



# **The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust/Poole Hospital NHS Foundation Trust**

A report on the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust

Competition Commission 2013

*Website:* [www.competition-commission.org.uk](http://www.competition-commission.org.uk)

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The Competition Commission has excluded from this published version of the report information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [X]. Some numbers have been replaced by a range. These are shown in square brackets. Non-sensitive wording is also indicated in square brackets.

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## Summary

1. On 8 January 2013, the Office of Fair Trading (OFT) referred the anticipated merger of The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCH) and Poole Hospital NHS Foundation Trust (PH) to the Competition Commission (CC) for investigation and report under the Enterprise Act 2002 (the Act). We are required to publish our final report by 21 October 2013.<sup>1</sup>
2. The reference requires us to determine:
  - whether arrangements are in progress or in contemplation which, if carried into effect, will result in the creation of a relevant merger situation; and
  - if so, whether the creation of that situation may be expected to result in a substantial lessening of competition (SLC) within any market or markets in the UK for goods or services.
3. On 29 November 2011, RBCH and PH (the parties) announced their intention to merge. RBCH and PH both provide a range of healthcare services in the Dorset area including hospital-based elective care, hospital-based non-elective care, outpatient services, specialised services, community services and private services.
4. RBCH and PH are both NHS foundation trusts and this is the first merger between two NHS foundation trusts to be referred to the CC. It follows the enactment of the Health and Social Care Act 2012 (HSCA 2012), which confirmed the OFT and CC's roles in assessing the competition aspects of mergers involving foundation trusts. Foundation trusts are independent organizations which have a significant degree of autonomy in managing their affairs.
5. In carrying out our inquiry we were conscious that, whilst there are important aspects of the NHS that distinguish it from other sectors, health policy has for some time been that patient choice is in itself an important aim and has an important role in incentivizing hospitals to maintain and increase quality. The fact that they stand to gain or lose revenues from patients exercising choice is important. We were also conscious of the significant changes taking place in the industry due to the HSCA 2012 and of the financial constraints faced by the NHS.
6. This is the first merger involving NHS foundation trusts to be considered by the CC. We note that the inquiry took longer than we would have wished. Our hope is that in future, merging NHS hospitals will ensure that they are able to provide us with timely, accurate and consistent information regarding their activities and proposals, and that they will carefully consider the rationale for the merger and their post-merger reconfiguration plans from the perspective of patients. This should assist that the CC will be able to deal with NHS hospital mergers more expeditiously in future.
7. We found that the proposed merger, if carried into effect, would result in the creation of a relevant merger situation because it would result in the parties ceasing to be distinct pursuant to section 79(1) of the HSCA 2012 and because the turnover of

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<sup>1</sup> The original deadline for our report was 24 June 2013. 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. 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. We issued a further [notice of extension](#) on 5 August 2013 and the period within which the report on the reference was to be prepared and published was revised to end on 21 October 2013.

each of RBCH and PH exceeded £70 million in the UK and the turnover test was therefore met.

## Industry background

8. The parties provide publicly-funded healthcare services to NHS patients. In our approach to this merger, we took account of the regulatory frameworks within which the parties must operate when providing services. We considered a number of questions relevant to how foundation trusts operate including 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; how foundation trusts receive funding; quality and governance of foundation trusts; competition policy and law in supply of NHS services; the extent to which foundation trusts have incentives to compete; and Monitor's supervision of foundation trusts.
9. We noted that foundation trusts are hospitals which are required to provide certain NHS services but are also afforded a degree of operational autonomy. Their principal purpose is the provision of goods and services for the health service in England. They 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.
10. We noted that the primary commissioner for RBCH and PH was the Dorset Clinical Commissioning Group (Dorset CCG). One of the areas West Hampshire Clinical Commissioning Group (West Hampshire CCG) is responsible for commissioning for is West New Forest and Totton & Waterside, which is served by hospitals including RBCH. For the purposes of our analysis we referred to the areas covered by Dorset CCG and the relevant areas covered by West Hampshire CCG (West New Forest and Totton & Waterside) as the wider Dorset area. The Wessex Area Team of NHS England (NHS England (Wessex)) commissions specialised services (which treat either rare conditions or those that need a specialised team working together at a centre) from the parties.
11. We considered the framework within which competition in the provision of NHS healthcare services has been considered in the past, for example by the Cooperation and Competition Panel (CCP). We noted that there are, broadly speaking, two different models of competition in the provision of NHS healthcare services:
  - (a) *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 set centrally. The initiatives related to patient choice are relevant to competition *in the market*, which occurs mainly in respect of routine elective (planned) services as well as maternity services. Hospitals are motivated to compete on quality in order to attract patient referrals and hence income.
  - (b) *Competition for the market*, which occurs where the commissioning entity uses a competitive process to choose between different providers for the right to provide services to patients.
12. 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.

13. We noted that patients have a choice of provider in respect of their first consultant-led outpatient appointment for elective care and for maternity services. We considered the extent to which foundation trusts have incentives to compete for patients and found that the patient choice and payment by results (PbR) regimes incentivize acute service providers to compete for patients. The PbR regime sets tariffs for procedures and providers are paid according to the number of procedures which they carry out. National PbR tariffs cover the majority of acute healthcare (elective and non-elective) in hospitals. Through the regulatory framework that has been set up, including the PbR regime and the commissioning of services by Clinical Commissioning Groups (CCGs), foundation trusts 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. However, tariffs do not always accurately reflect costs of provision and this may affect these incentives. The extent to which these incentives work according to policy in the wider Dorset area are considered in detail in our competitive effects assessment.
14. We noted Monitor's supervision of 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. Foundation trusts are incentivized to be financially healthy via the Monitor regulatory framework, one aspect of which rates foundation trusts on the basis of their financial stability. Monitor can put failing trusts into special administration, a process which may result, in extreme circumstances, in a provider (but not necessarily all of the services it provides) exiting the market.

### **Rationale for the merger**

15. The parties told us that they faced financial and clinical challenges, many of which were common to acute NHS hospitals, but that PH faced more significant financial challenges than most. RBCH told us it believed that a merger with PH would achieve economies of scale, improve its consultant cover, realize synergies and make both trusts more financially resilient. PH told us it concluded that a merger with RBCH would provide them with greater financial stability and enable them to meet Royal Colleges' guidance in relation to some aspects of their service provision.
16. The parties told us that the merger of RBCH and PH would involve a reconfiguration of some of the services provided by the hospitals but that the detailed planning for any such reconfiguration had not yet been done. The parties provided us with plans in relation to reconfiguration proposals for maternity, cardiology, haematology, accident and emergency (A&E) and emergency surgery services, which we considered in detail in our analysis of whether the merger would be likely to result in benefits to patients. Some of these reconfigurations would have to be consulted on to test that the reconfiguration had GP leads and commissioner support; would sustain or improve choice; and had a sound evidence base.

### **Counterfactual**

17. We considered the situation that would have prevailed absent the merger (the counterfactual).
18. The parties submitted that the appropriate counterfactual was one in which PH exited the market. Based on our analysis of the financial situations of RBCH and PH and our analysis of the manner in which the Monitor failure regime (including the special

administration process) operates, our conclusion is that, without the merger, neither party would have exited the market.

19. The parties had considered a number of alternatives to the merger. We reviewed the evidence and found that the most likely alternative, absent the merger, was that the hospitals remained as stand-alone entities.
20. We considered the extent to which the parties' service offerings might change in the counterfactual, in particular in the case of PH, due both to financial constraints and in light of information we received regarding service reconfigurations. We found that their service offerings were likely to remain broadly similar to their current offerings.
21. For the purposes of our competitive assessment, our conclusion is that in the counterfactual both parties would remain as stand-alone entities, providing broadly similar service offerings to their current offerings.

### **The relevant markets**

22. RBCH and PH both provide a wide range of hospital-based services including elective and non-elective secondary inpatient care, specialised clinical services and community and outpatient services. These services can be classified as specialties, which can be further divided into sub-specialties. We found that as there is typically only one treatment that is appropriate for a specific healthcare problem, there is effectively no demand-side substitutability.
23. We then considered whether different services could be aggregated into broader markets on the basis that suppliers may switch easily and in a timely fashion between the provision of certain services in response to changes in demand, or on the basis that the same suppliers compete to supply the services concerned and the conditions of competition are the same for each service.
24. We concluded that:
  - (a) Each specialty constitutes a separate market. Where there are limits to supply-side substitution within specialties we took constraints at sub-specialty level into account in our competitive effects assessment.
  - (b) Within each specialty:
    - (i) We treated outpatient and inpatient activities as separate markets and we noted that there is an asymmetric constraint between inpatient and outpatient, with inpatient providers readily capable of providing outpatient services but not vice versa. We considered day cases as part of the relevant inpatient market.
    - (ii) Outpatient (and to a lesser extent inpatient) services should not be further separated according to whether or not the services can be provided in community settings, but certain services are provided only in the community and should be viewed as separate markets.
    - (iii) Non-elective and elective activities are separate markets, although the provision of elective activities may be constrained to some extent by non-elective providers.
  - (c) Private services are separate markets from NHS services. Within private services, each specialty constitutes a separate market and within each specialty,

markets can be defined along inpatient and outpatient lines (as with NHS services).

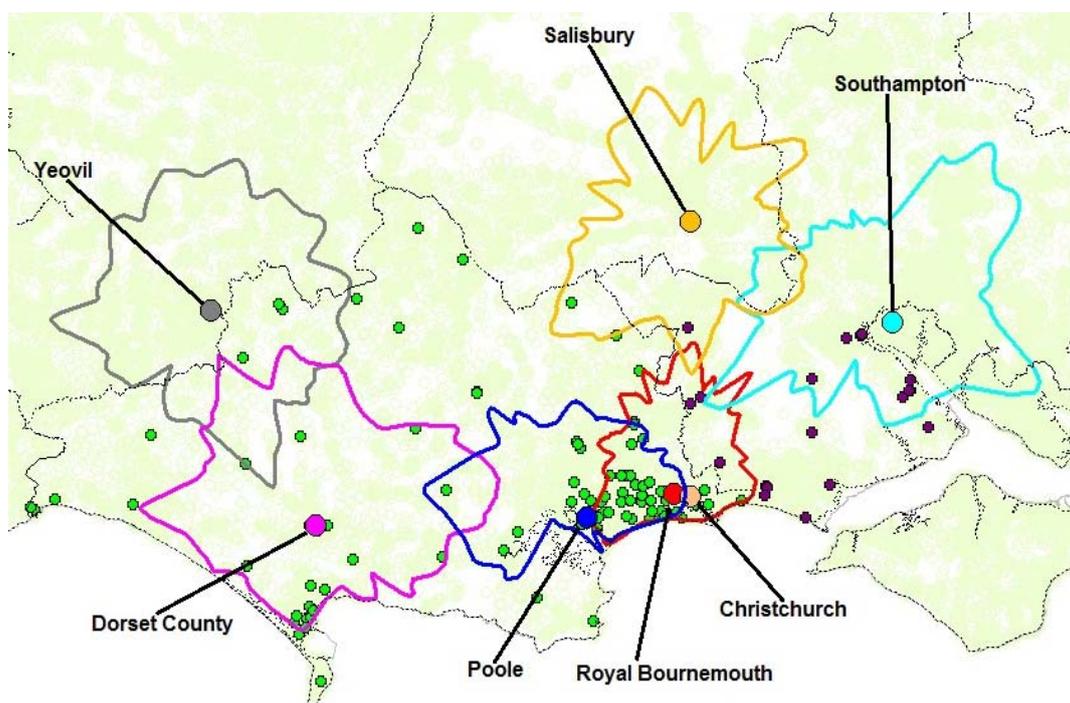
25. We considered the relevant geographic market in which to conduct our analysis. The evidence indicated that the merging trusts attract most of their patients from within a drive-time (or isochrone) of 17 minutes for RBCH and of 22 minutes for PH. We used the isochrones based on our catchment area 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 these isochrones.

## **Competitive effects**

26. We considered the likely effects of the proposed merger in relation to six groups of services in turn: elective services (including overlap elective specialised services), non-elective services (excluding maternity services and including non-elective overlap specialised services); maternity services—these are non-elective services but we considered them separately as they have many aspects (such as how patients choose) which make them more similar to elective services; community services; competition for the market in elective, non-elective, specialised and community services; and private services.
27. In order to assess whether the merger would give rise to a loss of competition in the provision of the relevant NHS acute services in the wider Dorset area, we considered: the relevant markets; the competitive effects of the proposed merger; and whether countervailing factors such as buyer power, entry and expansion or rivalry-enhancing efficiencies existed which would constrain the parties from reducing quality in relation to services where we found that unilateral effects were likely to occur as a result of the merger.
28. Unilateral effects are effects that may arise in horizontal mergers where the merger involves two competing entities and removes the rivalry between them. In relation to competition *in* the market for provision of NHS acute services, competition is almost always on quality, rather than on price, as the majority of services are covered by the PbR regime. From our assessment of the way in which competition in the market works in the NHS, we understood that the role of competition is to focus providers' strategic decisions such that they take account of those factors that matter to patients and their GPs when they decide which hospital to attend. For this reason, when analysing the likely unilateral effects of the merger in relation to quality competition, we assessed which quality factors were relevant to patient and GP choice such as clinical outcomes, location, waiting times, accessibility, quality of care and other issues identified by patients.
29. We noted that RBCH is 8 miles by road and 18 minutes' drive-time from PH and they are each other's closest geographical competitor. Both trusts are acute hospitals providing a comprehensive range of inpatient and outpatient healthcare services. In addition to providing general services, both trusts provided maternity services and consultant-led emergency services. RBCH and PH both perform well against a number of quality indicators.
30. Figure 1 below shows the locations of NHS foundation trusts in the region and the GP practices within the wider Dorset area. Much of our economic analysis also included data on activities provided in the area by NHS community hospitals. However, as we found that these hospitals only overlapped with the parties to a limited extent in the provision of acute services, we do not include them in Figure 1.

FIGURE 1

### Foundation trusts in the wider Dorset area



Source: CC calculations.

Note: The green dots indicate the locations of GP practices in the Dorset CCG region and purple dots, GP practices in the West Hampshire CCG region. The coloured line around each hospital shows its catchment area.

31. The parties told us that they were not close competitors because they provided a different range of services and because they did not have incentives to compete (because of their funding arrangements, capacity constraints and the degree of cooperation between them in the form of shared consultants).

### Overlaps

32. We analysed overlaps between the parties at specialty level. We found that the parties overlapped in provision of:
  - inpatient services in 19 elective specialties;
  - inpatient services in 21 non-elective specialties; and
  - outpatient services in 36 specialties.

These specialties represented a significant proportion of the parties' income, whether calculated at specialty level or at treatment level. We estimated that the parties overlapped in specialties that represented a significant proportion of their total clinical revenues (61–70 and 61–70 per cent for RBCH and PH respectively).

33. However, on the basis that there may be a degree of differentiation within specialties, we took constraints at sub-specialty level into account by analysing the extent to which the parties overlapped within specialties at treatment level.

34. We considered specialised services within our analysis of elective, non-elective and outpatient services and found that they overlapped in 17 specialised services in 2013/14 and a further four in the recent past.

### ***Elective services***

35. We examined whether the merger might lead to unilateral effects in relation to the provision of outpatient and inpatient elective services. We considered the views of the parties and third parties; the effects of the merger on actual competition *in* the relevant markets; and finally the effects of the merger on potential competition *in* the relevant markets. We considered competition *for* the relevant elective services markets separately later in our report.
36. Having established that the parties overlap to a significant degree in the provision of elective services, to determine whether a lessening of competition in relation to provision of elective services could arise, we analysed whether all of the following conditions apply to the overlap elective services:
- (a) patients and/or GPs have and exercise choice of provider;
  - (b) quality influences that choice;
  - (c) the parties would have an incentive to compete to attract patients absent the merger; and
  - (d) the parties are close competitors.
37. We then considered whether the merger would likely give rise to adverse effects in any elective services, due to a removal of rivalry between the parties.

### ***The nature of competition in elective services***

38. As providers of publicly-funded NHS services for patients, foundation trusts have many different objectives. Healthcare professionals and managers, in general, want to deliver high-quality care for their patients. However, these organizations also have the objective of ensuring they receive sufficient revenue to cover the costs of provision of healthcare services. Foundation trusts can retain any surplus for investment in new or improved services for patients, so they have an incentive to generate surpluses. As there is a fixed price for each elective treatment under the PbR regime, this means that foundation trusts have an incentive to compete on quality to attract patients to their profitable elective services.
39. There are many different aspects of quality, including clinical factors such as infection rates, mortality rates, ratio of nurses or doctors to patients, and compliance with best practice (eg Royal Colleges' guidance); and non-clinical factors such as waiting times, food and environment, choice of location (if services can be provided on more than one site), quality of non-clinical staff and parking facilities. Some aspects of quality, such as mortality rates or waiting times, are directly observable. In other ways, quality can only be judged once the patient has received treatment. This means that patients and GPs will assess quality in a number of different ways, including by reference to the general reputation of a hospital.
40. We found that GPs and patients both contribute to the choice of provider and will have access to different sources of information. Hospital services tend to be experience or credence goods, ie quality does not necessarily or entirely take the

form of qualities that can be measured or observed ex ante (or even ex post), and while patients may rely to some extent on their own or friends' personal experience, GPs are well placed to observe the quality of services and to interpret published information on quality. Therefore, we considered that GPs act appropriately as advisers in patients' decisions about choice of hospital. Unlike price or quantity, many aspects of quality cannot be set directly. The quality of a product or service is the outcome of many different decisions that are made at many different levels across an organization. In the case of hospital services, these decisions are taken by clinicians and managers. In doing so, we understand that they trade off different factors.

41. The effect of competition is to focus these decisions such that account is taken of the factors that matter to patients and GPs. The greater the number and quality of alternative hospitals in the local area, the stronger the trusts' incentives will be to focus on delivering those aspects of quality that are important to the trusts' patients and their GPs. In this way, we expected competition between hospitals to lead them to make spending decisions in a way that best reflects the factors that matter to patients and their GPs.

#### *Extent of patient/GP choice*

42. Patients have a right to choice of provider for their first consultant-led outpatient appointment for routine elective services, which is enshrined in the NHS Constitution. Even where patients do not exercise this choice themselves (either with or without the advice of their GP), their GP will take the decision as to where the patient should be referred, and similar factors may be relevant to the GP's choice. We found that, where there are realistic alternatives available, choice will be exercised by patients and/or GPs in relation to first outpatient appointments. This choice will affect both outpatient and inpatient parts of the pathway, and the exercise of this choice generates scope for hospitals to compete against one another in relation to both outpatient and inpatient services.

#### *The influence of quality on patient and GP choice*

43. We considered the extent to which quality of elective services influences patient and/or GP choices. We considered the views of RBCH, PH and third parties on the role of quality competition in the NHS. We also considered evidence from economic literature on choice and competition in the NHS; the evidence obtained via our survey of patients and GPs in the Dorset area on the role of quality in their choice of which hospital to attend; our analysis of GP referral patterns and what this tells us about the role of quality in their choice of which hospital to attend; and the marketing strategies of the parties.
44. The survey indicated that a significant proportion of patients do exercise choice in relation to hospitals; that quality influences choice; and that if quality (using waiting times as a quality indicator) were to decrease, a proportion of patients would consider switching. We also found that a significant proportion of patients attended their nearest hospital, indicating that proximity plays an important role in patients' decisions. We also analysed the evolution of hospital shares over time at the GP practice level, which showed some variation over time, indicating that factors other than location were likely to be influencing patients' choices.

#### *Incentives to compete*

45. A fundamental principle of the NHS policy framework (including the PbR framework, the introduction of foundation trusts with their ability to retain surpluses and changes

to the regime for competition enforcement), is that there are incentives for the parties to compete to attract patients in order to earn income.

46. We reviewed (a) information provided by the parties on their approaches to marketing and (b) their internal documents, with a view to establishing whether these were consistent with them competing on quality in the past and, if so, what quality measures were relevant. Some of RBCH's documents indicated that it had (or believed it had) the incentive and ability to affect referral patterns and the number of patients it treated, and that it competed with other healthcare providers (including PH, other hospitals in the wider area, and providers in the community for certain services). The parties' post-merger plans showed their awareness of the role of competition and provided some examples of the benefits of competition.
47. We assessed the extent to which the parties' incentives might have been affected by:
  - (a) the profitability of increasing elective activity given the tariffs and cost structure;
  - (b) the contracts the parties have in place with each other for sharing of clinical staff;
  - (c) capacity constraints;
  - (d) the relationships the parties have with CCGs; and
  - (e) regulatory factors relevant to quality standards.
48. We concluded that although their incentives are weakened to some extent by uncertainty over payment for extra activity and, at the aggregate level, by constraints on expanding overall capacity, incentives to compete remain. We considered that the parties' incentives to compete for patients could be stronger in the future.

### *Closeness of competition*

49. We considered the extent to which the parties are close competitors compared with other hospitals in and around the wider Dorset area. We found that:
  - (a) There is little overlap between the catchment areas of the parties and those of any other acute hospital.
  - (b) Location is important in patients' choice of hospitals, which implied that the parties could be expected to be each other's closest competitor and that other competitors could exert significantly less constraint.
  - (c) Our survey found that for patients who had chosen one of the parties, the other merging party was the most likely to be discussed with GPs and the most likely second choice, although not always a close second. It also showed that a large proportion of patients did not know where else they would go, and of those who did, a majority strongly preferred the other merging party to a third-choice hospital.
  - (d) Looking at GP referral patterns, the parties were the best ranked alternative to each other at the majority of GP practices from which they drew patients, and more so at practices from which they drew the bulk of their referrals.
  - (e) The merger would significantly reduce the proportion of the parties' revenue earned from referrals by GP practices where they currently face competition and

therefore we expected the merger would significantly alter their competitive incentives.

50. We found that the parties are the closest alternative to one another for patients and GPs in the local area and they are likely to face limited constraints from other healthcare providers in the area for a large proportion of their services. Our analysis indicated that the merger would significantly reduce the proportion of the parties' revenue earned from referrals by GP practices where they currently face competition and therefore we expected that the merger would significantly alter their competitive incentives.
51. We received evidence that the parties competed with each other prior to the decision to merge, in so far as they engaged in marketing and strategic behaviour to some degree. Evidence from the parties' internal documents provided examples of the benefits of competition and the parties' intent to attract patients by emphasizing aspects of quality. The examples include focusing on waiting times, implementing best practice guidance, delivering innovative models of care, extending expertise and enhanced service provision and improving facilities to attract patients. The parties were aware of the role of competition and the importance of quality in maintaining or growing share of patient referrals.

#### ***Conclusion on the effect of the merger on actual competition in elective services***

52. In summary, we found that the parties overlapped in relation to 19 elective inpatient and 36 outpatient specialties (although two related only to follow-ups to emergency treatments and one to maternity). We found that patients (and/or GPs) would be likely to exercise choice in relation to elective services and that quality mattered to patients and GPs and appeared to be a factor driving choice. We found that the parties do have incentives to compete and are each other's closest competitors. We found evidence of competition between the parties and found that they would be likely to compete more in the foreseeable future absent the merger.
53. We therefore concluded that the merger would be likely to lead to unilateral effects in these markets for 19 elective inpatient specialties and 33 outpatient specialties that related to elective inpatient activity.
54. We expected that the loss of actual competition between the parties would result in less pressure to maintain and improve the quality of the services that they offer to patients. We found examples of the benefits of competition including focusing on waiting times, implementing best practice guidance, delivering innovative models of care, extending expertise and enhanced service provision and improving facilities to attract patients. We expected the loss of actual competition between the parties to manifest itself in a reduction (or lack of improvement) in quality in the overlap specialties in which competition would be removed. We also expected that the reduction in competition could manifest itself in a reduction in quality at the hospital level.

#### ***Conclusion on competition in non-elective services***

55. We found that there were areas of substantial overlap between the parties in the provision of non-elective services. We found that many patients do not have a choice of hospitals, because they are transported by emergency services according to ambulance protocols. For those that are not, we noted that there is no guarantee of choice (unlike in relation to elective services). We also noted that the link between quality and choice was likely to be less clear than with elective services, because

there is less opportunity for patients to make a choice based on quality (because they will have less opportunity to research it when they need emergency treatment and may not have input from a GP). The parties, especially RBCH, were not strongly incentivized to attract additional patients, and in some specialties may have no incentive to do so at the margin, due to the 30 per cent marginal rate tariff for emergency services<sup>2</sup> and, to a lesser extent, the reduced certainty over payments reflecting activity due to managed contracts with commissioners. For these reasons, we found that the proposed merger was unlikely to result in an SLC in relation to non-elective services.

### ***Conclusion on competition in maternity services***

56. Maternity services are classified as non-elective services but not as emergency services. The issues that arise are different from other non-elective services and more similar to elective services (in the manner in which choice is exercised) and therefore we have assessed them separately.
57. We found that patients had choice between maternity services providers and aspects of quality appeared important to their choices. RBCH attracted a significantly smaller number of mothers compared with PH (and could only accommodate low-risk births), but it nevertheless appeared to be the only provider other than PH with a substantial number of births in the parties' catchment areas. We therefore thought it was likely to be the strongest constraint on PH. Finally, we found that PH had incentives to try to attract more expectant mothers, and those incentives were likely to increase once PH's capacity had increased (which would happen absent the merger through a planned refurbishment). Therefore we found that the merger could be expected to lead to unilateral effects in maternity services (both inpatient and outpatient services).

### ***Conclusion on competition in community services***

58. We considered whether the merger may be expected to result in unilateral effects in the provision of community services supplied by both parties.
59. With the exception of certain maternity services (which we considered separately), and a general dermatology outpatient service (which is captured within the scope of our outpatient analysis), there was no overlap between the parties' activities in the supply of community services. Therefore the merger would not reduce competition in the market. Although it is possible that in the future more services will move into a community setting, and that there could be less competition in provision of those services as a result of the merger, we did not find evidence that there were any such services that both parties would be likely to supply in the counterfactual; and we considered that the relative ease of entry would be likely to offset any unilateral effects.

### ***Conclusion on competition 'for the market' in elective, non-elective, community and specialised services***

60. We considered whether the merger would be likely to lead to reduced competition in relation to services which commissioners may change or reconfigure, because the

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<sup>2</sup> 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.

merger would reduce the number of potential suppliers. 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).

61. There are generally two concerns in a merger when competition is ‘for the market’:
- (a) in the event of a competitive tender the merger could lead to worse outcomes because there would be fewer bidders (which may be reflected in commissioners receiving reduced value for money, including lower quality or, if prices are not set at national rates, higher prices); and
  - (b) suppliers on existing contracts might provide lower-quality services, knowing that commissioners had fewer options to replace them post-merger than in the counterfactual.
62. Based on information provided to us by the commissioners, we did not find that the merger would be likely to give rise to SLCs in relation to competition for the market for elective, non-elective, community or specialised services.

### ***Conclusion on private services***

63. We found that the parties overlapped in provision of a number of private services. In relation to most of these services, we considered that the parties were likely to be constrained by competing providers of private services, who offered the same services in larger volumes than the parties and in close proximity to the parties.
64. However, we found that there were no major alternative competing providers of inpatient private cardiology services in the relevant area who would be likely to constrain the merged entity. We therefore found that the merger would be likely to give rise to unilateral effects in relation to the supply of private inpatient cardiology services.

### ***Countervailing factors***

65. We concluded that the unilateral effects in relation to elective, non-elective, maternity and cardiology services outlined above were unlikely to be mitigated by countervailing buyer power or entry. The parties did not put forward any arguments in relation to efficiencies and we did not consider that efficiencies were likely to enhance rivalry in a way that would counteract any adverse merger impacts.

### ***Conclusions on the SLC test***

66. We have concluded that the proposed merger may be expected to result in an SLC in the wider Dorset area in the supply of the following services:
- (a) 19 elective inpatient services: general surgery, breast surgery, colorectal surgery, upper gastrointestinal surgery, pain management,<sup>3</sup> general medicine, gastroenterology, endocrinology, clinical haematology, hepatology, diabetic medicine, rehabilitation service, palliative medicine, cardiology, dermatology, respiratory medicine, rheumatology, geriatric medicine and gynaecology;

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<sup>3</sup> In relation to services other than persistent pain management.

(b) 34 outpatient services: general surgery, urology, breast surgery, colorectal surgery, hepatobiliary and pancreatic surgery, upper gastrointestinal surgery, vascular surgery, trauma & orthopaedics, ENT, ophthalmology, oral surgery, cardiothoracic surgery, anaesthetics, pain management, general medicine, gastroenterology, endocrinology, clinical haematology, hepatology, diabetic medicine, clinical genetics, rehabilitation service, palliative medicine, cardiology, dermatology, respiratory medicine, medical oncology, neurology, rheumatology, paediatrics, geriatric medicine, gynaecology, clinical oncology and maternity;

(c) one non-elective inpatient service: maternity; and

(d) one private service: cardiology.

67. We found that the affected specialties together accounted for approximately 21 to 30 per cent of PH's total clinical income and 21 to 30 per cent of RBCH's total clinical income.

### **Relevant customer benefits and remedies**

68. Having found that the merger may be expected to result in a substantial lessening of competition (SLC) in 55 services, we considered whether the merger would be likely to give rise to relevant customer benefits (RCBs) and whether any action should be taken to remedy, mitigate or prevent the SLC or any adverse effect arising from it.

69. The parties proposed to us that the merger would result in RCBs in five clinical areas: maternity; cardiology; haematology; A&E and emergency surgery. More specifically, the parties' preferred options (subject to any and all necessary legally-compliant clinical, stakeholder and public engagement and consultation on service change) are:

- For maternity, the hospitals have told us that the primary benefit is that they could build a new maternity unit. Their current preferred option would be to build this unit at the Poole hospital site.
- For cardiology, the hospitals have told us that they could combine cardiology rotas which would mean that patients at Poole will have access to a cardiologist 24/7, which they do not currently have.
- For haematology, the hospitals have told us that the merger would provide them with the opportunity to consolidate the level 3 haematology services (these are complex treatments for lymphoma and leukaemia) at Poole hospital, with a 'spoke service' (including outpatient and day cases) at Bournemouth hospital. They have told us this would allow improvements in quality and outcomes for patients.
- For A&E and emergency surgery, the hospitals have told us that services could be reconfigured after the merger to have a major injury A&E unit at one site which has consultant staff present 16 hours a day, seven days a week (rather than 12 hours a day during the week and 3 to 4.5 hours a day at weekends) and a minor injuries unit at the other hospital. Emergency surgery would be located with the major injury A&E unit.

70. In addition we considered the following benefits: other clinical benefits; financial savings; merger-avoided costs; merger-enabled investments; balanced portfolio of services and cost savings to commissioners.

71. We assessed whether these were benefits to patients and whether they met the statutory test for RCBs. This test requires the proposed benefit to be a benefit to

customers (in this case patients and commissioners) in the form of lower prices, higher quality, greater choice or greater innovation. Also, we must believe that the benefit may be expected to accrue within a reasonable period as a result of the merger and is unlikely to accrue without the merger.

72. We did not find that any of the benefits put forward by the parties met the statutory test for RCBs, for the following reasons:

(a) *Maternity*: Monitor found that a reconfiguration of maternity services proposed by the parties would be likely to be a benefit. This benefit proposal was withdrawn by the parties in August 2013; we therefore did not consider this. The parties proposed that the merger would allow them to combine midwife rotas but did not explain how this would be a benefit to patients or how it would be implemented. We therefore did not consider this to be a relevant customer benefit. The parties proposed that the merger would allow them to build a new maternity unit which would improve the patient environment at PH. We found that this would be a benefit to patients. However, we did not find that this benefit could be expected to accrue within a reasonable period, because:

- (i) The new unit will not need to be operational until 2018/19 (due to the current investment occurring at PH in its existing maternity unit) and therefore a final decision to proceed with the investment in a new unit is not required immediately. The financial environment for all NHS hospitals over the next two years is expected to be challenging. This is likely to put a strain on the revenue budget of the merged entity, with a knock-on effect on the capital budget.
- (ii) 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 and we would expect the plans to consider the configuration of maternity services across the whole area.
- (iii) RBCH and PH have not developed their plans in detail. There has been only a very preliminary estimate of costs and revenues; the location of the new unit has not been decided; and the impact of the plan on clinically interdependent services has not been carried out.

(b) *Cardiology*: The parties put forward that the merger would result in: (i) a single dedicated rota of cardiologists across the two sites; and (ii) acute cardiac inpatient admissions being consolidated at RBCH. In line with Monitor findings, we did not find admissions consolidation to be a benefit that would be unlikely to accrue without the merger, particularly as this had in part already occurred since Monitor's assessment. Whilst we found that a single rota could be a patient benefit, we did not find that this would be unlikely to accrue without the merger.

