under any other consultant specialty resulted in a 14 per cent reduction in mortality risk.³⁴ In this paper the authors found that the mortality risk for patients admitted for all infarctions³⁵ under cardiologists compared to those admitted under non-cardiologists is consistently lower.
69. The parties told us that in NSTEMI³⁶ patients, mortality risk was 20 per cent lower and the risk of reinfarction³⁷ fell by 26 per cent when they were admitted directly to the care of a cardiologist compared with admission under any other consultant specialty.³⁸ We noted that the parties based their evidence on a study which concluded that patients with NSTEMI admitted under non-cardiologists were older and with more comorbidities, were less likely to receive guidelines-recommended treatments and invasive procedures and had a higher risk of mortality compared with patients admitted under the care of cardiologists. Therefore, the authors noted that because of confounding factors in their analysis—eg hospital characteristics and ‘type’ of patients treated by cardiologists relative to non-cardiologists—it was difficult to determine accurately the associations between cardiology care and treatment and outcomes for patients.
70. In addition, the parties stated that there was considerable evidence that patients with cardiac problems benefited from rapid specialist assessment and diagnosis. The parties told us that this was supported by the British Cardiovascular Society Working Group on Acute Cardiac Care which recommended that patients presenting with acute cardiac conditions should be managed by a specialist, multi-disciplinary cardiac team and have access to key cardiac investigations and interventions, at all times.
71. The parties also told us that releasing PH’s cardiologists from the general medical rota and allowing them to focus purely on cardiology work would allow those cardiologists to become more specialised which would further enhance clinical outcomes for patients.³⁹
72. The second change to cardiology services proposed by the parties post-merger relates to consolidating acute cardiac inpatient admissions at RBCH. The parties told us that, post-merger, changes in pathways would mean that patients with acute cardiac problems requiring admission would be admitted only by RBCH. The effect would be that approximately 400 patients a year would be treated at RBCH rather than PH.

³⁴ Birkhead et al, [Impact of specialty of admitting physician and type of hospital on care and outcome for myocardial infarction in England and Wales during 2004-05](#), BMJ, 2006, 332, pp1306-11.

³⁵ Myocardial infarction is the medical term for a heart attack, as commonly known, which is usually caused by a blood clot that can totally or partially stop the blood flowing to the heart.

³⁶ Non-ST segment elevation myocardial infarction (a type of ACS).

³⁷ An acute myocardial infarction (heart attack) that occurs within 28 days of an incident or recurrent myocardial infarction.

³⁸ Roe, Chen, Mehta et al, [Influence of inpatient service specialty on care processes and outcomes for patients with non ST segment elevation acute coronary syndromes](#), Circulation, 2007, 116(10), 1153-61.

³⁹ [Benefits of the merger](#), 26 July 2013.

73. The parties told us that consolidation of acute cardiac inpatient admissions would have two benefits: (a) RBCH was better equipped than the PH site and (b) RBCH would experience a higher volume of patients which would allow further specialisation of cardiologists.⁴⁰
74. RBCH noted that although this would result in some patients having to travel further, this would normally be in an ambulance due to the nature of the services.
75. The parties also told us that the proposed changes would improve their ability to recruit, as a modern cardiology service including a comprehensive and high-volume invasive site and out-of-hours cardiology (rather than general medical) care was more attractive to potential new consultants and trainees.
76. Dorset CCG stated that there would be benefits to patients in terms of:
- (a) the increase in specialist cover would ensure cardiologist cover 24/7, thus improving experience and outcomes for patients (PH was currently not a 24/7 cardiology rota);
 - (b) improved links and integration with other local providers; and
 - (c) acute cardiac problems centralized in the hub reduced transfers between sites, reduced waits for necessary treatments and reduced double charging to the commissioners.
77. In addition, Dorset CCG told us that it hoped the merger would enable greater clinical debate between cardiologists across the two sites as the RBCH cardiologists were believed to have a more interventionist approach than those at PH.
78. Dorset CCG also told us that it would like post-merger to see a reduction in delayed transfers of care of cardiology patients between PH and RBCH (currently seven to nine days).
79. The parties told us that The King's Fund was coordinating a review of consecutive PPCI cases that had been planned by RBCH and Dorset CCG and would involve the British Cardiovascular Intervention Society (BCIS). The parties told us that the review had not started yet and BCIS was yet to agree the terms. RBCH told us that it expected the BCIS review to take three months and that the outcomes of this review would not impact the merged entity's ability to create a single cardiology rota.
80. The parties said that commissioners had no intention of carrying out a structural review of cardiology services in the near future.⁴¹
81. The parties told us that, absent the merger, PH would not be able to release its cardiologists from the general medical rota as this would destabilize this rota and reduce cover.⁴² The parties said that there was no spare medical consultant capacity at PH to backfill the general medical rota (if the cardiologists were to be released from the general medical rota to create a separate cardiology rota).
82. PH told us that to increase cardiologist cover it would require at least three cardiologists which would cost approximately £0.5 million, which PH could not fund absent the merger. In addition, the parties told us that this outcome would be suboptimal as

⁴⁰ [ibid.](#)

⁴¹ [Relevant customer benefits submission](#), 12 February 2013.

⁴² [Benefits of the merger](#), 26 July 2013.

it would lower the volume of cases that each cardiologist saw and therefore reduce the skill level of all cardiologists.⁴³

83. The parties said that, absent the merger, it would not be in RBCH's financial interests or the interests of its current catchment population simply to support the PH service out of hours.
84. The parties told us that the complexity of the changes required to the general medical rotas across the two sites was part of the reason why these changes were merger-dependent. Given that the parties told us that they already shared rotas in other areas (see paragraph 89 below), we requested, but they did not provide, worked examples or to explain why cardiology rotas should be so complex. We were told that 'the degree of collaboration required across disciplines is too great to be feasible as two organisations'.
85. In relation to consolidation of acute cardiac inpatient services at RBCH, we noted that some patients have already been diverted to RBCH from PH, suggesting that it may be possible for this change to be effected without merger. The parties told us that since October 2012 approximately 200 patients a year who would previously have been admitted to PH now came directly to RBCH.
86. However, the parties told us that, absent the merger, PH would not voluntarily give up its acute cardiology work as this would lead to a loss of revenue and follow-on activity. It also could not give up its cardiologists since it would not be able to run an A&E without cardiology input.⁴⁴
87. Dorset CCG stated that 'absent of merger both parties would wish to retain cardiology services and would seek to cover their own rotas as their first priority before seeking to cover a neighbouring Trusts'.
88. The parties told us that commissioners would not be able to replicate the merger benefits because they would need to reorganize a large number of services to release cardiologists at PH from the general medical rota.⁴⁵ The parties said that they did not believe that commissioners had the leverage to drive clinical reconfiguration or shared rotas.
89. The parties stated that they already shared clinical rotas in A&E, obstetrics and orthopaedics. They also told us that there was a shared transient ischaemic attack 'mini-stroke' rota at weekends between RBCH, PH and Salisbury NHS Foundation Trust. The parties said that in deciding whether to share rotas they considered whether there was a financial penalty to sharing consultants (ie a loss of activity) and/or a mutual gain, and that this was not true in cardiology where only one party gained. Dorset CCG told us that these shared rotas were 'reliant on goodwill'. We also noted that the parties already share consultants in a large number of services (see paragraph 6.133).
90. The parties told us that the improvements to cardiology cover could be enacted without public consultation as there was no loss in service on either site.
91. The parties said that reconfiguration would allow savings of £[~~£~~] million to be realized and costs of £0.5 million to be avoided (see paragraph 288).

⁴³ Relevant customer benefits submission, 12 February 2013.

⁴⁴ Benefits of the merger, 26 July 2013.

⁴⁵ ibid.

92. The benefits of the proposed changes to cardiology post-merger are predominantly to those currently admitted to PH with an acute cardiac problem or patients at PH needing a cardiac opinion out of hours. We asked the parties to quantify the precise number of patients benefiting from the proposed changes to cardiology services but this was not provided to us.
93. The parties told us that they would achieve these changes within a year following the merger.⁴⁶
94. We received evidence from third parties (including the MP for Christchurch) that stated that it was not clear that the cardiology reconfiguration was merger-specific and that a joint cardiology rota would be likely whatever the outcome of the merger inquiry. Two anonymous responses to our provisional findings claimed that the cardiology benefits were not dependent on the merger. In the first, dated 14 July 2013, 'a concerned party' stated that cardiology out-of-hours consultant cover 'can easily happen without merger ... there are plans to deliver this service even if the two hospitals do not merge'. The second letter from 'a member of staff' and dated 15 July 2013 stated that 'a single rota of cardiologists across the two sites would not require the trusts to merge and is likely to be developed whatever the outcome of your enquiry'.

Monitor assessment of benefit—cardiology

95. Monitor found that there was strong evidence which supported the clinical benefits to patients of early review and specialist input by a cardiac expert, and indicated that this should be available on a round-the-clock basis.⁴⁷
96. Monitor noted that commissioners had requested that BCIS undertake a review of the local cardiac service which Monitor believed would be likely to have an impact on patient pathways and activity levels and would determine the nature of any reconfiguration required.⁴⁸
97. Monitor's view was that the parties' proposed reconfiguration of cardiology services was likely to deliver RCBs in the form of improved quality of service by providing increased out-of-hours consultant cover to patients at PH. Monitor noted that these benefits were likely to be time limited (only apply until any broader reconfiguration of patient pathways that occurred following the BCIS's review) and only affect a limited category of patients.⁴⁹
98. Monitor did not agree with the parties' submission that the merger would reduce the number of patients transferred from PH to RBCH and eliminate the duplicative fees associated with the double admission of these patients, as the majority of these (over 95 per cent) would be directly admitted to RBCH regardless of the merger, pursuant to the plans of the Dorset Network Cardiovascular Clinical Commissioning Group.⁵⁰
99. Monitor did not agree with the parties' submission that the merger would increase the merged entity's ability to attract trainees and qualified staff due to the integration of services across both sites. Monitor noted that PPCI services would continue to be offered from one site only post-merger. The parties submitted to Monitor that there were particular strengths of the cardiology department at PH, especially in stress

⁴⁶ Relevant customer benefits submission, 12 February 2013.

⁴⁷ Monitor's advice to the OFT under section 79(5) of the Health and Social Care Act 2012, 11 February 2013.

⁴⁸ *ibid.*

⁴⁹ *ibid.*

⁵⁰ *ibid.*

echo and academic research which were both lacking at RBCH, and which may be attractive to cardiologists in training and to physiologists. However, in Monitor's view there were many factors that might be relevant to attracting trainees and qualified staff and it was not clear to Monitor what the impact of stress echo and academic research was for recruitment, particularly in light of the reduction in the scope of cardiology services provided from PH that would result from the proposed reconfiguration.⁵¹

CC assessment of benefit to patients—cardiology

100. We found evidence that improving cardiology cover would be a benefit to patients in the form of higher-quality services (see paragraph 67 above), although we noted that the evidence cited by the parties on ACS patients) is not directly relevant to this case, as we understand ACS patients are already directly admitted to RBCH and therefore already benefit from 24/7 cardiology cover.
101. In respect of the consolidation of acute cardiac inpatient admissions at RBCH, we did not find that the statutory test of an RCB was met because the proposed consolidation of acute cardiac inpatient admissions may accrue absent the merger—see paragraph 107 below. We therefore did not find it necessary to conclude whether this proposal would be a benefit to patients.
102. In line with Monitor's conclusions, we also did not find that there would be a benefit in the form of the ability of the merged entity to recruit. The parties have not provided evidence of any current recruitment difficulties in cardiology or details of how the proposed reconfiguration would affect recruitment post-merger.

CC assessment of whether the statutory test is met—cardiology

103. Although we recognize that the merged entity would not be a solely profit-maximizing entity, we nevertheless consider that, as the cardiology reconfiguration is expected to deliver savings of £[§] million and limited capital investment is required, this is likely to incentivize the merged entity to reconfigure cardiology services post-merger to deliver the clinical benefits.
104. We therefore find that this benefit would be likely to accrue in the event that the merger proceeds and we consider that the proposed timescale for rota reconfiguration (within a year of the merger) would result in benefits accruing within a reasonable period.
105. As noted in paragraph 84 above, we have not been provided with the evidence or reasoning to explain why reconfiguring the cardiology rotas is so complex that it would not be undertaken in any event. We note that the parties have been able to reconfigure rotas in other services without merger, for example their stroke rotas (see paragraph 89 above). We understand that it may be difficult to reconfigure rotas due to the significant number of doctors whose rotas would be affected. However, in our view, if there is a clear clinical benefits case, it is not clear to us why this rota reconfiguration would not be likely to be implemented in the absence of the merger. We also note that the parties stated that there were £[§] million⁵² of merger savings associated with cardiology reconfiguration, compared with a cost of £0.5 million for PH to increase cardiology consultant cover without the merger. There may therefore

⁵¹ *ibid.*

⁵² £[§] million of these savings relate to reductions in length of stay arising from the consolidation of acute cardiac inpatient admissions at RBCH (see paragraph 258(g)).

also be a financial benefit to the reconfiguration of rotas which would enhance the case for change, with or without the merger, although we note that this financial benefit is relatively small.