(c) *Haematology*: The parties told us that reconfiguration of haematology services, whereby the most specialised (level 3) services would be located on one site, would be a benefit to patients resulting from the merger. We received mixed evidence from the parties and commissioners. In particular, NHS England (Wessex) (the commissioner of these services) told us that the parties had both recently assessed themselves as meeting the relevant standards for level 3 haematology and therefore it had no plans to reconfigure the services. We therefore did not have sufficient confidence that the merged entity would proceed with the reconfiguration of the services and therefore did not find it likely that the benefits would accrue.

(d) *A&E and emergency surgery*: The parties told us that the merger would enable a reconfiguration of A&E services which would result in better A&E consultant cover. This would be achieved by reconfiguring the two A&E units of PH and RBCH to a major injury A&E and a minor injury A&E, with the minor injury A&E being staffed primarily with nurses with input from GPs and remote oversight by A&E consultants situated at the major injury A&E unit. If A&E were reconfigured, then emergency surgery would be consolidated on the major injury A&E site, allowing that site to have a dedicated emergency theatre 24/7. We noted that significant reconfiguration of this type would involve moving interrelated services and that whilst such a reconfiguration could have benefits, it could also create disbenefits. No detailed model of care had been developed on a local basis, assessing the benefits and disbenefits of the proposal. Commissioners were therefore unable to provide support for the specific reconfigurations proposed. We thought that an A&E reconfiguration could create both benefits and disbenefits locally. This assessment of benefits and disbenefits had not yet been undertaken and without this assessment we therefore did not find that the proposal was an overall benefit to patients. We therefore did not find that the A&E benefit proposed by the parties was a relevant customer benefit.

(e) *Other clinical benefits; financial savings; merger-avoided costs; merger-enabled investments; balanced portfolio of services; and cost savings to commissioners*: we did not find that any of the proposals would be likely to result in RCBs within the meaning of the Act.

73. In the Notice of possible remedies, we invited views on prohibition of the merger as an appropriate remedy for the expected SLC in this case. The parties proposed a behavioural remedy based on the friends and family test which they told us would allow the quality of the merged trust to be monitored. If quality (as measured by this test) decreased at the merged trust, the parties proposed that the remedy should include a number of escalation arrangements. No other remedies were proposed by any parties.
74. We found that the proposed behavioural remedy is not likely to be an effective remedy to the SLC we have identified and did not consider that it could be modified to make it effective.
75. We concluded that the benefits proposed by the parties were not RCBs within the meaning of the Act and that it would not be appropriate to modify the only remedy that we have found to be effective, namely prohibition
76. We therefore concluded that prohibiting the merger was the only effective remedy and that it was proportionate to the SLC.

# Findings

## 1. The reference

- 1.1 On 8 January 2013, the OFT referred the proposed merger of RBCH and PH to the CC for investigation and report. We must decide, under [section 36](#) of the Act:
- (a) whether a relevant merger situation has been created; and
  - (b) if so, whether the creation of that situation may be expected to result in an SLC within any market or markets in the UK for goods or services.
- 1.2 Our terms of reference are set out in Appendix A. We are required to take our final decision and report by 21 October 2013.
- 1.3 This document, together with its appendices, constitutes our report, published and notified to RBCH and PH in line with the CC's Rules of Procedure.<sup>4</sup> Further information relevant to this inquiry, including a non-confidential version of the parties' initial submissions, the GfK report on the patient and GP surveys it carried out for the CC, summaries of hearing evidence and responses to the provisional findings report and notices of possible remedies, including the parties' joint submission on benefits of the merger, can be found on our [website](#).

## 2. Industry background and the parties

- 2.1 On 29 November 2011 RBCH and PH announced their intention to merge.<sup>5</sup> RBCH and PH are both NHS foundation trusts.<sup>6</sup> This is the first announced merger between two NHS foundation trusts. Both parties provide healthcare services in hospitals in the Dorset area.
- 2.2 Healthcare services in England are publicly funded and provided by the NHS. These services can broadly be divided between primary care, secondary care, tertiary care and community services, as follows:
- (a) *Primary care* consists of medical services provided by GP practices, dental practices, community pharmacies and high street optometrists. NHS walk-in centres, NHS 111 and the NHS Direct telephone service are also part of primary care. This care is commissioned and funded by the local commissioner (previously the local Primary Care Trust (PCT) and as of 1 April 2013 by the local CCG).
  - (b) *Secondary care* is 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. Acute services are a subset of secondary care, being those services which are provided in a hospital setting.
  - (c) *Tertiary care* refers to services provided in more specialised medical centres, often covering a much larger catchment population; examples include specialist

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<sup>4</sup> [Competition Commission Rules of Procedure, CC1](#), 2006.

<sup>5</sup> [www.hsj.co.uk/hsj-local/acute-trusts/poole-hospital-nhs-foundation-trust/poole-and-royal-bournemouth-agree-next-step-towards-merger/5038564.article](http://www.hsj.co.uk/hsj-local/acute-trusts/poole-hospital-nhs-foundation-trust/poole-and-royal-bournemouth-agree-next-step-towards-merger/5038564.article).

<sup>6</sup> Monitor Authorisation of PH pursuant to section 35 of the National Health Service Act 2006 (1 November 2007) and Monitor Authorisation of RCBH pursuant to section 35 of the National Health Service Act 2006 (1 April 2005).

centres in neurosurgery, paediatric cardiac surgery and cancer care. Patients may be referred to tertiary care by their GP or by a consultant. Tertiary care will in some cases involve provision of specialised services, which are those NHS services with large planning populations and definitions set out in the Prescribed Specialised Services Manual. Tertiary services are likely to be high cost due to specialised medical equipment requirements and the need for highly specialised staff to provide these services.

(d) *Community health services* is a term used to describe 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, community nursing, mental health services, nutrition and dietetics, occupational therapy, speech and language therapy and diabetes care.<sup>7</sup>

2.3 Services provided by hospitals may also be categorized as follows:

(a) hospital-based elective care, ie clinical care that is planned and typically requires a referral from a GP or an allied healthcare professional;<sup>8</sup>

(b) hospital-based non-elective care, ie clinical care that is unplanned or provided in urgent circumstances, such as A&E as well as supporting services such as emergency surgery, maternity and critical care services;

(c) outpatient services, which cover a vast range of specialties and generally involve the provision of medical assessment, diagnosis, treatment and care which does not require an overnight stay in hospital. Outpatient services can be linked to either elective or non-elective pathways or be required on a stand-alone basis; and

(d) specialised services, ie low-volume services which are planned around large population areas and which tend to have few, or only one, providers in a region. These services may be elective or non-elective.

2.4 The glossary describes various further categories of healthcare services, focusing on those that are provided by RBCH and PH.

2.5 Hospitals providing acute NHS services in England may be managed either by NHS trusts or NHS foundation trusts. The board of a trust is responsible for ensuring that hospitals provide high-quality, efficient care for the patients they serve. The board also decides how a hospital will develop so that services improve. Some hospitals providing acute services are regional or national centres for more specialised care (ie tertiary or specialised services), others are attached to universities and help to train health professionals. NHS trusts and NHS foundation trusts may also be providers of ambulance services, mental health services and community health services. They can provide services in the community, for example through health centres, in clinics or people's homes.<sup>9</sup> Hospitals which provide mainly community health services or more routine secondary care are referred to as 'community hospitals'.

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<sup>7</sup> Section 3(1) of the National Health Service Act 2006 (NHS Act 2006) (as amended) sets out the CCG's duty to provide what are known as 'hospital and community health services'. The term 'community health service' is often used to describe treatment or care provided by CCGs to fulfil their duty to provide treatment or care as described by sections 3(1)(d), section 2(1)(e), and Schedule 1 of the NHS Act 2006. Prior to the NHS Act Reorganisation Act 1973 these services were provided by local authorities under section 22 of the National Health Service Act 1946 and section 12 of the Health Services Public Health Act 1968.

<sup>8</sup> Consultants sometimes refer patients to other consultants (generally within the same hospital) for further elective care.

<sup>9</sup> [www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx](http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx).

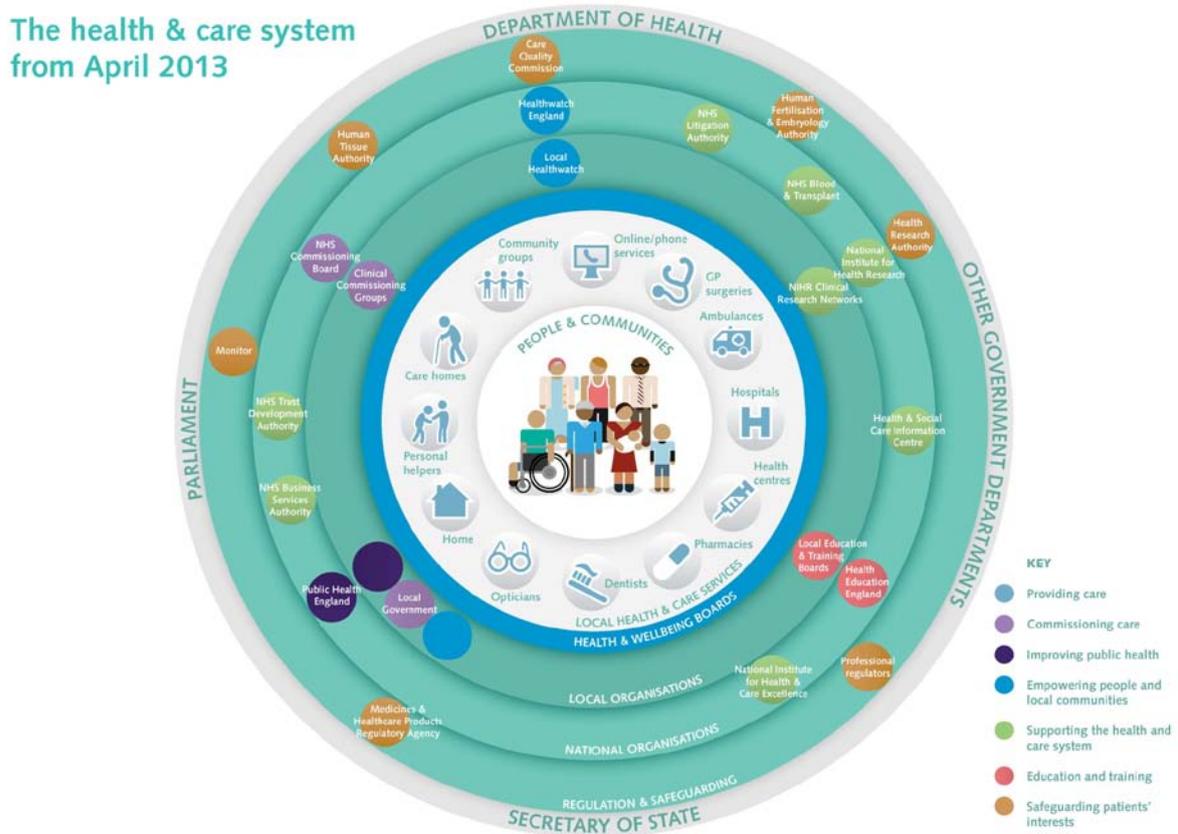
2.6 NHS foundation trusts, first introduced in April 2004, differ from other NHS trusts as they are independent legal entities, self-governing and accountable to local people, with some financial freedoms, including freedom to retain financial surpluses and to borrow to invest in the delivery of new and improved NHS services for patients and service users. Foundation trusts are regulated by Monitor.<sup>10</sup>

**Industry background**

2.7 The NHS has recently undergone major changes, most of which took effect formally on 1 April 2013, though some were in place before then. It will be some time before all the changes are fully implemented.<sup>11</sup>

FIGURE 2

**NHS healthcare system**



Source: [www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx](http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx).

2.8 These changes affect who makes decisions about NHS services, how these services are commissioned, and the way money is spent. The commissioning board, NHS England, took on full statutory responsibilities in April 2013. Prior to this, all NHS planning and delivery was done by the Department of Health, strategic health authorities and PCTs. As a result of the changes, PCTs and strategic health

<sup>10</sup> [www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx](http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx).

<sup>11</sup> [www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx](http://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhsstructure.aspx).

authorities were abolished and the newly-formed CCGs have taken their place in commissioning services for local areas.<sup>12,13</sup>

- 2.9 The provision of NHS services in England is highly regulated. Significant changes to regulation were introduced recently by the Health and Social Care Act 2012 (HSCA 2012) and associated secondary legislation and guidelines.<sup>14</sup> These changes are relevant to the activities of RBCH and PH and to our competitive assessment of the merger.
- 2.10 There are various aspects of regulation that are relevant to our assessment of the merger. We consider the following:
- (a) What are foundation trusts? In this section we consider the powers and obligations of foundation trusts and the extent to which these provide them with an ability and incentive to compete in supply of NHS services.
  - (b) How do foundation trusts receive funding? We consider how NHS services are commissioned. This section describes how different 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 supervising 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.
- 2.11 This report sets out our understanding of the law and policy as it applied at 1 October 2013.
- 2.12 Our detailed consideration of the factors set out in paragraph 2.10 is set out in Appendix C. A brief summary of the industry background is set out below.

### **Foundation trusts**

- 2.13 Foundation trusts are public benefit corporations which are required to provide certain NHS services but are also afforded a degree of operational autonomy. Their principal purpose is the provision of goods and services for the purposes of the health service in England. They can retain their surpluses and borrow to invest in new and improved services for patients and service users.

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<sup>12</sup> *ibid.*

<sup>13</sup> *ibid.*

<sup>14</sup> *ibid.*

- 2.14 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, foundation trusts 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. However, we understand that tariffs do not always accurately reflect costs of provision and this may affect these incentives.
- 2.15 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, which was the regulator of foundation trusts and became the sector regulator after April 2013. From April 2013, the authorizations of foundation trusts were replaced by provider licences.<sup>15</sup> Under the provider licence, licensees are prevented from ceasing to provide commissioner requested services, or from changing the way in which they provide commissioner requested services, without the agreement of relevant commissioners. Licensees must also notify Monitor if they cease to provide commissioner requested services or change the way in which these services are provided.<sup>16</sup>
- 2.16 For further information on foundation trusts see Appendix C, paragraphs 2 to 4.

### ***Funding of foundation trusts—commissioning***

- 2.17 Most of the services provided by foundation trusts, including RBCH and PH, are now commissioned by CCGs. CCGs were set up in 2013 to replace PCTs. They are broadly responsible for commissioning urgent and emergency care (111 services, accident & emergency (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.
- 2.18 The NHS Bournemouth and Poole PCT and the NHS Dorset PCT (together the Dorset PCT cluster) 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: the Dorset CCG). Prior to 31 March 2013, a significant proportion of RBCH's services were commissioned by the Hampshire PCT. Since that date, the West Hampshire CCG became responsible for commissioning for the area of the population in the two local areas in Hampshire (West New Forest and Totton & Waterside) served by hospitals including RBCH. For the purposes of our analysis we refer to the areas covered by Dorset CCG and the relevant areas covered by West Hampshire CCG (West New Forest and Totton & Waterside) as the wider Dorset area.
- 2.19 The HSCA 2012 established NHS England which is responsible for overseeing the financial situation of CCGs and compliance with their statutory duties and for commissioning specialised services. Specialised services are provided in relatively

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<sup>15</sup> As a result of the change from authorizations to provider licences, all mandatory services under the terms of authorization are now designated as commissioner requested services under the provider licence for a transitional period. Commissioners have three years to review these services and confirm or reject their designation as commissioner requested services. Commissioner requested services are those services to which the continuity of service licence conditions apply.

<sup>16</sup> Licensees must obtain Monitor's consent before disposing of relevant assets used in the provision of commissioner requested services when Monitor is concerned about the licensee's ability to carry on as a going concern.

few specialist centres. These services treat either rare conditions or those that need a specialised team working together at a centre. NHS England (Wessex) replaced the South West Specialist Commissioning Team in commissioning specialised services from the parties from 1 April 2013.

- 2.20 The NHS Standard Contract 2013/14 (NHS Standard Contract) must be used by CCGs and NHS England when entering into contracts for clinical services. It requires detailed reporting by providers and compliance, by providers and commissioners, with the patient choice regime.
- 2.21 Further information on how services are commissioned are set out in Appendix C paragraphs 5 to 29.

### ***Quality regulation of acute service providers***

- 2.22 It is up to CCGs and the NHS England Area Team to determine how best to configure healthcare services in their local area, in consultation with patients, healthcare providers and bodies providing clinical input. Providers may also institute change, based on legitimate clinical drivers. There are many mechanisms designed to safeguard the quality of NHS services, including regulation as well as Royal Colleges' recommendations regarding professional standards and consumer choice. We considered the regulation and quality oversight provided by contractual arrangements in the NHS Standard contract (such as CQUIN payments) and bodies such as the Care Quality Commission (CQC), The National Institute for Health and Care Excellence (NICE) and the Royal Colleges.
- 2.23 We noted that some of the regulatory and contractual mechanisms designed to safeguard the quality of NHS services may also incentivize hospitals to improve quality, and we considered this in our competitive assessment. 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 patient choice and competition in the provision of NHS-funded healthcare services. Choice is considered important as it is both desirable in itself and also because, when combined with PbR, it gives incentives to providers to attract, or not to lose, patients.
- 2.24 For further information on these aspects of quality regulation of acute service providers see Appendix C, paragraphs 30 to 42.

### ***Competition policy and law in the supply of NHS services***

- 2.25 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.
- 2.26 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:

- (a) from 1991, splitting the responsibility for providing healthcare from the responsibility for purchasing it (referred to as the purchaser/provider split);<sup>17</sup>
- (b) from 2003, the establishment of NHS foundation trusts<sup>18</sup> (into which NHS trusts could convert subject to meeting the relevant criteria) (see paragraph 2.13);
- (c) from around 2003, the introduction of PbR, namely the payment of fixed national tariff prices per treatment of NHS acute service providers according to the volume of patient treatments provided. PbR tariffs replaced block contracts remunerating providers irrespective of the number of patients treated;<sup>19</sup>
- (d) from 2004, the introduction<sup>20</sup> 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;
- (e) 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;<sup>21</sup>
- (f) from 2004, the provision by independent sector treatment centres (ISTCs) of some NHS services; and
- (g) 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.<sup>22</sup> This type of procurement is most relevant when considering competition for the market for NHS services (see paragraph 2.27 below).

2.27 We noted that there are, broadly speaking, two different models of competition in the provision of NHS healthcare services:

- (a) *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.

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<sup>17</sup> The purchaser/provider split was first introduced in 1991 following the [NHS and Community Care Act 1990](http://www.kingsfund.org.uk/topics/nhs-reform/white-paper/gp-commissioning): [www.kingsfund.org.uk/topics/nhs-reform/white-paper/gp-commissioning](http://www.kingsfund.org.uk/topics/nhs-reform/white-paper/gp-commissioning).

<sup>18</sup> Pursuant to the [Health and Social Care \(Community Health and Standards\) Act 2003](#), consolidated into the [National Health Service Act 2006](#).

<sup>19</sup> Department of Health, [Reforming NHS Financial Flows, Introducing payment by results](#) (October 2002).

<sup>20</sup> Department of Health, [Choice of Hospital, Guidance for PCTs, NHS Trusts and SHAs on offering patients choice of where they are treated](#) (July 2003).

<sup>21</sup> 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.

<sup>22</sup> 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.

(b) *Competition for the market* occurs where the commissioning entity uses a competitive process to choose between different providers for the right to provide services to patients.<sup>23</sup>

- 2.28 We noted that HSCA 2012 put the system for regulatory oversight of competition in the NHS on a statutory footing. HSCA 2012 sets 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. Monitor has enforcement powers in relation to those obligations and also has concurrent powers with the OFT to apply the Chapter I and Chapter II prohibitions in the Competition Act 1998 and Articles 101 and 102 of the Treaty on the Functioning of the European Union. The 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.<sup>24</sup>
- 2.29 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.
- 2.30 For further information on competition policy and law in the supply of NHS services, see Appendix C, paragraphs 43 to 53.

### ***Incentives of foundation trusts to compete***

- 2.31 We considered the extent to which foundation trusts have incentives to compete for patients and found that the patient choice and the PbR regime incentivize acute service providers to compete for patients.
- 2.32 Patients have a choice of provider in respect of their first consultant-led outpatient appointment for elective care and for maternity services and there are statutory and contractual obligations on providers and commissioners in respect of patient choice (see further Appendix C, paragraphs 58, 67, and 71 to 73).
- 2.33 The PbR regime sets tariffs for procedures, and providers are paid according to the number of procedures which they carry out. National PbR tariffs cover the majority of acute healthcare (elective and non-elective services) in hospitals. There is a specific tariff for emergency non-elective care (the 'marginal rate emergency tariff') which means that 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 (see further Appendix C, paragraph 64).
- 2.34 Monitor and NHS England are jointly responsible for setting the national tariff from 1 April 2014. They are currently carrying out work on costs which are used in tariff calculations, in order to enable them to send more appropriate price signals and incentives going forward (see further Appendix C, paragraphs 69 and 70).

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<sup>23</sup> By 'competitive processes' we mean 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.

<sup>24</sup> See further Appendix C, paragraph 51.

- 2.35 As described further in Appendix C, paragraph 63, providers may also be paid in accordance with local tariffs and under block contracts (whereby a fixed amount is payable to cover treatment for a population of patients) for some services. We considered the further mechanisms set out in the PbR Code of Conduct and the guidance resulting from CCP report on the operation of the ‘any willing provider model for the provision of routine elective care’, regarding the effects of block contracts (see Appendix C, paragraphs 71 to 73).
- 2.36 The AQP regime was designed to further facilitate patient choice and means that where a provider meets criteria for provision of services, a commissioner must include that provider on the lists of providers, to which patients and GPs will then have access via the Choose and Book website.
- 2.37 The extent to which these incentives work according to policy in the wider Dorset area is considered in detail in our competitive effects assessment. For further information on the structures set up to incentivize foundation trusts to compete, see Appendix C, paragraphs 54 to 74.

### **Role of Monitor**

- 2.38 Monitor was established as a regulator of NHS foundation trusts in 2004.<sup>25</sup> Following the HSCA 2012, Monitor became the sector regulator for the provision of health services in England.<sup>26</sup> 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. We consider various aspects of Monitor’s role which are relevant to our assessment in Appendix C.
- 2.39 In particular, we noted Monitor’s ability to determine whether or not a foundation trust is failing and the mechanisms it has to reduce the likelihood and impact of failure. Foundation trusts are incentivized to be financially healthy via the Monitor regulatory framework.
- 2.40 Using information from the trusts, Monitor has historically assigned each foundation trust a separate risk score for its financial and governance functions, 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. Similarly, foundation trusts were monitored as to their governance performance, according to a number of factors, leading to a governance risk rating of (from best to worst) green, amber-green, amber-red, or red.
- 2.41 This framework has recently been revised, and Monitor’s new Risk Assessment Framework, which applies from 1 October 2013, rates foundation trusts on the basis of their financial stability and governance. NHS foundation trusts will be assigned two risk ratings to allow Monitor to identify where there may be cause for concern with a trust’s governance (‘governance rating’) or the sustainability of that trust’s provision of key NHS services (‘continuity of services risk rating’ or ‘COS rating’).<sup>27</sup>
- 2.42 There are three governance ratings. 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

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<sup>25</sup> Section 2 of the Health and Social Care (Community Health and Standards) Act 2003.

<sup>26</sup> Monitor’s duties are found in Chapter 1 of Part 3 of HSCA 2012.

<sup>27</sup> Monitor, Risk Assessment Framework (27 August 2013), p4.

Monitor's proposed solution will take place. Where enforcement action has begun, Monitor will assign the trust a red rating.

2.43 Continuity of services risk ratings will replace the financial risk ratings and will be assigned to all NHS foundation trusts. 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 sustainably to provide key NHS services.<sup>28</sup>

2.44 Monitor has the ability to put failing trusts into special administration, a process which may result, in extreme circumstances, in a provider (but not necessarily all of the services it provides) exiting the market. Monitor told us that:

The objective of the trust special administrator is to secure the continued provision of such of the NHS services provided by the NHS foundation trust in such quantities as the commissioners of those services determine, until such time as it becomes unnecessary for the appointment of the trust special administrator to remain in force. 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.

2.45 Under the Risk Assessment Framework, 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. 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.<sup>29</sup>

2.46 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.<sup>30,31</sup> The failure of a healthcare provider is a rare event<sup>32</sup> 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'.<sup>33</sup>

2.47 For further information on the role of Monitor see Appendix C, in particular paragraphs 75 to 92.

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<sup>28</sup> Monitor, Risk Assessment Framework (27 August 2013), pp29–30.

<sup>29</sup> *ibid*, p45.

<sup>30</sup> Monitor, [Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts](#) (5 April 2013), p1.

<sup>31</sup> 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.

<sup>32</sup> Monitor, [Statutory guidance for Trust Special Administrators appointed to NHS foundation trusts](#), p2.

<sup>33</sup> *ibid*, p3.

## **RBCH**

- 2.48 Christchurch Hospital was first opened as an NHS public hospital in 1948 following the creation of the NHS. In 1992, the Royal Bournemouth Hospital opened and the acute services at Christchurch Hospital were relocated to it. RBCH gained foundation trust status in April 2005.
- 2.49 RBCH is a 601-bed acute trust that provides a wide range of hospital and community-based care for the residents of Bournemouth, Christchurch, east Dorset and part of the New Forest with a total population of about 550,000. Some of the services provided cover a wider catchment area, including Poole, the Purbecks and South Wiltshire. RBCH provides elective, non-elective and specialised services. It also has an A&E department and a maternity unit.
- 2.50 RBCH also provides some community services in the Bournemouth–Poole and Dorset areas. Aside from providing NHS services, RBCH also carries out some private patient work. RBCH does not provide mental health services.
- 2.51 For the past six financial years, RBCH generated a surplus each year except 2009; it generated a surplus of £3.6 million from total operating income of £249.1 million for the year to 31 March 2013.<sup>34</sup> It is forecasting surpluses on a stand-alone basis of £[~~3~~] million during 2013/14 and of £[~~3~~] million and £[~~3~~] million in the financial years 2014/15 and 2015/16 respectively.<sup>35</sup> RBCH told us that the decline in performance was primarily driven by assumed tariff deflations and cost inflation for drugs and clinical supplies, with additional income and cost savings plans unable fully to mitigate these cost pressures. Further details of RBCH's financial position and forecasts are set out in Appendix B.

## **PH**

- 2.52 PH was established in 1897 and following major modernization work was reopened in July 1969. PH became a foundation trust on 1 November 2007. PH operates across three sites: the main hospital, St Mary's Maternity Hospital and Forest Holme, its palliative care unit.
- 2.53 PH is a 623-bed acute general hospital, predominantly serving people living in Poole, east Dorset and Purbeck with a population of about 272,000. PH provides elective, non-elective and specialised services. It also has an A&E department and a maternity unit.
- 2.54 PH told us that its service offering had an emphasis on non-elective care. PH is the trauma unit for east Dorset, with a 24-hour major accident and emergency department. It provides a broad range of district hospital care and a number of core services for a wider catchment area, including Bournemouth and Christchurch. The hospital also provides specialist services to the county, such as oral surgery and neurological care, increasing the number of people served to more than 700,000.
- 2.55 PH provides some community services in the Bournemouth–Poole and Dorset areas. Aside from providing NHS services, PH also carries out some private patient work. PH does not provide mental health services.

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<sup>34</sup> [RBCH 2012/13 Annual Report](#).

<sup>35</sup> RBCH Annual Plan to Monitor 2013/14.

- 2.56 PH reported surpluses in its first two financial years as a foundation trust. However, in July 2010 the trust was judged by Monitor to be in significant breach of its terms of authorization as a result of a reported operational deficit of £4.5 million during the financial year ended 31 March 2010. PH told us that this was attributed to a weakness in its governance duties, and overtrading on a contract without agreement from the commissioning entity. A financial recovery plan was adopted in coordination with Monitor (involving substantial cost reductions which were identified following work carried out by KPMG), which delivered savings of £17 million over the following two years, generating an operating surplus of £1.0 million for the financial year ended 31 March 2011.<sup>36</sup> In addition, PH replaced a significant proportion of its board and improved its governance arrangements. On 23 January 2012, Monitor confirmed that PH was no longer in significant breach of its authorization.<sup>37</sup>
- 2.57 For the financial year ended 31 March 2013, PH reported an operating surplus of £1.3 million on total operating income of £200 million.<sup>38,39</sup> PH is forecasting a surplus on a stand-alone basis of £[redacted] million for 2013/14, then deficits of £[redacted] million and £[redacted] million in the financial years 2014/15 and 2015/16 respectively.<sup>40</sup> It told us that the surplus in 2013/14 was only due to payments which would be made to it by commissioners to keep it in surplus. PH told us that the decline in performance was driven by the trust being unable to generate sufficient savings fully to mitigate the assumed tariff deflation and cost pressures. Further details of PH's financial position and forecasts are set out in Appendix B.
- 2.58 Both RBCH and PH have scored well on published quality, financial and governance measures, although PH's governance rating has recently slipped. As at 1 October 2013 RBCH had a governance rating of green (on a spectrum of green to red, green being the best)<sup>41</sup> and a financial rating of 3 (on a 1 to 5 rating system, 5 being the best). PH's governance rating was green in recent years but its rating slipped to amber-red in the last quarter of 2012/13 after failing to meet its C Difficile infection rate objective and the A&E 4-hour wait target. It further slipped to red in May 2013 after PH predicted a financial deficit and declared financial sustainability concerns.<sup>42</sup> On 10 June, Monitor opened a formal investigation into PH's compliance with its licence, due to financial sustainability and governance concerns arising out of its forecasting a significant financial deficit in both 2014/15 and 2015/16 should the merger with RBCH not proceed. 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.
- 2.59 In Q2 2013/14, a new ratings system came into effect (see paragraphs 2.41 to 2.43 and Appendix C, paragraphs 75 to 92). For an interim period, Monitor will publish both the financial risk rating and a new continuity of service rating in relation to financial risk, and from Q3 2013/14 this continuity of service rating will replace the financial risk rating. Monitor told us that PH was forecasting a rating of [redacted] (out of a possible 4) for the whole of 2013/14, and RBCH was forecasting a rating of [redacted] for the whole of 2013/14. Under the new governance ratings, RBCH will have a rating from 1 October 2013 of [redacted] and PH's rating will be a statement that '[redacted]'.

<sup>36</sup> [Joint main party initial submission](#), Annex 3.

<sup>37</sup> [ibid](#), Annex 3.

<sup>38</sup> PH Annual Report 2012/13.

<sup>39</sup> 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.

<sup>40</sup> PH Annual Plan to Monitor 2013/14.

<sup>41</sup> From 1 October Monitor will assign a governance rating of green to a trust where it has no concerns, a rating of red if Monitor is taking regulatory action. Where Monitor identifies potential material causes for concern with the trust's governance (requiring further information or formal investigation), it will replace the trust's green rating with a description of the issue and the steps (formal or informal) we are taking to address it.

<sup>42</sup> [www.monitor-nhsft.gov.uk/about-your-local-nhs-foundation-trust/nhs-foundation-trust-directory-and-register-licence-holders/po](http://www.monitor-nhsft.gov.uk/about-your-local-nhs-foundation-trust/nhs-foundation-trust-directory-and-register-licence-holders/po).

- 2.60 RBCH and PH told us that they had, to some extent, been configured to work in a complementary manner. NHS England (Wessex) told us that:

In the 1980s, PH was the main hospital in the area with the new RBCH built after some discussions as to whether or not another large hospital so near Poole was needed. The two hospitals were set up to work in a complementary way to serve the population of east Dorset. In the early 1990s, another NHS reorganization brought about the purchaser-provider split, and around that time, the Dorset Health Authority was created. The two hospitals became independent trusts, set up with independent decision-making boards. An acute services review was carried out in the 1990s, seeking to ensure the most appropriate, on-going sustainable provision of services. The Dorset Health Authority was always keen to ensure that both hospitals were able to support their populations, and a lot of thought was given at that time to which services should be provided on which sites. For example, paediatrics and maternity needed to stay together at PH, whilst urology and other surgical services were provided from RBCH.

- 2.61 The West Hampshire CCG told us<sup>43</sup> that: ‘The configuration of services provided by PH and RBCH hospitals was partly determined, as far as West Hampshire CCG was aware, by the 1987 acute services review, and in some cases it was helpful to have the hospitals provide complementary services.’

### ***The overlap services***

- 2.62 RBCH and PH are both active in the provision of a range of hospital services including: hospital-based elective care, hospital-based non-elective care, outpatient services, specialised services, community services and private services.

## **3. The proposed merger and the relevant merger situation**

### ***Outline of merger situation***

- 3.1 An initial Memorandum of Agreement (MoA) was agreed between the parties on 8 May 2012 to set out the framework for the parties to agree to cooperate and work together towards achieving the merger. A revised MoA was agreed on 11 February 2013.<sup>44</sup> A Joint Programme Board (JPB) was established by the parties for the purposes of managing work towards the merger, overseeing progress of the process to completion, and satisfying the regulatory requirements of Monitor. The JPB oversaw the recruitment process for the Proposed Board of Directors, which was carried out during spring 2012.
- 3.2 A 12-week public consultation process was carried out beginning on 1 February 2012 regarding the merger and the proposed governance arrangements for the merged trust. It is proposed that Tony Spotswood, CEO of RBCH, will be the CEO of the merged hospitals and Jane Stichbury, Chairman of RBCH, will be the Chairman of the merged hospitals. The Proposed Board is overseeing the merger integration

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<sup>43</sup> [West Hampshire CCG hearing summary](#), paragraph 6.

<sup>44</sup> The revised MoA amended provision 2.2 of the previous MoA which stated that the parties would act together to negotiate DH Standard Services Contracts (with commissioning entities). The revised MoA states that ‘this MoA is an amended and restated version which reflects the fact that the Merger has not occurred and that the Parties will act separately in negotiating their individual DH Standard Services Contracts’.

planning. In addition, further joint bodies have been established including the Merger Finance Steering Group and Organisational Development Steering Group.

- 3.3 There are legislative requirements which apply to implementing a merger between two NHS foundation trusts.<sup>45</sup> The following paragraphs summarize the main steps for implementing a merger between NHS foundation trusts.
- 3.4 The two merging foundation trusts make a joint application to Monitor for the dissolution of the trusts and the establishment of a new NHS foundation trust.<sup>46</sup> Monitor's transaction assessment<sup>47</sup> process is designed to ensure that any transaction is in the best interests of patients. To assess this, Monitor looks closely at whether the enlarged organization will be well led and able to provide good-quality services on a sustainable basis. At the end of this process, Monitor will make a decision whether or not to grant the application for a merger and issue risk ratings for the merged entity. Trusts which do not address risks which Monitor has identified will be subject to the range of Monitor's regulatory intervention powers.
- 3.5 Monitor must grant the application if it is satisfied that such steps as are necessary to prepare for the dissolution of the trusts and the establishment of the new trust have been taken.<sup>48</sup> If the application is granted by Monitor, Monitor must make an order dissolving the trusts in question and transferring the property and liabilities specified to the new trust,<sup>49</sup> and that order is conclusive evidence that the new corporation is an NHS foundation trust.<sup>50</sup>

### ***Rationale for the merger***

- 3.6 The parties told us that they, and the rest of the healthcare sector, were facing a number of challenges over the future years and that:
  - (a) the NHS in England and Wales was facing a future of constrained spending growth, with savings being driven in hospitals by an absolute reduction in the unit price paid to hospitals for each procedure, intervention or consultation;
  - (b) the health system was seeking to redistribute health and healthcare services away from acute hospitals towards prevention and management of care in primary and community care settings;<sup>51</sup>
  - (c) Monitor provided guidelines for sector-wide efficiency requirements on foundation trusts that obliged acute hospitals to find additional savings of 5 per cent recur-

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<sup>45</sup> Section 56 of the NHS Act 2006, as amended by section 168 of HSCA 2012. All the section references to the NHS Act 2006 in the footnotes are to the NHS Act 2006 as amended (or to be amended) by HSCA 2012.

<sup>46</sup> NHS Act 2006, section 56(1).

<sup>47</sup> 'Overview of the Monitor transaction assessment process', Monitor Guidance Document, February 2013. Monitor will require the merging parties to make a number of submissions regarding their proposed transaction, which may include: a business case, setting out the reasons for the merger and noting any reconfiguration of services; a long-term financial model, exhibiting financial forecasts for the combined entity for a period of five years; a post-merger integration plan, including plans to integrate quality governance systems, risk management systems, financial reporting procedures, performance management systems and IT systems. The parties' submissions may also set out the potential risks inherent in the merger and plans to manage those; submissions pertaining to the governance of the integrated entity, detailing what arrangements have been put in place to ensure quality governance; and any due diligence undertaken to ensure that the merging entities are aware of the risks that they are undergoing by the transaction. In addition, Monitor will require the opinions of independent accountants on various matters pertaining to the financial health of the trust, including its working capital, financial reporting procedures, and post-transaction integration plan.

<sup>48</sup> NHS Act 2006, section 56(4).

<sup>49</sup> NHS Act 2006, section 57(2).

<sup>50</sup> NHS Act 2006, section 57 (2A).

<sup>51</sup> [Joint main party initial submission](#).

rently in the financial year 2013/14 and a further 5 per cent in 2014/15, and 4.2 per cent in the financial years 2015/16 and 2016/17;<sup>52 53</sup>

- (d) these savings would require all foundation trusts to find ways to offset some of their fixed and semi-fixed costs (ie mainly staff), as previous savings had largely been focused on variable costs (ie mainly supplies). However, the challenge for acute hospitals was that they needed to provide a core level of staff and equipment in order to provide a safe, high-quality service;
- (e) Monitor performed a review of foundation trust performances in the financial year 2011/12 and found that more than half of foundation trusts had missed their savings plan targets.<sup>54</sup> Therefore, achieving the required savings during the financial year 2012/13 would become increasingly difficult;
- (f) there was a government policy drive towards the creation of regional 'centres of excellence' in the provision of a range of acute healthcare services. The Royal Colleges (particularly the Royal College of Surgeons and the Royal College of Physicians) had recommended and provided guidance that the UK model of the district general hospital should be replaced by fewer and larger hospitals which each serviced populations in excess of 500,000;<sup>55</sup> and
- (g) the Royal Colleges and commissioners were seeking to ensure that all acute or emergency services were staffed by senior and experienced doctors and nurses 24 hours a day and seven days a week.<sup>56</sup> This was a drive to have more consultant-driven care for quality reasons.

3.7 In consideration of the financial and clinical challenges that they faced, the parties considered their options, including merging with other trusts (see further Section 4). RBCH told us it believed that a merger with PH would achieve economies of scale, improve its consultant cover, realize synergies and make both trusts more financially resilient.<sup>57</sup> PH told us it concluded that a merger with RBCH would be the most beneficial outcome in ensuring the greatest financial stability and complying with the Royal Colleges' guidance.<sup>58</sup>

3.8 The parties told us that the rationale for the proposed merger was:<sup>59</sup>

- (a) to ensure that they could continue to maintain and provide the high quality of patient care, because as stand-alone organizations they would be clinically sub-scale and financially unviable;
- (b) to allow the parties to meet the Royal Colleges' and national guidance on the delivery of high-quality services, and the need to provide more consultant-delivered care 24 hours a day, seven days a week;
- (c) to respond to the Royal Colleges' guidance on key services that were best delivered through single regional 'centres of excellence', which could bring new and improved services to patients;

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<sup>52</sup> [Joint main party initial submission](#), paragraph 112.

<sup>53</sup> Monitor noted that it did not set efficiency savings requirements for foundation trusts.

<sup>54</sup> [Joint main party initial submission](#), paragraph 117.

<sup>55</sup> [ibid.](#), paragraph 55.

<sup>56</sup> [ibid.](#)

<sup>57</sup> [ibid.](#)

<sup>58</sup> [ibid.](#)

<sup>59</sup> [ibid.](#)

- (d) the enforcement of the EU working hours directive made rotas unsustainable and the transaction would help the parties to overcome this problem;
  - (e) to maintain the financial stability of the parties in the face of the funding challenges which were arising from the movement of healthcare services to community settings and the pressure on the NHS budget (the parties considered that the merger would be able to deliver additional cost savings—see further paragraph 3.10 below); and
  - (f) to provide greater funding capacity to be able to invest in challenged clinical services, due to the borrowing limit which placed a cap on the amount a foundation trust was able to borrow. The parties said that the merger would enhance the merged trust's ability to raise capital, and they would also have the ability to direct necessary capital resources from RBCH (which had a surplus) to PH as part of the wider service reconfiguration plans and renewal of estates, especially for maternity.
- 3.9 The parties provided a joint Cost Improvement Plan (CIP) and information on the forecast financial performance of the merged trust, which highlights that the merged trust would generate a [redacted] of £[redacted] million and a [redacted] of £[redacted] million in the financial years ending 31 March 2015 and 2016, respectively.
- 3.10 The parties estimated that the merger would deliver merger-specific savings<sup>60</sup> of £13.3 million (or approximately 3 per cent of their combined revenues), which could be achieved over and above those the trusts could deliver on a stand-alone basis during the financial years 2014/15 and 2015/16. In addition, the parties noted in their forecasts that the merged trust would also avoid additional cost pressures of £[redacted] million that would occur on a stand-alone basis (although the parties subsequently said that they would not, in practice, incur these costs if the merger did not proceed—see Appendix M, paragraphs 290 and 291). The parties also noted that these savings were recurrent; however, they have not undertaken a detailed analysis of additional cost savings beyond this period. We analyse the parties' information on merger savings in Appendix B and discuss them further in Section 4.
- 3.11 The merger of RBCH and PH would involve a reconfiguration of some of the services provided by the hospitals. The parties provided us with details of possible changes in relation to maternity, cardiology, haematology, A&E and associated emergency surgery services, which we consider in detail in our analysis of whether the merger would be likely to result in benefits to patients. See further Section 9 below.
- 3.12 The parties told us that some aspects of the proposed reconfigurations would have to be consulted on to test that the reconfiguration: had GP leads and commissioner support; would sustain or improve choice; and had a sound evidence base. The parties also told us that ahead of these processes they must keep an open mind, or might be at risk of judicial review for decisions. The parties noted that they were under statutory obligations when seeking to make service reconfiguration decisions and that the options put forward to the CC did not represent a commitment to any particular course of action on the part of the parties or their management.

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<sup>60</sup> The parties carried out several different analyses in order to identify the savings each could make on a stand-alone basis, and the savings that the merged trust could generate, including commissioning work from McKinsey & Co (McKinsey) and PwC. See [Joint main party submission on relevant customer benefits](#).

## ***Jurisdiction***

- 3.13 Under section 36 of the Act, and pursuant to our terms of reference (see Appendix A), we are required to decide whether arrangements are in progress or contemplation which, if carried into effect, will result in the creation of a relevant merger situation. If so, we must consider whether the creation of that situation may be expected to result in an SLC within any market or markets in the UK for goods or services.
- 3.14 A relevant merger situation is created if two or more enterprises cease to be distinct within the statutory period for reference and either the share of supply or turnover test set out in the Act is satisfied.
- 3.15 The HSCA 2012 provides in section 79(1) that where the activities of two or more NHS foundation trusts cease to be distinct activities, this is to be treated as a case in which two or more enterprises cease to be distinct enterprises for the purpose of Part 3 of the Act (completed and anticipated mergers).
- 3.16 On 29 November 2011, RBCH and PH announced their intention to merge. As noted in paragraph 3.1 above, on 8 May 2012 they entered into an MoA which provided a high-level summary of the basis on which they would work towards achieving a merger and which was intended to give rise to legally binding commitments between the parties.<sup>61</sup> We are satisfied that, pursuant to section 79(1) of HSCA 2012, which came into effect on 12 June 2012,<sup>62</sup> this situation is to be treated as one where two or more enterprises cease to be distinct enterprises, for the purpose of the Act.
- 3.17 As noted above, the Act provides that for a relevant merger situation to be created, either the turnover test or the share of supply test must be satisfied. The turnover test is satisfied where the value of turnover in the UK of the ‘enterprise being taken over’ exceeds £70 million. The turnover of each of RBCH and PH exceeds £70 million. Therefore the turnover test is satisfied, and there is no need to consider the share of supply test.
- 3.18 For the reasons given above, we are satisfied that the proposed merger between RBCH and PH will, if carried into effect, result in the creation of a relevant merger situation. We therefore have jurisdiction to consider whether the creation of that situation may be expected to result in an SLC within any market or markets in the UK for goods or services.

## **4. Counterfactual**

### ***Framework for our analysis***

- 4.1 We must decide whether the merger of RBCH and PH may be expected to result in an SLC by considering the competitive situation without the merger. This situation is referred to as the counterfactual.<sup>63</sup> When identifying the counterfactual we have regard to the following:
- Our assessment is affected by the extent to which events or circumstances and their consequences are foreseeable, enabling us to predict with some confidence that they will occur. The foreseeable period can sometimes be relatively short.<sup>64</sup>

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<sup>61</sup> Memorandum of agreement, paragraphs 3.1 & 3.4.

<sup>62</sup> [Statutory Instrument 2012 No. 1319 \(C. 47\)](#), section 2(3).

<sup>63</sup> *Merger Assessment Guidelines*, CC2, [paragraphs 4.3.1 & 4.3.6](#).

<sup>64</sup> CC2, [paragraph 4.3.2](#).

- Since the counterfactual may be either more or less competitive than the prevailing conditions of competition, the selection of the appropriate counterfactual may increase or reduce the prospects of an SLC finding.<sup>65</sup>
  - We may examine several possible scenarios, one of which may be the continuation of the pre-merger situation; but ultimately only the most likely scenario will be selected as the counterfactual.<sup>66</sup>
  - We will typically incorporate into our assessment only those aspects of scenarios that appear likely to occur on the basis of the facts available to us and the extent of our ability to foresee future developments. We seek to avoid importing into this assessment any spurious claims to accurate prediction or foresight.<sup>67</sup>
- 4.2 Our guidelines note that future changes in market conditions, such as regulation or market liberalization, are often addressed as part of our competitive assessment. In this case, significant reforms to the NHS have recently occurred and these are taken into account where relevant in our competitive assessment.
- 4.3 In this case, the parties submitted that, without the merger, PH would be likely to fail in the foreseeable future and exit the market.
- 4.4 Against this framework and in light of the parties' submissions, we considered the following:
- the parties' submissions on the counterfactual generally, including the current state of cooperation between the parties;
  - the views of third parties on the counterfactual;
  - whether both parties were likely to remain in the market, and as part of that analysis we considered their financial positions;
  - other counterfactual options for PH and RBCH in the event that the merger did not proceed and both parties remained in the market; and
  - the service offerings that PH and RBCH could be expected to provide in the absence of the merger. In particular, we considered the extent to which we were able to foresee whether PH's service offering would change due to financial constraints without the merger compared with its current offering.

### ***Parties' submissions***

- 4.5 The parties told us that without the merger, both of them would face considerable financial difficulties, but these would be much more acute for PH such that it would be likely to fail and exit the market in the short to medium term without the merger.
- 4.6 The parties told us that by 2014/15, PH as a stand-alone trust would be in an unsustainable loss-making position. This would lead to it failing Monitor's regulatory requirements for financial viability, leading to regulatory intervention and to the trust facing administration. PH would not be able to achieve a financial turnaround without the merger, since as a stand-alone organization it could not grow revenues (non-

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<sup>65</sup> CC2, [paragraph 4.3.4](#).

<sup>66</sup> CC2, [paragraph 4.3.6](#).

<sup>67</sup> CC2, [paragraph 4.3.6](#).

elective activity above the level provided by the trust in 2008/09 is reimbursed at only 30 per cent of the standard rate);<sup>68</sup> and it could not cut costs: it has exhausted scope for efficiencies, and its main loss-making services cannot be closed—they are core to its non-elective service offering.

- 4.7 The parties told us that financial failure by PH would lead to its services being transferred—either in whole or in large part—to other providers. RBCH would be the natural recipient of such services. The parties said that the appropriate counterfactual was therefore most likely a disorderly form of consolidation of the parties' services in which key patient benefits of the proposed transaction would be lost.
- 4.8 PH also told us that without the merger PH would be likely to be put into special administration. We discuss Monitor's failure regime (including the role of a special administrator) above in paragraphs 2.38 to 2.46 and Appendix C; we discuss the likelihood of PH becoming subject to this regime in paragraphs 4.38 to 4.48.
- 4.9 The parties told us that PH had reviewed the possibility of merging with other hospitals, but none had appeared to provide the financial or clinical benefits of the proposed merger with RBCH, or expressed any interest in merging with PH.
- 4.10 The parties told us that they had achieved as much integration as they were able to without completing the merger. At present, they cooperated in many clinical areas (including sharing consultants and joint rotas for some services) and non-clinical areas (such as joint procurement and IT projects). They told us that this had been driven by a number of factors including:
- Duty of cooperation/the need to provide an integrated clinical service and to improve patient, care.
  - The history and geography of the two hospitals: RBCH was set up as complementary to PH in order to provide additional services. The two hospitals were always intended to be considered together and have always coordinated their activities.
  - The need to achieve operating efficiencies. Both parties were under pressure to reduce their costs in each year (as is the rest of the NHS). This had led to some sharing of their respective cost bases.
- 4.11 The parties told us that in the event that PH remained in the market in the counterfactual it would struggle and that this would affect the services it was able to provide. They also told us that there were no other alternatives available to PH other than merger with RBCH that delivered the clinical and financial benefits of the merger. We discuss the other alternatives the parties considered in paragraphs 4.53 to 4.64, and the effect on services in paragraphs 4.65 to 4.86.
- 4.12 We also noted the Chief Executive of PH's comments to the *Bournemouth Daily Echo* that:

It's absolute nonsense [to think that PH would close]. It's ridiculous to even think that Poole Hospital would be closing. There have been no plans and no discussions – not even hypothetical. There's still going to

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<sup>68</sup> However, we note that PH is not currently affected by the 30 per cent marginal tariff as its revenues remain below the baseline. PH told us that its activity in its 2013/14 contract was forecast to be below the 30 per cent marginal tariff.

be a need to continue to provide healthcare to local people. The issue is about who runs local healthcare.<sup>69</sup>

### **Views of third parties**

4.13 Third parties were divided between those that saw the counterfactual being the same as the present, and others who saw the parties struggling in the counterfactual with worse outcomes for patients. Third parties in general have less information than the parties to make this judgement but may also be more objective in proposing a view. See further Appendix E for details of their views.

### **Exiting firm scenario**

4.14 Our analysis of whether a ‘firm’ is failing is explained in the *CC/OFT Merger Assessment Guidelines* and follows the following steps:

- We first consider whether either RBCH or PH would have exited the market.
- Secondly, if we believe that this is the case, we consider what would have happened:
  - whether there would have been another purchaser for the assets and services of the exiting foundation trust, eg would it have been taken over by an entity other than the merging party? and
  - what would have happened to the services of the exiting foundation trust in the event of its exit. Would the services be provided elsewhere by another provider?

4.15 To determine whether RBCH or PH would be likely to exit the market in the foreseeable future we considered their financial positions and forecasts and the manner in which the Monitor failure regime (including the special administration process) operates. We also considered submissions PH put to us as to why it is in an exceptional position compared with other foundation trusts and therefore more likely to fail.

4.16 In order to assess a party’s performance in the absence of the merger, we normally review its stand-alone historical performance and its forecast financial performance. In this case, however, the parties told us that they had been operating on the assumption that the merger would proceed and that their future plans were predicated on the merger taking place. Nevertheless, they submitted stand-alone forecasts.

4.17 Forecast financial information is necessarily based on assumptions about cost and/or income movements in the future and is therefore less certain than current or historical performance. As we set out in Appendix B, we received several iterations of the financial figures for PH, RBCH and the merged trust, many of them prepared for the purposes of our inquiry. In this report we have used the figures submitted by the parties to Monitor and provided to us on 31 May 2013 as we would expect these to have been subject to significant scrutiny by the parties. The parties provided us with some further information to support these figures on 7 and 18 June 2013 which we

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<sup>69</sup> [www.bournemouthecho.co.uk/news/10488623.Poole\\_hospital\\_close\\_\\_Ridiculous\\_\\_says\\_chief\\_executive/](http://www.bournemouthecho.co.uk/news/10488623.Poole_hospital_close__Ridiculous__says_chief_executive/), 17 June 2013.

have taken into account. Where we have comments about these figures, we have noted these in Appendix B.

### *Analysis of RBCH*

- 4.18 We considered RBCH's financial position and forecasts (see Appendix E). We noted that it forecast that it would achieve surpluses going forward and that it would keep its substantial cash reserves. We noted that it had a financial risk rating of 3 as at 1 October 2013 and anticipated that its continuity of services risk rating would be [X] under the new Monitor ratings system.
- 4.19 Our assessment of RBCH is that it would continue to be profitable and would therefore remain in the market without the merger. Although it would be under financial pressure due to general budgetary constraints within the NHS (rather than anything specific to RBCH), having regard to RBCH's financial position, we did not expect RBCH to encounter financial difficulties that would result in it becoming subject to Monitor's failure regime. We therefore did not need to consider whether the services it provides would ultimately exit the market. We consider at the end of Section 4 how RBCH's service offering would be likely to change absent the merger.

### *Analysis of PH*

- 4.20 As we described in paragraph 2.58, PH has been for many years, and continues to be, a clinically and operationally successful foundation trust. It has been (and is currently) cash generative, apart from in the period around 2010. In 2010, PH suffered from financial and governance failures. We noted that, in order to address these problems, it had made substantial cost saving efficiencies, with the consequence that in 2012, according to PH, it was 7 per cent more efficient than the average foundation trust.
- 4.21 In order to determine whether PH would be likely to exit provision of acute services in the foreseeable future, we first considered PH's submissions that it faced structural issues which were likely to result in it continuing to face greater financial difficulties than other foundation trusts. We then considered PH's financial position and forecasts (see further Appendix B). These forecasts changed during the course of our inquiry and our analysis in this report was ultimately based on the forecasts provided to Monitor on 31 May 2013. We noted that in June 2013 Monitor opened an investigation into PH's financial position due to concerns about the long-term financial viability of PH. Against this backdrop, we considered whether Monitor would be likely to place PH into special administration, thus leading to a possibility that PH would cease to provide acute services. Further details of our analysis of whether PH would be likely to exit are set out in Appendix E.

### *Comparison with other foundation trusts*

- 4.22 PH told us that it was in an exceptional position within the foundation trust estate, due to the fact that it provided a high proportion of non-elective services compared with elective services, and its inability to access significant additional revenue streams from elective specialties, community care or private patients due to the number of competing providers nearby. PH also told us that:
- the historic division of elective services between PH and RBCH meant that RBCH provided a number of the more profitable elective specialties;

- neither PH nor RBCH had acquired significant community care services, as Dorset had a specialist community care trust in Dorset HealthCare University NHS Foundation Trust (DHUFT) that provided these services; and
  - PH faced a number of private providers nearby which constrained its ability to grow private patient revenue.
- 4.23 We considered the extent to which PH is exceptional either in terms of its size or its elective/non-elective case mix (see Appendix E). We then considered how, if at all, this should affect our analysis.
- 4.24 We considered the size of other foundation trusts and found that PH is a medium-sized foundation trust in terms of revenue and bed numbers.
- 4.25 We then considered the proportion of non-elective activity at PH and found that PH is a foundation trust that has an above-average proportion of non-elective activity. However, it did not appear to be unique in this respect.
- 4.26 In considering whether PH was exceptional due to the proportion of non-elective services it provides, we found that PH's income has not been affected (and its 2013/14 income will not be affected) by the 30 per cent marginal rate paid for non-elective services above the 2008 baseline, as it still provides a lower volume of relevant services than in 2008/09; therefore this is not—and is unlikely to be in the near future—the cause of financial pressure on PH.
- 4.27 PH told us that its financial difficulties were driven by the high proportion of non-elective services that it provided (and could not reduce) and a tariff structure that may not fully remunerate it for these services. However, PH also noted that these cost pressures did not specifically relate to the proportion of non-elective services, and that all NHS acute providers would face broadly the same increase in costs. PH's financial information did not show a link between its level of profitability and the proportion of its non-elective services. Data provided by PH showed that PH provided a number of profitable non-elective services. 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 also when measured against fully allocated total costs, and that closing them would reduce rather than increase the overall profitability of PH. See Appendix E for further details.
- 4.28 In summary, we found that there was nothing structural about PH (in terms of its size or case mix) indicating that it would be under more financial pressure than many other foundation trusts: it is efficient and high quality; and although it has a high proportion of non-elective services, we saw no evidence that this would lead to PH facing greater financial pressure than many other foundation trusts.

#### *Financial assessment*

- 4.29 PH provided us with forecasts showing that its cash balances were expected to start reducing in FY 2013/14. Although it forecast a surplus for that year, it told us that this was due only to a subsidy provided to it by Dorset CCG. Dorset CCG confirmed that it would be unlikely to continue such payments of subsidies to PH. 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.

- 4.30 PH forecast deficits of £[x] million in 2014/15 and of £[x] million in 2015/16 on a stand-alone basis. Its Annual Plan to Monitor for 2013/14 assumed that it would need to borrow £[x] million in total during 2014/15 and 2015/16 in order to maintain a positive cash balance, although it had not identified a source from which it would be able to borrow such an amount.
- 4.31 PH also told us that it had no more scope for additional cost reductions (in addition to those set out in its CIPs plan) and could not curtail its capital expenditure programme, but due to the assumptions underlying its forecasts it would need to make savings of £[x] million each year in order to break even. It also told us that it would have no ability to grow its income, due to its focus on non-elective services and the intense competition for AQP services.
- 4.32 PH told us that it considered that any changes to improve its performance were not within the power of the board to implement. PH considered that it had already exhausted the avenues available to it to improve its financial position to a material extent.
- 4.33 We considered in Appendix B the assumptions behind PH's forecasts and noted that many of these assumptions (regarding efficiency savings, tariff deflation and inflationary cost increases—drugs and pay costs) would apply to all NHS foundation trusts. These forecasts were also based on assumptions regarding the extent to which PH would benefit from non-merger-specific cost savings.
- 4.34 We tested these assumptions and noted that a different set of assumptions would generate smaller deficits for PH. We also found that there were some savings which, although described by the parties as merger specific, may be achievable by PH (and RBCH) on its own (see further Appendix B). Although we were not able to quantify these precisely, we noted that achieving these savings on a stand-alone basis would improve PH's forecast deficits.
- 4.35 The time period over which these forecasts extended coincides with the period when the manner in which the national tariff is calculated may change significantly (see paragraph 2.34 above and Appendix C, paragraphs 69 and 70). In our view, it is possible that some of those changes will benefit PH, although the precise effect of such changes on PH and their timing cannot be predicted with confidence at this stage.
- 4.36 We also noted that forecasts for the coming years were based on assumptions that may prove inaccurate and the accuracy of these forecasts will be affected by the factors listed above (level of savings which PH benefits from in a stand-alone scenario; levels of efficiency savings required; the extent to which capital expenditure is necessary at its current rate; level of commissioner support PH receives; changes to the tariff).
- 4.37 Our preliminary view of PH's financial situation was that on a stand-alone basis, if nothing else changed (eg in terms of the tariff structure or increased cooperation with RBCH), commissioners did not pay further subsidies and PH could identify no further material steps to address its problems (eg realizing some of the cost savings anticipated through the merger), PH would likely become loss-making in 2014/15 or 2015/16. However, some assumptions underlying the forecast may prove incorrect. For example, the tariff may change, capital expenditure may be avoided or cost improvements may be realized in ways not yet contemplated. In our view, the forecasts may paint a picture of PH's future financial situation that is unduly bleak. We also noted that Monitor's investigation may prompt changes aimed to put PH in a stronger financial position.

### *Monitor failure regime*

- 4.38 As noted above, on the basis of PH's forecasts of financial deficit, Monitor opened a formal investigation into PH's compliance with its licence.<sup>70</sup> It downgraded PH's governance rating. Its financial risk rating (which is tied to current levels of cash) was amended from 3 to 2 in August 2013 due to a deterioration in its financial position at Q1 2013/14 and as a result PH has been put on monthly financial monitoring. See paragraphs 2.58 and 2.59 for a description of changes to PH's ratings.
- 4.39 We noted that for a foundation trust to exit the market in the context of the failure regime (ie other than via a merger) it would need to go through Monitor's special administration process. In order to assess the likelihood of Monitor recommending that PH be put into special administration in the event of a deficit, we considered the Monitor failure regime (details of which are set out in paragraphs 2.39 to 2.46 above and in Appendix C) and what has happened to other trusts that have been struggling (see further Appendix E).
- 4.40 We noted, first, that Monitor said that it would step in when there were warning signs that a provider was struggling financially, with the aim of encouraging the provider to return to financial sustainability. In exceptional circumstances where this was not achieved, and financial failure became likely, there would be an ordered process—the failure regime—during which a Trust Special Administrator may be appointed to take control of the provider's affairs and work with commissioners to ensure that patients continued to have access to the services they needed.<sup>71</sup>
- 4.41 We asked Monitor whether it thought PH was likely to fail, based on the figures we were provided with, and, if so, what that failure would look like and the steps Monitor would take in terms of any intervention. Monitor told us that it would assess PH's financial performance in accordance with its usual risk-rating process and drew our attention to its Risk Assessment Framework (which we describe in Appendix C).
- 4.42 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. Monitor told us that, absent of merger, PH would 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.
- 4.43 We therefore considered PH's submission regarding failure in light of the Risk Assessment Framework. We also considered the circumstances in which other foundation trusts had been put into special administration.
- 4.44 As noted in Section 2, the intention is for special administration only to be used in exceptional circumstances. As noted in Appendix E, Monitor expected that more small and medium-sized hospitals were likely to face financial risk and that an increasing number of individual trusts would be in significant breach of their licences for financial reasons over the next three years. 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; only one of these trusts is currently

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<sup>70</sup> [www.monitor-nhsft.gov.uk/home/news-events-publications/latest-press-releases/monitor-announces-investigation-poole-hospital-n](http://www.monitor-nhsft.gov.uk/home/news-events-publications/latest-press-releases/monitor-announces-investigation-poole-hospital-n).

<sup>71</sup> Monitor's website at [www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-5](http://www.monitor-nhsft.gov.uk/home/news-events-publications/our-publications/browse-category/guidance-health-care-providers-and-co-5).

in special administration (Mid-Staffordshire Foundation Trust, which had specific serious clinical problems).

- 4.45 Based on the experience of other trusts in financial difficulty, we noted that the process for intervention by Monitor and the appointment—where appropriate—of a trust special administrator is lengthy. In the case of Mid-Staffordshire Foundation Trust (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.<sup>72</sup> We set out in Appendix E information on MSFT and one other foundation trust which has struggled and on an NHS trust which was put into administration in 2013 by the Secretary of State.
- 4.46 Our review of the use that has been made of the failure regime indicated that a trust is only put into special administration by Monitor in exceptional circumstances and following a fairly lengthy process, and that even trusts which have run up large deficits for several years are not necessarily put into special administration (for example, Peterborough had a deficit of £46 million in 2011/12 and a deficit of £37 million in 2012/13 and was not in special administration).
- 4.47 We also considered the CCP's approach to assessing the failure of NHS hospitals as part of their assessment of mergers. We noted that, although the circumstances of those mergers, and the framework in which they were assessed, were different from our own, the CCP's approach generally indicated that market exit in the NHS would be rare.
- 4.48 We considered that, even if PH's financial forecasts were entirely accurate, having regard to Monitor's guidance and Monitor's approach in other cases, it was very unlikely that PH would be put into special administration and that its services would exit the market in the foreseeable future. We did not therefore consider PH to be an exiting firm within the meaning of our *Merger Assessment Guidelines*.

### *Conclusion—exiting firm*

- 4.49 Based on our analysis of the financial situations of RBCH and PH respectively and the manner in which the Monitor failure regime (including the special administration process) operates, our conclusion is that, without the merger, neither party would have exited the market. This means that there is no need for us to consider what would have happened to the services of either hospital in the event of its exit.
- 4.50 We noted that the parties disagreed with elements of our exiting firm analysis but did not dispute the fact that PH's services would not exit the market.
- 4.51 We also noted that some of the arguments made by PH regarding the profitability of its non-elective services and its future financial position are relevant to our wider assessment. We take its likely future financial position into account when considering how its service offering may change in the counterfactual. We consider the profitability of PH's elective and non-elective services in Section 6.

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<sup>72</sup> [www.monitor-nhsft.gov.uk/home/news-events-publications/latest-press-releases/monitor-announces-appointment-trust-special-admi](http://www.monitor-nhsft.gov.uk/home/news-events-publications/latest-press-releases/monitor-announces-appointment-trust-special-admi). See also 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 NHS Act 2006.

## ***Other counterfactual scenarios***

- 4.52 We considered counterfactual scenarios other than those relating to exit for either of the parties. These are described in detail in Appendix E.

### ***Other options for RBCH***

- 4.53 RBCH and PH commissioned 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,<sup>73</sup> and recommended 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.
- 4.54 RBCH also considered a number of other options should the merger not proceed or not be considered as desirable by the board.<sup>74</sup> RBCH told us that it had considered five possible options including cooperating further with PH; [redacted]; merging with other trusts; or [redacted].<sup>75</sup> In all cases, apart from [redacted] (which RBCH identified as an opportunity), RBCH did not consider these options viable. In particular, RBCH approached [redacted] regarding a potential merger (these parties were approached at the same time as RBCH approached PH). However, none of these trusts expressed any interest in the proposal,<sup>76</sup> and RBCH did not consider that a merger with one of them would be as beneficial as a merger with PH given that the distances involved would limit the scope for shared clinical services.
- 4.55 RBCH is currently in surplus and is forecast to remain in surplus for the next few years. Our conclusion is that without the merger RBCH is most likely to continue as a stand-alone trust as it did not consider other options desirable and will not be in a financial position which will force it to reconsider these options in the immediate future.