106. For the reasons noted in paragraph 105 above, we therefore did not find that this benefit would be unlikely to accrue absent the merger..
107. In respect of the consolidation of acute cardiac inpatient admissions at RBCH, we noted that Monitor had found that this benefit might not be merger specific, and since Monitor's review the parties had already implemented some of the proposed changes without a merger (see paragraph 85 above). We therefore found that the proposed consolidation of admissions may accrue absent the merger.

Finding on possible RCB—cardiology

108. We concluded that the proposal to reconfigure cardiology rotas would benefit patients and would be likely to accrue in the event that the merger proceeds but did not find that the benefit would be unlikely to accrue absent the merger. In respect of the consolidation of acute cardiac inpatient admissions at RBCH, we noted that Monitor had found that the majority of this benefit would accrue regardless of the merger, and since Monitor's review the parties had already implemented some of the proposed changes without a merger (see paragraph 85 above). We therefore did not find that the proposed consolidation of acute cardiac inpatient admissions would be unlikely to accrue absent the merger.
109. We therefore concluded that the cardiology benefit proposed by the parties is not an RCB.

Haematology

110. Currently both parties provide inpatient, outpatient and day-case haematology services. In total, the parties currently serve around 1,500 haematology inpatients a year.⁵³
111. The most complex types of haematology services that the parties provide are often referred to as 'level 3' care and primarily comprise bone marrow transplant. Both parties currently provide separate level 3 haematology services.
112. Bone marrow transplant services at RBCH and PH are commissioned by the NHS England (Wessex). Other haematology services are primarily commissioned by Dorset CCG.
113. The parties told us that there were national recommendations on the scale necessary to provide cancer services. According to the National Cancer Action Team, the recommended minimum efficient scale for establishing a haemato-oncology cancer service is a population of 500,000.
114. The parties told us that at present neither PH nor RBCH had a sufficient number of patients to reach the recommended minimum efficient scale for provision of level 3 haematology services.⁵⁴

⁵³ Relevant customer benefits submission, 12 February 2013.

⁵⁴ ibid.

Benefit proposed by the parties—haematology

115. The parties told us that consolidating the level 3 services only would leave the level 2 service at an unsustainable level, therefore consolidating the level 3 services following clinical recommendations would automatically entail consolidating the level 2 services as well.
116. The parties said that there were three possible options for the configuration of haematology services post-merger:
 - (a) subject to an agreed derogation with specialist commissioners, maintaining inpatient haematology services at both RBCH and PH; or
 - (b) consolidating inpatient haematology services (levels 2 and 3) at PH with the provision of a ‘spoke’ service (outpatient and day-case services) at RBCH; or
 - (c) consolidating inpatient haematology services at RBCH with the provision of a spoke service at PH.
117. The parties told us that in each of the scenarios there would be no change for patients requiring more routine care (eg day-case and outpatients or level 1 haematology), as these services would continue to be provided on both sites.
118. The parties said that their preferred option was to consolidate their inpatient haematology (ie level 2 and level 3) at one site following the merger.⁵⁵ They told us that, in line with national recommendations, the haematology malignancy diagnostic service (a specialised laboratory service) which was currently at RBCH would be co-located with the inpatient haematology service. Therefore this service would need to move from RBCH to PH in the event that PH was selected to be the hub. The parties have been unable to confirm that the full costs of resiting this service (in the scenario that the hub is at PH) are included in the draft capital programme of the merged entity.
119. The parties told us that the consolidation of inpatient haematology services would involve creating a combined haematology consultant rota which would improve senior cover.⁵⁶ There would be a consultant haematologist at the inpatient hub to see complex patients every day of the week.
120. In addition, the parties said that the merged entity’s consultants would treat greater patient volumes as a group which was likely to result in greater specialisation. This was a benefit to patients as they would be seen by a consultant and clinical nurse specialists with a specialist interest in their condition.⁵⁷
121. The parties also told us that some duplication of work between the two sites (eg transplant quality management or educational programmes for staff) would be avoided, allowing clinical staff to spend more time doing clinical work resulting in a better patient experience and higher patient volumes being seen.⁵⁸
122. The parties told us that another benefit of consolidation of inpatient haematology services was that R&D between the two sites would be rationalized, which would

⁵⁵ [Benefits of the merger](#), 26 July 2013.

⁵⁶ [Relevant customer benefits submission](#), 12 February 2013.

⁵⁷ *ibid.*

⁵⁸ *ibid.*

increase the number and availability of clinical trials on offer to patients and release savings of £[§] a year to reinvest into care.⁵⁹

123. The parties told us that these benefits would accrue regardless of location. However, PH is deemed to be a better ‘hub’ than RBCH due to the lower cost (capital costs being [£1–£10] million lower than if the hub was at RBCH) and additional clinical benefits from collocation with complex oncology at PH. Collocation with complex oncology would allow the creation of a joint three-tier on-call rota of consultants, registrars and junior doctors and increase the availability of specialised nurses. This would improve expert overnight cover for both haematology and oncology (to the benefit of a further 1,700 inpatients each year). Co-location with oncology will also allow the parties to release a significant efficiency by closing one of the two aseptic pharmacies.⁶⁰
124. The parties’ preferred option for the configuration of haematology services post-merger (hub at PH, spoke at RBCH) was consistent with the conclusion of the Outline Business Case prepared in June 2012 by the joint East Dorset Haematology Service Project, which was set up by the parties and commissioners to develop a proposal for the best possible, sustainable haematology service across east Dorset.⁶¹
125. Dorset CCG told us that PH was the preferred site for the haematology hub to ensure co-location with cancer services.
126. If services are reconfigured as proposed by the parties, patients currently receiving inpatient services at RBCH would potentially have to travel further to PH. However, the parties told us that in the absence of the merger, patients would have to travel even further as services would be located outside Dorset—see paragraph 134.
127. Dorset CCG stated that there would be benefits to patients in terms of:
 - (a) improved quality and outcomes for level 3 patients as increased senior clinical cover and with the combined haematologist numbers would support expansion of specialism;
 - (b) services would stay within Dorset—should commissioners wish to proceed with procurement of level 3 inpatient services, there was a risk that the optimum service would lay outside Dorset (absent of merger); and
 - (c) improved physical environment, as capital investment would be made [§].
128. However, NHS England (Wessex) told us that both parties had recently self-assessed themselves as meeting the relevant standards for level 3 haematology services and therefore it, as commissioner of these services, had no immediate plans to reconfigure or tender these services.
129. We asked the parties for copies of what NHS England (Wessex) had requested from them and for their self-assessments. The parties did not provide these. They provided summaries of their JACIE⁶² reports for level 3 transplant services, noting that this accreditation did not cover all level 3 haematology services. Both trusts received

⁵⁹ *ibid.*

⁶⁰ *ibid.*

⁶¹ *ibid.*

⁶² The Joint Accreditation Committee-ISCT (Europe) & EBMT is a non-profit body established in 1998 for the purposes of assessment and accreditation in the field of haematopoietic stem cell transplantation.

JACIE accreditation in 2012 and we noted that these accreditations did not contain a recommendation as to minimum number of patients treated.

130. The parties told us that it was possible for the commissioner to lead the reconfiguration process but the requirement for capital investment would still remain.
131. The parties and [X].⁶³
132. The other configuration options considered by EDHS were:
 - (a) Do nothing. This option was the cheapest in terms of capital and operational expenditure but was dismissed as it would not deliver the desired level of care.
 - (b) Consolidate all haematology services at one site, preferably at PH due to this being the site of radiotherapy services. This option was dismissed as it would go against the commissioner's objective of providing care closer to home.
 - (c) Create a hub at RBCH and a spoke at PH.⁶⁴
133. The parties told us that, absent the merger, RBCH would not bid to provide these services as the capital investment would be very high (approximately £11–£20 million) and the return on that investment would be uncertain (its haematology services are increasingly loss making, with a loss of £[X] million in 2012/13).⁶⁵
134. The parties said that if neither of the two trusts was able or willing to offer those services, the commissioners would have to commission them from outside Dorset, most likely from [X].⁶⁶ However, the position of NHS England (Wessex) (see paragraph 128) suggests that this is an unlikely outcome.
135. The parties told us that this would not be ideal for patients receiving these services because the patients affected were often children and young people who required lengthy stays in isolation units. It was very important for these patients to receive visits from their friends and family, which would be considerably more difficult if the service were moved outside Dorset.
136. In addition, to the parties' knowledge, [X] would not have the capacity to provide these services.⁶⁷
137. The parties told us that it might in theory be possible to deliver some aspects of the benefits of the consolidation of the haematology service without the merger, but not all or on the same timescale.
138. The parties told us that £1–£10 million would be invested if the hub was located at PH and that this was within the draft capital programme of the merged entity. They said that this investment might be seen as of lesser importance than the proposed investments in maternity and A&E, as it would benefit the smallest number of patients.
139. The parties stated that the proposed changes to haematology services were expected to deliver savings of £[X] million.

⁶³ Relevant customer benefits submission, 12 February 2013.

⁶⁴ ibid.

⁶⁵ ibid.

⁶⁶ ibid.

⁶⁷ ibid.

140. The parties told us that they would deliver the benefits of reconfiguration of haematology services within two years following the merger.⁶⁸

Monitor assessment of benefit—haematology

141. Monitor found that commissioners had identified a clear rationale for delivering certain haematology services from a single site for the area, with benefits from having out-of-hours access to certain highly specialist services for cancer patients.⁶⁹
142. Monitor was not satisfied that the benefits to patients of a consolidated level 3 service would be unlikely to accrue without the merger, given the well-developed commissioner plans to consolidate certain haematology services in the area. In addition, Monitor believed that, as commissioners had not yet identified which facility should host the inpatient haematology service, the parties' proposal to centralize services at PH may conflict with commissioner plans if ultimately a different site for the level 3 facility was chosen.⁷⁰
143. Monitor found that the parties' proposed reconfiguration of haematology services did not deliver RCBs (in the form of improved quality of haematology services by providing services at a centre of excellence) because these benefits were likely to be delivered by commissioner-led reconfiguration of haematology services.
144. Monitor did not agree that, absent the merger, commissioners would lose the choice of locating the haematology service at PH. It believed that in the absence of the merger it would be for PH to assess whether the potential revenue from providing the service warranted investment in expanding its facility to bid on a stand-alone basis. Alternatively, it would be possible for PH to bid jointly with another provider (for example, RBCH) to operate the service.⁷¹
145. It was Monitor's view that it was for commissioners to decide which provider was the best placed to provide the service. Improving PH's ability to bid for the service did not, in Monitor's view, constitute an RCB. Monitor's view was that the parties' proposed reconfiguration of haematology services was not an RCB as it was not specific to the merger and was likely to occur regardless of the merger.⁷²

CC assessment of benefit to patients—haematology

146. The business case prepared by EDHS in June 2012 (see paragraph 124) includes the clinical case for reconfiguration. This case was accepted by the trusts and the commissioners at that time and consequently we consider that there may be benefits to patients in the form of higher-quality services from the proposed reconfiguration.
147. However, it is unclear to us whether this benefits case is up to date and what the scale of the clinical benefits are, in light of the evidence from NHS England (Wessex) that the parties now both meet the relevant standards for level 3 haematology services and that no reconfiguration is necessary in the immediate term (see paragraph 128 above). This impacted on our assessment of the likelihood of reconfiguration of haematology services in the event that the merger proceeds.

⁶⁸ *ibid.*

⁶⁹ Monitor's advice to the OFT under section 79(5) of the Health and Social Care Act 2012, 11 February 2013.

⁷⁰ *ibid.*

⁷¹ *ibid.*

⁷² *ibid.*

CC assessment of whether the statutory test is met—haematology

148. Due to the clinical benefits of collocating haematology inpatient services with oncology services at PH and the cost implications of centralizing haematology inpatient services at RBCH compared with PH, we did not consider it likely that the ‘hub’ will be at RBCH.
149. We have therefore considered whether the benefits of a hub-and-spoke model with the hub at PH may be expected to accrue within a reasonable period as a result of the merger and whether that benefit is unlikely to accrue absent the merger.
150. We considered that the proposed timescale for reconfiguration (within two years of the merger) constituted a reasonable period.
151. We did not consider that PH would be able to finance the haematology capital investment absent the merger. In addition, the position of NHS England (Wessex), as set out in paragraph 128, suggests that commissioners are unlikely to lead reconfiguration of haematology services. We therefore concluded that the benefits were unlikely to accrue absent the merger.
152. We received conflicting evidence on the extent to which the parties’ current haematology services meet the required standard. The quality of their current provision (and the commissioner’s perception of its quality) directly affects the likelihood that the trusts would reconfigure their haematology services, with or without the merger. Given the conflicting evidence, we did not find that the parties would have a strong incentive to reconfigure haematology services if the merger proceeded.
153. The evidence we received from NHS England (Wessex) indicated that it would not be driving any reconfiguration. We noted that this evidence is different from the information provided to Monitor by South West Specialist Commissioning Team (a predecessor of NHS England (Wessex)) at the time of its report. In addition, the parties may consider this reconfiguration to be of lesser importance given the small number of patients affected (see paragraph 138 above); we also noted that cost savings associated with the proposal were low relative to the expenditure that would be required. Overall, we do not have sufficient confidence that the parties will proceed with the reconfiguration. We therefore did not find it likely that the benefits would accrue in the event that the merger proceeds.