### ***Other options for PH***

- 4.56 We also considered what PH would have done in the event that the merger did not proceed.
- 4.57 PH provided us with a detailed description of the process leading up to the merger (see further Appendix E). From approximately autumn 2009 to March 2010, PH's previous senior management<sup>77</sup> 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. From approximately April 2010 to January 2011, the management focused on the immediate financial difficulties of the trust.
- 4.58 From approximately February 2011 to April 2012, PH considered options. At a board meeting in September 2011 it discussed eight possible options, of which 'three clear

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<sup>73</sup> [Joint main party initial submission](#).

<sup>74</sup> [ibid](#).

<sup>75</sup> These options were discussed at the 24 November 2011 meeting of the board alongside the McKinsey report. [Joint main party initial submission](#), paragraph 171.

<sup>76</sup> [Joint main party initial submission](#).

<sup>77</sup> As noted in paragraph 2.56 PH's management changed in 2010 to 2011.

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. As noted above in relation to RBCH, McKinsey produced a report in November 2011 recommending the merger. From approximately May 2012 until present, PH's senior management investigated alternatives to the merger and reappraised PH's long-term options.

- 4.59 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. In July 2012, the board considered three alternative options to the merger: adopting a franchise model under which a franchise partner would take operational control of the trust and accept all risks; a vertical integration model, which would involve PH partnering or merging with another trust (in preference [REDACTED]); and a partnership model under which PH would find a partner to assist it in managing its finances (see further Appendix E for details of these options). PH told us that these options were rejected as substandard in clinical terms; none would deliver the patient benefits that could be achieved by merging with RBCH; the best hypothetical candidate for a vertical merger—[REDACTED]—did not want a merger with PH; and the other two options were novel, untested models without evidence showing that they could work in the NHS.
- 4.60 PH, with the assistance of a PwC reappraisal, reconsidered the eight options discussed in 2011 and discussed the options again at the September 2012 board meeting.<sup>78</sup> Of the eight options, PH told us<sup>79</sup> 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'.<sup>80</sup>
- 4.61 It discarded the options of merging with [REDACTED] as this would not allow PH to deliver significant clinical benefit, especially compared with other options available. PH therefore considered in detail a merger with [REDACTED] and RBCH.
- 4.62 PH found that a merger with [REDACTED] would not bring the same patient [REDACTED] to PH as a merger with RBCH or allow integration of haematology and consolidation of A&E services. A merger with [REDACTED] 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 continued their follow-on rehabilitation in the community services facilities of [REDACTED].<sup>81</sup> However, in PH's view these were not as high as the benefits delivered by the merger with RBCH. Finally, the options of merger with [REDACTED] and [REDACTED] were considered by the board to remain hypothetical since neither organization expressed an interest in merging with PH.

#### *Preliminary assessment of other options for PH*

- 4.63 It appeared from the detailed analysis that PH carried out that were PH to merge, [REDACTED] was its preferred merger party after RBCH. However, according to the merger

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<sup>78</sup> 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.

<sup>79</sup> [Joint main party initial submission](#), paragraph 166.

<sup>80</sup> 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 [REDACTED] and then remaining stand-alone came third of the eight with a score of 121. The remaining options were all given a score of less than 100 points. Given that the parties told us that the [REDACTED] was hypothetical, it appears to us that the next best feasible option to the RBCH merger considered by PwC was remaining stand-alone.

<sup>81</sup> [REDACTED]

parties, [X] had expressed no interest in such a merger and would not be likely to provide the same level of benefits that PH expects from the merger with RBCH.

- 4.64 Due to a lack of interest from [X], not merging, ie remaining stand-alone, was the most likely alternative to a merger. Therefore, our preliminary assessment is that without the merger PH would be likely to continue as a stand-alone trust.

#### *Changes to the services provided by RBCH or PH*

- 4.65 We next considered whether, in the counterfactual, either RBCH or PH would be likely to change their service offerings significantly, compared with their current offerings.

#### *RBCH service offering in the counterfactual*

- 4.66 RBCH provided evidence that it would remain in surplus and be under limited financial pressure and did not consider that it would change its service offering significantly absent the merger, except that it would be likely to increase its provision of [X] services in particular areas; and would be unlikely to provide Level 3 haematology services, as they are currently offered absent the merger. The parties also told us that from 2013/14, the Persistent Pain Management services<sup>82</sup> (which included both outpatient and inpatient activity) would be transferred out of an acute setting and provided in the community by DHUFT, so it was not a service that either PH or RBCH would provide in the future.
- 4.67 The parties indicated that they believed that the most complex aspects of their haematology services (the Level 3 offering, which primarily comprised the bone marrow transplant (BMT) specialised service), would be likely to leave the area. We received evidence from the parties and commissioners that changes had been considered to the provision of haematology in the Dorset area for some time. However, we also received evidence from the commissioner of specialised services, NHS England (Wessex), that both parties had recently self-assessed 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.
- 4.68 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.
- 4.69 We therefore do not believe that RBCH's service offering would change significantly in the counterfactual.

#### *PH service offering in the counterfactual*

- 4.70 Given the information we received regarding PH's financial position, we considered whether this would significantly affect its service offering and its ability to compete in the counterfactual. We also considered whether there were other reasons why PH's service offering would be likely to change in a stand-alone counterfactual.

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<sup>82</sup> Persistent Pain Management services are a subset of services classified under the Pain Management specialty.

- 4.71 We considered whether PH would be able to negotiate improved terms from the commissioning bodies, for example by extracting from the commissioners sufficient settlements for it to remain profitable. PH told us that further additional resource may not be forthcoming from the commissioning bodies without the merger, and the Dorset CCG confirmed this.
- 4.72 We therefore considered whether PH would be likely to attempt to reduce costs further, eg by targeting loss-making services. However, the parties told us that further efficiency savings would be difficult, and that they had already generated all the benefits that could be achieved without merger. We considered the extent to which some clinical rationalization could be achievable through contractual arrangements and not through merger. We also considered whether PH would be likely to focus on specific areas that are profitable, eg by expanding services into more elective work, or by working more closely with private healthcare providers.
- 4.73 PH told us that continuing as a stand-alone entity, it would experience increased financial fragility and a decline in clinical quality across its services with patients suffering as a result of the lower quality. However, PH also told us that it would not be likely to allow its services to decline in quality but would run up a deficit in preference to that.
- 4.74 We first consider whether PH is likely to close any services. This assessment relies on the assumption that PH is able to identify which services are genuinely loss making or profitable (the calculations are complicated, rely on cost allocations and require an understanding of service interdependencies).
- 4.75 PH told us that its financial position was related to its provision of a high proportion of non-elective services. However, as we noted above, we found that there was no clear link between its provision of non-elective services and its financial position. PH also told us that it would not reduce its non-elective services. It said that the loss-making services were at the core of its service offering, and the clinical interdependencies that existed between the services meant that one could not 'turn off' a loss-making service and continue providing all other services. PH considered that closing loss-making services on a stand-alone basis could not save PH, as these services made a positive contribution to the fixed costs of the trust. Whilst not profitable when measured against fully allocated total costs, closing them would reduce rather than increase overall profitability at PH.
- 4.76 Based on the above, we did not consider it likely that PH would close existing services. We then considered whether PH would be likely enter new services that are profitable, eg certain profitable elective services.
- 4.77 PH told us that it lacked funds to finance investment in new services and it would not consider borrowing more money to finance any service expansion as it did not believe that it would have sufficient income to support the interest costs. However, if the service expansion is profitable, then we might expect PH to consider that it would be worth investing to win it (although it may struggle to find a willing lender). PH also said that the commissioner would not support new services given its fixed financial envelope (ie the managed contract with Dorset CCG) and for reasons of clinical safety. Under the managed contract, the level of activity was 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. PH told us that this made launching new services, or a major drive to expand an existing service, a financially risky endeavour without explicit commissioner support. It said that any expansion in its services would involve winning patients from nearby hospitals. As PH's elective base is currently around £25 million, PH told us that it would have to expand several times over to make any

impact on its financial situation. This would be resisted by the hospitals losing business.

- 4.78 We considered on this basis that PH would be unlikely to expand into new specialties. We separately considered the impact of the relationships between the parties and local CCGs on the parties' incentives to compete in our competitive effects analysis (Section 6) and have taken this into account in our consideration of whether the parties would be likely to compete more strongly in the foreseeable future if the merger did not proceed.
- 4.79 We noted that foundation trusts have in the past been limited in their ability to offer private services, but the cap on this (1.5 per cent for PH) was lifted in October 2012. Therefore PH could expand its private services to the extent that this is profitable, for example we note that the Acute Surgery Shadow Clinical Directorate papers [8 May 2013] question whether increased income from private [redacted] services would be merger dependent.<sup>83</sup>
- 4.80 PH told us that its budget for 2013/14 included an increase in private patient income, but that PH faced strong competition from a nearby private hospital. Following the merger, PH believed it would be able to generate more private income as the merged trust would have an elective orthopaedics service and offer an improved, integrated cardiology service.
- 4.81 We therefore do not believe that PH's service offering would change substantially in the counterfactual.
- 4.82 We note that the parties put forward a number of patient benefits, and we considered whether these were likely to be RCBs within the meaning of the Act in Section 9. We note that if we determined that any of these benefits were likely to accrue but were not merger-specific, we would then need to consider whether these would occur within the foreseeable future, such that our counterfactual analysis should reflect these likely changes to services. We did not find that the benefits put forward in relation to A&E, emergency surgery, haematology or maternity were likely to accrue in the absence of the merger and, therefore, did not need to take any of these benefits into account in our counterfactual analysis.
- 4.83 We did not find that the cardiology rota reconfiguration proposed as a benefit would be unlikely to accrue absent the merger. We therefore considered that in the counterfactual, this rota reconfiguration was likely but that this change would not impact our competitive assessment, for the reasons set out in our analysis of shared consultants (see Section 6), noting that the parties share rotas in a number of other areas.

#### *Assessment on parties' service offerings in the counterfactual*

- 4.84 Our assessment is that both RBCH and PH would continue to provide a broadly similar range of services in the counterfactual as they currently provide. We took the view that PH would be likely to be financially constrained from significant expansion into new specialties.
- 4.85 It is likely that there will continue to be small changes to specific services as occur at the moment but we considered that these would be too minor to impact on our competitive assessment.

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<sup>83</sup> [redacted]

4.86 We understand that both parties will cease to provide many aspects of pain management services and would provide more private patient services. We do not have detailed evidence of other significant changes to their service offerings absent the merger.

### **Conclusion on the counterfactual**

4.87 For the purposes of our competitive assessment, based on the evidence set out above, we considered that in the counterfactual both parties would remain as stand-alone entities, providing broadly similar service offerings to their current offerings.

4.88 The parties submitted that the appropriate counterfactual was one in which PH exited the market. Based on our analysis of the financial situations of RBCH and PH and our analysis of the manner in which the Monitor failure regime (including the special administration process) operates, our conclusion is that, without the merger, neither party would have exited the market.

4.89 We considered the evidence regarding other options the parties had considered as alternatives to the merger and found that in each case the most likely alternative option was that the hospital remained as a stand-alone entity.

4.90 We considered the extent to which the parties' service offerings might change in the counterfactual, in particular in the case of PH due to financial constraints and also in light of information we received regarding service reconfigurations, and found that their service offerings were likely to remain broadly similar to their current offerings.

## **5. Market definition**

5.1 In order to assess whether the merger would give rise to a loss of competition in the provision of the relevant NHS acute services in the Dorset area, we considered: the relevant markets (Section 5); the competitive effects of the proposed merger (Section 6); and whether countervailing factors such as buyer power, entry and expansion or rivalry-enhancing efficiencies existed which would constrain the parties from reducing quality in relation to services where we found that unilateral effects<sup>84</sup> were likely to occur as a result of the merger (Section 7).

5.2 In this section, we describe the relevant markets in which we will assess the effects of the merger.

5.3 The purpose of market definition is to provide a framework for our analysis of the competitive effects of the merger. The relevant market contains the most significant competitive alternatives available to the customers of the merger firms and includes the sources of competition to the merger firms that are the immediate determinants of the effects of the merger. We note that market definition is a useful tool, but not an end in itself, and that the boundaries of the market do not determine the outcome of our competitive assessment in any mechanistic way.<sup>85</sup>

5.4 The common approach to define relevant markets is based on the hypothetical monopolist test, as set out in our Merger Assessment Guidelines (paragraph 5.2.10):

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<sup>84</sup> See CC2, [paragraph 4.1.5: Unilateral effects](#). These may arise in horizontal mergers where the merger involves two competing firms and removes the rivalry between them. CC2 notes that such removal of rivalry may allow the merged firm profitably to raise prices. In this case, we consider whether the merger may result in a removal of rivalry which would allow the merged firm to reduce quality, as for the most part the firms do not compete on price.

<sup>85</sup> CC2, [paragraphs 5.2.1 & 5.2.2](#).

A set of substitute products (a ‘candidate market’) will satisfy the hypothetical monopolist test if a hypothetical firm that was the only present and future seller of the products in the candidate market would find it profitable to raise prices. Under this framework, a candidate market will fail the hypothetical monopolist test, and will be too narrow to comprise the relevant market, if customers would respond to the price rise by switching to products outside the set to such an extent that the price increase by the hypothetical monopolist would not be profitable.

- 5.5 The majority of the prices for acute services are regulated and centrally set by the Department of Health under the PbR system<sup>86,87</sup> which reimburses providers according to the number of NHS patients that they treat.<sup>88</sup> Healthcare providers therefore have limited ability to influence prices in relation to their NHS activity (except for the subset of services which are not covered by the PbR regime). However, providers can compete along other dimensions, namely various aspects of quality, and the logic of the hypothetical monopolist test can then be applied with reference to the impact of small but significant reduction in quality on a hypothetical monopolist’s profits.<sup>89</sup>
- 5.6 Both of the parties offer some services to private (fee-paying) patients (including elective secondary care, day-care and outpatient clinical services), although these services currently account for a very small proportion of their income.

### **Product market**

- 5.7 RBCH and PH both provide a wide range of hospital-based services including elective and non-elective secondary inpatient care, specialised clinical services and community and outpatient services. Services can comprise various activities: procedures, diagnosis (together ‘treatments’) and attendances.<sup>90</sup> Acute healthcare services cover a very large number of procedures. The classification system used by the NHS to report the various procedures delivered to patients (OPCS-4) includes over 9,000 different codes and covers a range of different operations, interventions and procedures.
- 5.8 We considered the extent to which the numerous different types of procedures and other services are substitutable on the demand side. We found that as there is typically only one service that is appropriate for a specific healthcare problem, the starting point for market definition is one of narrowly delineated product markets covering each different service.<sup>91</sup>
- 5.9 We then considered whether, despite the lack of demand-side substitution, different services may be aggregated into broader markets on the basis of supply-side factors, to the extent that: suppliers may switch easily and in a timely fashion (typically within one year) between the provision of various services in response to a small but signifi-

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<sup>86</sup> As outlined in Section 2 above, these prices will be set by Monitor from 2014.

<sup>87</sup> There is a subset of services which are not covered by the PbR regime.

<sup>88</sup> In some cases the reimbursement scheme can be more complex.

<sup>89</sup> We expect that the logic we have set out in this report relating to acute hospital services that are remunerated on the basis of PbR would also apply to acute hospital services remunerated on the basis of non-PbR even though it might be appropriate to motivate the market definition exercise on the basis of small but significant non-transitory increases in price instead of, or as well as, quality.

<sup>90</sup> Attendances do not necessarily result in procedures or a diagnosis. Patient episodes do not always involve procedures. However, when we discuss the scope for supply-side substitution below, we focus on procedures because rigidities in supply-side substituting between services are more likely to arise in relation to these services due to the dedicated equipment and the specific consultants’ expertise that may be required to carry out a given procedure.

<sup>91</sup> Indeed, the market could be even narrower than a given treatment code if treatments can be differentiated on the demand side according to the characteristics of the patient that is being treated.

cant worsening in the quality of provision of the candidate service by a hypothetical monopolist (ie supply-side substitution); or the same suppliers compete to supply the services concerned and the conditions of competition are the same for each service.<sup>92</sup>

- 5.10 We considered the extent to which we could aggregate the services/clusters of services provided by RBCH and PH due to supply-side factors. We assessed:<sup>93</sup>
- (a) the extent to which services/clusters of services or sub-specialties (whether they are commissioned by CCGs or NHS England) can be aggregated within a specialty as a result of supply-side factors;
  - (b) the extent to which specialties can be aggregated due to supply-side factors;
  - (c) the extent to which outpatient and inpatient services (where the patient requires admission to hospital) that take place within a given specialty can be considered as part of the same relevant market; and
  - (d) the extent to which providers of non-elective services (which are provided in conditions of emergency) can constrain providers of elective services (which are planned in advance), where the hospital offers the same cluster of services, and vice versa.
- 5.11 The resources (consultants, equipment, infrastructure) required to treat patients in a given specialty will generally be quite different from those required to treat patients in another specialty (although there will be some common resources and these may be quite significant in the case of related specialities).<sup>94</sup> However, we also note that even within a given specialty, services may require different resources depending on whether a service is provided in conditions of emergency or planned in advance (non-elective versus elective services), and whether or not patients need to be admitted into a hospital (inpatient versus outpatient).
- 5.12 Certain acute services, both elective and non-elective, are defined by the NHS as 'specialised services'. These services are designated based on their complexity and the fact that few such treatments will be carried out in a particular area and therefore, in principle, there are unlikely to be numerous providers of such services in a given geographic area. In practice, we consider that specialised services are not intrinsically different from other particular treatments or subspecialties in any way other than their commissioning (ie from the point of view of patients, or from the point of view of providers on a day-to-day basis).

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<sup>92</sup> CC2, paragraph 5.2.17.

<sup>93</sup> In considering these questions, we assume that providers' incentives to offer new services in response to a reduction in quality by the existing provider(s) are not undermined by lack of responsiveness of patients/GPs to quality changes or by the nature of the relationship between providers and commissioners. We consider this issue explicitly in our competitive effects analysis.

<sup>94</sup> 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). The parties told us that specialties and diagnosis/procedure codes were assigned via two separate processes, 'meaning that the latter do not nest within the former'. The parties' SUS data (see Appendix G for further details on the activities covered by SUS) confirmed that treatments are often not uniquely identified within specialties. While this may be in part due to miscoding, this also arises because in some circumstances the relevant treatment may need to be undertaken in different departments and/or by consultants who are registered under different specialties. Although specialties do not always uniquely identify sets of distinct services, the classification of services by specialty is broadly used in the NHS and appeared to constitute a reasonable and practical approach to grouping services that have clinical commonalities.

### *Supply-side factors within a specialty*

- 5.13 The availability of specialised clinicians, dedicated equipment and facilities are major components supporting the supply of healthcare services.
- 5.14 RBCH and PH provided us with evidence that providers of a particular specialty typically have the capacity to provide the full range of routine treatments within that specialty, with consultants typically having expertise to provide a range of routine services within each specialty.<sup>95</sup>
- 5.15 We considered whether there is a cluster of routine services within each specialty across which supply-side substitution is easy to achieve or which are commonly provided by all hospitals active in a specialty. Then we considered the ease with which NHS hospitals can expand into less routine services based on their provision of routine care services.
- 5.16 Whilst some providers noted the ability of consultants to provide general care across their specialty, most NHS providers noted increased sub-specialisation of consultants resulting in consultants being less able to provide a wide range of treatments than in the past.
- 5.17 To test the ability of providers to provide a range of treatments within a specialty, we analysed all inpatient elective procedures provided by PH, RBCH, Dorset County Hospital, Salisbury District Hospital and University Hospital Southampton in the period April 2010 to December 2012.<sup>96</sup> We found that the five hospitals tended to provide a set of procedures that represented the large majority of the volume 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 activity in many specialties related to procedures that all five hospitals provided<sup>97</sup>).<sup>98</sup> On average, the five hospitals overlapped on procedures that represented 74 per cent of the total activities carried out by these hospitals in the elective specialties considered (76 per cent in relation to non-elective services). Details of our analysis are set out in Appendix F.
- 5.18 This suggested to us that although a level of sub-specialism was present (ie not all hospitals provide all procedures), when a hospital has activities in a specialty it tends 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 and that the same hospitals are, in the main, competing to supply the same core set of routine procedures within each of these specialties.
- 5.19 We next considered the role of supply-side factors with regard to less routine services within a specialty. The parties submitted<sup>99</sup> that the scope for supply-side substitution within specialties is more limited in relation to the treatment of some complex and specialist cases (ie some 'sub-specialties' within specialties), where clinicians are required to undertake a minimum number of procedures per year to retain experience levels and to allow the provider to cover fixed costs. Salisbury District Hospital also referred to these points as obstacles to expansion within specialties. The parties also submitted that the availability of spare capacity, appropriately trained

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<sup>95</sup> [Joint main party initial submission](#), paragraphs 118 & 119.

<sup>96</sup> This is the period covered by the data of all five trusts considered.

<sup>97</sup> See the final column of Table 1 in Appendix F.

<sup>98</sup> 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 are 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.

<sup>99</sup> [Joint main party initial submission](#), paragraph 190.

staff and equipment were potential obstacles to expansion in sub-specialties in which providers are not already present.

- 5.20 We received evidence from a number of third party acute providers in the area as to the extent of their expansion within specialties in the past five years and received some evidence of expansion (see further Appendix F). We also received evidence from some providers on the costs of expansion within specialties. This information is described in more detail in Appendix F. The information received showed that: (a) expanding into sub-specialties involves non-negligible investment; (b) some of these investments appear to be sunk; and (c) providers need to develop dedicated capacity in the form of new equipment, laboratories, additional theatre capacity, etc (ie they cannot simply shift capacity from other areas within those specialties). This does not rule out that expansion into sub-specialties could be feasible 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).
- 5.21 Also we noted that in some cases hospitals required permission from the local commissioners in order to start the provision of a new service/set of services within a given specialty and this may represent another potential obstacle to expansion.
- 5.22 In summary, we found that, while there are sub-specialties into which providers cannot expand easily and quickly, the hospitals tended to provide a core set of routine services in specialties in which they were active. On balance, we therefore decided to treat each specialty as a separate market. However, in our competitive effects analysis, we also consider the competitive constraints in relation to sub-specialties and address any relevant sub-specialism that could affect the level of overlap between RBCH and PH (whether this sub-specialism relates to services commissioned by the CCG or by NHS England) and the extent of the constraint exerted by other providers in our competitive effects analysis.

### *Supply-side factors between specialties*

- 5.23 We also considered whether it could be possible to substitute readily between specialties on the supply side.
- 5.24 In general, a provider willing to start supplying services within a specialty where it is not yet active cannot rely on its existing resources, but needs to invest in hiring new staff, facilities and equipment. We asked RBCH and PH and the major NHS acute hospitals<sup>100</sup> in the area to provide estimates of the investments involved in starting to supply services in relation to a number of different specialties in which the parties told us they did not currently overlap.<sup>101</sup> This information is described in detail in Appendix F.
- 5.25 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, and some of these costs appear to be sunk. A non-negligible proportion of these costs appear to be not divisible (in particular, equipment and development of additional theatre and ward facilities) and therefore cannot be scaled

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<sup>100</sup> We received information from four of the five hospitals we asked.

<sup>101</sup> We focused on these specialties as, in addition to the market definition assessment, they were also relevant also to analysing the overlap between the parties.

to accommodate small-scale expansion.<sup>102, 103</sup> Dorset CCG told us that the need to achieve sustainable economies of scale was a major concern for hospitals operating in the areas with a small catchment population, such as Dorset.

- 5.26 We did not consider it appropriate to aggregate different specialties into the same market. Even though the nature of the constraints to suppliers in substituting between specialties is broadly similar to that described above in the context of expanding across sub-specialties, the magnitude of the required investments, the scale of entry, the likelihood of having appropriate experience within existing staff and the need for contractual rearrangements with the commissioners are likely to be more onerous. This makes substitution across specialties less likely to occur in the short time frame for supply-side substitutability. We also noted that different hospitals do not all provide the same specialties. On this basis, we treated markets as being no wider than specialty level.

### *Outpatient versus inpatient services*

- 5.27 Outpatient services are generally defined as those services which do not require a patient to be admitted to hospital, whereas inpatient services do require patients' admission to hospital (and also involve an overnight stay). There is also an 'in-between' case where a patient is admitted but the service is completed within the day (ie they do not stay overnight): these are referred to as 'day-case' activities and we understand that hospital activity data tends to group these activities in with inpatient activity. We therefore treated day-case activities together with inpatient activities throughout our analysis. Most specialties have both an inpatient and an outpatient element (though there are some specialties that include only, or to a very large extent, outpatient services, such as diabetic medicine or clinical genetics). Outpatient activity includes first and follow-up consultant appointments as well as diagnostic procedures and treatments that do not require admission.
- 5.28 We considered which were the most common outpatient activities (by volume) in the wider Dorset area and found that a high proportion of activity (both by volume and value) related to consultations, rather than diagnostic tests or procedures (see full evidence in Appendix F). We also found that in some cases outpatient services will form part of an admitted care pathway (ie leading to hospital admission or as a follow-up from a procedure) but in other cases outpatient services will be offered on a stand-alone basis.

### *Supply-side substitution*

- 5.29 We first considered the scope for supply-side substitution from outpatient services into inpatient services and from inpatient services into outpatient services.
- 5.30 The parties told us<sup>104</sup> that supply-side substitution from inpatient care into outpatient-only activity within the same specialty is likely to be possible.
- 5.31 The evidence we collected suggested that hospitals provide outpatient care in all the specialties where they are active as an inpatient provider. This is either because input and facilities required for inpatient services are also used for outpatient care in

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<sup>102</sup> CC2 sets out that in the presence of economies of scale small-scale entry may not be feasible and large-scale entry or expansion is generally successful only if the provider expects the total market to significantly expand, or to substantially replace one or more existing firm.

<sup>103</sup> University Hospital Southampton told us that 'the lowest denominators are additional sessions for theatres but usually require out of hours working and a bay for beds but cannot plan for any significant change on this scale'.

<sup>104</sup> [Joint main party initial submission](#), paragraph 205.

the same specialty or because the two types of services are interlinked from a medical perspective.

- 5.32 However, the opposite does not appear to hold true, that is hospitals can and do provide outpatient care even in specialties in which they are not active on the inpatient side. We therefore found that inpatient providers can constrain outpatient providers but that outpatient providers cannot readily start providing inpatient care.

### *Stand-alone versus care pathway outpatient services*

- 5.33 We next 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 for inpatient services.

- 5.34 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)'.<sup>105</sup> The parties said that outpatient services not linked to an inpatient spell (outpatient-only services) should instead be considered separately. We observed that outpatient and inpatient services within the same care pathway were often provided separately and we therefore 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.

- 5.35 The parties also told us that there was no national guarantee of choice for inpatient services<sup>106</sup> and patients had the right to choose care only in relation to the first outpatient appointment. That is, they claimed that there was no, or very limited, competition for inpatient services as once a patient had chosen their outpatient provider they were 'locked in' with that provider even for the associated inpatient activity. We considered evidence on the manner in which outpatient care is provided and this is set out in full in Appendix F.

- 5.36 We considered that what a hospital provides in relation to inpatient elective activity would influence the choice of hospital for the first outpatient referral for a number of reasons. First, in some instances, the patient or GP has foresight of the entire care pathway that the patient will require. Second, we noted that the quality indicators are typically reported for inpatient services such that the choices of patients and GPs are likely to be influenced by the quality of the inpatient services irrespective of whether a patient needs (or anticipates that he or she needs) an inpatient treatment. Also, in some cases patients will be 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 for inpatient treatment following the outpatient appointment on the basis of some assessment of the relative quality of the hospitals located in the area.<sup>107, 108</sup>

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<sup>105</sup> *ibid*, paragraph 202.

<sup>106</sup> [Joint main party submission, 'The role of Competition in the merger of RBCH and PH FTs'](#).

<sup>107</sup> If the hospital where the patient has been referred for the outpatient appointment does not provide an inpatient service, the patient may be referred back to their GP where a decision over the inpatient provider is 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. The CCG's document 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).

- 5.37 As such, we expect that the extent to which hospitals are able to compete will be influenced by the degree of overlap at an inpatient as well as outpatient level and that hospitals will face incentives to improve quality in relation to both inpatient and outpatient services in order to attract more patients.
- 5.38 We also noted that some outpatient services were follow-ups to emergency admissions (or, in a minority of cases, follow-ups to A&E attendances that did not result in admissions) and that for these services, patients would typically not have a choice of provider and had no right of choice. Therefore, although all outpatient services are technically classified as elective, in most specialties they could in principle be separated into those which are truly elective (either because they were part of an inpatient elective pathway or because patients could choose a provider using Choose & Book) and those which relate only to emergency pathways. Where this was the case, we therefore considered these outpatient services linked to non-elective pathways separately from outpatient services linked to elective pathways in our analysis. For example, we understand that two outpatient specialties—A&E and transient ischaemic attack—relate only to emergency pathways and do not relate at all to elective pathways.<sup>109</sup>

#### *Outpatient in community versus acute settings*

- 5.39 The parties also submitted<sup>110</sup> that the providers of community-based care, including community hospitals and GP practices (particularly those who have a GP with a special interest in the area), can also supply-side substitute into the provision of stand-alone outpatient services.
- 5.40 We noted that certain types of outpatient care could readily be provided in a community setting while others could not because of their complexity; that certain types of service were specifically community services and not generally provided in acute settings (notably those provided under the NHS Standard Contract for Community Services); and that within a community setting, certain types seemed best provided by acute hospitals (those closely linked to the pathway of care),<sup>111</sup> whereas there may be some relatively simple stand-alone procedures or consultations which were unlikely to be part of a broader elective pathway and could more easily be provided by non-acute suppliers.
- 5.41 The latter outpatient services included relatively less complex care that can be offered by a range of providers other than acute hospitals, eg community hospitals, private providers, and in some circumstances general practitioners. We considered that acute hospitals are able relatively easily to start providing these activities since they already have the necessary technical expertise and qualified consultants (and often equipment) to do so. In our view, we think it less likely, however, that community-service-only providers could constrain acute general hospitals in relation

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<sup>108</sup> 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 was an RBCH outpatient-only service that was provided by RBCH consultants. Similarly, PH mentioned restorative dentistry as an instance of specialty which was a PH outpatient-only service that was provided by PH consultants.

<sup>109</sup> There are also maternity (midwifery and obstetrics) outpatient services which do not relate to elective pathways. We consider these as part of the maternity pathway. We also understand that within the trauma & orthopaedics specialty, all trauma outpatient services relate to emergency pathways and are only provided at PH, whereas orthopaedic outpatient services relate to elective pathways and are provided at both RBCH and PH (although PH primarily provides only first outpatient appointments and any inpatient procedure, and the majority of follow-up appointments to an inpatient procedure, will be at RBCH).

<sup>110</sup> [Joint main party initial submission](#), paragraph 206.

<sup>111</sup> We did not rule out the possibility that GPs/community hospitals can also compete for outpatient treatments that form part of an admitted care pathway. However, it might be that such pathways involve more acute concerns and as such GPs might tend to make a referral to an acute hospital.

to more complex outpatient activities due to the lack of expertise and, possibly, the necessary facilities and equipment. It seems likely that the scope for supply-side substitution is similarly asymmetric. In other words, when we examine an outpatient service that can be provided in a community setting (such as straightforward consultations), the market is relatively broad and includes more complex outpatient services, since providers of these can easily start supplying straightforward consultations if they do not already do so; but looking from the perspective of a more complex service, the relevant market is likely to be narrower. We discuss this further below in the competitive effects section and with respect to possible entry.

- 5.42 Therefore we concluded that outpatient services which could be provided either in the community or in an acute setting were part of wider outpatient markets, with acute hospitals placing a stronger constraint on community-only providers than vice versa. Other services would generally only be provided in a community setting (generally funded under non-PbR arrangements) and we considered it appropriate to treat them as separate markets.

### *Conclusions on outpatient versus inpatient*

- 5.43 In our view:

- (a) there is an asymmetric competitive constraint between inpatient and outpatient services, with inpatient providers capable of supply-side substituting into outpatient services but not vice versa;
- (b) while in some circumstances outpatient and inpatient activity associated with a given pathway can be regarded as part of the same market, this is not always the case; we do not consider it appropriate to draw a distinction between stand-alone and care pathway outpatient services; and
- (c) outpatient services can be separated on the basis of whether the services can be provided in community settings or exclusively in acute general settings.