Finding on possible RCB—haematology

154. We consider that there may be benefits to patients from the proposed reconfiguration of haematology services and concluded that these benefits are unlikely to accrue absent the merger. However, we did not find that the benefits would be likely to accrue in the event that the merger proceeds. We have therefore concluded that the haematology benefit is not an RCB.

A&E

155. At present, both RBCH and PH provide A&E services. RBCH treats around 64,000 patients a year (of which approximately 20,000 are major injuries⁷³) and PH, which is

⁷³ The parties noted that there was no definition of ‘major injuries’ and they believed that the proportion of major injuries at RBCH was similar to PH.

a designated trauma unit for East Dorset,⁷⁴ treats around 59,000 (of which approximately 29,000 are major injuries). They employ five full-time equivalent (FTE) consultants each (and are in the process of recruiting one additional consultant each) and provide consultant cover of 12 hours per day during the week and 3 or 4.5 hours per day during the weekend on alternate weekends (consultant cover will increase to 9 hours at the weekend once the sixth consultant at each trust is in post). Outside these hours, consultant input is provided on an on-call offsite basis under a shared rota.⁷⁵

156. A&E services at RBCH and PH are primarily commissioned by Dorset CCG.

Benefit proposed by the parties—A&E

157. The parties told us that the merger would lead to one of the following two outcomes:
 - (a) maintaining the current model of provision at both sites with one closing at night; or
 - (b) maintaining two A&E departments but with consultant expertise concentrated on one site which would focus on the most serious emergency cases (major injury A&E); the other being a location for minor injury services but with the facility for the admission of medical emergencies (minor injury A&E). The parties said that the minor injury A&E would be staffed primarily with nurses with input from GPs and remote oversight by A&E consultants situated at the major injury A&E.⁷⁶
158. The parties told us that option (b) was their preferred configuration of services post-merger.⁷⁷
159. The parties said that this reconfiguration would be possible at both sites and that the sites of the major and minor units had not yet been decided. They told us that they were currently undertaking work to ascertain which site would be more suitable and develop consultation proposals.⁷⁸
160. As set out in paragraph 19, the parties prepared an Integrated Estate Strategy which evaluates a number of different service and estate configuration options for the merged entity, including the types of changes required to reconfigure A&E (for example, clinical interdependencies and impact on theatre capacity). In the base case option of this strategy, the major injury A&E unit is at [☒].
161. The parties told us that the required physical capacity changes to create a major injury A&E were relatively limited as the reconfiguration was expected to improve patient flow and turnaround times.
162. The parties said that PH and RBCH could both expand their emergency departments for larger resuscitation and trolley assessment areas. A cost of [£1–£10] million has been assumed in the Integrated Estates Strategy for this expansion, regardless of whether the major injury A&E unit is located at RBCH or PH. The parties told us that the [£1–£10] million cost was a high-level ‘ball-park’ estimate and that a full-depth costing analysis would be likely to produce slightly different estimates for these costs,

⁷⁴ From April 2012, PH was designated a trauma unit (second tier trauma provider) within the Wessex Trauma Network, with SUHT as the local major trauma centre (the highest level centre).

⁷⁵ [Relevant customer benefits submission](#), 12 February 2013.

⁷⁶ *ibid.*

⁷⁷ [Benefits of the merger](#), 26 July 2013.

⁷⁸ [Relevant customer benefits submission](#), 12 February 2013.

depending on the choice of location for the major injury A&E unit. In practice, siting the major injury A&E unit at PH may well require more investment due to the clinical adjacencies required (ie co-location of vascular surgery, urology and complex elective surgery).

163. The parties said that although capital expenditure plans for the merged entity had not been prioritized, improving A&E consultant cover (which the parties expected to achieve through the proposed reconfiguration) was considered of the ‘utmost importance’.
164. The parties have not told us that there are any specific savings that will be delivered through the reconfiguration of A&E services. The parties said that costs of [£1–£10] million would be avoided through the proposed reconfiguration—see paragraph 288 below.
165. The parties stated that there were a number of services that needed to be co-located with a major injury A&E and would need to move if they were not already located at the site chosen to be the major injury A&E. If PH was selected as the major injury A&E site, vascular surgery and urology surgery would have to move to PH from RBCH. If RBCH was selected as the major injury A&E site gynaecology, paediatrics and trauma would need to move to RBCH from PH. In both cases, the site with the major injury A&E would also keep complex elective surgery while the other site would lose this type of activity. As set out in paragraph 211 onwards, the parties proposed to consolidate emergency surgery and co-locate this service with the major injury A&E.⁷⁹
166. The cost estimate does not include the resiting of interrelated services. PH told us that the capital cost of moving interrelated services would be a consideration in determining the location of the major injury A&E unit. The base case in the Integrated Estate Strategy (which assumes that the major injury A&E unit is at [☒]) includes [£1–£10] million and [£1–£10] million to relocate [☒], respectively, from [☒] to [☒]. It also includes [£1–£10] million to increase [☒] capacity at [☒]. These costs are expected to be incurred in years 5 and 6 after the merger.
167. The parties told us that the proposed model of care—allowing the concentration of consultants predominantly on one site, enabling the development of one major accident and two minor accident units—was in line with current national thinking on the future of emergency services as set out in ‘High Quality Care for All, Now and For Future Generations: Transforming Urgent and Emergency Care Services in England’ (NHS England 2013).
168. This document sets out the evidence base for the review of urgent and emergency systems in England and illustrates the main challenges to provision of these services. It concludes that ‘there is a clear need to adopt a whole-system approach to commissioning more accessible, integrated and consistent urgent and emergency care services to meet patients unscheduled care needs’ but does not set out how this will be achieved.⁸⁰
169. Specifically in relation to A&E departments this document notes that:
 - (a) Proper staffing is the single most important factor in providing high-quality care.

⁷⁹ *ibid.*

⁸⁰ [High Quality Care for All, Now and For Future Generations: Transforming Urgent and Emergency Care Services in England](#), NHS England 2013, p73.

(b) There is an issue with care being provided by inexperienced junior doctors.

(c) There is clear evidence of the benefits of consultant-delivered care but there is a shortage of emergency medicine trained senior doctors (middle grade and consultant).⁸¹

170. The NHS Medical Director Professor Bruce Keogh is leading a national Urgent and Emergency Care Review.⁸² We spoke to the National Clinical Director for Urgent Care, who told us that the outcomes of this review were likely to impact on NHS England's and local commissioners' decisions as to the type of urgent care reconfigurations which should be carried out in a local area. The preliminary report is expected to be published in October 2013.
171. NHS England (Wessex) told us that the 'Call to Action' exercise was being nationally led and in September/October discussions would be taking place at a local area level. It said that any reconfiguration of A&E would need to be driven by this national process.
172. Monitor told us that there was considerable national discussion at present regarding the configuration of NHS services and in particular A&E services. In these circumstances, Monitor would expect commissioners to be paying close attention to the configuration of services.
173. The parties told us that the College of Emergency Medicine (CEM) recommended consultant cover of 24 hours a day, seven days a week ('24/7' cover). Recognizing that this might not be achievable, it recommended a minimum senior cover of at least 16 hours per day, seven days a week ('16/7' cover). Typically this cover required a minimum of 12 consultants and ideally 14 to 16.⁸³
174. We reviewed the College of Emergency Medicine (CEM) Consultants Workforce Recommendations (April 2010). In this document, the CEM notes that the average number of consultants in each emergency department in England is inadequate (4.39 FTE in late 2009, with a typical attendance of 60,000 patients). The CEM reports that evidence is building regarding tangible and demonstrable benefits of consultant presence. It is therefore pursuing an agenda of expansion with the aim of providing 10 FTE consultants (participating fully in an out-of-hours rota) as a minimum in every emergency department, with greater numbers in particularly busy departments (12 FTE for 80,000–100,000 patients a year and 16 FTE for more than 100,000) which would provide consultant presence 16 hours a day, seven days a week. The total number of consultants in England would increase from 852 to 2,144 WTE. To achieve 24/7 cover would require an extra 2,222 WTEs and with the current level of trainees that would not be achieved until 2025.
175. We noted that, based on the 2011/12 A&E attendance figures detailed in paragraph 155, and assuming that the reconfiguration does not result in the diversion of any minor injuries from the major injury A&E site to the minor injury A&E site, if the major injury A&E site was at RBCH total attendances would be approximately 93,000, and if the major injury A&E site was at PH total attendance would be approximately 79,000.

⁸¹ [ibid](#), p73.

⁸² www.england.nhs.uk/ourwork/pe/uec-england/.

⁸³ [Benefits of the merger](#), 26 July 2013.

176. The parties told us that they did not currently comply with the recommendation outlined in paragraphs 173 and 174.⁸⁴ If the parties were successful in their current recruitment of one additional consultant each, the parties told us that the merger would allow sufficient consultants to be provided to provide 16/7 on-site cover at the major injury A&E.⁸⁵ They said that commissioners had expressed their wish that this recommendation was adhered to.⁸⁶
177. The parties told us that there was evidence of the impact of improved cover at the weekend and cited a study published by Dr Foster Intelligence. The study noted that previous studies found evidence of higher mortality rates among patients admitted as an emergency at the weekends compared with those admitted between Mondays and Fridays. On average, mortality rates for a number of conditions, including stroke, heart attack, heart failure, some cancers and aneurysms, were 7 per cent higher.⁸⁷ Dr Foster reports that the national picture in 2010/11 confirms the findings that mortality rates rise sharply for patients admitted at weekends. The parties also told us that the Dr Foster Hospital Guide 2012 linked the increase in mortality at A&E at the weekend to inadequate supervision of junior doctors.
178. RBCH had higher than average weekend mortality rates in 2011/12 and was one of six trusts identified as 'high risk' by the CQC in July 2013 for an inspection within five months.⁸⁸
179. The parties accept that the consolidation of serious injuries on one site will lead to some patients travelling further than they would have done in the past.⁸⁹ However, they told us that empirical evidence showed that patients with serious emergency conditions were better off travelling further by ambulance rather than being admitted into a closer but poorly-staffed unit. We noted a recent publication by the Academy of Royal Colleges⁹⁰ which stated that to achieve proposed standards for high-quality care, 'it is likely that service reconfiguration onto fewer sites will be needed'.
180. The parties told us that the CEM stated that in reorganization of A&E departments between 10 and 20 km apart the local health communities would have to make a judgement on the balance of risk of having ill patients travel further against the benefits of centralization.⁹¹ The parties noted that, in this case, the A&E units at PH and RBCH were just under 13 km apart and the actual impact (on travel time) to patients was minimal, especially as 75 per cent were ambulance ('blue light') journeys and would be unaffected.⁹²
181. However, we noted that a number of patients in the local area told us that it was difficult to travel on public transport across the area and that having, for example, a single major injury A&E unit could be a significant disbenefit.
182. The parties told us that the combined consultant rota would also enable closer supervision of junior doctors by bringing middle-grade staff to the major injury A&E site.

⁸⁴ Relevant customer benefits submission, 12 February 2013.

⁸⁵ Benefits of the merger, 26 July 2013.

⁸⁶ Relevant customer benefits submission, 12 February 2013.

⁸⁷ Dr Foster Intelligence, *Inside your Hospital: Dr Foster Hospital Guide 2001-2011*, 2011..

⁸⁸ www.cqc.org.uk/media/chief-inspector-hospitals-announces-inspection-plans.

⁸⁹ Relevant customer benefits submission, 12 February 2013.

⁹⁰ Academy of Royal Colleges, *Seven Day Consultant Present Care*, December 2012.

⁹¹ College of Emergency Medicine, 2008, *The way ahead: 2008-2012 Strategy and guidance for Emergency Medicine in the UK and Ireland*.

⁹² Relevant customer benefits submission, 12 February 2013.

We noted a report by the CEM which found that increased supervision of more junior members of the ED medical team was linked to improved patient safety.⁹³

183. The parties said that the creation of a major injury A&E would also generate sufficient patient throughput which in turn would allow A&E consultants to improve further their skills as consultants. This is because consultants would see a larger volume of patients and as a result would be familiar with a larger number of conditions and become better at diagnosing and treating them.⁹⁴
184. The parties told us that A&E consultants were attracted to units with higher patient throughput⁹⁵ and therefore the parties expected recruitment of A&E consultants to be easier for the merged entity.
185. The parties stated that the creation of a separate minor injury A&E would also be beneficial as it was likely to reduce waiting times for patients who currently had to give priority to more urgent emergencies at A&Es catering for both major and minor injuries.⁹⁶ The parties did not provide evidence to support this claim.
186. The parties also told us that GPs' input was likely to be more appropriate for minor injuries than specialist A&E input.⁹⁷
187. Without merger, the parties told us that they would need to hire six additional consultants each (ie 12 consultants in total) to achieve 16/7 cover on a stand-alone basis. The parties said that this was not a likely outcome for the following reasons:
 - (a) It was not possible, because there was a national shortage of A&E consultants—the parties had tried and failed to hire just one A&E consultant each in the last 12 months.
 - (b) It was not advisable, because increasing stand-alone rotas would reduce the number of cases seen by each consultant, which would be detrimental to their ability to develop their diagnostic abilities.⁹⁸
 - (c) It was not affordable, as the six consultants would cost in total about £1 million per year for each trust.⁹⁹
188. The parties told us that, absent the merger, neither trust would exit the provision of A&E services¹⁰⁰ as neither trust could afford to lose the contribution generated by A&E services and the interrelated services.
189. The parties said that they estimated that closure of A&E and the follow-on closure of emergency surgery would result in a loss of contribution to overheads of [£1–£10] million at PH and [£1–£10] million at RBCH. The parties believed that this was a conservative estimate because it did not take account of further reductions in elective activity due to clinical dependencies. In addition, the parties told us that they would not be able to avoid incurring all current costs (in the best case scenario, [£1–£10] million of costs would still be incurred by [X] if A&E was closed).

⁹³ The College of Emergency Medicine, *Emergency Medicine Consultants, Workforce Recommendations*, April 2010.

⁹⁴ Relevant customer benefits submission, 12 February 2013.

⁹⁵ ibid.

⁹⁶ ibid.

⁹⁷ ibid.

⁹⁸ Benefits of the merger, 26 July 2013.

⁹⁹ Relevant customer benefits submission, 12 February 2013.

¹⁰⁰ ibid.

190. The parties therefore believed that, absent the merger, there would continue to be two sub-scale A&E services.¹⁰¹
191. The parties told us that commissioners were unlikely to be able to achieve these benefits absent the merger. First, the parties said that the commissioners currently had no plans for structural changes to the delivery of A&E services in Dorset.
192. In addition, the parties believed that commissioners would be unable to consolidate major injury A&E activity on one site as the loss of this activity and the interrelated services (as set out in paragraph 165) would lead to the collapse of the hospital without the major injury A&E activity.¹⁰²
193. Dorset CCG told us that a commissioner-led reconfiguration of A&E would take longer and be more challenging.
194. The CC received an anonymous response to its provisional findings dated 14 July 2013 which stated that:
- Bournemouth Hospital Accident and Emergency Department was only ever set up as a minor injuries unit and is not generally recognised as a proper A and E department as it does not deal with trauma or paediatrics. It would therefore not be difficult to concentrate the A and E consultants at Poole out of hours, as the medical and surgical admissions through the Bournemouth A and E would be covered by the medical and surgical on-call consultants. This scenario would not result in a loss of income to either Trust in a non-merged situation and is therefore not merger-dependent.
195. West Hampshire CCG told us that in its view there would ‘need to be some reconfiguration, merger or not’.
196. The FTN told us that there were a number of reports evidencing the benefits of consultant-led care, including the Dr Foster and Academy of Medical Royal Colleges reports referred to in paragraphs 177 and 179 respectively. In addition, the FTN drew our attention to the Health Select Committee’s report on urgent and emergency care services that was published in July 2013 and concluded that there was an unquestionable need to restructure the way urgent care was delivered across the NHS, particularly so that emergency departments could meet the minimum recommended level of 16 hours consultant cover a day during the working week.
197. The parties told us that informal discussions had been held with the GP community and Ambulance trusts and the response had been recognition and support of the national and evidence-based trend for this model, although no site preference had been mentioned.
198. The parties said that the detailed planning of the proposed reconfiguration was being undertaken as part of the shadow clinical directorate meetings. However, they had not yet prepared a clinical and financial case for local clinicians and commissioners to consider setting out the clinical benefits on a local basis and how the proposed reconfiguration would be implemented.

¹⁰¹ [ibid.](#)

¹⁰² [ibid.](#)

199. The parties initially told us that these changes would be achieved within three years following the merger.¹⁰³ They subsequently told us that changes to medical workforce rotas could be achieved very quickly and that the physical changes to estate could be implemented within one year of agreement to proceed.

Monitor assessment of benefit—A&E

200. Monitor found that there was sound evidence for the argument that creating a comprehensive consultant presence and cover for emergency departments which was compliant with national standards provided benefits to patients in terms of senior clinical input and care around the clock.¹⁰⁴
201. Monitor noted that combining the parties' emergency departments would only provide 12 rather than 16 consultants as recommended by Royal College standards for departments in excess of 100,000 attendances (as set out in paragraph 174). The parties told Monitor that the merged entity could absorb the cost of hiring additional consultants to provide the requisite cover but did not explain how they proposed to fund the additional positions.
202. Monitor noted that any benefit accruing from the proposed reconfiguration must be balanced against the potential adverse impact for patients of having reduced access to emergency care at the minor injuries site, for example a proportion of patients may have to travel further to reach the major injury A&E. Monitor was not able to assess whether the potential clinical benefits of increased consultant cover at the major injury A&E would outweigh the potential disadvantages of the loss of access at the minor injury A&E and believed it was appropriate for such matters to be dealt with fully during a consultation process on any reconfiguration.¹⁰⁵
203. Monitor found that, in relation to the parties' submitted benefits regarding closer supervision of junior doctors and savings, the parties had not provided detail such as the numbers of middle-grade doctors likely to be shared between the trusts, or the quantity of savings that would be delivered. Accordingly, Monitor considered that there was insufficient evidence to accept these submitted benefits.¹⁰⁶
204. Monitor had some doubts about the likelihood of increased consultant cover being realized by the options proposed, specifically:
- Neither party would have the capacity to take all of the other party's patients if one of the emergency departments were to close. Monitor noted that the parties submitted that this option was unlikely to occur.
 - Closure of one of the emergency departments at night would be unlikely to deliver increased consultant capacity as the parties currently shared out-of-hours consultant cover.
 - In Monitor's view, any reconfiguration of emergency departments would need to be consistent with the needs of the local population and area-wide outcomes for

¹⁰³ *ibid.*

¹⁰⁴ Monitor's advice to the OFT under section 79(5) of the Health and Social Care Act 2012, 11 February 2013.

¹⁰⁵ *ibid.*

¹⁰⁶ *ibid.*

service delivery that were determined by the commissioner-led urgent care review.¹⁰⁷

205. Monitor concluded that the merger was unlikely to give rise to RCBs (in the form of improved quality of service by providing increased consultant cover) because the benefit would not be delivered unless the range of services at one of the parties' emergency departments was reduced. Monitor believed that the merger parties could not achieve this without the consent of the commissioners. It noted that commissioners were currently undertaking a review of urgent care services which would inform what the requirements should be for emergency care and emergency departments across the area and would occur regardless of the merger.¹⁰⁸

CC assessment of benefit to patients—A&E

206. The parties have provided us with a number of studies considering the benefits of A&E reconfiguration on a national basis (see paragraphs 167 to 169, 173, 174 and 177).
207. We note that commissioners are generally supportive of the parties' A&E reconfiguration proposal and we found that, in theory, if planned and implemented effectively, reconfiguration of A&E services could be a benefit to patients in the form of improved quality of services. However, as Monitor noted (see paragraph 202 above), we consider that there will also be disbenefits to some patients, and whether such a reconfiguration is a benefit overall will depend on how it is implemented locally, and the extent to which the benefits to some patients outweigh the disbenefits to others (for example, increased travel time)—see paragraphs 180 and 181 above.
208. We set out in paragraph 9.52 the steps we would have expected the parties to have gone through in order to demonstrate that a significant service reconfiguration such as the proposal for A&E was an RCB. We understand that the first steps are to establish relevant clinical groups to develop a model of care and assess the clinical benefits and disbenefits and the financial viability of a proposal. The parties have not yet prepared a clinical and financial case setting out the benefits on a local basis and how the proposed reconfiguration will be implemented (including the clinical inter-dependencies and services that will need to be co-located with the major injury A&E unit—see paragraph 165 above) for the local clinicians and commissioners to consider. NHS England (Wessex) told us that it was in principle supportive of the A&E and emergency surgery reconfiguration but it had not had detailed conversations with the parties about this. Dorset CCG told us that any changes would be subject to scrutiny by commissioners and public consultation and that this work had not yet commenced.
209. We thought that an A&E reconfiguration could create both benefits and disbenefits locally and, given the current configuration of services, the benefits and disbenefits are likely to differ depending on where the major injury A&E and clinically interdependent services are located. This assessment of benefits and disbenefits has not yet been undertaken and without this assessment we therefore did not find that the proposal was an overall benefit to patients.

¹⁰⁷ [ibid.](#)

¹⁰⁸ [ibid.](#)

Finding on possible RCB—A&E

210. We did not find that the proposal to reconfigure A&E services was an overall benefit to patients and therefore did not find that the A&E benefit proposed by the parties was a relevant customer benefit.

Emergency surgery

211. The parties told us that their emergency surgery served 4,000 patients every year¹⁰⁹ and that emergency surgical caseload accounted for half of general surgical activity.
212. Emergency surgery services at RBCH and PH are primarily commissioned by Dorset CCG.
213. RBCH has eight FTE general surgeons on its emergency surgery rota and treats approximately 2,066 patients a year. PH has 5.5 FTEs¹¹⁰ on its own emergency surgery rota and treats approximately 1,854 patients.¹¹¹
214. The parties told us that both trusts currently offered 24/7 consultant cover (on-call out of hours). Consultants at both sites were supported by middle-grade doctors (trainee surgical registrars and staff-grade doctors); both trusts were struggling to staff this middle-grade rota due to a nationally-driven reduction in the number of surgical trainees.¹¹²
215. RBCH does not have a dedicated emergency theatre—instead emergency surgery cases are fitted within some rotated theatre sessions, with the most urgent emergency surgery cases resulting in last-minute cancellations of elective cases.¹¹³
216. PH has a dedicated emergency theatre which runs Monday to Friday from 11:00 to 21:00. It is staffed by a full theatre team and covers general surgery, ENT, oral maxillo facial, gynaecology and some trauma after 17:00. The parties told us that an elective list would only be interrupted if the case needed to be done outside the emergency theatre hours or a second emergency theatre was needed.

Benefit proposed by the parties—emergency surgery

217. Post-merger, the parties are proposing to consolidate emergency surgery services on one site.¹¹⁴ The parties propose to have a dedicated emergency theatre 24/7, with consultants freed from elective activity when on-call.
218. Emergency surgery services will be co-located with the major injury A&E. Royal College guidance recommends that emergency surgery is located on the same site as an emergency department.¹¹⁵
219. The parties told us that commissioners would not support consolidating emergency surgery without consolidating A&E.¹¹⁶

¹⁰⁹ [Benefits of the merger](#), 26 July 2013.

¹¹⁰ The parties told us that an additional upper GI/paediatric consultant will be in post from 1 October 2013 and will lead on developing the emergency surgery pathway.

¹¹¹ [Relevant customer benefits submission](#), 12 February 2013.

¹¹² [ibid.](#)

¹¹³ [ibid.](#)

¹¹⁴ [ibid.](#)

¹¹⁵ The College of Emergency Medicine, Emergency care 2015: building on the evidence (2008) and the way ahead 2008–2012 – strategy and guidance for emergency medicine in the United Kingdom and the Republic of Ireland (2008).

220. The parties have not yet determined at which site the major injury A&E and emergency surgery services will be located.
221. The parties told us that without reconfiguration they would not comply with standards.¹¹⁷ We have received some conflicting evidence on the expected position post-reconfiguration—the parties told us that following consolidation of emergency surgery on one site, the joint rota would be able to provide the recommended senior and middle-grade 24/7 cover,¹¹⁸ but later stated that consolidation of the emergency surgery service ‘moves the service towards the College recommendation’.
222. The parties told us that senior cover was crucial for patient outcomes as better senior cover led to reduced mortality and morbidity rates.¹¹⁹ These studies noted that early involvement of senior clinicians in the management of patients admitted as an emergency could improve the quality of care and, ultimately, patient outcomes. They reported that the initial assessment and continuing senior cover improved continuity of care and decision making, ensured adequate supervision of junior doctors and made more efficient use of resources.
223. The parties told us that the presence of consultant surgeons in the operating theatres significantly improved patient outcomes while poor outcomes were often associated with unsupervised non-consultants performing major emergency surgery.¹²⁰
224. The parties noted a recent study which found that mortality for elective care was higher during later parts of the week and at the weekends when there were fewer senior staff in attendance.¹²¹
225. The parties said that the benefit of relieving senior surgeons of their on-call duties when carrying out elective care was that it would reduce the numbers of cancellations of elective operations¹²² and allow more timely delivery of emergency care.¹²³
226. The parties believed that theatre throughput and efficiency was likely to improve with a dedicated surgeon ‘driving’ the list, and not distracted by elective and other activities.
227. The parties expected that there would be 12 emergency surgery beds closed as a result of the merger, as the same number of patients would be treated more efficiently because senior decision-making and quicker access to emergency theatres would reduce time spent waiting in a hospital bed.
228. Dorset CCG stated that ‘the main benefit to patients [of the proposed emergency surgery reconfiguration] is improved quality and outcomes of care’.
229. The parties also told us that rationalizing emergency rotas would allow surgeons to see higher volumes of patients which in turn would allow them to specialise further.¹²⁴

¹¹⁶ Benefits of the merger, 26 July 2013.

¹¹⁷ Relevant customer benefits submission, 12 February 2013.

¹¹⁸ Benefits of the merger, 26 July 2013.