### *Elective versus non-elective*

- 5.44 Routine elective clinical care is planned and typically requires a referral from a GP or another consultant. By contrast, non-elective care is provided in unplanned and urgent circumstances (such as A&E, emergency surgery, maternity) and it does not usually require a referral (though in some circumstances patients may go urgently to an A&E department following the recommendation of a GP). All of an inpatient pathway resulting from an emergency admission will be classified as non-elective even if part of this pathway could have occurred on an elective basis. The price paid for the same service by a commissioning entity may depend on whether it occurs in an elective or non-elective patient pathway.
- 5.45 The parties submitted evidence to show that they had limited ability and incentives to supply-side substitution between elective and non-elective due to the additional capacity and facility requirements; the different incentives to expand provision of elective and non-elective services (due to the 30 per cent rate of tariff for non-elective service volumes above the 2008/09 level of provision); uncertainty regarding the elective tariff; and the need to enter on a sufficient scale to ensure safe care.
- 5.46 We asked third party acute hospitals in the area if they had in the past five years started providing elective services related to non-elective services that they were

already providing (within a given specialty) and also if it made sense to offer non-elective services without offering elective services within the same specialty.

5.47 The evidence we collected suggested that elective providers are unable to expand quickly to provide non-elective services in the same specialties, but shifting supply from non-elective to elective services appears to be relatively easier.<sup>112</sup> It was unclear whether this may occur in the timely and relatively inexpensive fashion required for supply-side substitution, and any expansion from one function to another may be limited by the need to obtain approval from the local commissioners and certainty over remuneration. We also understand that it is not generally practical to supply non-elective services without also providing elective services in the same specialty. This is because the resources required (such as clinicians, diagnostic and theatre equipment) are broadly the same; a base of elective services helps hospitals to manage the irregular volume of non-elective services; and providing elective services helps consultants to maintain skills and competency to provide non-elective services. This suggested that although supply-side substitution from non-elective to elective may be a constraint in theory, in practice it is unlikely that there are non-elective-only suppliers of a service who could start supplying the corresponding elective service.

5.48 We therefore considered elective and non-elective services as separate markets.

### *Private services*

5.49 The parties both provide acute services to private patients (including elective secondary care, day-care and outpatient clinical services).

5.50 Privately-funded healthcare services comprise a variety of medical treatments that are paid for directly by individuals or through private medical insurance. For the purposes of this investigation, such services have been defined as services provided to patients by private hospitals and other facilities, including NHS hospitals (either through their private patient units or elsewhere), through the services of consultants, and medical and clinical professionals who work within these facilities.

5.51 We considered that much of the rationale set out above for aggregating treatments at the specialty level and separating elective inpatient and outpatient services into separate markets would also apply to provision of private services. We also considered that private services should be treated as a separate market from NHS services for the purposes of our analysis because:

(a) In line with previous CC and OFT merger decisions, we considered that privately-funded healthcare services constitute a separate market from the provision of NHS services. In its BUPA/CHG report,<sup>113</sup> the CC considered that there was limited demand-side substitution, because many people could not afford private treatment and taxpayers were not in any event able to opt out of paying for the NHS, and because, although elective treatment for acute medical conditions was available from both the NHS and private healthcare, the latter offered additional, and valued, services including greater choice of consultant, and earlier treatment. The report found that whilst standard NHS Trust hospitals provided an element of price constraint, the willingness of customers to pay an extra charge for private healthcare indicated that free services fell into a separate market. The OFT has

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<sup>112</sup> See further Appendix F.

<sup>113</sup> *British United Provident Association Limited and Community Hospitals Group Plc: A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Hospitals Group Plc; and Salomon International LLC and Community Hospitals Group Plc: A report on the existing mergers*, December 2000.

distinguished privately-funded healthcare services from NHS services for similar reasons.

- (b) The OFT has also considered private healthcare services separately from NHS services in its consideration of subsequent private hospital mergers.<sup>114</sup> The OFT's recent consultation for its Private Healthcare Market Study noted that submissions from private health providers had set out how they differentiated themselves from NHS provision in terms of offering greater convenience for patients, more choice regarding appointment times and ensuring that the patient sees the same consultant throughout their treatment, to name a few.<sup>115</sup> The OFT therefore took the view that the NHS as a whole was unlikely to be part of the relevant product market.

5.52 We therefore considered that privately-funded healthcare services were likely to be a separate product market from NHS services for the reasons set out above. Within private services, each specialty constitutes a separate market and within each specialty, markets can be defined along inpatient and outpatient lines (as with NHS services).

### **Summary of our conclusions on the product market definition**

5.53 Our view on the basis of reasons set out above, and taking into account the evidence set out in Appendix F, is that, for NHS services:

- (a) Each specialty constitutes a separate market. There may be a degree of differentiation within specialties and any constraint at sub-specialty level will be taken into account, when relevant, in our competitive effects assessment.
- (b) Within each specialty:
- (i) We treat outpatient and inpatient as separate markets and we note that there is an asymmetric constraint between inpatient and outpatient, with inpatient providers capable of readily supply-side substituting into outpatient services but not vice versa. We considered day-cases as part of the relevant inpatient market.
  - (ii) Outpatient services should not be further separated according to whether or not the services can be provided in community settings, but certain services are provided only in the community and should be viewed as separate markets.
  - (iii) Non-elective and elective activities are separate markets, although the provision of elective activities may be constrained to some extent by non-elective providers.
- (c) Private services are separate markets from NHS services. Within private services, each specialty constitutes a separate market and within each specialty, markets can be defined along inpatient, outpatient, elective and non-elective lines (as with NHS services).

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<sup>114</sup> Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008, p6; Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, 2008.

<sup>115</sup> [www.of.gov.uk/shared\\_of/market-studies/OFT1412.pdf](http://www.of.gov.uk/shared_of/market-studies/OFT1412.pdf).

## **Geographic market**

- 5.54 In this section, we present our view on the geographic aspects of the provision of healthcare services in the area surrounding the merging trusts.
- 5.55 The parties submitted<sup>116</sup> 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.
- 5.56 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**

- 5.57 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 CC<sup>117</sup> 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.
- 5.58 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,<sup>118</sup> a catchment area will typically be narrower than the geographic market identified using the hypothetical monopolist test. We took account of this when carrying out our competitive assessment. The catchment area will depend on many factors, including drive-times, public transport availability. In this case, since the large majority of patients travelled to hospital by car, we approximated catchment areas using drive-times or 'isochrones'<sup>119</sup> 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.
- 5.59 We used information provided by the parties and the CCGs to calculate drive-times from which PH and RBCH draw 80 per cent of their patients, split by specialty and type of service (elective, non-elective and outpatient). For details of this analysis please see Appendix F. We view this as informative about the extent of patients' willingness to travel to receive acute care where they have a choice of provider.
- 5.60 For PH, the figures suggested 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 generally small, amounting to a few minutes. There were more significant variations in a few specialties (eg longer drive-times arise when the volume of activity is small, and therefore a few outliers may severely affect the average; and/or when few hospitals offer the specialty and hence patients are obliged to

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<sup>116</sup> [Joint main party initial submission](#), paragraph 222.

<sup>117</sup> See [Commentary on retail mergers – a joint report by the OFT and the Competition Commission](#) (April 2011).

<sup>118</sup> CC2, [paragraph 5.2.25](#).

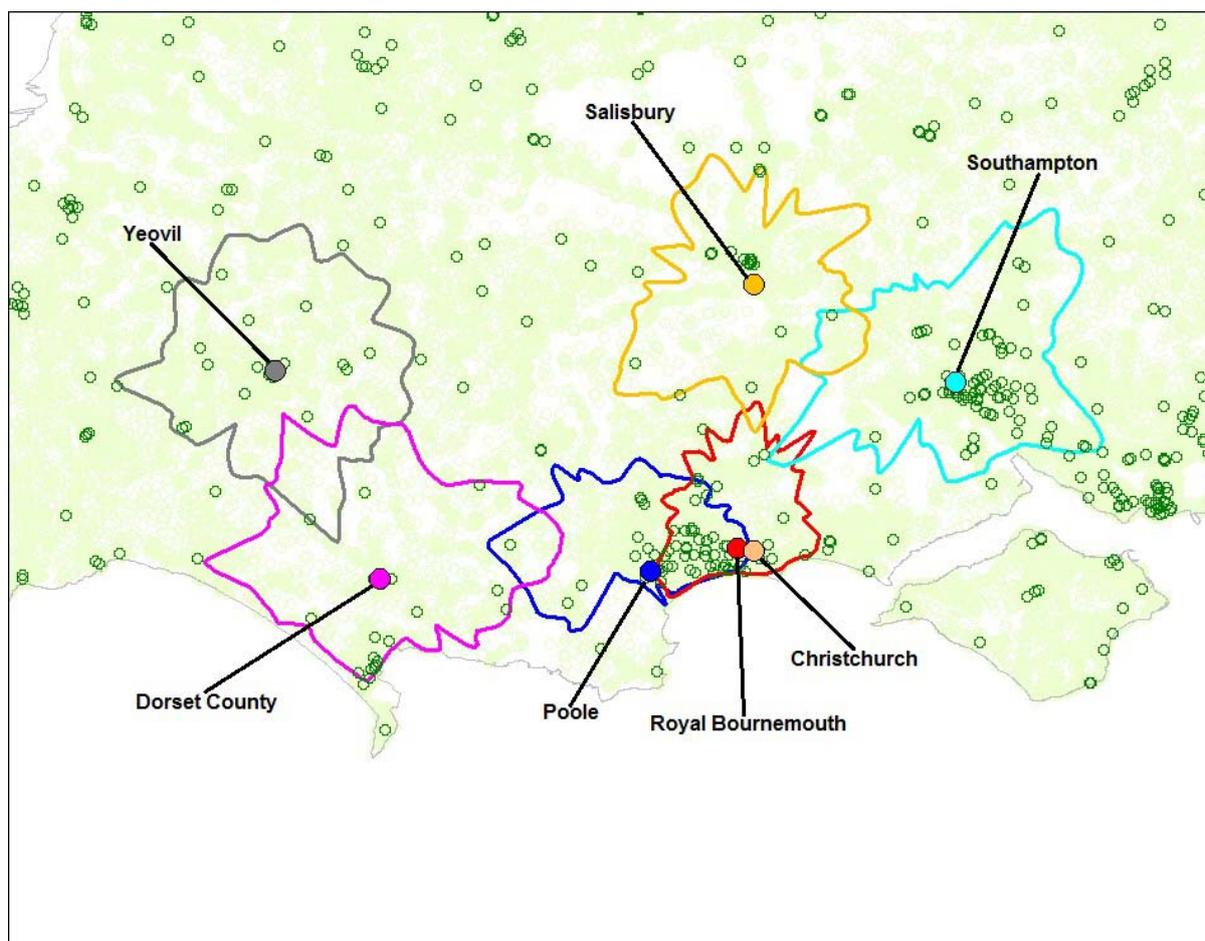
<sup>119</sup> Each isochrone shows all the points that can be reached within a certain drive-time, starting from the central point (in this case, a hospital).

travel further, on average, but this did not necessarily imply anything different about their willingness to travel), but in general drive-times were sufficiently consistent for us to apply a single isochrone across all specialties for these purposes. For further details please see Appendix F.

- 5.61 The outcome for RBCH was broadly consistent with that of PH (with average drive-times of 17.5 minutes for elective services and 17 minutes for non-elective and outpatient services). Variations in drive-time between elective, non-elective and outpatient are again present but generally small. Likewise, differences in drive-time between specialties are of small magnitude and appear to be driven by a few 'outlier' observations. On average, PH's patients travelled slightly further than RBCH's.
- 5.62 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 isochrones around each party's main site.
- 5.63 Figure 3 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; although we note that using the lower figure would not affect our conclusions).

FIGURE 3

**Catchment areas based on 80 per cent threshold**



Source: CC elaboration of RBCH and PH data.

- 5.64 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.
- 5.65 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. For details of this analysis see Appendix F. Enlarging the isochrones increased the number of GP practices in the region in which the parties overlap (59). All of these GP practices except three still did not lie within the catchment areas of any other hospitals.
- 5.66 To test these catchment areas, we also looked at the parties' share of referrals at GP practice level based on CCG data covering all services for 132 GP surgeries in the wider Dorset area for the period April 2010 to November 2012. Whilst we were aware that past referral flows do not necessarily reflect patients' actual willingness to

travel,<sup>120</sup> referral patterns can provide useful indications of the degree of substitutability between hospitals and therefore on the incentives that a hypothetical monopolist controlling the merging trusts would have to impose a small but significant reduction in quality. We also noted that RBCH uses referral patterns to analyse competition (for example, in its 2013/14 annual plan to Monitor). For further details of our analysis see Appendix F.

- 5.67 In Figure 4 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.<sup>121,122</sup> 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 4 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 paragraph 5.62 above). We also analysed GP practice referrals by elective, non-elective and outpatient episodes and found similar results (see further Appendix F).

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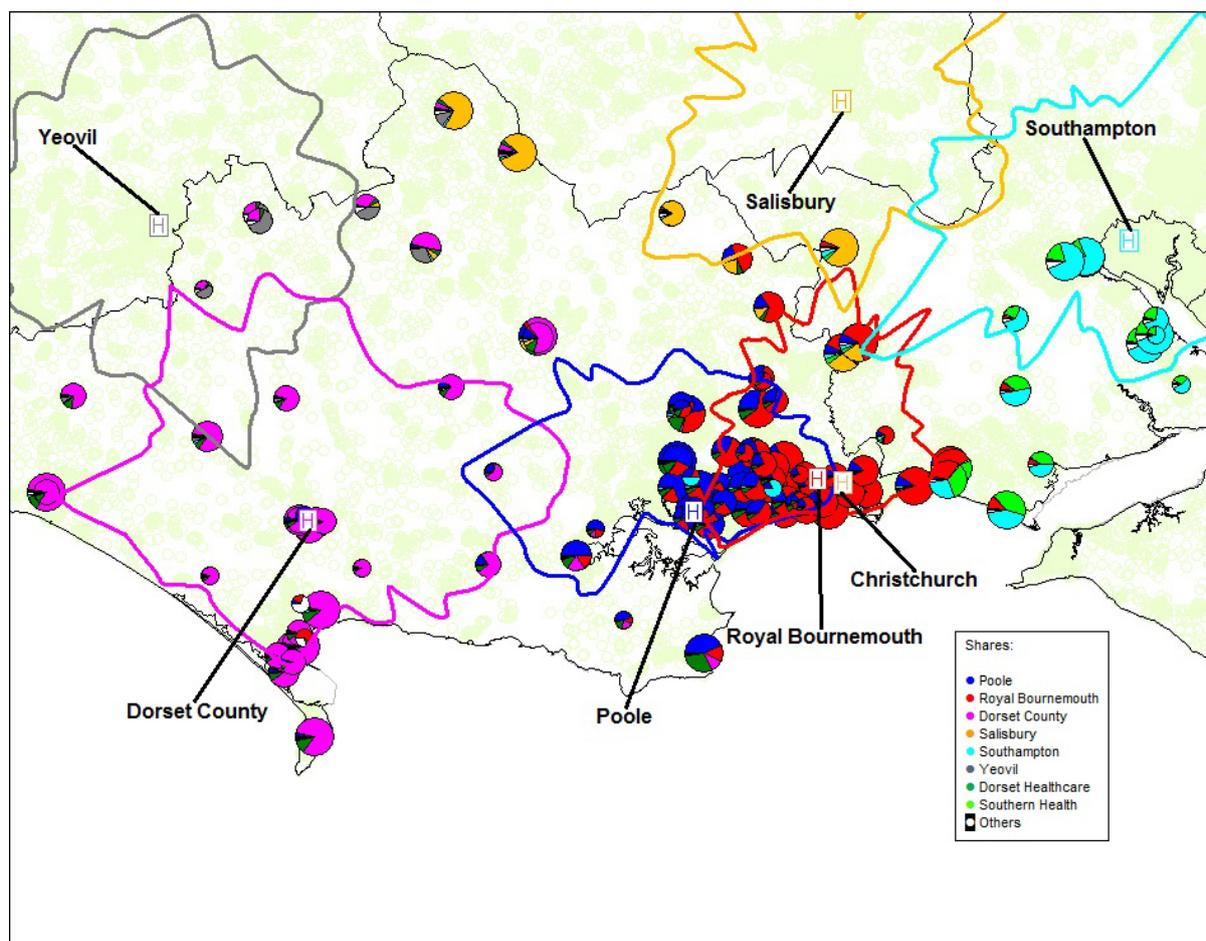
<sup>120</sup> This is particularly the case in the absence of significant differences in the quality of services provided by hospitals. When quality across hospitals is similar, patients are likely to travel to the nearest hospital and therefore past patient flows may not be informative as to how patients trade off quality and distance. See Appendix K for further discussion on this point.

<sup>121</sup> 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.

<sup>122</sup> 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 has been attributed to, Southern Health NHS Foundation Trust.

FIGURE 4

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.

5.68 Figure 4 illustrates that patients' choices of hospital are broadly consistent with the catchment areas we have used in Figure 3. 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.<sup>123</sup> 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.

5.69 We noted that these figures include services that are provided by only a hospital or a subset of hospitals in the region, and they may therefore result in under- or over-stating patients' actual preference for a given hospital. To address this problem we estimated the hospitals' share at GP practice level focusing on the services<sup>124</sup> that are provided by all five major acute hospitals in the wider Dorset region. This analysis showed that for these treatments, over which patients could be treated at any of the

<sup>123</sup> 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.

<sup>124</sup> At treatment level, ie treatments which could be carried out at any of these five hospitals.

five, 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 at either of the merging trusts' sites. For further details of our analysis see Appendix F.

### *Conclusions on geographic market definition*

- 5.70 The evidence indicated that the merging trusts attract most of their patients from within a drive-time of 17 minutes for RBCH and of 22 minutes for PH. Whilst we noted some differences in the travel time between specialties and types of service provision, these were in general of limited magnitude or resulted from small samples of activities. We also tested these catchment areas by reviewing the shares of referrals by GP practice in the wider Dorset area, which we found to be relatively consistent with the catchment areas.
- 5.71 For the reasons we explained above, a catchment area is typically narrower than a geographic market identified using the hypothetical monopolist test. We take this into account in our competitive assessment and use the isochrones based on catchment areas as the starting point of reference for our competitive assessment. As part of the assessment, we also considered the constraints posed on the parties by rivals located further away than that strictly implied by the isochrones discussed above (see paragraphs 6.13 to 6.23 for a description of these rivals and paragraphs 6.186 to 6.208 where we consider the constraint they pose on the parties).

## 6. Assessment of the competitive effects of the merger

6.1 At the outset of this inquiry, we identified and published theories of harm (our framework for assessing the effects of a merger and whether or not it could lead to an SLC)<sup>125</sup> in our issues statement.<sup>126</sup> We considered whether the merger would give rise to an SLC compared with the counterfactual in the following ways:

(a) *Unilateral effects in the provision of the hospital-based elective services in which RBCH and PH overlap*, ie whether the merger would be likely to give rise to unilateral effects via the ability of the merged entity to exercise market power in the provision of certain elective services, resulting in a reduction in quality or affecting other aspects of provision of services.

(b) *Unilateral effects in the provision of the hospital-based non-elective services* for which the parties would be close competitors, ie whether the merger would be likely to give rise to unilateral effects via the ability of the merged entity to exercise market power in relation to certain non-elective services, resulting in a reduction in quality or affecting other aspects of provision of services.

(c) *Unilateral effects in the provision of community services* resulting in a reduction in quality or affecting other aspects of provision of services.

(d) *Unilateral effects in the provision of specialised services* where the two hospitals do or would compete (either for patients or in tenders to provide the service), resulting in a reduction in quality or affecting other aspects of provision of services.

(e) *Unilateral effects in the provision of services to private (fee-paying) patients.*

6.2 Unilateral effects are effects that may arise in horizontal mergers where the merger involves two competing entities and removes the rivalry between them. In this case, we considered whether the merger might result in a removal of rivalry which would allow the merged trust to reduce quality, as for the most part RBCH and PH do not compete on price.

6.3 In relation to all of the theories of harm relevant to provision of NHS services (ie all but private services), we considered whether there was likely to be an SLC in relation to competition in the market and/or competition for the market (as described in paragraph 2.27 above). In order to assess the effect of the merger on competition for the market, we considered whether or not potential reconfiguration of services by commissioners (including by tender) was likely to occur and, if so, whether the merger was likely to create a loss of competition in relation to such reconfiguration.<sup>127</sup>

6.4 When analysing these theories we considered whether unilateral effects would be likely to arise relating to potential competition (because one or both hospitals might expand into additional services in the future so increasing the overlap).

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<sup>125</sup> See CC2, paragraph 4.2.1.

<sup>126</sup> [www.competition-commission.org.uk/assets/competitioncommission/docs/2013/royal-bournemouth-and-christchurch-poole/rbch\\_ph\\_issues\\_statement.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2013/royal-bournemouth-and-christchurch-poole/rbch_ph_issues_statement.pdf).

<sup>127</sup> 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.

- 6.5 As described in Section 2 in relation to competition in the market for provision of NHS acute services, we noted that competition is almost always on quality, rather than on price, as the majority of services are covered by the PbR regime. When analysing the likely effects of the merger in relation to quality competition, we considered the various quality factors likely to be relevant to patient choice such as clinical outcomes, waiting times, accessibility, quality of care, location of services and other issues identified by patients (see Appendix I and footnote to paragraph 6.8). Whilst the parties provided some services which were not recompensed on a PbR basis, we did not consider that these were likely to affect our analysis significantly and therefore did not consider them separately in this report. Given the significant restructuring of the NHS in 2013, as noted in Section 2, in assessing the competitive effects of the proposed merger we attached some weight to the effect of government policy on the manner in which these services will be commissioned in future following full implementation of HSCA 2012.
- 6.6 Against this industry background of government policy which encourages competition on quality, we noted that RBCH is 8 miles by road and 18 minutes' drive-time from PH. Both trusts are acute service hospitals providing a comprehensive range of inpatient and outpatient healthcare services. In addition to providing general services, both trusts provided maternity services and consultant-led emergency services. RBCH and PH both provided high-quality healthcare services, on the basis of a number of indicators.<sup>128</sup>
- 6.7 The nearest other trust to PH is Dorset County Hospital, which is 24 miles, 34 minutes' drive-time, from PH. The nearest other trusts to RBCH are Salisbury (24 miles, 34 minutes' drive-time from RBCH) and Southampton (28 miles, 32 minutes' drive-time from RBCH).<sup>129</sup>
- 6.8 We expected that location was likely to be an important factor when patients and/or GPs choose a hospital for treatment. Given the proximity of RBCH and PH, we expected them to be the best alternatives to one another for local patients, subject to quality differences. To the extent that providers of NHS-funded services for patients compete, we expected that, given their proximity, the parties would be one another's closest competitors if all providers offered the same quality.<sup>130</sup> As described in paragraph 6.11, we tested these points in our analysis.
- 6.9 The parties told us that they were not close competitors because they provided a different range of services. They also explained that they did not have incentives to compete (because of their funding arrangements, capacity constraints and the degree of cooperation between them in the form of shared consultants).<sup>131</sup>
- 6.10 In this section, we set out our analysis of the theories of harm described above in paragraph 6.1, taking into account the factors outlined in paragraphs 6.2 to 6.9.
- 6.11 This section is structured as follows:

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<sup>128</sup> See Appendix D.

<sup>129</sup> See paragraph 6.13ff for further detail of other providers.

<sup>130</sup> Consistent with this, the Department of Health National Patient Choice Survey found that closeness to work or home was selected most often (by 38 per cent of patients who were offered choice) as the single most important factor when choosing their hospital. (See [www.gov.uk/government/publications/report-on-the-national-patient-choice-survey-england-february-2010](http://www.gov.uk/government/publications/report-on-the-national-patient-choice-survey-england-february-2010) (Figure 4 and Annex Table A.6).) Other patients cited personal experience of the hospital and good previous experience (given by 12 and 6 per cent of patients respectively), waiting times (10 per cent), accessibility (5 per cent) and quality of care (5 per cent). Location issues (differently defined), waits and quality of care were also in the top six factors selected most often in previous surveys, where all patients were invited to select as many factors as they felt were most important in choosing a hospital. Whilst earlier surveys identified cleanliness or low levels of infection and friendliness of staff as important factors for patients, these were the single most important factor for only 2 and 1 per cent respectively of patients choosing a hospital in February 2010.

<sup>131</sup> [Joint main party initial submission.](#)

- (a) First, we set out information on other providers of elective, non-elective, specialised, community, maternity and private services whose activities may constrain those of the parties.
- (b) Then we considered the extent of pre-existing competition between RBCH and PH. As noted in paragraph 6.9, the parties told us that they provided a different range of services, and we tested this by considering the extent of overlap between RBCH and PH in provision of elective and non-elective services in areas covered by the Dorset CCG and West Hampshire CCG (West New Forest and Totton & Waterside) (which we refer to in our analysis as ‘the wider Dorset area’). This information included some specialised services in the appropriate categories as these services can be elective or non-elective. Details of the parties’ overlaps in provision of maternity, community and private services are separately set out in the relevant sections.
- (c) We then considered the likely effects of the proposed merger on competition within the relevant markets, including the level of competitive constraint placed on RBCH and PH by other NHS acute service providers.<sup>132</sup> As noted in paragraph 6.9 above, the parties told us that they did not have incentives to compete. We gathered evidence to understand the extent to which they had incentives to compete and the extent to which they have responded to these incentives in the past, and whether the extent of current competition is likely to be a good indicator of the extent of competition in the foreseeable future. We considered the likely effects of the proposed merger in relation to six areas in turn:<sup>133</sup>
- (i) Elective services. In this part we considered the effects of the merger on competition in relation to elective services, including those overlap specialised services which are elective. We considered the extent of patient/GP choice and the extent to which quality influences choice. We then considered the incentives of RBCH and PH to compete in provision of elective services, including the effects of the following factors on their incentives to compete: the profitability of elective services; capacity constraints; sharing consultants between the parties; relationships between the parties and commissioners; and quality regulation. We then considered closeness of competition of RBCH and PH. Finally, we considered whether the merger would be likely to affect potential competition for elective services (paragraphs 6.55 to 6.238).
  - (ii) Non-elective services (excluding maternity services and including non-elective overlap specialised services) (paragraphs 6.239 to 6.272).
  - (iii) Maternity services—these are non-elective services but we considered them separately as they have many aspects (such as how patients choose) which make them more similar to elective services (paragraphs 6.273 to 6.304).
  - (iv) Community services (paragraphs 6.305 to 6.314).

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<sup>132</sup> In the case of private services we also started with an analysis of overlaps and then considered the likely effects of the proposed merger. We did not consider that private hospital providers significantly constrained NHS acute hospitals in the provision of NHS acute services and have therefore explicitly considered the constraint posed by these hospitals only in relation to private services, although to the extent that they may pose some constraint on the parties this would be captured in much of our evidence on competitive effects (eg the patient survey).

<sup>133</sup> These six areas are related to but not identical to the five theories of harm we describe in paragraph 6.1, because we analysed competition in the market for specialised services in our elective and non-elective services analysis, as relevant; separately analysed maternity services; and separately analysed competition for the market in relation to some services (see (v)).

- (v) Competition for the market in elective, non-elective, specialised and community services (paragraphs 6.315 to 6.320).
- (vi) Private services (paragraphs 6.321 to 6.345).

6.12 Where our analysis of the factors relevant to competitive rivalry described in relation to elective services was also relevant to the other services we considered, we cross-refer back to the discussion set out in the elective services section.

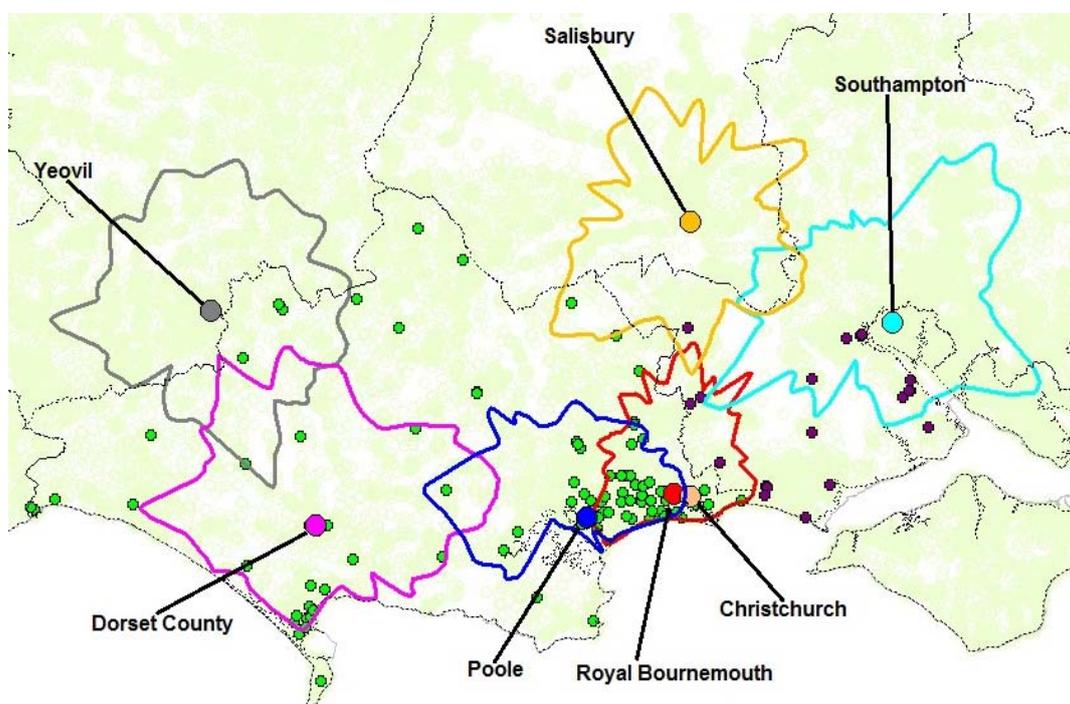
**Other providers of NHS elective, non-elective, specialised, community, maternity services and of private services**

6.13 There are a number of local healthcare providers in the Dorset region including NHS acute hospital trusts, NHS community hospital trusts and private healthcare providers, which included both private hospitals and private providers of community care. NHS community hospital trusts can be distinguished from NHS acute hospital trusts as they do not generally focus on surgical care or offer specialised care. They may provide some inpatient services but often act as a bridge between acute hospital care and homecare and provide a wide range of outpatient services. In this report we refer to care providers of this type, whether NHS community hospital trusts or private providers of community care, as ‘community providers’.

6.14 Figures 5 and 6 and Table 1 below set out further information on the locations of some of these hospitals.

FIGURE 5

**Foundation trusts in the wider Dorset area**

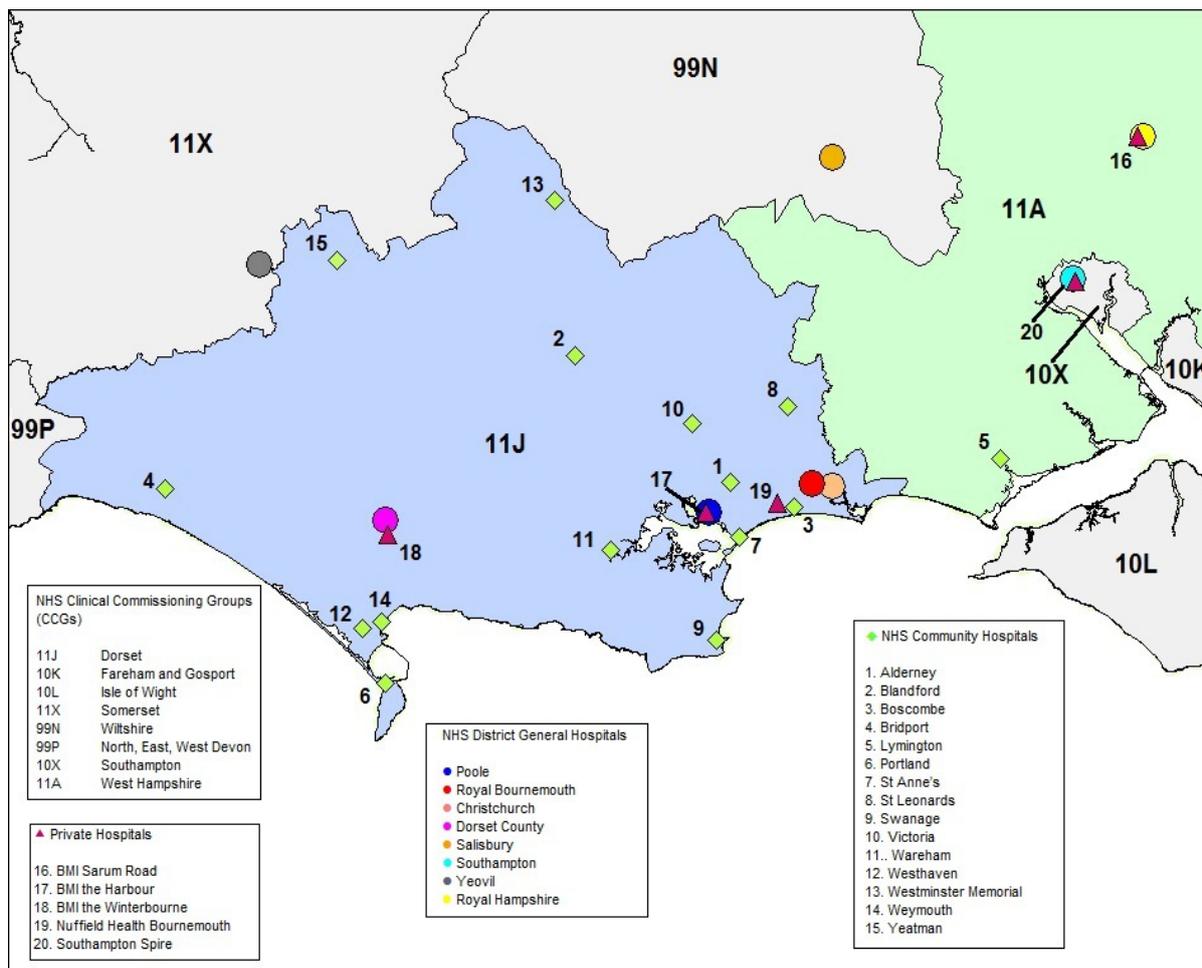


Source: CC analysis.