¹¹⁹ (1) NCEPOD, Emergency admissions: a journey in the right direction, 2007; (2) Royal College of Surgeons, Emergency surgery: standards for unscheduled surgical care, 2011; (3) ASGBI, Emergency surgery survey, ASGBI Newsletter, 2010, No 31; and (4) NCEPOD, An age old problem: elective and emergency surgery in the elderly, 2010.

¹²⁰ Relevant customer benefits submission, 12 February 2013.

¹²¹ Benefits of the merger, 26 July 2013.

¹²² ibid.

¹²³ ibid.

¹²⁴ Benefits of the merger, 26 July 2013.

- 230. The parties said that additional benefits from the proposed reconfiguration of emergency surgery services included ‘the opportunity for audit, research and genuine innovation and service transformation, all of which are vital to attracting high quality trainees and consultants to the merged organisation’.¹²⁵
- 231. The parties told us that, absent the merger, neither trust would independently divest itself of emergency surgery as it made a positive contribution to both trusts (£[~~£~~] million at PH and £[~~£~~] million at RBCH) and was a gateway for further elective work and therefore income.¹²⁶
- 232. The parties told us that they attempted to cooperate to co-locate emergency surgery and interrelated services in the past but were unable to agree on a fair level of compensation.¹²⁷
- 233. The parties said that, in theory, each trust could increase the number of surgeons to improve cover. The parties carried out an indicative costing analysis which found that they would have to appoint six to eight additional consultants to prevent the loss of elective surgery activity.¹²⁸ However, the parties noted that this would be suboptimal as it would mean that patient throughput per surgeon would drop thereby reducing opportunities for specialisation.¹²⁹
- 234. This would also incur costs of £1.2 million (see paragraph 288) and the parties told us that neither trust could justify this increased number of consultants as it would not be accompanied by a corresponding increase in patient throughput.¹³⁰
- 235. The parties noted that it was also unclear whether there were suitably trained emergency consultant surgeons available to recruit to these posts.¹³¹
- 236. The parties told us that they would deliver the changes to the emergency surgery by the same time as the changes to their A&E services, ie within three years following the merger.¹³²

Monitor assessment of benefit—emergency surgery

- 237. At the time Monitor undertook its review, the parties were proposing that the reconfiguration of emergency surgery was likely to be completed within the first year following the merger and that it was not dependent on their proposed A&E reconfiguration (planned for the third year following the merger).¹³³
- 238. Monitor concluded that the parties’ proposed reconfiguration of emergency surgery did not deliver RCBs because Royal College guidance recommended that emergency surgery was located on the same site as an emergency department. Therefore, either the ability to reconfigure emergency surgery was dependent on the reconfiguration of the parties’ A&E departments (which might not occur), or if it could occur sooner and independently of the reconfiguration of emergency departments, some patients might be disadvantaged by having to transfer from an emergency department at one site to another site for emergency surgery.

¹²⁵ Relevant customer benefits submission, 12 February 2013.

¹²⁶ Benefits of the merger, 26 July 2013.

¹²⁷ Relevant customer benefits submission, 12 February 2013.

¹²⁸ *Ibid.*

¹²⁹ Benefits of the merger, 26 July 2013.

¹³⁰ Relevant customer benefits submission, 12 February 2013.

¹³¹ *Ibid.*

¹³² *Ibid.*

¹³³ Monitor’s advice to the OFT under section 79(5) of the Health and Social Care Act 2012, 11 February 2013.

239. In addition, Monitor noted that there was a lack of clarity about the likely effect of the proposed reconfiguration on interdependent services at each of the trusts (such as paediatrics, trauma orthopaedics, vascular and urology) which made it difficult to assess the consequent effects on patients for these services.¹³⁴
240. Monitor found that, in relation to the parties' submitted benefits regarding combining trainee surgeons on to a single rota, there was insufficient evidence to accept this as an RCB as the parties had not provided detail such as the numbers of trainees likely to be shared between the trusts, or clinical evidence of the benefits of a shared trainee rota.¹³⁵

CC assessment of benefit to patients—emergency surgery

241. We noted Monitor's view that consolidation of emergency surgery services was only a benefit where it was co-located with major injury A&E. However, as set out in paragraph 218, the parties are now proposing to implement these reconfigurations at the same time. If this is the case, we consider that it is possible that there may be benefits to some patients in the form of higher-quality emergency surgery services.
242. However, the parties did not clearly explain to us to what extent the reconfiguration would lead to improvements, for example in terms of meeting recommended Royal College guidance. We also noted Monitor's views that there is a lack of clarity about the likely effect of the proposed reconfiguration on interdependent services at each of the trusts, making it difficult to assess the consequent effects on patients for these services.
243. In line with our conclusion on A&E, we noted that, in theory, if planned and implemented effectively, reconfiguration of emergency surgery services could be a benefit to patients. However, the parties have not yet prepared a clinical and financial case (setting out the benefits and disbenefits on a local basis and how the reconfiguration will be implemented) for the local clinicians and commissioners to consider. Without this analysis, we therefore did not find that the proposal was an overall benefit to patients.

Finding on possible RCB—emergency surgery

244. For the reasons set out above, we did not find that the proposal to reconfigure emergency surgery services was an overall benefit to patients and therefore did not find that the emergency surgery benefit proposed by the parties was a relevant customer benefit.

Other clinical benefits

Benefit proposed by the parties—other clinical benefits

245. The parties told us that the merger would more generally allow them to deliver improved medical staff cover in all key areas and therefore improve patient outcomes and reduce patient morbidity and avoidable mortality.
246. The parties said that the merger provided the only credible opportunity for the parties to achieve viable scale in a number of services which had traditionally operated with

¹³⁴ *Ibid.*

¹³⁵ *Ibid.*

undesirably low patient volumes. According to the parties, this would deliver significant clinical benefits. This would mean that joint medical teams would be able to treat a larger throughput of patients which would allow medical staff to specialise further (in the case of specialisms such as maternity, cardiology, haematology or emergency surgery) and further develop their diagnostic abilities (in the case of A&E).

247. We noted that the parties told Monitor that the current configuration of service provision at both trusts was clinically (and financially) unsustainable. They stated that the scale of each organization inhibited them from being able to offer around-the-clock access to expertise within a number of specialties as recommended by Royal Colleges. They added that this made recruitment difficult and resulted in an over-reliance on temporary staff.¹³⁶
248. In addition, the parties submitted to Monitor that the merger would allow the new entity to provide a comprehensive range of elective and non-elective services on an around-the-clock basis. They submitted that the improved scope of services would enable them to recruit, retain and train key clinical staff, with greater volumes of activity and expanding the range of sub-specialties, making the organization a more attractive place to train and work. Further, they submitted that the benefits would directly affect patients as they would have increased access to appropriate clinical care.¹³⁷

Monitor assessment of benefit—other clinical benefits

249. Monitor concluded that around-the-clock consultant cover did not constitute an RCB because the parties had not provided sufficient detail about how this benefit would be realized in relation to services other than cardiology, emergency, emergency surgery, haematology and maternity. The parties did not provide Monitor with details of how this benefit would be realized, for example the specific services which were likely to be improved and how the merger would change service delivery.¹³⁸

CC assessment of benefit to patients—other clinical benefits

250. The parties provided details of the benefits of improvements to consultant cover and increased specialisation of medical staff in maternity, haematology, cardiology, A&E and emergency surgery services and the CC's assessment of this evidence is set out in the relevant sections above.
251. The parties have not provided details of any other services where there are plans to improve consultant cover and increase specialisation of medical staff. As we noted earlier (see paragraph 9.32), there is no evidence that mergers automatically lead to improvements to the clinical services provided by a foundation trust.
252. We therefore did not find that the proposed benefit would be a benefit to patients. This is in line with Monitor's conclusion.

Finding on possible RCB—other clinical benefits

253. We did not find that this proposal would be a benefit to patients and therefore did not find that this proposal was an RCB.

¹³⁶ *Ibid.*

¹³⁷ *Ibid.*

¹³⁸ *Ibid.*

Financial savings

Benefit proposed by the parties—financial savings

254. As we noted in our provisional findings, the parties told us that the merger would achieve cost savings by releasing important synergies and efficiencies. The parties told us that the inability to achieve these savings would mean that they were unable to meet their licence conditions and lead to their failure.¹³⁹
255. The parties initially provided us with information indicating that the merger could result in £17.4 million of financial savings. The parties then revised their estimate of financial savings to £13.7 million.
256. We set out details of the financial savings identified by the parties in Table 1 below. Each category of saving in Table 1 may include more than one saving. The savings in Table 1 are forecast to occur during 2014/15 (£[§] million) and 2015/16 (£[§] million), and will then occur on a recurrent basis. The parties noted that they had not undertaken a detailed analysis of additional cost savings beyond this period.

TABLE 1 **Merger-specific savings**

	£'000
<i>Clinical savings</i>	
Emergency surgery	[§]
Cancer care (incl haematology)	[§]
Cardiology	[§]
Maternity	[§]
Medicine	[§]
Pathology/Pharmacy/Therapy	[§]
Radiology	[§]
Specialist services	[§]
Surgical specialties	[§]
Trauma and orthopaedics	[§]
Total clinical savings	[§]
<i>Corporate savings</i>	
Chief Executive	[§]
Management structure	[§]
Finance	[§]
Human Resources	[§]
Nursing	[§]
Operations	[§]
Service development	[§]
Total corporate savings	[§]
Total merger-specific savings	13,690

Source: RBCH and PH.

257. In its submission of 16 August 2013, the parties reduced the level of financial savings by £0.4 million to £13.3 million to reflect the change to the proposed maternity benefit as set out in paragraph 10.
258. The parties provided a breakdown of the individual proposed savings. The largest savings were as follows:
- (a) savings of £[§] million in the Chief Executive directorate described as ‘savings arising from having one corporate function rather than two’;

¹³⁹ Relevant customer benefits submission, 12 February 2013.

- (b) savings of £[£] million in microbiology (part of pathology/pharmacy/therapy saving) resulting from [£];
- (c) savings of £[£] million arising from reducing the Chief Operating Officer's management structure (part of the Chief Executive saving);
- (d) savings of £[£] million in the HR directorate arising from having one corporate function rather than two;
- (e) savings of £[£] million (originally £[£] million but the parties told us this had reduced by £[£] million to reflect the change in the proposed maternity benefit as set out in paragraph 10) from a [£] maternity service;
- (f) savings of £[£] million in specialist palliative care integration arising from economies of scale, [£];
- (g) savings of £[£] million in cardiology from length of stay reductions as patients will be admitted directly to RBCH (rather than being admitted at PH and requiring transfer to RBCH);
- (h) savings of £[£] million in radiology from increased staff efficiency delivered through combined rotas and waiting list reduction initiatives;
- (i) savings of £[£] million in emergency surgery delivered by reductions in the emergency and elective bed bases due to reductions in length of stay;
- (j) savings of £[£] million in pathology, pharmacy, therapies and outpatients by [£];
- (k) savings of £[£] million from the [£] leading to better utilization of this [£] (both parties currently have to have a minimum number of staff to carry out this function: this number is currently inefficient); the parties noted that these savings would be 'much more difficult to realise absent the merger' (part of the cancer care saving);
- (l) savings of £[£] million in the administrative part of the medical directorate delivered by a [£] (part of the cancer care saving);
- (m) savings of £[£] million in maternity using [£] more efficiently by adopting a single rota;
- (n) savings of £[£] million arising from the [£] (part of the cancer care saving);
- (o) savings of £[£] million in pathology, pharmacy, therapies and outpatients by [£]¹⁴⁰ services;
- (p) savings of £[£] million in pathology, pharmacy, therapies and outpatients delivered through [£]. The parties noted that 'while there is nothing to stop RBCH [£];
- (q) savings of £[£] million from merging [£];
- (r) savings of £[£] million in emergency surgery from rationalization of rotas [£];

¹⁴⁰ [£]

- (s) savings of £[~~X~~] million arising from reducing the Nursing Director's management structure; and
 - (t) savings of £0.3 million in cardiology procurement from eliminating the need for each party to have a [~~X~~].
259. All other savings not listed in the paragraph above (totalling £[~~X~~] million) were each less than £[~~X~~] million.
260. The parties told us that each clinical saving would be subject to a quality impact assessment to ensure that patient quality was maintained or improved.
261. We noted that for a number of savings (for example, paragraph 258(b), (h), (j) and (k)), the information provided by the parties does not clearly explain what form the saving will take, ie whether it is a reduction in headcount or a non-pay saving.
262. At the drop-in session we held on 5 September 2013 and in written responses to our provisional findings (including a response from RBCH's Council of Governors),¹⁴¹ several people told us that they believed there would be financial savings arising from the merger. However, we were also told by third parties that increasing scale would not necessarily reduce costs and in a response to our provisional findings we were told that the financial benefits of joint procurement of services and equipment could be achieved through cooperation short of merger.

Monitor assessment of benefit—financial savings

263. The parties told Monitor that they were likely to achieve merger-related savings of around £22.2 million between 2013/14 and 2015/16.¹⁴² Monitor focused its assessment on the savings of £8.6 million identified as being dependent on the merger.^{143,144}
264. The parties told Monitor that their status as not-for-profit organizations that existed to serve their patients' interests, combined with regulatory obligations to operate efficiently, meant that all savings would be reinvested in patient care. The parties submitted to Monitor that the savings were RCBs because they would use the savings to protect and improve the quality of services, and benefits would thereby accrue directly to patients as a result of the merger.¹⁴⁵
265. The largest component of the merger-dependent savings identified by the parties was a £[~~X~~] million saving from reducing length of stay through bed reconfiguration involving a reduction of [~~X~~] beds. Monitor found that it was not clear which beds the parties intended to remove, or why they could be removed as a result of the merger. In order to evidence these savings, Monitor stated that it would expect to see a business case or implementation plan that described and explained how the savings would be achieved.¹⁴⁶

¹⁴¹ RBCH Council of Governors response.

¹⁴² The parties told us that the savings of £22.2 million reviewed by Monitor were predicated on the merger being completed in the financial year 2013/14. Since it is now clear that the merger will not be completed before the start of the financial year 2013/14, the parties had to revise their savings projections ([Relevant customer benefits submission](#), 12 February 2013).

¹⁴³ Monitor's report stated that the balance of £13.6 million was identified by the parties as highly unlikely to be delivered without the merger, that is, savings which may be technically possible to achieve as two separate organizations but would be more likely to be delivered under the direction of a single governing body.

¹⁴⁴ [Monitor's advice to the OFT under section 79\(5\) of the Health and Social Care Act 2012](#), 11 February 2013.

¹⁴⁵ [ibid.](#)

¹⁴⁶ [ibid.](#)

- 266. Other savings submitted to Monitor included £[☒] million from reducing the number of emergency beds after reconfiguring general surgery emergency admissions/activity. The parties told Monitor that ‘bed reductions will be achieved through changes in clinical practice and the efficiency gain from being in one location’. The parties did not explain what the change in clinical practice was or how the efficiency gain would be achieved. In order to evidence these savings, Monitor would expect to see an analysis of bed usage in the two departments and how that would be done differently post-merger and implementation plans or business cases.¹⁴⁷
- 267. In addition, the parties submitted to Monitor that savings of up to £[☒] million were possible through reducing the overlap in corporate functions through a single board as well as moving to single back-office systems, such as finance and human resources.¹⁴⁸
- 268. Monitor concluded that the financial savings which the parties submitted would result from the merger did not constitute RCBs because the savings had not been sufficiently evidenced. In addition to this, Monitor did not accept the parties’ submission that the savings from the integration of back-office functions were dependent on the merger; in Monitor’s view, these savings could be delivered in a number of ways, for example by a merger with an alternative provider.¹⁴⁹

CC assessment of benefit to patients—financial savings

- 269. We noted that some of the proposed clinical savings may be a disbenefit to some groups of patients, for example the rationalization of services as set out in paragraph 258(o) above. The parties have not yet undertaken quality impact assessments for each proposed clinical saving which would allow any potential impacts on quality to be understood and assessed.
- 270. We considered that any proposed headcount reductions (both clinical and non-clinical) would need to be considered in the round to ensure that the overall effect was not damaging to the performance of the merged entity. We have not seen any evidence that the parties have undertaken strategic HR planning to ensure that the skills mix is appropriate post-merger or identified specific roles that will be removed where savings involve a reduction in headcount.
- 271. We have therefore seen insufficient evidence to determine whether the benefit of the financial savings outweighs any disbenefits.
- 272. In addition, we considered that some of the proposed savings may have associated implementation costs, such as redundancy costs and investment in technology (see paragraph 258(m) above). It is not clear to us that the value of the savings proposed by the parties is net of any such costs. Where implementation costs have not been fully taken into account, the value of financial savings is likely to be less than anticipated.
- 273. We also have concerns that, given the evidence on economies of scale (as set out in paragraphs 9.22 to 9.24), there may be unanticipated additional costs or inefficiencies from operating a larger organization, for example additional layers of management may be required. As set out in Appendix B, paragraph 39, any

¹⁴⁷ [ibid.](#)

¹⁴⁸ [ibid.](#)

¹⁴⁹ [ibid.](#)

inefficiencies or additional recurring costs created by the merger were not separately identifiable in the forecasts of the merged entity.

274. We therefore could not assess whether the financial savings would be an *overall* benefit to patients.

CC assessment of whether the statutory test is met—financial savings

275. We considered that the proposed timescale for delivery of financial savings (within two years of the merger) constituted a reasonable period.
276. Although we noted that the parties have a relatively good track record of CIP delivery, Monitor found in its report on the performance of the foundation trust sector as a whole in 2012/13 that delivery of CIPs was 14.8 per cent lower than plan, as delivery of significant financial savings is challenging for any organization. We also noted that there is evidence that previous mergers have not always delivered the planned level of cost savings, as set out in paragraph 9.29.
277. We noted that the savings included reductions in management in a number of areas (for example, paragraph 258(c), (l) and (s)). We considered that a significant reduction in management could impact the merged entity's ability successfully to deliver proposed service reconfigurations and the associated financial savings.
278. A number of the proposed savings relate to planned reductions in length of stay. We note that in some cases (for example, paragraph 258(i)) the parties told us that reductions in length of stay would allow reductions in bed numbers; however, this is not specified for every proposed saving arising from reductions in length of stay (for example, paragraph 258(g)). We expect that, in general, a reduction in length of stay will only deliver a reduction in costs where beds are being reduced, rather than allowing an increase in patient throughput. Any reduction in bed numbers is likely to require commissioner agreement and may require public consultation (see paragraphs 326 to 339 for more detail on consultation requirements).
279. In addition, as we noted above, it was not clear what form some of the proposed savings will take and we have not seen detailed implementation plans or business cases for all proposed savings. Therefore, in line with Monitor's views, we did not find that the financial savings benefit may be expected to accrue within a reasonable period as a result of the merger.
280. It was not clear to us that all of the proposed clinical savings can only be achieved through merger, for example a [X] (see paragraph 258(k)) or RBCH purchasing a new [X] (see paragraph 258(p)).
281. As set out above (see paragraph 108), we did not agree with the parties' assertion that the reconfiguration of cardiology services was unlikely to occur absent the merger, therefore we did not consider that the financial savings from this reconfiguration (totalling £[X] million) were unlikely to accrue absent the merger.
282. As regards the corporate savings of £[X] million, we agreed with Monitor's assessment that these were not necessarily merger specific as we considered that there was scope for closer sharing of some back-office costs. The parties may also be able to explore shared services arrangements to deliver these financial savings absent the merger. We noted that the parties were granted a derogation under the undertakings in respect of the implementation and procurement of a single patient record for the two hospitals; they were also granted a derogation in respect of other specified joint procurement activities.

283. We therefore concluded that some of the financial savings proposed by the parties would accrue absent the merger.

Finding on possible RCB—financial savings

284. We did not find the financial savings proposed by the parties would be an overall benefit to patients.
285. We therefore did not find that the financial savings benefit proposed by the parties was an RCB.
286. In addition, we found that the parties were likely to be able to achieve some of the proposed savings absent the merger and they were unlikely to achieve some of the proposed savings in the event of the merger.

Merger-avoided costs

Benefit proposed by the parties—merger-avoided costs

287. The parties initially told us that they would be able to avoid costs of £[§] million as they would be able to put in place more efficient rota systems using fewer consultants and midwives as a result of the merger.¹⁵⁰ Following the response hearing, the parties told us that the level of avoided costs had reduced to £[§] million as a result of the change to the proposed maternity benefit (see paragraph 10), which meant that the costs of increasing midwife cover at PH (£[§] million) would no longer be avoided post-merger.
288. The parties provided the following breakdown of avoided costs:
- increasing cardiology consultant cover at PH—£0.5 million;
 - increasing emergency surgery consultant cover at PH and RBCH—£1.2 million; and
 - increasing A&E consultant cover at PH and RBCH—£2.0 million.
289. The parties told us that, absent the merger, PH could not fund increased cardiology consultant cover. In addition, the parties told us that this outcome would be sub-optimal as it would lower the volume of cases that each cardiologist saw and therefore reduce the skill level of all consultants.
290. The parties said that it would be sub-optimal to increase emergency surgery consultant cover as it would mean that patient throughput per surgeon would drop, thereby reducing opportunities for specialisation. The parties told us that, absent the merger, neither trust could justify the increased number of consultants as it would not be accompanied by a corresponding increase in patient throughput. The parties also noted that it was unclear whether there were suitably trained emergency consultant surgeons available to recruit to these posts.
291. In the case of the costs of increasing A&E consultant cover, the parties told us that it would not be affordable to increase consultant cover. In addition, they said that it would not be possible to increase consultant cover as there was a national shortage

¹⁵⁰ Relevant customer benefits submission, 12 February 2013.

of A&E consultants, and that it would not be advisable as it would deskill A&E consultants by reducing the number of cases seen by each consultant.

Monitor assessment of benefit—merger-avoided costs

292. Monitor did not specifically consider merger-avoided costs in its assessment.

CC assessment of benefit to patients—merger-avoided costs

293. We consider that, in theory, avoiding costs as a result of the merger should ultimately be a benefit to patients where this allows greater investment in services to improve quality.
294. However, some of the avoided costs could be a disbenefit to some patients, for example if staff costs are avoided to an extent where the merged entity does not have sufficient staff, this may impact on the quality of patient services. The parties have not yet undertaken quality impact assessments for these proposed savings which will allow any potential impacts on quality to be understood and assessed. As a result, we could not determine whether the benefits of the avoided costs outweigh any disbenefits and therefore did not find that there will be an overall benefit to patients.

CC assessment of whether the statutory test is met—merger-avoided costs

295. The parties indicated that they would not incur these costs absent the merger (see paragraphs 289 to 291 above). As a result, we consider that these costs are likely to be avoided absent the merger.

Finding on possible RCB—merger-avoided costs

296. As we did not find that the proposed benefit would be a benefit to patients and we found that these costs are likely to be avoided absent the merger, we have therefore concluded that the merger-avoided costs benefit proposed by the parties is not an RCB.

Merger-enabled investments

Benefit proposed by the parties—merger-enabled investments

297. The parties told us that the merger would enable a number of capital projects at PH which would not proceed if the merger did not happen. The parties said that the draft capital programme for the merged entity was £156 million over seven years, of which approximately £96 million would be spent on PH's facilities.¹⁵¹
298. The parties told us that the draft capital programme for the merged entity included the following capital expenditure that was planned at PH:
 - new maternity unit—[£31–£40] million;¹⁵²

¹⁵¹ *ibid.*

¹⁵² The parties told us there is no certainty at this stage regarding the final cost; [£31–£40] million is an estimate based on the approximate required size of the building and average building costs per square metre.

- [§]—[£11–£20] million;
 - centralization of haematology inpatient services—[£1–£10] million;
 - [§]—[less than £5] million;
 - investment in [§] to accommodate the new [§] for the delivery of improved [§] services at PH; the parties told us that PH had [§] the [§] but would be unable to use it absent the merger as it could not afford to build the [§] that was required to [§] it—[less than £5] million;
 - investment in [§] savings—[less than £5] million;
 - additional [§]—[less than £5] million;
 - development of [§]—[less than £5] million; and
 - refurbishment and centralization of [§] suite to allow centralization of services—[less than £5] million.
299. The parties told us that the merged entity's capital programme would be financed from RBCH's existing cash reserves and operating cash surpluses generated by the merged entity. They said that the merged entity did not expect to need additional borrowing to finance its capital programme.¹⁵³
300. They told us that RBCH was in a different position from PH, having a stronger cash balance and ability to borrow. This meant that, absent the merger, RBCH would not finance the investments that PH needed to undertake but would be able to finance its own projects.

Monitor assessment of benefit—merger-enabled investments

301. The parties told Monitor that PH did not have the financial means to enable investment in maternity and haematology because of the prudential borrowing limit which placed a cap on the amount a foundation trust was able to borrow.¹⁵⁴ In addition, the parties stated that PH was not in a financial position to acquire a loan. They said that the merger would enhance the merged entity's ability to raise capital, as it would have an estimated borrowing capacity of around £82.2 million and be able to redirect necessary capital resources from RBCH to PH.¹⁵⁵
302. Monitor found that, with the exception of the proposed reconfiguration of haematology and maternity services, the parties had not demonstrated how any increased borrowing capacity would be passed on as a benefit to relevant customers. It also noted that any borrowing had an opportunity cost and the parties had not demonstrated the relative value that they would obtain from investing the borrowed funds as a merged entity, as against the relative value that could be obtained from investing the borrowed funds as separate providers. Monitor did not consider that increased borrowing capacity was in itself a benefit, particularly in a challenging financial environment. Therefore Monitor's view was that this did not constitute an RCB.¹⁵⁶

¹⁵³ Relevant customer benefits submission, 12 February 2013.

¹⁵⁴ Monitor sets the prudential borrowing limit based on the Prudential Borrowing Code and specifies the prudential borrowing limit in each foundation trust's terms of authorization.

¹⁵⁵ Monitor's advice to the OFT under section 79(5) of the Health and Social Care Act 2012, 11 February 2013.