Note: The green dots indicate the locations of GP surgeries in the Dorset CCG region and purple dots, GP practices in the West Hampshire CCG region. The coloured line around each hospital shows its catchment area, as described in Section 5.

FIGURE 6

CCGs in the South-West of England and all hospitals in the wider Dorset area



Source: CC analysis.

TABLE 1 Other hospitals based in and around the wider Dorset area\*

Type of hospital	Name	Address	Postcode	Trust / Parent
NHS district general hospitals	Dorset County Hospital	Williams Avenue Dorchester Dorset	DT1 2JY	Dorset County Hospital NHS Foundation Trust
	Royal Hampshire County Hospital	Romsey Road Winchester Hampshire	SO22 5DG	Hampshire Hospitals NHS Foundation Trust
	Salisbury District Hospital	Odstock Road Salisbury Wiltshire	SP2 8BJ	Salisbury NHS Foundation Trust
	Southampton General Hospital	Tremona Road Southampton Hampshire	SO16 6YD	University Hospital Southampton NHS Foundation Trust
	Yeovil District Hospital	Higher Kingston Yeovil Somerset	BA21 4AT	Yeovil District Hospital NHS Foundation Trust
NHS community hospitals	Lymington New Forest Hospital	Wellworthy Road Lymington Hampshire	SO41 8QD	Hampshire PCT
	Alderney Hospital	Ringwood Road Parkstone Poole Dorset	BH12 4NB	Dorset HealthCare University NHS Foundation Trust (DHUFT)
	Blandford Community Hospital	Milldown Road Blandford Forum Dorset	DT11 7DD	DHUFT
	Bridport Community Hospital	Hospital Lane North Allington Bridport Dorset	DT6 5DR	DHUFT
	Portland Hospital	Castle Road Castletown Portland Dorset	DT5 1AX	DHUFT
	Westminster Memorial Hospital	Abbey Walk Shaftesbury Dorset	SP7 8BD	DHUFT
	Yeatman Hospital	Hospital Lane Sherborne Dorset	DT9 3JU	DHUFT
	St Anne's Hospital	69 Haven Road Canford Cliffs Poole Dorset	BH13 7LN	DHUFT
	St Leonards Community Hospital	Ringwood Road St Leonards	BH24 2RR	DHUFT
	Swanage Community Hospital	Queens Road Swanage Dorset	BH19 2ES	DHUFT
	Victoria Hospital	Victoria Road Wimborne Dorset	BH21 1ER	DHUFT
	Wareham Community Hospital	Streche Road Wareham Dorset	BH20 4QQ	DHUFT
	Westhaven Hospital	Radipole Lane Weymouth Dorset	DT4 0QE	DHUFT
	Weymouth Community Hospital	Melcombe Avenue Weymouth Dorset	DT4 7TB	DHUFT
	Boscombe Community Hospital	11 Shelly road Bournemouth	BH1 4EQ	DHUFT
Private hospitals	BMI The Winterbourne Hospital	Herrington Road Dorchester Dorset	DT1 2DR	BMI
	BMI the Harbour Hospital	St Mary's Road Poole Dorset	BH15 2BH	BMI
	BMI Sarum Road Hospital	Sarum Road Winchester Hampshire	SO22 5HA	BMI
	Nuffield Health Bournemouth Hospital	67 Landsdowne Road Bournemouth Dorset	BH1 1RW	Nuffield
	Southampton Spire Hospital	Chalysbeate Close Southampton Hampshire	SO16 6UY	Spire
	Proposed Circle Hospital	To be confirmed but likely to be in Poole, BH11	BH11	Circle

Source: Joint main party initial submission, p100.

\*Circle told us that it was not planning to build a hospital in the area.

6.15 As Figure 5 sets out, there are five NHS acute trusts operating in the region alongside RBCH and PH, all of which have achieved foundation trust status:

- (a) *Dorset County Hospital NHS Foundation Trust*, which operates Dorset County Hospital in Dorchester. The hospital has 360 beds, providing a broad range of elective, non-elective and outpatient services, including A&E, cardiology, dermatology and orthopaedics.
- (b) *Hampshire Hospitals NHS Foundation Trust* operates Royal Hampshire County Hospital. This hospital has 391 beds and provides a range of elective, non-elective and outpatient services, including A&E services, maternity, diagnostics and some community-based services.
- (c) *Salisbury NHS Foundation Trust* operates Salisbury District Hospital. This hospital has 473 beds and covers a range of clinical care including general acute and emergency services. The hospital also provides a number of specialist services such as burns, plastic surgery, cleft lip and palate, genetics, spinal injury and rehabilitation care.
- (d) *University Hospital Southampton NHS Foundation Trust* operates Southampton General Hospital which is a large teaching hospital providing specialist care in cancer, heart disease, respiratory illness, neurological disease, gastro-intestinal conditions and paediatric illness. The hospital has 1,207 beds, with a dedicated palliative care unit.
- (e) *Yeovil District Hospital NHS Foundation Trust* operates Yeovil District Hospital, providing acute care across 383 beds. The hospital covers a wide range of medical and surgical procedures including breast surgery, dermatology and vascular surgery.

6.16 The parties told us that the above trusts between them provided elective, non-elective and outpatient care across the large majority of the ‘overlap’ treatments<sup>134</sup> that were provided by both RBCH and PH.

6.17 Table 2 sets out the distances (by road) and drive-times between the parties and other acute services foundation trusts’ hospitals in the area.

TABLE 2 Distances and drive-times between acute foundation trust hospitals in the wider Dorset area

	Drive-time to PH (minutes)	Distance to PH (miles)	Drive-time to RBCH (minutes)	Distance to RBCH (miles)
PH	-	-	17.8	8.0
RBCH	17.8	8.0	-	-
Dorset County Hospital	34.0	24.3	49.6	31.9
Salisbury District Hospital	49.5	30.8	34.3	23.8
University Hospital Southampton	47.4	34.6	32.2	27.6
Yeovil District Hospital	61.8	43.9	77.4	51.5

Source: CC calculations.

6.18 The parties told us that in addition, the new Lymington New Forest Hospital in Hampshire offered services which ‘compare favourably with those provided by RBCH and PH’ and in their view would be a highly credible competitor across the full range of routine elective inpatient and outpatient services it provided.

<sup>134</sup> See Appendix G and paragraph 6.33 for a description of ‘overlap’ treatments.

- 6.19 As shown in Figure 6, there are also NHS community hospitals in Dorset, all of which are run by DHUFT. The parties told us that these provided a range of outpatient services, as well as some specialist paediatric, adolescent or geriatric care, and that between them these community hospitals already provided outpatient care (and, in some cases, elective inpatient care) across a number of the 'overlap' treatments that were currently provided by both RBCH and PH.
- 6.20 There are a number of independent hospitals in the region:
- (a) *BMI Healthcare* operates three private hospitals in the vicinity. *The Harbour Hospital* in Poole has 40 beds. The Harbour Hospital offers multiple elective services to NHS patients across the following clinical specialties: ENT, gastroenterology, general surgery, ophthalmology, pain management and orthopaedics. In addition to this, the hospital specialises in the provision of elective services to private patients across a broad range of other specialties, including oncology. *Winterbourne Hospital* in Dorchester has 38 beds. It offers elective services to NHS patients. In addition to this, the hospital specialises in the provision of elective services to private patients across a broad range of other specialties. *Sarum Road Hospital* in Winchester has 48 beds and provides a range of elective surgical, medical and diagnostic services. The Sarum Road Hospital offers multiple elective services to NHS patients. The hospital also specialises in the provision of elective services to private patients across a broad range of other specialties.
  - (b) *Spire Healthcare* operates one hospital in the vicinity, *Southampton Spire*. The hospital has 78 beds. Southampton Spire offers services to NHS patients, across general medicine, general surgery, gynaecology and orthopaedics. The hospital also specialises in the provision of elective services across a broad range of other specialties, including cardiology procedures and breast and cancer surgeries.
  - (c) *Nuffield Health* operates one hospital in Bournemouth. The hospital has 57 beds. Nuffield currently provides pain management, general surgery and occasional orthopaedic services to the NHS, and also specialises in the provision of elective services across a broad range of other specialties including cardiology. Surgical specialties include breast and bowel cancer. The hospital also provides a wide range of physiotherapy services and has a limited paediatric service.
- 6.21 The parties provided us with information regarding healthcare providers which operated within 41 to 60 minutes' drive-time of them; they also emphasized that location was a crucial factor in patients' choice of hospital for patients in need of emergency care and an important consideration for many elective patients. The catchment area analysis we carried out (Section 5) indicated that a catchment area of approximately 22 minutes around PH and 17 minutes around RBCH would reflect 80 per cent of referrals (based on GP postcode) and a catchment area of 21 minutes for RBCH and 28 minutes for PH would reflect 90 per cent of referrals. There is little overlap between the catchment areas of the parties and any of the other NHS foundation trusts listed above, assuming similar sizes of catchment areas for those trusts. However, the parties' catchment areas overlapped with each other and that area of overlap was outside the catchment area of any other acute hospital.
- 6.22 To test the extent to which the parties were likely to be constrained by other providers, we sought information from the Dorset CCG and West Hampshire CCG (for the relevant region) on the elective and non-elective, inpatient and outpatient acute

services provided in the area.<sup>135</sup> From this we were able to identify providers competing in provision of services in each of the specialties where RBCH and PH overlapped. We then considered the extent to which these other providers were likely to provide a strong competitive constraint to the parties in our analysis of GP referrals on a specialty level; we took into account the comments from patients in the GP survey; and analysis of share of supply to GPs located in the Dorset and West Hampshire areas (from which RBCH and PH receive most of their income). (See further paragraphs 6.186 to 6.208.)

- 6.23 In considering the constraint of these hospitals, our economic analysis was mainly based on data provided to us by Dorset CCG and West Hampshire CCG (which included information on the SUS activity of all providers, including community and private hospitals) and our surveys (where patients and GPs were free to mention acute, private and community hospitals). Therefore much of our analysis captured the extent of constraint from community hospitals. We did not seek detailed comments from the community hospitals as we found that they overlapped with the parties only to a limited extent in provision of the acute services on which our analysis focused (and which represent the large majority of the SUS activity). We also found that these hospitals do not generally constrain acute service providers (see paragraphs 6.186 to 6.208). University Hospital Southampton told us:

Because of the nature of the elective work it did, University Hospital Southampton did not face competition from GPs or community hospitals. Community hospitals did not compete with it in relation to acute care and over the last two to three years there had instead been a collaborative effort to try to make the work more affordable. For example, the majority of community hospitals did not have any theatres and so were medical or rehabilitation facilities effectively. Furthermore, diagnostics often required very large machines (eg CT scanners and MRI scanners), which cost millions of pounds each and therefore for this equipment to be in community hospitals was a significant investment.

### ***Overlaps between RBCH and PH in provision of NHS acute services***

- 6.24 In this section we consider the elective and non-elective activities of the parties, including specialised services (which can be elective or non-elective).
- 6.25 In Section 5, we concluded that each specialty could be treated as a separate product market but that in relation to some specialties we might need to consider sub-specialty issues in detail. We therefore analysed overlaps at three levels: category (eg elective services; non-elective services), specialty and treatment. We also evaluated the extent of overlaps in relation to outpatient care separately from inpatient care (inpatient care includes day cases).<sup>136,137</sup>
- 6.26 We aimed to identify specialties where the merger could have a substantial effect on competition, by removing rivalry. The extent to which each specialty would be affected by the merger depends on the degree of overlap between RBCH and PH within the specialty and the extent to which supply-side substitution is possible within

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<sup>135</sup> The data submitted by the CCGs covers the period April 2010–November 2012.

<sup>136</sup> On this we said that within each specialty, inpatient activities may be a separate market from outpatient activities, although outpatient activities can be readily provided by those active in the same specialty at an inpatient level and some outpatient activities are subject to competition from community hospitals and GPs.

<sup>137</sup> See paragraphs 6.34 & 6.35 for details of the information we used and the manner in which we define ‘treatments’.

that specialty (ie treatments currently supplied by only one party but which the other party could start to supply in response to a reduction in quality by the incumbent).

- 6.27 In our view, it was not appropriate to assess competition on a treatment-by-treatment basis as to do so would significantly underestimate the effect of the merger in situations where supply-side substitution could easily occur between treatments in a specialty. However, as described in Section 5, there are limits to supply-side substitution, particularly in specialties where there are complex sub-specialties. It was not possible to carry out an analysis of sub-specialties as there was no clear way in which to identify sets of treatments which might form a sub-specialty across which supply-side substitution would not apply (see Appendix F). Therefore, we carried out an overlap analysis at both specialty and treatment level, to provide upper and lower bounds to quantifying our overlaps analysis.
- 6.28 The parties submitted that the degree of overlap between them was small relative to their overall activity. To assess this claim and address the issues of supply-side substitution mentioned in paragraph 6.27, we took two approaches to quantification:
- (a) We included the total value of each overlap specialty for both parties, including both overlap treatments and non-overlap treatments. This would be relevant if supply-side substitution within specialties is relatively straightforward, and could be viewed as an ‘upper bound’ to the level of activity for which the parties may compete for patients.
  - (b) We included only the value of treatments provided by both parties. This would be relevant if supply-side substitution were not possible, or would not take place in response to a reduction in quality by the incumbent. This could be viewed as the corresponding ‘lower bound’.
- 6.29 We found the difference between ‘upper’ and ‘lower’ bounds to be relatively small (the lower bound was approximately 65 to 80 per cent of the upper bound.<sup>138</sup> This suggested that our approach was relatively robust and that our analysis captured the approximate scale of affected services without needing a precise investigation of the degree of supply-side substitution.
- 6.30 We considered that the effect within each specialty may be wider than just overlap treatments since at the point of referral, GPs and patients may not know exactly which treatment is appropriate. For example, a patient being referred to a cardiologist may care about the overall quality of a hospital’s cardiology department rather than a specific treatment. Therefore the quality of a non-overlap treatment may still contribute to the perceived quality of an overlap treatment, which would mean that competition can still create incentives to improve the quality of non-overlap treatments. To the extent that this is the case, the effect of the merger would be to a greater set of treatments than the lower bound.
- 6.31 Related to this, there may also be hospital-wide quality measures that will affect patients’ and GPs’ choice of hospital. This could include both measures that apply only at the hospital level (eg parking, quality of food) and measures that are in practice reported at the hospital, rather than specialty or treatment, level (eg mortality rates, MRSA infections). The greater the degree of overlap between the parties, the stronger the incentives to improve hospital-wide quality, because for a given cost of improving quality, the financial benefits will be felt primarily in overlap treatments/ specialties.

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<sup>138</sup> See Tables 4 & 5.

6.32 We have included specialised services within our overlap analysis.<sup>139</sup> Although these services are commissioned separately, the nature of any competition within the market is not in general different from that of any other sub-specialty that is not classified as a specialised service. Therefore, any consideration we discussed in the following sections as regards the pre-merger competition in elective and non-elective applies also to specialised services. For this reason, all the results by specialty we present in this section include specialised services. We acknowledge that supply-side substitution into specialised services may be difficult even for providers active within the same specialty due to the way in which they are commissioned.<sup>140</sup> Nevertheless, we did not consider it necessary to analyse specialised services separately for the following reasons:

- (a) where the parties overlapped in the provision of a specialised service, we considered that overlap within our approach; and
- (b) where only one party provided a specialised service but RBCH and PH overlapped in provision of other, non-specialised services in that specialty, expansion from the specialised service into other aspects of the specialty was likely to be possible (as it will generally be possible to supply-side substitute from provision of more complex services to more straightforward services). However, the reverse was not true for specialised services due to different commissioning rules relating to specialised services, which are likely to be a barrier to substitution into those services. The value of these non-overlap specialised services 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 them.<sup>141</sup>

### *Parties' views*

6.33 RBCH and PH provided us with a table setting out their position on the current degree of overlap between them at a specialty level.<sup>142</sup> This table (updated as per the footnote to Appendix G paragraph 1) is set out in Appendix G and shows that there are 18 specialties where, in their view, the parties overlapped in relation to inpatient elective care (for all of these they also overlap in relation to outpatient services). The table submitted by the parties shows 34 specialties where the parties overlapped in relation to outpatient elective care. The parties' table showed 20 overlaps in relation to non-elective care. The parties told us that, in aggregate, PH undertook less elective work than RBCH. They also told us 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, their range of genuine overlap was more limited. Further details of their submission relating to particular specialties are set out in Appendix G.

6.34 In order to test these points we assessed:

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<sup>139</sup> Specialised services may fall within elective, non-elective or outpatient services and we include each specialised episode within the appropriate category.

<sup>140</sup> 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.

<sup>141</sup> Non-overlap specialised services 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'.

<sup>142</sup> The parties submitted information on their overlap 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 present the specialty overlap submitted by the parties based on the SUS classification. More specifically, we consider:

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

See the first footnote to paragraph 6.35 for a description of SUS.

- (a) The extent to which each party was active at specialty level. To do this we looked at the volume of patient episodes each party provided in the last three years (January 2010 to December 2012) within that specialty. We did this by volume of both inpatient episodes (distinguishing between elective and non-elective activities<sup>143</sup>) and outpatient episodes.
- (b) The degree of treatment overlap within each overlap specialty that was identified. To do this we looked at what proportion of each merging party's activity in each overlap specialty relates to procedures (measured using Finished Consultant Episode (FCE) Dominant Procedure<sup>144</sup>) and diagnoses (measured using Primary Diagnosis<sup>145</sup>) that are also undertaken by the other merging party.<sup>146</sup>
- 6.35 We used SUS data<sup>147</sup> provided by the parties, which we adjusted to try to address differences in coding practices between the parties and discrepancies between the SUS data provided by the parties and that provided to us by Dorset and West Hampshire CCGs. The SUS data we considered for this overlap analysis does not include all of the parties' sources of income.<sup>148,149</sup> We acknowledge that there is a margin of error in the figures below and thus the activity of either party in a given specialty may be slightly under- or overstated, but this methodology appears to be the most sensible on the basis of the information we have been provided with. 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. (For further details of our analysis and methodology, see Appendix G.)
- 6.36 On the basis of our initial assessment of their SUS data, we identified a larger set of potential overlapping specialties compared with what the parties submitted. RBCH and PH submitted information to us regarding certain of these overlaps, explaining that despite the identification of an overlap, they should not in fact be treated as overlapping in provision of some services. Their detailed reasoning is set out in Appendix G. On this basis, we revised our analysis to exclude the following specialties as overlaps: genitourinary medicine (inpatient), adult cystic fibrosis (inpatient),

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<sup>143</sup> We consider day-case episodes as elective inpatient activities because they are recorded as such in the SUS data and because we understand that the dividing line between day-case treatments and inpatient activities is based on time of discharge rather than a fundamental difference in treatment.

<sup>144</sup> 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.

<sup>145</sup> Many patients admitted by physicians have multiple diagnoses. For each admission, a primary diagnosis is designated relating to the main condition treated or investigated.

<sup>146</sup> Please see Appendix G for further details on how the treatment was defined for inpatient and outpatient services.

<sup>147</sup> SUS is a data warehouse containing patient-based data related to episodes undertaken by NHS hospitals. It is defined as:

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.

On these activities RBCH and PH generated revenue of, respectively, £[redacted] million and £[redacted] million in FY 2011/12. These figures plus the SUS revenue add up to £[redacted] million for RBCH and £[redacted] million for PH. We note, however, that these values do not match the SLR reports submitted by the parties which show revenue of £[redacted] million for RBCH and £[redacted] million for PH.

<sup>148</sup> The parties told us that the SUS data sets did not include: (a) radiology or pathology, tests, drugs data, devices data, GUM attendances and any specialty specific databases like prosthetics; (b) outpatient activity that is not part of PbR contracts but which may form part of the parties' managed contract with commissioners (for example, physiotherapy attendances and multi-disciplinary teams); (c) community-based activity; and (d) ward attenders. On these activities RBCH and PH generated revenue of, respectively, £[redacted] million and £[redacted] million in FY 2011/12.

<sup>149</sup> Each FCE may entail a number of diagnoses and procedures. We referred to procedures and prognosis together as treatments. When an FCE includes a number of diagnoses, it also in general contains the information on the 'primary diagnosis', ie the most relevant diagnosis among all the diagnoses received by the patient. Similarly, when a patient was treated with more than one procedure, the SUS data in general indicates the 'dominant procedure', ie the most relevant procedure among all the procedures carried out within the FCE. To evaluate overlap between the parties at treatment level, we consider the 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.

hepatobiliary & pancreatic surgery (inpatient), clinical immunology and allergy (inpatient), clinical immunology (inpatient), and allergy (inpatient), medical oncology (inpatient), paediatric sub-specialties<sup>150</sup> (outpatient), clinical oncology (inpatient), medical oncology (inpatient), anaesthetics (inpatient)<sup>151</sup> oral surgery (inpatient). We also excluded the activity related to persistent pain management which is a subset of the pain management specialty. In some cases, the overlap we initially saw was the result of our reapportioning of activity between specialties; in other cases, it resulted from classifications of treatments which the parties submitted could be better classified elsewhere; and in some cases RBCH had since exited provision aspects of that service (medical oncology inpatient activity, oral surgery day-case activity) or both parties had (persistent pain management).

- 6.37 Table 3 shows our view on the specialties in which the parties overlapped in provision of elective, non-elective and outpatient services.<sup>152</sup> Compared with what the parties submitted, we identified two additional overlaps in inpatient elective (clinical haematology and pain management), one additional in inpatient non-elective (clinical haematology) and two additional overlaps in outpatient services (A&E<sup>153</sup> and anaesthetics).

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<sup>150</sup> Paediatric surgery, neurology, respiratory medicine, medical oncology, diabetic medicine, cardiology and cystic fibrosis.

<sup>151</sup> The parties told us that, as for inpatient services, anaesthetics was a support service and the 'outpatient' activity picked up in the SUS data was likely to refer to pre-operative assessment work. However, RBCH did not indicate how these episodes could be reallocated to other specialties and thus for the scope of consistency between our treatment of the parties, we did not re-allocate the outpatient episodes related to pre-operative assessments 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 specific 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 of reallocation on the overall overlap between the parties was likely to be very small.

<sup>152</sup> We report on overlaps for other services (community and private) in the appropriate sections below.

<sup>153</sup> 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.

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

Treatment specialty description	Elective	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	N/A	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	N/A	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*	N/A	X	X
Gynaecology	X	X	X
Clinical oncology	-	-	X
Total	19	21	36

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

\*We amalgamated obstetrics and midwifery service into a single specialty 'maternity' because many of the services provided at RBCH under midwifery were provided at PH under obstetrics. Maternity services are classified as non-elective services but not as emergency services. The parties submitted that only PH provided a full range of maternity services (including high-risk obstetrics, midwife-led hospital births and home births) while RBCH offered a small midwife-led unit and hence was only suitable for low-risk births (which did not require the presence of a consultant).

Note: N/A = not applicable.

6.38 The parties also said that we should exclude the following specialties from our overlaps analysis or recharacterize these overlaps as part of another specialty: hepatology (inpatient), transient ischaemic attacks (inpatient), clinical haematology and hepatobiliary & pancreatic surgery (outpatient). We did not accept the parties' arguments in relation to these submissions. For our detailed analysis of these arguments, see Appendix G. In general, in some cases we did not see a strong reason for regrouping the treatments within another specialty (hepatology, programmed pulmonary rehabilitation (outpatient), transient ischaemic attacks); in other cases, we did not accept that the parties would definitely not overlap in the specialty going forward (clinical haematology); and in relation to hepatobiliary and pancreatic surgery, we did not agree that sharing consultants was a reason for removing the specialty as an overlap (see paragraphs 6.133 to 6.142).

6.39 In our assessment of competitive effects of the merger when considering actual competition in the market for inpatient elective or non-elective and outpatient services, we focused on the specialties listed in Table 3 above. However, we considered all services where one party was present when considering potential competition and

reviewed all specialties when considering whether the merger would create unilateral effects in relation to competition *for* the market.

- 6.40 Considering all the specialties listed in Table 3, our analysis suggested that the parties overlapped 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 and 94 per cent of, respectively, PH's and RBCH's activities. For outpatient services, overlap specialties accounted for 95 and 76 per cent, respectively, of PH's and RBCH's outpatient activities.
- 6.41 In some cases, hospitals may focus on different treatments within a specialty. We therefore looked at the degree of treatment overlap within each overlap specialty (see Appendix G). We found that when only the volume related to procedures/diagnosis for which both merging trusts recorded activities is 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 is a degree of differentiation within specialties and the merging trusts did not fully overlap over the entire range of treatments that fall under a given specialty. However, in aggregate<sup>154</sup> the parties overlapped in relation to elective services that still account for a significant proportion of the parties' activity by volume, ie 55 and 32 per cent, respectively, for PH and RBCH. On the non-elective side, the aggregate<sup>155</sup> overlap represented 56 and 80 per cent,<sup>156</sup> respectively, of PH's and RBCH's activities.<sup>157</sup>
- 6.42 We carried out a similar analysis for outpatient services.<sup>158</sup> Similarly to inpatient activities (elective and non-elective), the volume related to procedures/HRG codes for which the parties had recorded outpatient activities was lower than the total volume observed in each specialty.<sup>159</sup> However, the aggregate overlap was still significant, accounting for 87 and 62 per cent, respectively, of PH's and RBCH's outpatient volume.
- 6.43 Although all outpatient services are technically classified as elective, we thought that in most specialties they could in principle be separated into those which are truly elective (either because they were part of an inpatient elective pathway or because patients had a choice of provider using Choose & Book); those which relate to maternity pathways; and those which relate only to emergency pathways. We attempted to separate these out, to the extent possible, using the 'source of referral' field in the parties' data.<sup>160</sup> Our understanding was that all outpatient overlap services, except A&E, transient ischaemic attack and maternity, involved elective

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<sup>154</sup> We only included in the estimate the 19 specialties listed in Table 3 above.

<sup>155</sup> We only included in the estimate the 21 non-elective specialties listed in Table 3 above.

<sup>156</sup> The volume associated with the overlap treatments in maternity represented 9 per cent of PH's non-elective volume activity and 2 per cent of RBCH's non-elective activity.

<sup>157</sup> These percentage figures have been 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).

<sup>158</sup> The large majority of outpatient attendances have neither dominant procedure nor primary diagnosis. For these episodes we identified as instances of overlap those cases when both party provided services that fall under the same HRG code. We acknowledge, however, that HRG codes may fail to capture some differences between the outpatient services provided by the merging trusts.

<sup>159</sup> Due to the lack of information on the outpatient episodes that required reallocation, it was not possible to evaluate precisely the overlap at treatment level for the specialties affected by the reallocation (eg endocrinology, breast surgery, colorectal surgery, etc). As a proxy, we assessed which treatments both trusts provided on the basis of the specialties as recorded in the original SUS data submitted by the parties (ie we assessed the overlap before reallocating outpatient episodes from general surgery and general medicine episodes at treatment level). This approach may result in slightly overstating the overlap at treatment level in general surgery and general medicine but understating the overlap in other specialties. We expected the aggregate effect, if any, to be negligible.

<sup>160</sup> See Appendix G, paragraph 17.

overlaps (with these three exceptions, there are no specialties with an inpatient non-elective overlap but no inpatient elective overlap).

### *Specialised services*

6.44 The parties told us<sup>161</sup> that:

... for specialised services, 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 by controlled by the National Commissioning Board

and

Specialised services are defined in law as those services with a planning population of more than one million people ... This means that there should at one time be only a single provider of specialised services in an area like Dorset (population circa 700,000).

6.45 From 2013/14 all services defined as specialised services will be procured by NHS England, meaning that some services will move from previously having been non-specialised to being designated as specialised services. Hence a portion of RBCH and PH income has moved from being locally commissioned to being commissioned by NHS England (although the same services are being provided). Services are still being defined and healthcare providers are being asked to self-assess whether they currently provide specialised services; hence there is some uncertainty about exactly which hospitals provide which specialised services.

6.46 The NHS is developing Identification Rules (IRs) which are used to map SUS level data to the 143 services.<sup>162</sup> We understand that the IRs are the most practical way to identify specialised services and have used them as the basis of our analysis. However, we note the parties’ view that they are new and do not always appear to match the written specifications for specialised services; hence they are evolving and may be slightly misleading in some cases. In our analysis, we considered the 143 specialised services as defined from April 2013. Where we used historical data, it was on that basis (ie the IRs were retrospectively applied to identify historical activity that would be counted as one of these 143 services if carried out today).

6.47 We considered the overlaps between the parties in provision of specialised services (which may include a number of different treatments). and found that the parties overlapped either now or in the recent past in:

(a) 20 elective specialised services, of which five services—related to the following clinical areas: vascular, sickle cell anaemia, neurology, complex minimal access gynaecology surgery, HIV—were currently offered by only one merging party;

(b) 16 non-elective specialised services, of which five services—related to the following clinical areas: cardiac other, vascular, paediatric cancer, paediatric

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<sup>161</sup> Joint main party initial submission, paragraphs 14 & 53.

<sup>162</sup> Identification Rules for Prescribed Specialised Services, [www.england.nhs.uk/wp-content/uploads/2012/11/pss-ir.pdf](http://www.england.nhs.uk/wp-content/uploads/2012/11/pss-ir.pdf).

ophthalmology and maternal medicine (complications of pregnancy)—were currently provided by only one of the parties; and

(c) three outpatient specialised services.

### Overlaps as proportion of parties' activities, by value

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

However, in making these comments the parties restricted their attention only to 17 elective specialties, compared with the wider analysis we have carried out.

6.49 We estimated how much the specialties in which the parties overlapped represented in terms of revenue generated for elective, non-elective and outpatient services.<sup>163</sup> The details of our methodology are set out in Appendix G. We found that PH generated £[redacted] million in the financial year 2011/12 in specialties where RBCH is also active and RBCH generated £[redacted] million in specialties where PH is also active. Table 4 shows the revenue generated by the parties in the overlap specialties as a proportion of the total parties' revenue recorded in SUS data.

TABLE 4 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]
RBCH	[31–40]	[91–100]	[71–80]	[61–70]

Source: RBCH and PH internal data, CC analysis.

6.50 The figures in the last column of Table 4 indicated that the parties overlapped in specialties that represented a significant proportion of their revenue ([61–70] per cent). 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 tended to carry out more elective and outpatient services, whilst in relation to non-elective services the proportion was higher for RBCH than PH.

6.51 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. We found that the parties overlapped on procedures/diagnosis from which PH generated revenue of £[redacted] million and RBCH generated revenue of £[redacted] million in the financial year 2011/12. As a proportion of the total parties' revenue recorded in SUS data, the overlapping procedures/diagnosis represented [51–60] per cent of PH's revenue and [41–50] per cent of RBCH's (see Table 5).

<sup>163</sup> We report on overlaps for other services (community and private) in the appropriate sections below.

TABLE 5 SUS revenues (£) generated by the parties at treatment/diagnosis level, FY 2011/12

<i>All overlap treatments/diagnosis</i>	<i>Elective</i>	<i>Non- elective</i>	<i>Outpatient</i>	<i>per cent</i>
				<i>Total</i>
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.

6.52 The analysis showed that even if we took a narrower view of overlaps (ie at treatment/diagnostic level rather than specialty level), the parties' overlapping activities accounted for a substantial proportion of their activity and income.

#### *Conclusion on overlaps*

6.53 In summary, the parties overlapped in provision of (see Table 3 above):

- inpatient services in 19 elective specialties;
- inpatient services in 21 non-elective specialties; and
- outpatient services in 36 specialties.

6.54 These specialties represented a significant proportion of the parties' income, whether calculated at specialty level or at treatment level. Within the overlapping specialties we identified 17 specialised services in which the parties overlapped in the current year and a further four which both had supplied in the recent past. Many of these specialised services included elective, non-elective and outpatient activity.

### **Elective services**

6.55 In this section we examine whether the merger might lead to unilateral effects in relation to the provision of outpatient and inpatient elective services. We first consider the views of the parties and third parties; then we consider the effects of the merger on actual competition *in* the relevant markets; and finally the effects of the merger on potential competition *in* the relevant markets. We consider competition *for* the relevant elective services markets separately later in our report (starting at paragraph 6.315).

#### *Parties' views on elective services*

6.56 RBCH and PH told us that there was no realistic prospect of the transaction leading to an SLC in relation to elective services, because the scope for competition in the provision of NHS services was limited as providers could only compete in terms of quality and not on price because foundation trusts had no power to set or negotiate the tariffs they were paid. However, we note that in the context of its counterfactual submission, PH told us that there was 'intense competition for AQP services' which limited its ability to grow its income.

6.57 Secondly, they said that they were not actual or potential competitors for the majority of the elective inpatient and outpatient services they provided. They said that local commissioning practices over the last 20 years had been designed to ensure that they, for the most part, provided complementary services and that consequently they had specialised in different areas, with PH being more focused on non-elective care and RBCH more focused on elective care. They submitted that the specialties where

there was scope for them to compete accounted for a small proportion of their clinical income. For the reasons set out above in our overlaps analysis, we did not accept this claim and, in our view, the parties overlap in the provision of a significant proportion of their elective services.

- 6.58 They said that where there was scope for competition, there were alternative local providers within a short drive-time who would be well placed to compete across a large range of clinical services offered by the parties, and this was enhanced by the care 'closer to home' approach of CCGs which involved providing more elective care in settings outside acute hospitals.
- 6.59 Finally, the parties told us that there were regulatory safeguards and incentive mechanisms in place to ensure that foundation trusts provided a high quality of care to patients (regardless of the level of competition).

### *Third parties' views on elective services*

- 6.60 NHS England (Wessex) told us that it 'recognised that the proposed merger could lead to less competition and a reduction in patient choice. However, given the current distribution of services, between the two sites, the impact of this is likely to be minimal.' It said that:

the people of Dorset and the surrounding area benefit from quite a wide range of choice relating to acute providers, with a large number of NHS trusts providing this type of care within a relatively small geographical area ... Bournemouth and Poole NHS Trusts taken together potentially serve a very large population, and taken as a whole, these people will continue to be able to access services from a number of different providers of acute care.<sup>164</sup>

- 6.61 Dorset CCG told us that:

There remains good choice in the area with Dorset County Hospital, Yeovil Hospital, Salisbury Hospital, Southampton Hospital, 3 Private Hospitals in Dorset – (Winterbourne, Harbour, Nuffield), as well as out of county at Shepton Mallet Treatment Centre and Spire, all providing NHS Funded care via choose and book. There are also a number of smaller community hospitals.

It said:

as commissioners we are looking increasingly at integrated service provision, clinical outcomes, and cost effective solutions, we are less concerned about the level of competition purely for competition sake and we see the outcomes for the patient as more important. If anything, multiple organisations can lead to increased risks and complexities around patients falling through the 'gaps' in service provision between different organisations ... we would see cooperation through the merger leading to a better solution for the patients than a purely competitive process.<sup>165</sup>

- 6.62 A local healthcare provider, [redacted], told us that:

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<sup>164</sup> NHS England (Wessex) submission, p2.

<sup>165</sup> Dorset CCG submission, p2.

each of RBCH and PH are clearly each other's closest competitors ... each Trust presents the strongest competitive constraint to the other, and although [X] would of course remain in the market competing against the parties to the merger inquiry for NHS funded healthcare episodes, [X] does not have the capacity to replace the constraint lost as a result of the merger. We believe competition for NHS activity within the local market would therefore be adversely affected should the Trusts merge.<sup>166</sup>

- 6.63 We received a number of submissions from members of the public, some of whom were concerned that the merger would result in loss of patient choice and longer travel times. For example, we were told that:

Patients currently have the facility to choose between two Trusts that are quite different in ethos but which both offer very good services. I do not believe that merging will significantly enhance the already high quality services provided by the two Trusts, but it would mean that the vast majority of people would lose the important ability to choose their provider since it would be the same organization.<sup>167</sup>

- 6.64 We were also told that some patients had had bad experiences at particular hospitals and therefore strongly preferred not to go back to the hospital in question. A local resident told us that after a recent bad experience of care at PH, if ever admitted again, he would try to be admitted at RBCH but that he was also considering the possibility of private patient insurance. Another concerned party told us that after a bad experience of care at RBCH, his GP had agreed that he should be dealt with at a different hospital and had referred him to PH.

- 6.65 However, a number of other respondents were also concerned about the limited impact of competition in supply of NHS acute services. For example, a governor at PH told us:

Over all these years I have never known of an individual who has chosen to use the services of a Hospital on the basis of the standard of care offered by one of the Hospital over the other. The perception is that in this area we are blessed with two hospitals where the standard of care is excellent, Would-be patients, myself and my wife included, select the hospital that is the more convenient ... some individuals might have to travel a bit further for treatment, but ... is not a significant enough factor to argue that the merger should not be allowed.<sup>168</sup>

- 6.66 Many of the respondents who referred to the limited importance of competition emphasized the importance of weighing competition with the benefits case for the merger and this evidence is considered in Section 9.

- 6.67 We also received comments from a number of other hospitals, third parties and members of the public, including at our public drop-in session held in the Dorset area on 5 September 2013. Summaries of some third party comments are posted on our website.

- 6.68 We considered that the evidence showed that, in line with our survey evidence, some patients value choice of provider.

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<sup>166</sup> [A hospital provider submission.](#)

<sup>167</sup> A submission from a member of the public.

<sup>168</sup> [Brian V Newman submission.](#)

## *Actual competition*

6.69 Our first theory of harm is whether the merger could lead to unilateral effects in the provision of the hospital-based elective services in which RBCH and PH overlapped. Having established that the parties overlap to a significant degree in the provision of elective services, in order to determine whether a lessening of competition could arise under this theory we analysed whether all of the following conditions apply to the overlap elective services:

- (a) patients and/or GPs have and exercise choice of provider;
- (b) quality influences that choice;
- (c) the parties would have an incentive to compete to attract patients absent the merger; and
- (d) the parties are close competitors.

6.70 We consider these factors below. We then consider whether the parties' past competitive behaviour would be likely to change in the foreseeable future, such that pre-merger evidence of competition is unlikely to be the most suitable guide for the level of competitive behaviour between the parties going forward.

6.71 First, we set out a general description of our views on the nature of competition in elective services.

### *The nature of competition in elective services*

6.72 As providers of publicly-funded NHS services for patients, foundation trusts have many different objectives. Healthcare professionals and managers, in general, want to deliver high-quality care for their patients. However, these organizations also have the objective of ensuring that they receive sufficient revenue to cover the costs of provision of healthcare services. Foundation trusts can retain any surplus for investment in new or improved services for patients, so they have an incentive to generate sufficient income to at least cover their costs, and we observed that RBCH in particular has engaged in wider commercial behaviour which seems consistent with seeking revenues or profits, rather than simply seeking to cover costs.<sup>169,170</sup> As there is a fixed price for each elective treatment, this means that foundation trusts have an incentive to compete on quality to attract patients to their profitable elective services.

6.73 There are many different aspects of quality, including clinical factors such as infection rates, mortality rates, ratio of nurses or doctors to patients, best practice and non-clinical factors such as waiting times, cleanliness and parking facilities. Location may also be viewed as an aspect of quality if a provider offers, or could offer, a choice of locations at which particular services are made available. Some aspects of quality, such as mortality rates or waiting times, are directly observable. In other ways, quality can only be judged once the patient has received treatment. This means that patients and GPs will assess quality in a number of different ways, including by reference to the general reputation of a hospital.

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<sup>169</sup> See paragraphs 6.112–6.120.

<sup>170</sup> To the extent that PH seems to have been less commercial, this may be related to past management and its financial situation.

- 6.74 Patients and GPs do not always know at the time of referral which procedure the patient will require and may demand that a provider offers a range of services within a given specialty. Quality indicators published by providers which are used by patients and GPs to choose provider may also reflect services wider than a particular procedure.
- 6.75 We found that GPs and patients both contribute to the choice of provider<sup>171</sup> and will have access to different sources of information. Hospital services tend to be experience or credence goods, ie quality does not necessarily or entirely take the form of qualities that can be measured or observed ex ante (or ex post), and while patients may rely to some extent on their own or friends' personal experience, GPs are well placed to observe the quality of services and to interpret published information on quality. Therefore, we considered that GPs act appropriately as advisers in patients' decisions about choice of hospital.
- 6.76 Unlike price or quantity, many aspects of quality cannot be set directly. The quality of a product or service is the outcome of many different decisions that are made at many different levels across an organization. In the case of hospital services, these decisions are taken by clinicians and managers. We understand that in doing so they trade off different factors. For example, the decision not to fill a nursing vacancy is made by trading off the possible effect on quality of care and the impact on the cost of providing care. The priorities that determine how these decisions are made will affect individual aspects of the hospital's quality, such as the ratio of nurses to patients, as well as feeding into the hospital's overall reputation.
- 6.77 The effect of competition would be to focus these decisions such that account is taken of the factors that matter to patients and GPs. The greater the number and quality of alternative hospitals in the local area, the stronger the trusts' incentives will be to focus on delivering those aspects of quality that are important to the trusts' patients and their GPs. In this way, we expected competition between hospitals to lead them to make spending decisions in a way that best reflects the factors that matter to patients and their GPs.
- 6.78 Academic studies found that competition in the provision of NHS-funded services for patients can lead to improvements in hospital quality.<sup>172</sup> A study by the CCP described some of the steps that hospitals have taken to respond to competition, including investments in technology and a focus on communication with patients.<sup>173</sup>
- 6.79 Our concern is that the merger would lead to a reduction in competition in the Dorset area, which would reduce one incentive on the merged trust to spend money to improve or maintain quality, and thus lead to lower quality than in the counterfactual.

#### *Extent of patient/GP choice*

- 6.80 In order for the parties to have an incentive to compete, they must expect that the decisions they make that affects the quality of their services will affect the extent to which patients and/or GPs decide to choose their services. That is, that decisions that increase the quality of services will attract more referrals, or conversely, that

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<sup>171</sup> See paragraphs 6.89–6.92. Consistent with this, the Department of Health National Patient Choice Survey found that the GP was the single most important source of information to help choose their hospital for 43 per cent of patients offered choice. The patient's own experience, or that of their friends and family, was given by 29 per cent, with 6 per cent citing a booklet about choice, and 4 per cent gave the NHS Choices website. See [www.gov.uk/government/publications/report-on-the-national-patient-choice-survey-england-february-2010](http://www.gov.uk/government/publications/report-on-the-national-patient-choice-survey-england-february-2010) (Figure 3 & Annex Table A.4).

<sup>172</sup> See Appendix H.

<sup>173</sup> See Appendix H.

decisions that reduce the quality will lead to fewer referrals. As set out in Section 2, patients have a right to choice of provider for their first consultant-led outpatient appointment for routine elective services. Even where patients do not exercise this choice themselves (either with or without the advice of their GP), their GP will take the decision as to where the patient should be referred, and similar factors may be relevant to the GP's choice.

- 6.81 The parties said that because there was no national guarantee of choice for inpatient elective services (ie because choice was only mandated for the first consultant-led outpatient appointment for elective services), there might be fewer grounds for competition concerns in relation to these activities.<sup>174</sup>
- 6.82 Whilst there is no right to patient choice in relation to any inpatient treatment, what a hospital provides in relation to inpatient elective activity (including the scope and quality of that activity) is often likely to influence the choice of hospital for the first outpatient referral. First, there may be instances where the patients or the GPs have 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. 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.<sup>175</sup>
- 6.83 In summary, where there are realistic alternatives available, choice will be exercised by patients and/or GPs in relation to first outpatient appointments. This choice will affect both outpatient and inpatient parts of the pathway, and the exercise of this choice generates scope for hospitals to compete against one another in relation to both outpatient and inpatient services.

#### *The influence of quality on choice*

- 6.84 We considered the extent to which quality of elective services influences patient and/or GP choices. We considered the views of RBCH, PH and third parties on the role of quality competition in the NHS. We also considered evidence from economic literature on choice and competition in the NHS; the evidence obtained via our survey of patients and GPs in the Dorset area on the role of quality in their choice of which hospital to attend; our analysis of GP referral patterns and what this tells us about the role of quality in their choice of which hospital to attend; and our analysis of the marketing strategies of the parties and what this tells us about the extent of quality competition between NHS hospitals in the wider Dorset area. Our detailed analysis of these factors is set out in Appendix H and our conclusions are summarized below.
- 6.85 If patients and/or GPs tend to choose between RBCH and PH on the basis of quality when deciding where to go for treatment, then we would expect RBCH and PH to take account of the impact on referrals of changes in their quality relative to one another. In this context there may be a range of different quality metrics that hospitals compete on. In Appendix D we set out a summary of some publicly available information on the performance of acute service providers in the Dorset area in relation to quality. From this, we noted that RBCH and PH tend to be ranked fairly similarly in terms of quality and have strong quality offerings.

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<sup>174</sup> The parties said that 'the maximum possible area for concern around competition in the market represents about 8 per cent of spending. That relates to outpatient services where the OFT analysis indicates there is sufficient competition. There is no national guarantee of choice for inpatient services. However, if there are concerns they are limited to less than [a further] 7 per cent of each trust's income'. See paper: '[The role of competition in the merger of RBCH and PH](#)'.

<sup>175</sup> For example, Dr Foster gathers and publishes information on the length of stay, post-operation mortality, revision rate, infection control, and HSMR, which are mostly indicators relevant for inpatient services' assessment.

- *Parties' and third parties' views*

- 6.86 The parties submitted that competition would not emerge as an important lever for driving quality in a relevant (say five-year) time period in part because very important aspects of quality were not observable by patients (either because data was too poor or because they were inherently difficult to observe, or both).
- 6.87 The King's Fund, commissioned by RBCH, submitted a paper<sup>176</sup> making a number of points on the role of competition in the NHS. In general, this stated that choice of provider has not acted as a particularly strong driver for service improvement (Dixon et al 2010<sup>177</sup>). It noted that econometric studies have shown that areas of the country with more competitive markets seem to have achieved greater quality improvements (eg reduced mortality) than areas with less competition, although these findings have been contested on methodological and other grounds (Mays 2011<sup>178</sup>). It said that neither these nor any other empirical work have tackled the question of the cost effectiveness of this sort of competition as a way to achieve quality improvements in health care. The Foundation Trust Network (FTN) told us that it was difficult to isolate the effect of competitive pressures from the impact of other government policies. It also indicated that parts of the machinery of choice were not yet functioning adequately across the board. It said that there were other mechanisms for improving quality in the NHS, for example using integration to improve services for patients.

- *Academic literature on effect of choice and competition in the NHS*

- 6.88 We also considered some of the academic literature on choice and competition in the NHS in England and in Appendix H set out the findings from the articles that have been published in peer-reviewed journals and the main findings from other potentially relevant papers. This economics literature and studies of hospitals in the UK, taken in the round, provide some evidence that quality, among other factors (including location), influences the decisions of patients and/or GPs. The academic literature suggests that in addition to location, waiting times, infection rates and mortality rates are quality factors that affect choice of hospital.

- *Patient and GP survey*

- 6.89 We also explored the issue of quality competition between hospitals via the patient and GP surveys we commissioned. Specifically, we examined the factors that influence choice and the extent to which patients and GPs would react to changes in relative quality of the merger trusts. The results of this survey are published on our website<sup>179</sup> and the survey report is Appendix I. In this we asked patients and GPs:
- (a) whether patients were aware that they could choose which hospital they went to;
  - (b) what factors patients/GPs considered important in relation to choosing a hospital;
  - (c) the factors that were discussed between the GP and the patient (where a discussion occurred);
  - (d) which hospitals were discussed/considered; and

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<sup>176</sup> A note from The King's Fund commissioned by RBCH.

<sup>177</sup> Dixon A, Appleby J, Robertson R, Burge P, Devlin N, Magee H (2010), *Patient choice: how patients choose and how providers respond*. The King's Fund, London, [www.kingsfund.org.uk/publications/patient-choice](http://www.kingsfund.org.uk/publications/patient-choice).

<sup>178</sup> Mays N (2011), *Is there evidence that competition in healthcare is a good thing?* No. BMJ (2011), vol. 343: 4205.

<sup>179</sup> [www.competition-commission.org.uk/our-work/directory-of-all-inquiries/royal-bournemouth-and-christchurch-poole/evidence/cc-commissioned-research-and-surveys](http://www.competition-commission.org.uk/our-work/directory-of-all-inquiries/royal-bournemouth-and-christchurch-poole/evidence/cc-commissioned-research-and-surveys).

(e) how patients would change their behaviour/GPs would change their recommendations in response to a change in quality or if the treatment they were being referred for was unavailable. In the latter case, where respondents indicated that they would choose a different hospital, we asked how strongly they preferred their first option to the second option (on the basis that if they strongly preferred their first option they might be less likely to react to the changes in quality of the magnitude we might be concerned about).

- 6.90 Issues (a) to (c) assisted our understanding of the factors that affect choice, whereas (d) and (e) provided more direct information on the strength of quality competition between the parties (and also with other providers). Unfortunately, due to a small sample size we were unable to place significant weight on the results we obtained from GPs (although we do comment on the direction of the results obtained where we consider them relevant).
- 6.91 The GPs we spoke to said that they discussed with patients waiting times, access/location and the clinical expertise of consultants and other healthcare professionals. They were more likely to consider outcome-focused features, such as infection rates, as essential than features relating to comfort or convenience.
- 6.92 We asked our survey sample of 456 patients what they had known about choice at the time of their GP appointment, which led to their initial outpatient appointment.<sup>180</sup> Approximately 50 per cent of patients (46 per cent of RBCH patients; 54 per cent of PH patients) knew that they had a choice of hospitals, most of these being aware before they saw the GP.<sup>181</sup> This is broadly in line with existing national research into this area which suggests that approximately 50 per cent of patients are aware they have a choice.<sup>182</sup> Of those who were aware of having a choice, more than half already knew which hospital they wanted to attend. However, of this same group, for at least 12 per cent the GP's recommendation was important. GPs told us that they discussed the choice of hospital with patients in more than half of cases, and of those, around half knew which hospital they wanted to attend and a further quarter had a good idea, whereas the remainder did not.<sup>183</sup> Both surveys therefore suggested that the GP's choice or recommendation is important for more than half of patients—either directly because they made their choice in consultation with GPs or indirectly because the GP made the choice for them—and we sought to explore further what factors were considered by patients who were involved in the choice of hospital.
- 6.93 We asked patients who knew they had a choice what factors they considered 'essential' or 'very important' when assessing a hospital for their condition.<sup>184</sup> The results are summarized in Appendix I. The five aspects named most frequently as 'essential/very important' all relate to aspects of clinical quality, namely: clinical expertise of healthcare professionals; availability of specialist medical equipment at the hospital; quality of nursing care; clinical outcomes; and quality of aftercare in

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<sup>180</sup> These were patients who completed our survey and were visiting one of the named GPs/consultants/specialist nurses for one of the specialties listed (these were selected to reflect specialties where the parties indicated that patients could have chosen between them) and had been referred within the last four months.

<sup>181</sup> 42 per cent of RBCH patients and 48 per cent of PH patients were aware of choice before they visited the GP for the referral they were being asked about.

<sup>182</sup> National Patient Choice Survey (England) (Feb 2010) indicated that: (a) the percentage of patients recalling being offered a choice of hospital for their first outpatient appointment was 49 per cent in February 2010; (b) 54 per cent of patients were aware before they visited their GP that they had a choice of hospitals for their first appointment; and (c) 63 per cent of patients who were aware of choice recalled being offered choice, whereas only 32 per cent of those not aware of choice recalled being offered it.

<sup>183</sup> We noted that the small sample sizes for our GP survey means that we took these proportions as indicative but did not rely upon them.

<sup>184</sup> The full question was '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'.

follow-up visits. They also show that the next most frequently-named aspects related to waiting times, ease of access/parking, appointment times offered and previous experience. Comfort of waiting rooms and overnight stay rooms was mentioned least frequently.

- 6.94 Approximately 25 per cent of patients who were aware they had a choice had a discussion with the GP about which hospital to attend, and the issue these patients discussed most with the GPs was waiting times.<sup>185</sup>
- 6.95 In order to better understand the strength of quality competition between the parties (and against others, which we discuss in more detail below), we looked at the extent to which patients/GPs respond to changes in quality generally or, to put it another way, by how much quality would need to decrease/increase in order to induce a change in hospital choice. There are many dimensions of quality, some of which are difficult to quantify. We used waiting time, since it was an aspect of quality that was quantifiable. We acknowledge it is likely that different patients will react to different quality parameters, but in our view focusing on one measure of quality in this context is practical and provides useful indicative results for these purposes.
- 6.96 Our patient survey asked all respondents who were aware of choice (RBCH: 117 and PH: 109) to tell us how much longer they would have waited for an appointment before they switched hospital. The results showed that:
- If waiting times were to increase by 10 per cent at RCBH, 26 per cent of RBCH patients would switch hospital, which implied an (own) waiting time elasticity of 2.6.
  - If waiting times were to increase by 10 per cent at PH, 24 per cent of PH patients would switch hospital, which implied an (own) waiting time elasticity of 2.4.
- 6.97 If waiting times were to increase by two weeks (regardless of original waiting time), our results indicated that: 48 per cent of RBCH patients would switch hospital; and 47 per cent of PH patients would switch hospital. This implied that patients are (or at least claim to be) very responsive to changes in waiting times. This observation is subject to a number of caveats, detailed in Appendix H, and therefore we placed weight on the observation that patients would respond to changes in waiting times but did not rely on the precise elasticity estimates. We discuss later in this report the hospitals to which patients would have switched (see paragraph 6.188ff).
- 6.98 In summary, the survey indicated that a significant proportion of patients do exercise choice in relation to hospitals; that quality influences choice; and that if quality (using waiting times as a quality indicator) were to decrease, a proportion of patients would consider switching. It also demonstrated that GPs play an important role in the referral process for many patients and, although we were not able to draw strong conclusions on the factors that affected GPs, we would expect them to be in general better informed than patients, especially with regard to clinical quality of hospitals.
- *Evidence from GP referral patterns*
- 6.99 As part of our assessment of the extent to which quality affects patients' and/or GPs' choice of elective service provider,<sup>186</sup> we performed two further analyses: (a) we esti-

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<sup>185</sup> However, just 54 respondents answered this question and therefore the answers we have received may not be representative of the wider population.

<sup>186</sup> If quality measures play a role in influencing choice, then we would expect hospitals to have incentives to compete on these parameters of quality (assuming they would expect to be remunerated in whole or in part for treating additional patients).

mated the proportion of patients attending their nearest hospital by GP practice, and (b) we analysed the evolution of hospital shares over time at the GP practice level. In the following paragraphs we discuss the outcome of these analyses (further details of both analyses are provided in Appendix H).

- *Patients attending the nearest hospital*

6.100 We estimated the extent to which patients attended their nearest suitable hospital (ie the nearest hospital offering the required treatment). We found that over 80 per cent of elective patients attended the nearest hospital (with some variations by specialty but in general a high level of consistency—see Appendix H, Table 1). The proportion of patients attending the nearest hospitals for outpatient services was similar, and for non-elective services, slightly higher.

6.101 The high proportion of patients attending the nearest hospital supported the view that proximity plays an important role in patients' decisions. We would expect this to be the case if quality across hospitals is roughly similar (ie no significant differences in quality are perceived by patients/GPs), because location would be the main or only differentiator, and in such circumstances referral patterns would be largely driven by hospital location. Our assessment of the evidence on quality suggested that the parties ranked fairly similarly in terms of the quality of the service they provide (see further Appendix D).

6.102 For these reasons, in our view, this analysis could not inform our assessment of the extent to which quality affects patients' and/or GPs' choice of hospitals.

- *Evolution of provider shares at GP practice level*

6.103 We also considered a more dynamic measure of provider shares. If distance were the sole driver of choice, one would expect that hospital shares at a GP practice level would be roughly stable over time. By contrast, if quality played a role in patients' choice, one might expect 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 recognize that there may be other explanations for why hospital shares can vary, and we discuss this in more detail below and in Appendix H).

6.104 We analysed variations in shares of the GP practices which are roughly equidistant between the parties' hospital (ie the difference in drive-time to the parties' sites is less than 5 minutes) and for which therefore one might expect that factors other than distance may have, if any, more tangible effects. We identified 14 GP practices meeting this condition and carried out an analysis of a selected set of specialties (see further Appendix H).

6.105 The analysis showed some volatility in PH and RBCH's shares over time, especially in colorectal surgery, dermatology, gastroenterology, general surgery and rheumatology in elective services.<sup>187</sup> The volatility in outpatient shares appears more limited than in inpatient services, however, we still observed some non-negligible variability within certain specialties, eg clinical haematology, dermatology, rheumatology and obstetrics.

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<sup>187</sup> Breast surgery, general surgery, gynaecology and medical oncology also showed some variability over time but these specialties were characterized by lower volume and may therefore be more exposed to undue volatility which does not necessarily reflect changes in the referral pattern (ie in the choice preference of patients and/or GPs).

- 6.106 We interpreted these results with some caution because in some cases variation may have been introduced into our results as a result of small sample sizes and capacity constraints and because we used GP practices as a proxy for patient location (which may not have fully reflected the relative distance between available hospitals that patients faced). That said, the evidence indicated that variation in GPs' referral patterns had occurred over time, which would not be expected if patients chose hospitals based solely on location. Our analysis therefore showed factors other than location playing some role, at least at the margin, in referral patterns.
- 6.107 The parties submitted that GPs tended to refer almost all (80 per cent or more) of their patients to the same trust for a given overlap specialty, rather than spreading referrals across a range of trusts. They argued that this was not what one would expect to see if GPs were actively offering patients a choice of provider and experimenting with different providers to test service quality and that this supported a picture of 'entrenched patient referral patterns'.
- 6.108 We do not agree with this conclusion. It is essentially a static analysis, and we find the dynamic analysis summarized in paragraphs 6.103 to 6.106 more relevant. The parties' static analysis is consistent with either of two scenarios: (a) the majority of patients generally travel to their nearest hospital (especially when hospitals are of similar quality); or (b) GPs play a strong role in the choice of hospital (and would be expected consistently to choose the same hospital). We find both plausible and consistent with other evidence, but neither is inconsistent with patients responding to quality changes by travelling to a different provider.
- 6.109 The parties also submitted evidence of the effect on GP referral patterns of (a) several outbreaks of norovirus in RBCH, and (b) RBCH's recall of a number of patients to its breast screening clinic. They told us that, based on an analysis of the volume of first outpatient appointments for all elective services by booking date, there was no evidence that the norovirus outbreaks had any discernible or systematic impact on RBCH's referral patterns, despite being publicized by the trust. They also submitted that breast screening issue had no noticeable impact on first attendance outpatient volumes at RBCH (excluding the recalls themselves).
- 6.110 We agree that the data does not demonstrate any clear responsiveness to these events in booking patterns. We do not know whether potential patients would have perceived these events as transitory problems, perhaps accompanied by a tightening of quality control that would make RBCH better in the future, or as indicative of low quality. We agree that this evidence seems to indicate that RBCH patients may not always be responsive to quality changes (albeit these are the types of issues that should be prevented by minimum (regulatory) standards, rather than the type of quality that competition aims to improve incrementally).
- 6.111 In summary, we found that some of the information on GP referrals suggested that referrals were driven by factors other than distance, but we also found that some incidents which might have been expected to affect referrals did not have any discernible effect. Finally, we took into account patients' stated willingness to respond to waiting times (one aspect of quality) in our patient survey<sup>188</sup> and comments made to us by third parties.<sup>189</sup> Overall, these led us to believe that at least some aspects of quality (ie factors other than location) to some extent affect choice of hospital (although not all aspects of quality may do so). We also consider in paragraph 6.224 below whether this may be expected to change in the future.

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<sup>188</sup> Paragraph 6.97.

<sup>189</sup> Paragraphs 6.60–6.68.

- *Parties' marketing material and internal documents*

6.112 We reviewed (a) information provided by the parties on their approaches to marketing and (b) their internal documents, with a view to establishing whether these were consistent with them competing on quality in the past and, if so, what quality measures were relevant.<sup>190</sup>

6.113 We asked the parties for any market or advertising strategy documents or promotional materials they had produced. 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. However, we reviewed other documents and publicly available information regarding the parties' communication strategies (see Appendix H) and 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.

(b) PH circulated a 'GP newsletter' which appeared to market and promote the hospital, for example by reporting details of new and existing services, information on new consultants and their specialisations, and information on the quality of food, infection rates and patient safety. These strategies to engage with GPs and the marketing of particular aspects of the services that they provide are similar to some of the examples noted by the CCP in its study of how hospitals respond to competitive incentives (see Appendix H).<sup>191</sup>

(c) Prior to the decision to merge, RBCH engaged in marketing and promotional activities in relation to the quality and range of its services; and prior to 2009/10, it sought referrals from local GPs and discussed actively targeting particular practices. RBCH actively monitored GP referrals and told us that it would [redacted], which suggested that it believed it had tools at its disposal to retain patient referrals.

(d) To the extent that either party has limited its marketing in recent years, in our view this may be because it perceived that its financial incentives were muted by CCG contracts; and, particularly in the case of PH, it may have considered that its quality standards were well known and not have had the financial capabilities to engage in more marketing.

6.114 We also reviewed the internal documents and board minutes submitted by the parties with a view to understanding what quality measures they focus upon and whether they do so for regulatory or competition reasons; and whether they appear to take strategic decisions in response to competition.

6.115 The parties monitored a number of key performance and quality indicators (KPIs) used to measure and evaluate clinical and management performance against set internal targets. These indicators focused on a range of areas, some of which used to monitor performance towards CQUIN goals and Monitor's requirements (see further Appendix H). It is impossible to know the extent to which these KPIs are monitored because of competition rather than regulatory or other reasons.

6.116 Certain documents also suggested that RBCH has engaged in activity to attract patients from other hospitals. A marketing plan from November 2007 said 'Marketing

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<sup>190</sup> If the parties compete on quality, we would expect quality of services to be an aspect of marketing.

<sup>191</sup> See Appendix H for more detail.

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. RBCH's 'GP Engagement Plan', produced in November 2009, discussed focusing on marginal GP practices and persuading them to refer to RBCH.

6.117 This suggested that RBCH had the ability and incentive to attract additional patients. 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 [redacted] and move towards [redacted]'. RBCH decided to discontinue its approach of targeting 'marginal' GP practices and encouraging them to refer patients to it, and to move away from attracting additional volume.

6.118 RBCH also told us that:

For example, where we [redacted] draw patients from Southampton, what we have tended to emphasise is either short waiting times or particular skills that we have. Perhaps the most obvious example of where we have been successful is the development of the cardiology service, certainly in particular what we call the interventional cardiology service which started out from scratch and is now, from an elective standpoint, one of the largest elective services in England.

6.119 RBCH told us that these patients were drawn from RBCH's own catchment area, who were previously having to go to Southampton for treatment, and from Poole and Salisbury catchment areas. Again, this behaviour is partly historical but reflects an apparent intent and ability to attract patients by emphasizing aspects of quality.

6.120 RBCH's latest strategic plan reflected the importance of attracting patients. RBCH's Strategic Plan 2013–14 featured a section titled 'Market Share and Competition', which presented RBCH's share of secondary care activity at each GP practice in the region (similar to our analysis in Section 5 above), noting that 'Maintaining or growing share in these practices remains a constant watching brief'.<sup>192</sup>

6.121 We also reviewed the parties' joint plans for the future if the merger were permitted, and found that they included many references to market shares, being a provider of choice, attracting and retaining patients, and the importance of quality in this. We view these as examples of the parties' awareness of the role of competition, in various forms, in the NHS and would expect them to have many of the same plans absent the merger. These are discussed in more detail in Appendix H (paragraph 71).

6.122 The parties' plans provided examples of the benefits of competition and the parties' intent to attract patients by emphasizing aspects of quality. The examples include focusing on waiting times, implementing best practice guidance, delivering innovative models of care, extending expertise and enhanced service provision and improving facilities to attract patients.

6.123 In summary, some of RBCH's documents indicated that it had (or believed it had) the incentive and ability to affect referral patterns and the number of patients it treated, and that it competed with other healthcare providers (including PH, other hospitals in the wider area, and providers in the community for certain services). RBCH's behaviour may have been affected in recent years by its relationship with

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<sup>192</sup> These documents are discussed in more detail in Appendix H.

commissioners, which we explore the reasons for this in paragraphs 6.155 to 6.178 and 6.224ff below. The parties' post-merger plans showed their awareness of the role of competition and provided some examples of the benefits of competition.