¹⁵⁶ *Ibid.*

CC assessment of benefit to patients—merger-enabled investments

303. We agree that, in theory, enabling investments as a result of the merger should ultimately be a benefit to patients where those investments improve the quality of services.
304. We have considered whether the proposed reconfigurations of maternity, haematology and A&E and associated capital expenditure would be a benefit to patients in the relevant sections above. References to merger-enabled investments in the following paragraphs are to investments other than those proposed in maternity, haematology and A&E.
305. The parties provided limited detail of the capital projects and resulting benefits to patients which would be enabled by the merger.
306. The merged entity will need to consider the relative merits and opportunity costs of different capital projects and prioritize its capital spend accordingly. We have not seen evidence of the approach the merged entity intends to take to prioritize capital spend to ensure that there is an overall benefit to patients.
307. We therefore did not find that merger-enabled investments would be a benefit to patients.

Finding on possible RCB—merger-enabled investments

308. We did not find that the proposed benefit of merger-enabled investments would be a benefit to patients and therefore concluded that the merger-enabled investments proposed to us were not RCBs.

Balanced portfolio of services

Benefit proposed by the parties—balanced portfolio of services

309. The parties told us that a large part of their income was based on centrally-set PbR tariffs. These tariffs were based on the average costs of NHS foundation trusts and NHS trusts and could change significantly from year to year.¹⁵⁷
310. In a report commissioned by Monitor, PwC found that a large proportion of the tariff base—over 40 per cent of prices set under PbR—changed by more than 10 per cent each year.¹⁵⁸ The tariff changes occurred in both directions and most tariffs changed by between ± 10 to 50 per cent.¹⁵⁹
311. The parties told us that large swings in tariffs left trusts financially exposed and prevented effective future planning. They said that while trusts could mitigate the impact of the tariff fluctuations in their annual financing discussions with the commissioners, they could not eliminate it.¹⁶⁰
312. The parties believed that the most effective way to mitigate the impact of the tariff changes was through a balanced portfolio of services—given that, on average, similar proportions of tariffs were increased and decreased each year. Provided that a

¹⁵⁷ Relevant customer benefits submission, 12 February 2013.

¹⁵⁸ An evaluation of the reimbursement system for NHS-funded care, Report for Monitor, PwC, February 2012.

¹⁵⁹ Relevant customer benefits submission, 12 February 2013.

¹⁶⁰ ibid.

trust provided services across the main tariff categories, it should be able to remain resilient to the swings.¹⁶¹

313. The parties told us that they did not currently have balanced portfolios—RBCH had a disproportionate representation of elective and outpatient care and PH had a disproportionate representation of non-elective care. The parties believed that the merger would allow this imbalance to be redressed and that the merged entity would be considerably more resilient to swings in the tariff.¹⁶²
314. The parties told us that, absent the merger, RBCH would attempt to stave off failure by ceasing to provide those [§]. It would also consider [§] the provision of all [§] which overall were [§] due to the marginal tariff rates.¹⁶³
315. RBCH told us that in order to exit the provision of services, it would need to obtain agreement to do so under its contract with the commissioners and Monitor's licence conditions.¹⁶⁴
316. It said that it would need to think carefully about the interrelated services that would be affected by such closures. If, for instance, it closed geriatric services, it might also need to close its general medicine service (RBCH noted that this point was both hypothetical and for illustrative purposes only).¹⁶⁵
317. The parties told us that, absent the merger, PH was forecasting to be in deficit by 2014/15. PH said that it would not be able to close many services. The services that made a negative contribution could not be closed because of the impact this would have on interrelated services. PH also did not believe that it would be allowed by the commissioners and Monitor to cherry-pick some services while exiting from others.¹⁶⁶
318. At the drop-in session we held on 5 September 2013, a number of third parties expressed similar concerns about PH's financial position absent the merger. We were told that the tariff for PH was 'wrong' and that there would not be a need for the merger if the tariff was right.

Monitor assessment of benefit—balanced portfolio of services

319. Monitor did not specifically consider the benefit of a balanced portfolio of services in its assessment.

CC assessment of benefit to patients—balanced portfolio of services

320. As set out in our counterfactual, we consider that, absent the merger, PH is likely to be under greater financial pressure than RBCH. Therefore, PH is potentially at greater risk of financial pressures resulting in a decrease in the quality of services.
321. The parties have not explained the specific quality deteriorations that would be expected at PH absent the merger.
322. Further, there is a risk that, in the event that the merger proceeds, the quality of services at PH is maintained or improved by the merged entity at the expense of

¹⁶¹ *ibid.*

¹⁶² *ibid.*

¹⁶³ *ibid.*

¹⁶⁴ *ibid.*

¹⁶⁵ *ibid.*

¹⁶⁶ *ibid.*

potential improvements in quality of services at RBCH. We have not seen any details from the parties to enable us to assess whether the benefits of subsidizing services at PH outweigh the potential disbenefits of reducing investment in services at RBCH.

323. On the basis of the available evidence, we did not find that this would be an overall benefit to patients.

Finding on possible RCB—balanced portfolio of services

324. As we did not find that this would be a benefit to patients, we therefore concluded that a balanced portfolio of services was not an RCB.

CC view on RCBs

325. We have not found relevant customer benefits in any of the areas proposed by the parties for the reasons set out above.

The potential effect of consultation requirements on RCBs

Framework for consultation on service reconfigurations

326. When an NHS body or other health service provider is considering proposals for substantial development or variation of the health service, it must consult the local authority.¹⁶⁷ In practice, this is usually done via the Health Overview and Scrutiny Committees.¹⁶⁸ The local authority may then comment on the proposal; where the comments include a recommendation and the NHS body or health service provider disagrees with it, the two parties must take reasonable steps to try to reach agreement. Failing that, the authority may report to the Secretary of State, for example: (a) if it is not satisfied that the consultation was adequate in relation to content or time allowed; or (b) if it considers that the proposal would not be in the interests of the health service in the area.
327. Where a local authority has reported to the Secretary of State, the Secretary of State will usually approach the IRP for advice.¹⁶⁹ The Secretary of State then decides whether the referral was based on inadequate consultation; or makes a final decision on the proposal where the referral was on the basis that the proposal was not in the interests of the health service. In both scenarios, the Secretary of State may give directions to NHS England in relation to the proposal. NHS England may, in turn, give those directions to the relevant CCG. This includes directions: (a) to consult or consult further; (b) to determine the matter in a particular way; and (c) to take or not take any steps in relation to the matter.
328. The other route of challenging a consultation exercise is via an application for judicial review; there have been a number of such legal challenges in recent years and the resulting judgments have formed the basis of Cabinet Office guidance on how consultations should be conducted. This guidance emphasizes that the right judgements about when, whom and how to consult are informed by the principle of proportion-

¹⁶⁷ There is no definition of what constitutes a substantial development/variation; this is something on which the commissioner and local authority are encouraged to reach agreement. See: Department of Health, *Local Authority Health Scrutiny, Proposals for consultation*, 12 July 2012, paragraph 42.

¹⁶⁸ The detail relating to the operation of section 244 is set out in the Local Authority (Public Health, Health and Wellbeing Boards and Health Scrutiny) Regulations 2013.

¹⁶⁹ The IRP was established in 2003 to provide advice to the Secretary of State for Health on contested proposals for health service change in England. It is an advisory non-departmental public body.

ability. The type and scale of involvement should reflect the potential impact of the proposal or decision. Consultation is part of wider engagement, and whether and how to consult will in part depend on the wider scheme of engagement.

329. The guidance also emphasizes that engagement should begin early in policy development when the proposal is still under consideration and views can genuinely be taken into account. Our understanding is that this does not mean that the consulting body cannot consult on a preferred option rather than a range of options, but only that it must genuinely be open to a potential change.¹⁷⁰ Time frames for consultation should be proportionate and realistic to allow stakeholders sufficient time to provide a response, depending on the complexity and impact of the proposal. The amount of time typically varies between 2 and 12 weeks; for consultations in respect of NHS services, a 12-week consultation period is common practice.
330. In addition to the legal requirements and guidance for consultation outlined above, the Department of Health has set out four tests for reconfiguration proposals involving substantial service changes. The guidance was contained in the 2010/11 Revised Operating Framework for the NHS and was also endorsed in the 2012 consultation entitled Local Authority Health Scrutiny.¹⁷¹ The tests require reconfiguration proposals to demonstrate: (a) support from GP commissioners; (b) strengthened public and patient engagement; (c) clarity on the clinical evidence base; and (d) consistency with current and prospective patient choice.

Views of the parties

331. The parties told us that the general position in the sector was that a public consultation was only undertaken when the NHS proposed changes which might adversely impact how services were provided, for example by consolidating a service and reducing patient access (for example, by moving a service from one site to another) or reducing the range of services that were provided (for example, reducing the hours that an A&E department was open).
332. The parties said that public consultation did not give the public the right to veto a proposal because it was not a referendum. Furthermore, they explained that any reconfiguration proposal needed to be ultimately agreed by the commissioners of the relevant services—if commissioners believed that there was a strong clinical case for proposed reconfiguration they would push for the changes, even with public opposition, and explain the real benefits of change to patients and the public. The parties said that in this case, the commissioners strongly supported the merger benefits.
333. We asked the parties about the extent of their engagement with stakeholders on the proposed reconfigurations that they put forward as RCBs. They explained that there had been a large number of informal communications between each of the parties and key stakeholders such as commissioners, ambulance trusts, community trusts and the local authority, to discuss benefits.
334. They had, however, not yet consulted on any service reconfigurations associated with the merger or provided their commissioners with details (other than a broad overview of the benefits as they had been proposed to us) of any cases for service reconfiguration for their consideration (see further paragraph 9.51 below).

¹⁷⁰ See, for example, *Royal Brompton & Harefield NHS Foundation Trust v Joint Committee of Primary Care Trusts [2011] EWHC 2986 (Admin)*.

¹⁷¹ Department of Health, *Local Authority Health Scrutiny, Proposals for consultation*, 12 July 2012.

335. They had been advised by external consultants that the best option would be to first merge the trusts and then carry out service reconfigurations. The parties explained that the merger would allow the creation of a single clinical body; if clinicians remained separate at reconfiguration then they might disagree over location and distribution of services due to understandable loyalty to their existing foundation trust. The parties also thought that a merger would create more unified local community support for reconfiguration, including at a political level. In addition, they considered that merging first would resolve competition and patient choice issues.
336. In terms of timing, the parties submitted that a reconfiguration process could take approximately 38 weeks, beginning with a listening exercise, followed by user engagement and stakeholder engagement and terminating with a formal consultation. The parties indicated that they might consult on more than one service reconfiguration within a single exercise, although they would allow themselves flexibility if one area was challenged to avoid delays to implementation in other areas.

Assessment

337. In our view, formal consultation is likely to be relevant to the proposed reconfigurations of haematology, A&E and emergency surgery. In relation to maternity services, it is not proposed to consolidate the services provided at RBCH and PH on to one site, and the parties confirmed that a public consultation was not required for the building of a new maternity unit at PH.
338. There is a fairly consistent view from the parties and third parties with whom we discussed this that consultation on reconfiguration of services is more challenging in a situation where there are two separate organizations (and sites) and where it is proposed that services will in future be mainly (or exclusively) provided at one site. That is because it will be more difficult to align clinical opinion on the benefits of reconfiguration compared with a situation in which such reconfiguration is proposed in the context of a single (merged) organization.
339. In general, we did not consider that the merger was a prerequisite to successful consultation on reconfiguration of services between providers; although in some circumstances a merger may make a consultation process shorter and more straightforward. We did, however, recognize that consultation in relation to certain services would be more controversial, and could therefore potentially take longer, than in relation to other services. The greater the number of people potentially affected by the reconfiguration, and the longer the additional distance that people have to travel to reach services, the greater the potential for opposition to the proposals.

Glossary

Note: In this glossary we describe the main categories of NHS services that are relevant to our consideration of the merger. These categories of services are not legally defined, and they are not mutually exclusive.

ACS	Acute coronary syndromes.
Act	Enterprise Act 2002.
Acute services	A subset of secondary care ; services which are provided in a hospital setting.
AQP	Any Qualified Provider. Previously referred to as Any Willing Provider (AWP). Under the AQP scheme, patients can select from any NHS or independent sector provider of acute elective care in England that is registered with the CQC , has a local commissioner or nationally-led NHS Standard Contract , and is willing to provide services at the NHS tariff.
AWP	See AQP .
BCIS	British Cardiovascular Intervention Society.
Block contract	A fixed amount is payable to a provider to cover treatment for a population of patients, irrespective of the numbers of patients treated or the type of treatment provided. See also managed contract .
BMI	BMI Healthcare Limited. BMI The Harbour Hospital is located in Poole and is part of BMI. BMI is a provider of independent health-care with a nationwide network of hospitals and clinics.
BMT	Bone marrow transplant. It is a Level 3 haematology service.
Catchment area	The area from which a hospital draws most of its patients.
CCGs	Clinical Commissioning Groups, responsible for implementing the commissioning roles as set out in the HSCA 2012 . CCGs are groups of GP practices that are responsible for commissioning most health and care services for patients within their local communities. CCGs are not responsible for commissioning all services. They have the flexibility to decide which commissioning activities they undertake themselves or choose to buy in commissioning support from external organizations.
CCP	Cooperation and Competition Panel.
CEM	College of Emergency Medicine.
Choose and Book	A national electronic referral service which gives patients a choice of place, date and time for their first outpatient appointment in a hospital or clinic: www.chooseandbook.nhs.uk .
CIP	Cost Improvement Plan.

Community health services	A diverse range of services that are provided to patients in the home, in health centres, schools, community buildings or in small local hospitals. Services include: health visiting, school nursing, district nursing, health promotion drop-in sessions, residential care home visits, community dentistry, nutrition and dietetics, occupational therapy, speech and language therapy, diabetes care and many more.
COS rating	Continuity of services rating.
CQC	Care Quality Commission, the independent regulator of health-care, adult social care and primary dental care services in England. It also protects the interests of vulnerable people, including those whose rights are restricted under the Mental Health Act.
CQUIN	Commissioning for Quality and Innovation, introduced in April 2009 as a national framework for locally-agreed quality improvement schemes. It enables commissioners to reward excellence by linking a proportion of English healthcare providers' income to the achievement of local quality improvement goals.
Day case	Where a patient is admitted electively during the course of a day with the intention of receiving care, who does not require the use of a hospital bed overnight and who returns home as scheduled. If this original intention is not fulfilled and the patient stays overnight, this will be an ordinary admission.
Deaneries	Responsible for the management and delivery of postgraduate medical education in addition to supporting the continuing professional development of all doctors and dentists.
Diagnostic service	Service used for the analysis or detection of diseases or other medical conditions.
Diagnosis	Many patients admitted by physicians have multiple diagnoses. For each admission a primary diagnosis is designated relating to the main condition treated or investigated.
Dorset CCG	Dorset Clinical Commissioning Group.
Dorset County Hospital	Dorset County Hospital NHS Foundation Trust.
DHUFT	Dorset HealthCare University NHS Foundation Trust, which provides integrated community health and mental health, specialist learning disability services, community brain injury, community dental services including community hospitals and prison healthcare across a range of locations throughout Dorset.
Dorset PCT cluster	The NHS Bournemouth and Poole PCT and NHS Dorset PCT, which were the primary commissioners for RBCH and PH . On 31 March 2013, these PCTs ceased to exist and were replaced by one CCG covering all of Dorset and Poole. It is known as the Dorset CCG .

Dr Foster	Provider of comparative information on health and social care services.
EDHS	East Dorset Haematology Service.
Elective service	A service that is scheduled in advance for a particular patient (for example, a scheduled operation). Generally, the decision to admit the patient is separated in time from the actual admission. Elective services are provided by medical specialists in a hospital or other secondary care setting.
Emergency surgery	Emergency surgery is non-elective surgery performed when the patient's life or well-being is in direct jeopardy.
FCE	Finished Consultant Episode. A consultant episode is the time a patient spends in the continuous care of one consultant using the site in one healthcare provider. When a consultant episode ends, the episode is finished.
FFT	Friends and family test.
Foundation Trust Network	The membership organization for the NHS acute hospitals and community, mental health and ambulance services that treat patients and service users in the NHS .
FRR	Financial Risk Rating (issued by Monitor to a foundation trust).
FTE	Full-time equivalent.
GMC	General Medical Council, the independent regulator for doctors in the UK.
Governance arrangements	A set of rules that govern the internal conduct of an organization and are usually set out in the constitutional documents of the organization and part of the licence of NHS foundation trusts .
Governor	A foundation trust member elected to serve on the Council of Governors.
GP	General Practitioner, a doctor who works in a local surgery or health centre, providing medical advice and treatment to patients registered on their list.
Hampshire Hospitals	Hampshire Hospitals NHS Foundation Trust.
HES	Hospital Episode Statistics, a data warehouse containing data from SUS . At prearranged times during the year, SUS takes an extract from its database and sends it to HES. Data on SUS will continue to change, but HES data is fixed as it was when that particular extract was taken. This is why there may be differences between analyses from SUS and from HES. HES validates and cleans the SUS extract, before deriving new items and making the information available in the data warehouse. HES is the data source for a wide range of healthcare analysis for the NHS, Government and many other organizations and individuals. It contains admitted patient care data from 1989 onwards, with more than 12 million new records added each year, and outpatient

attendance data from 2003 onwards, with more than 40 million new records added each year.

Hospital admission	A hospital admission records the event that a clinical decision to admit a patient to a particular healthcare provider has been made by or on behalf of someone who has the right of admission. This decision to admit denotes that the patient is intended to be admitted to a hospital bed, either immediately or subsequently in the future.
HRG	Healthcare Resource Group, groupings of interventions (of similar cost and clinical meaning), eg coronary artery bypass grafts.
HSCA 2012	Health and Social Care Act 2012.
Indicative Activity Plan	The NHS Standard Contract requires detailed reporting by providers and compliance (by commissioners and providers) with the patient choice regime. (Service conditions 6, 28 and 29, NHS Standard Contract . This includes a requirement that 'The Parties must not agree or implement any action that would operate contrary to Patient Choice Guidance or so as to impede the exercise of Patient Choice.) The parties must agree an Indicative Activity Plan within the framework of the NHS Standard Contract before the start of each contract year, setting out the activity the provider will be expected to provide and be remunerated for under the contract.
Inpatient service	Service provided to patients who have been admitted to hospital, either as a day case (RBCN noted that it referred to 'admissions' which captured inpatient and day-case activity), or for a longer period of time.
IRP	Independent Reconfiguration Panel.
Isochrone	Line joining points of equal travel time to a hospital site.
ISTC	Independent Sector Treatment Centre.
Managed contract	Under the managed contract the level of trust's activity is pre-agreed at the start of the year and the commissioner need not pay for activity over and above the level agreed within the contract. We note that this is similar to the NHS definition of a block contract .
Members	Individuals and organizations with an interest in the development and well-being of an NHS foundation trust which registers as a member. Members are able to stand for election to the Council of Governors.
Monitor	The Regulator of all NHS foundation trusts which oversees performance.
MSFT	Mid-Staffordshire Foundation Trust.
NHS	National Health Service.

NHS England	The HSCA 2012 established the NHS Commissioning Board (known as NHS England) in October 2012, although it only took on its full functions on 1 April 2013. NHS England is responsible for overseeing the financial situation of CCGs and compliance with their statutory duties and for commissioning services including primary medical services and specialised services . NHS England is comprised of eight directorates. The operations directorate is split across four regions: (a) NHS North of England; (b) NHS Midlands and East; (c) NHS South of England; and (d) NHS London. There are 27 local area teams. The merger parties are in the NHS South of England region and are covered by Wessex NHS England. The NHS England (Wessex) replaced the South West Specialist Commissioner in commissioning specialised services from the merging parties from 1 April 2013.
NHS England (Wessex)	The Local Area Team of NHS England for Wessex. It has direct commissioning responsibilities for services including primary medical services and specialised services in the Wessex area.
NHS foundation trust	A public benefit healthcare organization created by Act of Parliament to treat NHS patients.
NHS Standard Contract	The NHS Standard Contract 2013/14 must be used by CCGs when entering into contracts for clinical services and by NHS England when entering into all contracts for non-primary care clinical services. Commissioning has been carried out within the framework of similar NHS Standard Contracts for a number of years. The 2013/14 NHS Standard Contract is available on NHS England's website. It is prepared by the Department of Health NHS Standard Contracts Team on behalf of NHS England .
NHS Trust	A public benefit healthcare organization created by Act of Parliament to treat NHS patients.
NICE	The National Institute for Health and Care Excellence.
Non-elective service	These are not scheduled in advance; they arise when admission is unpredictable and at short notice because of clinical need. A particular service can be provided on an elective or non-elective basis. For example, an elective caesarean section is a planned caesarean, when the need for the procedure is agreed in advance and the operation takes place before the natural onset of labour. An emergency (non-elective) caesarean section is carried out when the need for a caesarean is urgent. This may happen if an elective caesarean was planned but labour has started earlier than predicted, if there are complications with the pregnancy, or if labour has stopped or is very slow.
Nuffield Health	Established through the purchase of Cannons gyms, and the evolution of Nuffield hospitals and Proactive Health. It combined its private hospitals, health clinics, fitness and wellbeing centres, diagnostic units and a wide range of treatments into one complete healthcare service and has over 200 facilities across the UK. Nuffield Health Bournemouth Hospital (Nuffield Health) provides private healthcare, offering a wide range of medical and surgical services.

OFT	Office of Fair Trading.
Outpatient service	These are provided by a healthcare organization on an appointment basis without the need to be admitted or stay in hospital. An outpatient appointment may be used to assess further treatment or to follow up a patient after they have had a period of treatment or an operation.
PbR	Payment by results.
PbR Code of Conduct ('Code')	Published by the Department of Health, it aimed to establish the principles that should govern organizational behaviour under PbR and set expectations as to how the system should operate. It is reviewed annually and is drafted so that it is consistent with the NHS Standard Contract . The 2013/14 Code is the final Code for which the Department of Health was responsible. It will be for NHS England and Monitor to determine whether a successor document will be published.
PCTs	Primary care trusts, organizations with responsibilities for improving the health of the community, developing primary and community health services and commissioning secondary care, community and mental health services.
PH	Poole Hospital NHS Foundation Trust.
PPCI	Primary percutaneous coronary intervention.
PPU	Private patients unit.
Primary care	Medical services provided by GP practices, dental practices, community pharmacies and high street optometrists. It is defined by the World Health Organization as 'essential health care; based on practical, scientifically sound, and socially acceptable method and technology; universally accessible to all in the community through their full participation; at an affordable cost; and geared toward self-reliance and self-determination'.
Private healthcare services	The defining characteristic of these services is their source of funding: patients or their insurers directly pay for the provision of these services as opposed to NHS commissioning groups. As these activities are not publicly funded through the NHS , private healthcare providers—or NHS providers of private work—have flexibility in choosing the services and specialties to offer and in negotiating tariffs. In addition, services offered to fee-paying patients are likely to be routine elective services that are typically planned in advance and often require a referral from a GP or another consultant. These services may be offered as outpatient , inpatient or day-case activities.
Procedure	Any type of intervention or operation as classified under OPCS-4 (<i>Classification of Interventions and Procedures</i>). The OPCS Classification of Interventions and Procedures (OPCS-4) is a Fundamental Information Standard. The classification is used by Health Care Providers and Strategic Health Authorities.

RBCH	The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust.
RCBs	Relevant customer benefits.
Salisbury District Hospital	Salisbury Hospital NHS Foundation Trust.
Secondary care	Medical care provided by specialists (consultants) in a particular field of medicine, whether in a hospital or community setting. Patients are referred to these specialists by another doctor, commonly a GP . Examples of specialists include cardiologists, gynaecologists or psychiatrists.
SLC	Substantial lessening of competition.
South West Specialised Commissioner	In the Dorset area, specialised services have in the past five to six years been commissioned by the South West Specialised Commissioner.
Specialised services	Those NHS services defined in law as having a planning population of more than 1 million people as formerly set out in the Specialised Services National Definitions Set and revised in the Manual for Prescribed Specialised Services. These are services normally commissioned (or to be commissioned) by a specialist commissioner .
Specialist commissioner	Commissioner of specialised services.
Specialty	According to the Health & Social Care Information Centre , specialties are divisions of clinical work which may be defined by body systems (dermatology), age (paediatrics), clinical technology (nuclear medicine), clinical function (rheumatology), group of diseases (oncology) or combinations of these factors. Specialties are designated by Royal Colleges. Healthcare services can be classified according to the specialty within which the consultant with prime responsibility for the patient is recognized or contracted to the organization (main specialty) or the specialised service within which the patient is treated (treatment function).
Spell	The whole hospital stay of a patient, from admission to discharge. For complex patients, the spell may contain many episodes (FCE) of care under different consultants. Under PbR , costs are assigned to spells based on the dominant episode within the spell (this is usually the most expensive one). Each FCE may contain a number of treatments . Each treatment can be either a diagnosis or a procedure .
Spire Southampton	Spire Healthcare is a provider of private healthcare, with 37 private hospitals throughout the UK. Spire Southampton Hospital offers comprehensive private hospital treatments, procedures, tests and scans to patients from Hampshire, Dorset, Wiltshire, the Isle of Wight, the south coast of England and the Channel Islands.

SUS	Secondary uses service. The single repository of person and care event level data relating to the NHS care of patients, which is used for management and clinical purposes other than direct patient care. These secondary uses include healthcare planning, commissioning, public health, clinical audit, benchmarking, performance improvement, research and clinical governance. The data currently managed within SUS is derived from commissioning data sets, which providers of NHS care must submit and make available to commissioners.
Tertiary care	Services provided in more specialised medical centres, often covering a much larger catchment population; examples include specialist centres in neurosurgery, paediatric cardiac surgery and cancer care. Patients may be referred to tertiary care by their GP or by a consultant.
TIA	Transient ischaemic attack.
Treatment	We use the phrase ‘treatment’ to cover diagnoses and procedures .
University Hospital Southampton	University Hospital Southampton NHS Foundation Trust.
West Hampshire CCG	Hampshire PCT was split into five CCGs and the West Hampshire CCG is now responsible for commissioning for the area of the population which is served by hospitals including RBCH .
Wider Dorset area	Area covered by the Dorset CCG and the West Hampshire CCG (New West Forest and Totton & Waterside). These two CCGs commission the large majority of activity provided by RBCH and PH .
Yeovil District Hospital	Yeovil District Hospital NHS Foundation Trust.