### *Incentives to compete*

6.124 A fundamental principle of the NHS policy framework (including the PbR framework, the introduction of foundation trusts with their ability to retain surpluses and changes to the regime for competition enforcement), is that the parties have incentives to compete to attract patients in order to earn income. This is consistent with the parties' statement that 'Under the PbR framework, healthcare providers have an incentive to compete for large volumes of procedures, provided that the PbR tariffs are sufficiently high to cover the marginal costs of providing these services'.<sup>193</sup> In this section, we assess the extent to which their incentives might have been affected by (a) the profitability of increasing elective activity given the tariffs and cost structure; (b) the contracts the parties have in place with each other for sharing of clinical staff; (c) capacity constraints; (d) the relationships the parties have with CCGs; and (e) regulatory factors relevant to quality standards.

- *Profitability of elective services*

6.125 We analysed the costs and revenues of RBCH and PH by specialty for the year 2011/12 (see further Appendix J for our methodology<sup>194</sup>).

6.126 For RBCH, we observed that all elective services earned a contribution for the marginal patient when only variable costs were taken into account. Most service lines ([redacted] out of 23) continued to earn a contribution even if semi-fixed costs were also taken into account. Loss-making services at this level accounted for around [redacted] per cent of elective income. [redacted] out of 23 continued to earn a positive profit when fixed costs were also taken into account, and across all elective service lines as a whole RBCH recorded a [redacted] ([redacted] per cent of elective revenue). [redacted] services made a substantial profit (of more than £[redacted] million) after fixed costs: [redacted]. Loss-making services at this level accounted for around [redacted] per cent of elective income, whereas [redacted] per cent of income came from the [redacted] services that were profitable. This implied that (subject to capacity and to being paid by commissioners for extra volume) RBCH would have an incentive to attract elective patients at the margin across all service lines, but in a few service lines (accounting for only [redacted] per cent of its elective income) would not want to attract further patients if they were to cause further semi-fixed costs (ie the incentive is blunted once costs reach a step change).

6.127 For PH, we observed that all elective services earned a contribution for the marginal patient when only variable costs were taken into account, and [redacted] out of 28 earned a contribution even if semi-fixed costs were also taken into account. If fixed costs were also taken into account, [redacted] out of 28 service lines continued to earn a positive contribution. The loss-making services were relatively small, with the exception of oral surgery (which was only loss-making when fixed costs were taken into account). This implied that PH would have an incentive to attract elective patients at the margin across all service lines, although there were two relatively small service lines ([redacted])

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<sup>193</sup> [Joint main party initial submission](#), paragraph 254. The parties went on to state that in their view, tariffs were not cost reflective and the nature of their contracts with commissioners gave them little financial incentive to outperform their agreed volume targets, arguments which we address below.

<sup>194</sup> We could only examine specialties as they were recorded at the 'service line' level and so although most service lines matched internal recordings of specialties, they did not perfectly reflect the way we analysed them. 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, and we reassigned them in our overlap analysis, we were not able to do so here.

where it would not want to attract further patients if they were to cause further semi-fixed costs (ie the incentive is blunted once costs reach a step change).

- 6.128 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,<sup>195</sup> estimates of the incremental revenues that RBCH would generate from a 20 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 not be able to cover the incremental costs for any of the above specialties.
- 6.129 The figures submitted by the parties did not appear consistent with the detailed service line reporting information previously provided to us (see Appendix J, paragraphs 37 to 41). They told us that this was partly due to recording revenue in varying ways in different sets of accounts.<sup>196</sup> It was also because, for these seven specialties, RBCH had estimated the extra staff that it would need to provide 20 per cent extra volume, and (a) it would need to utilize these staff at evenings and weekends in order to make use of existing theatres and equipment outside the hours in which they were already being used (or make large capital investments) and would potentially have to pay staff a premium to work during these hours, and (b) this was a greater than 20 per cent increase in staff numbers due to indivisibilities and to ensure that its theatres were fully staffed during these hours even where they were not being fully utilized during evening/weekend working.
- 6.130 RBCH said that its purpose was to illustrate how even the revenue associated with a 20 per cent increase in activity volumes might not be enough to cover this discrete step-up in incremental costs, at least with regard to these specific specialties. Whilst there are indivisibilities and semi-fixed costs which may make certain increases in activity unprofitable, in our view this would be the exception rather than the rule, since we have found that these specialties are in general profitable at the current level of activity and fixed costs would not change; and hospitals can to some extent control the amount of elective work they do to avoid these problems. Equally, RBCH's analysis prima facie suggests that it would likely be profitable for it to reduce its volume in these specialties, but it has also told us that it tries hard to protect its share of referrals.<sup>197</sup>
- 6.131 We also acknowledge that in the short term a hospital may have to pay premium staff costs, but we would not expect this to be the case in the long term as it recruits accordingly. Hospitals would also have the option of reducing the volume supplied of less profitable services in order to expand supply of more profitable services. Finally, because elective specialties tended to be profitable even taking into account appropriate contribution to overheads, we would expect there to be long-term profitable opportunities for investment in capital expenditure. Therefore 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.

o *Conclusion on profitability of tariffs*

- 6.132 In summary, both parties' elective services appeared to be generally profitable at the margin. On this basis, both parties would have an incentive to prevent a decline in

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<sup>195</sup> [redacted]

<sup>196</sup> For example, when a patient receives treatments that fall under more than one specialty, whether revenue is attributed entirely to the main specialty or spread among specialties by treatment.

<sup>197</sup> See Appendix H, paragraphs 77ff.

referrals and to attract patients in most or all elective activities across all specialties, subject to capacity constraints and to receiving payments for the activity they carry out.

- *Sharing of consultants between the parties*

- 6.133 The parties told us that they shared consultants and other key resources in relation to a number of specialties including: cardiology, trauma & orthopaedics, gynaecology, palliative medicine, neurology, ENT, medical oncology, vascular surgery, oral and maxillofacial surgery; anaesthetics; radiology; pathology specialties (including microbiology and histopathology); ophthalmology; urology; clinical oncology; A&E; pain management; paediatrics and obstetrics.<sup>198,199</sup> We understand that sharing consultants in most cases involves consultants employed by RBCH visiting PH to offer outpatient services (or vice versa), and the specialties where shared consultants offered inpatient services were limited to elective inpatient services in urology, gynaecology, anaesthetics, trauma and orthopaedics, and non-elective inpatient services in A&E. PH currently hosts consultants from RBCH at an annual cost of around £[redacted] and other specialists costing around £[redacted]; whereas RBCH pays PH around £[redacted] for consultants and £[redacted] for other staff.
- 6.134 The parties said that sharing consultants would reduce or remove incentives to compete, for three reasons.
- 6.135 First, they said that their ability to differentiate themselves from one another in terms of quality of care in affected treatments was limited, because consultant care was central to the provision of care and directly influenced the quality metrics that most influenced patient choice, eg mortality rates, waiting times, CQC rankings and MRSA infection rates.
- 6.136 Whilst we accept that the consultant has an important bearing on clinical outcomes, it is not the sole factor contributing to patient choice, and there are also other aspects of quality that hospitals can compete on even when they both use the same consultant. Both these points are demonstrated by the range of factors that our patient survey found to be relevant to choice, as discussed in paragraph 6.93 above.
- 6.137 Secondly, the parties said that the financial arrangements for accommodating shared consultants and visiting consultants limited the trusts' incentives to compete with one another. Whilst the parties acknowledged that the tariff income fell to the relevant organization that delivered the service ('hosting organization'), they said that because the hosting organization would have to pay a recharge for the consultant's time, this stifled its incentives to compete.
- 6.138 We reviewed the contractual arrangements between the parties and found that:
- (a) Where consultants or other medical/clinical staff are lent to other hospitals, they tend to be charged out at cost (based on the proportion of clinical time spent at the other hospital, with total cost assessed on an 'on-cost' basis<sup>200</sup>). This implied that the hospital which employs these staff is not earning any margin on these activities and therefore its incentives to compete with the 'host' hospital in relation to these activities should not be muted.

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<sup>198</sup> The parties told us that in relation to non-elective services the sharing extends to trauma and orthopaedics, A&E, obstetrics, gynaecology, microbiology, radiology, palliative care and neurology.

<sup>199</sup> Cardiothoracic surgery services are provided at both trusts by University Hospital Southampton.

<sup>200</sup> ie not only salary but taking into account National Insurance and pension contributions, holiday and sickness entitlements, etc.

(b) On the other side of the relationship, the ‘host’ hospital appeared to pay for the staff at cost (with the amount fixed in advance unless significantly more activity is undertaken). It is not clear how this is any different from the financial situation a hospital faces when it employs the staff itself.

(c) We also considered that there may be some advantages to these arrangements for the providing hospital, as (i) these arrangements make it possible for the host hospital to utilize and pay for fractions of visiting staff’s total employment cost based on time utilized, rather than having to employ full-time consultants; and (ii) lending a consultant to provide outpatient services may lead to additional referrals for inpatient services. Therefore it is unclear to us why incentives to compete would be muted.

6.139 For these reasons, in our view the SLAs between RBCH and PH do not stifle their incentives to compete.

6.140 Thirdly, the parties also said that, in the event that one of the parties sought to expand significantly its elective activity in competition with the other party, this might cause that party to terminate the shared service arrangement as it would have no incentives to make it easier for the rival to compete with it; and that this might stifle incentives to compete.

6.141 It appeared that there were arrangements in place for marginal increases in activity to be serviced under the agreements, so this would not disincentivize competition at the margin, and PH confirmed this. It seemed to us that if one of the parties were to expand significantly beyond this point, it could make a case to employ a consultant of its own.<sup>201</sup> As such, sharing consultants would not affect its incentives to compete. PH said that the real issue was around a hospital effectively starting a new inpatient service where it currently relied on visiting consultants for an outpatient service, since it would have to build facilities and attract other staff, not just consultants. We agreed that entry into a new specialty at inpatient level would be more difficult (see further our analysis of cost of entry into a new specialty in Appendix F) and potentially could not be done on the basis of borrowed consultants. That said, we do not accept that this argument removes incentives to compete in existing overlap services (either at the outpatient level, if that is the extent of the overlap, or at inpatient level if that overlap currently exists).

- *Conclusion on shared consultants*

6.142 We concluded that the parties’ arrangements to share consultants do not remove their incentives to compete in overlap areas.

- *Capacity constraints*

6.143 We considered whether capacity constraints might affect the parties’ incentives to compete. Our starting position was that if both parties are genuinely capacity constrained, then absent the merger that might undermine incentives to improve quality, since quality improvements might attract more patients. However, as one of our concerns<sup>202</sup> was that post-merger the parties might *reduce* quality below current

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<sup>201</sup> The parties told us that they would also need to employ junior doctors, that the Deaneries controlled the allocation of junior doctors and could be wary of allocating them to work for a service where there was a single consultant. As such, it was not clear to us that the requirement in some instances to hire additional staff in relation to an expansion at the margin would always remove the incentive to expand at the margins, although we did note that entry into a new specialty would be more difficult.

<sup>202</sup> Paragraphs 6.77–6.79.

levels, that incentive would not be undermined by capacity constraints, since a reduction in quality would be associated with a reduction in the number of patients.

6.144 We also considered whether capacity constraints applied at the level of individual specialties or activities, which might undermine incentives to increase quality in those specialties; or only at the level of the hospital as a whole, which might permit the hospital to increase quality and patients in some (profitable) areas and reduce quality and patients in other (less profitable) areas.

6.145 The parties told us<sup>203</sup> that they were operating at close to full capacity. They submitted utilization statistics for the period 2009 to 2012 showing that bed day occupancy<sup>204</sup> was a consistent annual average of around [redacted] per cent at both merging trusts, and the theatre utilization rates were around [redacted] per cent at PH<sup>205</sup> and approximately [redacted] per cent at RBCH. Table 6 summarizes the capacity utilization for both trusts.

TABLE 6 Utilization at PH and RBCH, 2009/10 to 2011/12

	<i>per cent</i>		
	<i>2009/10</i>	<i>2010/11</i>	<i>2011/12</i>
<i>PH</i>			
Occupied bed days	87	88	88
Theatre utilization	91	88	87
<i>RBCH</i>			
Occupied bed days	[redacted]	[redacted]	[redacted]
Theatre utilization	[redacted]	[redacted]	[redacted]

Source: RBCH and PH.

6.146 The parties submitted that these statistics might appear to suggest that the merging trusts had some spare capacity while in reality they did not, because these statistics did not capture a number of relevant aspects. With particular regard to bed occupancy, the parties stated that:<sup>206</sup>

- occupancy bed rates were measured at night, and therefore they did not account for inpatients (day cases) who occupied beds during the daytime only;
- demand was seasonal (higher from November to March<sup>207</sup> and lower in the summer months);
- beds allocated to elective services tended to be occupied less at weekends 'predominantly due to the level of relevant consultant coverage'; and
- due to service-specific requirements, beds were not always substitutable across specialties and services and where they were, this might lead to a suboptimal patient experience and poorer outcomes.<sup>208</sup>

<sup>203</sup> Joint main party initial submission, paragraph 242.

<sup>204</sup> 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'.

<sup>205</sup> 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'.

<sup>206</sup> RBCH also submitted that the numbers in Table 7 were 'averages, and therefore there are frequently periods where bed capacity is at 100 per cent'.

<sup>207</sup> The parties told us that they consistently hit or exceeded full capacity from November to December and they regularly had to enact escalation policies which entailed [redacted].

<sup>208</sup> The parties mentioned, as an example, paediatric beds which could not be filled with obstetrics patients.

6.147 We also considered whether these utilization statistics might have understated capacity because a measure of 100 per cent is not a true maximum. The parties told us that exceeding 100 per cent capacity involved emergency escalation policies and it would be ‘clinically unacceptable’ to make use routinely of such measures to attract additional patients. However, PH told us that expanding from 622 beds to 650 would be ‘relatively straightforward’, although a larger expansion would be more difficult. As described in detail in Appendix J, PH has reconfigured space in the past, and the parties told us that they had plans (dependent not on the merger, but on other factors) to close a number of beds (ie cease using them for existing activities), some of which we thought might therefore be available to expand elective activity; and we thought that theatres could sustainably be used at higher levels than present. This suggested to us that there may be some flexibility around capacity in the medium term.

6.148 Capacity available within a given specialty or for a given service may be increased either through expanding the existing facilities (beds, theatres and/or hiring additional consultants/staff) or by diverting capacity from other services.

6.149 We considered the parties and third parties’ views on the obstacles to moving capacity across services or specialties due to different service-specific requirements, which mean that resources used for different services are not readily substitutable.<sup>209</sup> We also took account of the fact that capacity expansion does not need to be discussed and agreed in advance with the local commissioners, although when it involves significant investment, it may need commissioners’ support. We also considered information provided by RBCH and PH showing capacity reconfiguration in recent years and information from Salisbury District Hospital showing it had expanded capacity in relation to some specialties in the last five years. Information provided by RBCH and PH and third parties regarding other levers (eg ward rounds, inpatient tests, pharmacy flexed capacity, changing staffing and weekend working) to respond to volume variation, as set out in the parties’ responses to questions and board documents, suggested that the trust has some flexibility also to address unexpected demand increases. This information we considered in relation to capacity is described further in Appendix J.

6.150 Against this background we considered the volumes (measured in terms of episodes) of all inpatient activity carried out by the parties in recent years, as recorded in SUS. Table 7 shows the total SUS elective and non-elective activities of the merging trusts in FY 2010/11 and 2011/12.

TABLE 7 **Volume of activity (number of FCEs) of elective and non-elective services at PH and RBCH, 2010/11 to 2011/12**

	2010/11	2011/12	% variation 2010/11–2011/12
PH	82,953	82,174	–1
RBCH	128,947	133,969	4

Source: RBCH and PH—SUS data.

Note: These figures account for all the inpatient activities recorded in the SUS data as submitted by the parties, including PbR and non-PbR, private and NHS patients, specialised and non-specialised services.

<sup>209</sup> RBCH added that the barriers in transposing services between sites include, 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’.

- 6.151 The figures in Table 7 show that PH slightly reduced its volumes of activity in the period 2010/11 to 2011/12 (–1 per cent) whilst RBCH increased its activity by 4 per cent.
- 6.152 We also looked at the annual volume variation at a specialty level (see Appendix J), which showed that the parties experienced significant variations in the annual volume of activity at a 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' hospital increased more than 10 per cent from 2010/11 to 2011/12. Considering that the overall utilization rates (see Table 7 above) had been relatively stable over the same period, this evidence suggested that the merging hospitals have some flexibility in adjusting various aspects of capacity to accommodate volume changes at specialty level.<sup>210</sup>
- *Conclusion on capacity*
- 6.153 Our view is that whilst in aggregate spare capacity at RBCH and PH appeared to be limited and it would be likely to constrain the ability to accommodate significant variations in total activity volume (especially during the seasons of high demand), the parties, and more generally hospitals, appeared to have a degree of flexibility in adjusting capacity to cope with changes in demand that may result from attracting patients previously referred to other hospitals. Overall, although there was not a significant level of spare capacity at RBCH and PH, in our view there is a level of flexibility around capacity which means that RBCH and PH could expand at the margins within specialties, and therefore capacity constraints do not remove their incentives to compete.
- 6.154 Over the long term, hospitals also appeared capable, when economically viable, of reconfiguring capacity to accommodate larger changes in volumes, and many of the issues involved in expanding activity appeared to relate to the nature of relationships with CCGs and certainty of payment rather than physical capacity.
- *Relationship with commissioners and commissioning behaviour*
- 6.155 We assessed the impact of the relationships between the parties and the local CCGs on RBCH and/or PH's incentives to compete in relation to elective services. In this regard, we considered their contracts with the CCGs and the manner in which these were negotiated and set. The major source of revenue for both parties was the revenue received from the Dorset PCT cluster (now Dorset CCG). RBCH also obtained approximately 13 per cent of its revenues from Hampshire PCT (whose commissioning from RBCH now occurs via West Hampshire CCG). We understand that in principle PbR services should be paid for using PbR tariffs based on the volume of activity (which would mean that the parties' incentives would be based on the profitability of those services as examined above), but that in practice both parties have entered into 'managed contracts' with Dorset CCG under which the relationship between volume of activity and payments is less direct in a single contracted year (each provider's contract is then adjusted for the following year in relation to activity the previous year), which could change their incentives to expand (or reduce) activity.

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<sup>210</sup> Since the total activity across all specialties has fallen, capacity increase may be, at least to some extent, the result of switching capacity between specialties. We also acknowledged that volume changes at specialty level may be partially due to the variations in the scope of the SUS data (ie the way treatments are recorded and/or remunerated).

- *Parties' submissions*

6.156 The parties told us<sup>211</sup> that 'PbR NHS clinical income' was remunerated through managed contract arrangements with local commissioners, rather than directly on the basis of volumetric PbR tariffs. They said that PbR tariffs and expected activity volumes were still used to determine the level of remuneration awarded to the trusts under these contracts,<sup>212</sup> but in practice both PH and RBCH had managed contracts with local commissioners, which awarded them a fixed sum for the provision of these services over the year.<sup>213</sup> Under these managed contracts, they said, the returns for services provided by the parties were fixed and did not vary within the year, except where the trusts' activity volumes turned out to be significantly higher or lower than anticipated. The parties said<sup>214</sup> that this meant that, once commissioners had set the parties' contracts for the year, the parties had little financial incentive to outperform their agreed volume targets, since they would not be reimbursed for doing so. This in turn meant that, even where the parties could in theory compete to attract volumes by offering a high quality of care, they had little financial incentive to do so, at least in the short run. The parties told us that the commissioners had made 'settlement payments' to them [ ] contractual amount, to address tariff fluctuations and for activity which occurred above the agreed cap.

- *Relationships with commissioners in recent years*

6.157 PH had had a fully managed contract with local commissioners for a number of years, whereas RBCH had a partially managed contract under which it expected to be paid at a marginal rate for volumes above the agreed level. Dorset CCG told us that it considered this reasonable since RBCH would have already covered its fixed costs at agreed activity levels, and hence a portion of the tariff provided an adequate return past that point. Since 2011/12 RBCH has also agreed a fully managed contract. RBCH had a similar arrangement with West Hampshire CCG.

6.158 In 2009/10 both parties expanded their elective output as part of a regional initiative to reduce waiting times. We understand that commissioners endorsed an increase in activity up to a level affordable within its budget, but not beyond this level since the regional waiting time targets were not a priority for it within its fixed budget, and as a result they declined to pay at the full tariff rate for the extra activity above the agreed level.

6.159 The parties told us that since then they had been careful to ensure where possible that they did not take on additional activity without the support of commissioners, and that when activity exceeded the pre-agreed level it was for reasons acceptable to the commissioner and where the parties could expect to be paid. However, they also said that commissioners could refuse to pay for activity volumes within-year that exceed agreed volumes, even if that additional activity was 'genuine' in the sense that it could not be attributed to coding practices; and that further payment mechanisms (such as winter pressure allowances) were often unpredictable and not controlled by local commissioners.

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<sup>211</sup> [Joint main party initial submission](#), note to Figure 15.

<sup>212</sup> [ibid](#), note to Figure 15.

<sup>213</sup> [ibid](#), paragraph 254.

<sup>214</sup> [ibid](#), paragraph 254.

- *Dorset CCG's views*

6.160 We asked Dorset CCG about the relationship it (and its predecessor Dorset PCT cluster) had with the parties. Dorset CCG told us that there had been times when it had paid less than the full value of activity, and there were a number of reasons for this. In some cases it disputed coding (ie the way in which a trust had classified its activity); in others it believed that trusts had carried out unnecessary activity by setting too high a level of interventions; and in 2009/10 it believed that the parties had engaged in too much activity (to reduce waiting times), and to pay for it all would breach its own financial envelope. It said that these were all examples of activity that either was not a genuine result of increased demand for services (eg simply managing down waiting times) or activity that it did not approve of (eg levels of intervention which were high compared with national averages). However, it said that it would generally pay for genuine activity, which reflected genuine increases in demand for a hospital's services.

- *CC analysis*

6.161 The extent to which either party would have an incentive to compete for additional elective and non-elective patients depends upon the extent to which it believes it will be paid for additional activity (subject to the other factors which may weaken incentives we have discussed).

6.162 We analysed details of the parties' contracts with the Dorset PCT cluster for the past three years, comparing the parties' planned and actual activities with the amount paid for by commissioners to understand to what extent the parties were reimbursed for elective and non-elective services. Full details can be found in Appendix J and our conclusions are below.

- ○ *RBCH*

6.163 We found that in each of the last three years, RBCH consistently met or exceeded its planned activity in aggregate. In each case 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, and so RBCH was not fully remunerated for the actual activity that it undertook. 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 but the final level of remuneration was effectively a negotiation.

6.164 We also looked separately at elective services where, in the last two years, RBCH exceeded its planned activity (it was slightly below planned activity in 2010/11). RBCH was paid for [61–70] per cent of its £[ⓧ] million of additional activity in 2011/12. In 2012/13 it was only directly paid [51–60] per cent of its £[ⓧ] of additional activity but the PCTs paid over £[ⓧ] million in non-elective support to RBCH as part of winter pressures funding that was not contractually required and so, Dorset CCG told us, in effect RBCH was paid for all activity undertaken. However, it is unclear whether the Dorset PCT cluster was treating elective services differently from non-elective, since it paid for excess non-elective activity at approximately the same rate. We were told that although remuneration was assigned to different types of activity, the [ⓧ].

6.165 We considered RBCH's 'GP Engagement Plan' produced in November 2009, described in paragraphs 6.116 and 6.117, which showed that after the Dorset PCT cluster made clear that it would not pay for overactivity earlier in the year and

negotiated a block contract for the remainder of the year, RBCH decided to discontinue its approach of targeting 'marginal' GP practices and encouraging them to refer patients to it, and to move away from attracting additional volume. However, in our view, this does not mean that its incentives to compete for additional volume were entirely removed—rather that it would be likely to seek commissioner consent for any significant expansion (or to expand volume in ways that commissioners approved and would reimburse) and still seek additional volumes at the margins, especially in profitable activity.

6.166 Therefore, based on our understanding of RBCH's past activity levels and commissioner payments for activity, and in particular Dorset CCG's view that it would generally pay for genuine demand-led activity, we were of the view that the contracts did not remove RBCH's incentives to compete (although they may soften them by introducing some uncertainty as to the direct link between activity and income).

o o PH

6.167 In relation to PH's total activity and income, we found that the Dorset PCT cluster had paid PH [§] the amount agreed at the beginning of the year when the trust had higher than planned activity in 2011/12 and in fact paid more than the value of the actual activity. In years when PH had lower than planned activity, the Dorset PCT cluster paid the initially agreed amount in 2012/13, and [§] the initially agreed amount in 2010/11, [§]. PH told us that 'the actual payment in 10/11 and 11/12 is higher than the [agreed contract payment] because the PCT agreed to increase the amount paid for non-PbR services' and that this was to address certain issues of underfunding and other issues. PH told us that 2012/13 commissioners paid PH over the agreed amount, partly in the form of additional payments for winter pressures and other similar unanticipated events.<sup>215</sup> PH also received an additional compensation for the activity it carried out to which it would not have been normally entitled under a managed contract as part of the commissioners' commitment to ensure PH's viability until it merged with RBCH.

6.168 On this point, PH further told us that its financial framework for the 2013/14 contract with Dorset CCG would include a similar risk-sharing arrangement, and contract income in 2013/14 would be £[§] million higher than 2012/13; and in 2014/15 and 2015/16 would remain at this level (requiring flat cash settlements from the CCG in order to offset any reduction in the tariff and any loss in activity). PH said that this agreement, including a £3.3 million subsidy, was reached in order to help the Trust to achieve [§], but was not directly dependent on the merger, and that no repayment was required if the merger did not proceed.

6.169 Dorset CCG said that [§]. When asked what it would do if the merger did not proceed, Dorset CCG said that it did not know whether it would seek to support PH for longer or whether it would let PH fail and see what would happen in the context of the failure regime.

6.170 For the provision of elective services, PH appeared to have been paid [§] for provision of elective services when it was above the agreed level. On the face of it, the above analysis suggests that PH faced an incentive to compete in relation to elective services.

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<sup>215</sup> We also considered whether the extra payments given to PH to improve its financial situation was a subsidy likely to undermine competition, for example by reducing PH's incentives to compete or to innovate. Given that PH had no certainty over the award from year to year, and also its size relative to PH's income, we did not expect that it would significantly change PH's incentives or undermine competition.

- 6.171 Whilst PH [redacted] of not achieving the agreed activity levels in relation to non-elective care in 2010/11 and 2011/12, it was paid [redacted] agreed activity levels in 2012/13. However, it also told us that it expected that if its activity fell below the agreed activity level under a managed contract, it still expected to be paid at the agreed level this year.
- 6.172 It also said that it did not expect to be paid above the agreed level in total this year because of the extra £3.3 million of funding (unless its activity was more than £3.3 million over plan, which it said was not plausible); although again that may not apply in the future. However, we also note that it is not clear whether PH is being treated differently from RBCH because of Dorset CCG's view of PH's financial situation: if PH were perceived to be in a different position it might seek to reimburse it in a similar way to RBCH.
- *Conclusion on contracts*
- 6.173 Looking at the last three years, we found that PH tended to be remunerated in full when it exceeded planned activity whereas RBCH was only partially remunerated. Taking into account PH's current financial circumstances, we thought it most likely that under managed contracts in the future both parties would be paid for additional activity but could not be certain of being remunerated at full PbR rates.
- 6.174 The parties disagreed with our analysis on the basis that if they engaged in expanding activity without commissioner approval they would not expect to be remunerated in the same way as they had been in the last three years. They told us that in 2009/10 they expanded their activity significantly above the agreed level and were not fully paid for the activity they carried out (see paragraph 6.158); and that since then, they had been careful not to take on additional activity without the support of commissioners, and that when activity exceeds the pre-agreed level it was for reasons acceptable to the commissioner and they could expect to be paid.
- 6.175 We considered Dorset CCG's comments about the way in which it approached reimbursement and the circumstances under which it would or would not pay for extra activity. Most importantly, we thought that it would in general pay for genuine extra activity,<sup>216</sup> whereas it has challenged some reported activity ([redacted]) in the recent past and this is likely to account partially for the failure to pay for all reported activity, although it noted that the contract was reset every year and rebased to reflect actual activity undertaken; but we acknowledged that managed contracts removed certainty around the extent of extra payment. We considered whether the parties' incentives to attract more referrals from one another were stifled (or altogether removed) because of this uncertainty about remuneration. We recognized that payment for extra activity would be subject to negotiation with commissioners as to whether or not that activity is genuine. In our view, these negotiations introduce some uncertainty for the parties, which somewhat weakens (but does not remove) their incentives to gain extra volume, and we noted that RBCH, at least, is aware of and responds to changes in its financial incentives (based on its change in behaviour in 2009/10).
- 6.176 Therefore, in our view, the pattern of remuneration we observed did not mean that the parties' incentives to compete for additional volume were removed—rather they would be likely to seek commissioner consent for any significant expansion (or to expand volume in ways that commissioners approved and would reimburse) and still seek additional volumes at the margins, especially in relation to the more profitable services under PbR tariffs.

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<sup>216</sup> We noted that the parties disputed this and we considered the effect their views would have on their incentives to compete.

6.177 We also considered whether the parties would be concerned if their activity levels were to fall as a result of losing patient referrals to the other hospital since that may lead to reduced payments either in the current year or in the future if the CCG were to revise planned activity downwards. Both parties said that they expected to be paid at the agreed amount in the current year even if they had lower than planned activity, but RBCH said that the CCG might reasonably seek to reduce the agreed activity level for the following year. Therefore we expect that both hospitals have some level of incentive not to lose patients.

6.178 We consider separately in paragraph 6.224 below whether these incentives are likely to be stronger in the counterfactual.

- *Quality regulation*

6.179 The parties submitted that there was no scope for the merger to reduce quality due to the quality regulation which existed in relation to the parties' services. We considered whether regulatory factors might crowd out the scope for current or future competition to influence quality, because they either imposed quality standards or provided financial rewards to an extent that removed the parties' incentives or ability to compete on quality.

6.180 As described in Section 2 and Appendix C, 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, regulatory requirements exist to prevent some aspects of quality from falling below specified minimum thresholds.

6.181 In our view, such requirements would not act so as to change the parties' incentives for quality at the margin, since both are well rated in terms of the quality of the services they provide and may be above the minimum standards or national average in many areas. All UK hospitals are subject to the same set of regulations as the parties and vary significantly in terms of quality,<sup>217</sup> and both the NHS policy framework and academic research suggest that competition may have a role to play in improving quality over and above regulation (see paragraph 6.88).

6.182 We also considered whether quality standards (such as NICE clinical guidance<sup>218</sup>), national targets (such as waiting time targets) or financial incentives (such as CQUIN) remove the ability for the competitive process to influence quality (see further Appendix D). We found that:

- (a) Quality standards are a concise set of statements derived from the best available evidence such as NICE guidance and other evidence sources accredited by NICE. They are not mandatory requirements or targets; however, the care system should have regard to them in planning and delivering services, as part of a general duty to secure continuous improvement in quality.<sup>219</sup> As such, there is still

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<sup>217</sup> For example, the Hospital Standardised Mortality Ratio, a measure of deaths while in hospital care, where 100 is the expected rate for a hospital given its patient mix) varies between 70 and 121, ie by up to 30 per cent away from the mean. Dr Foster, The Hospital Guide 2013: <http://drfosterintelligence.co.uk/thought-leadership/hospital-guide/>.

<sup>218</sup> [www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/nice\\_and\\_the\\_nhs.jsp](http://www.nice.org.uk/aboutnice/whatwedo/niceandthenhs/nice_and_the_nhs.jsp).

<sup>219</sup> Each quality standard will highlight which domains of the NHS outcomes framework the standard is likely to contribute to and where possible, information on likely outcomes and relevant data sources (such as national audits) will be provided at an individual statement level. Quality standards are intended to drive up the quality of care, so achievement levels of 100 per cent should be aspired to (or 0 per cent if the quality statement states that something should not be done). However, NICE told us that it recognized that this may not always be appropriate in practice when taking account of safety, choice and professional judgement and so desired levels of achievement should be defined locally.

an ability for different quality levels to occur in provision of a treatment across hospitals, even when all hospitals meet the standard.

(b) Financial incentives (such as CQUIN) could be used to incentivize specific quality goals but (i) these would not cover all aspects of quality; (ii) it was not clear to us (based on information from the CCGs—see further Appendix D) that changes around the measures set out in CQUIN targets would necessarily trigger changes to whether or not the hospital received the payment, and (iii) CQUIN would not incentivize further improvements beyond the target level, whereas competition might. For these reasons, we concluded that there was still a role for quality competition despite these payments.

(c) National targets (such as waiting time targets) did not entirely remove a role for quality competition as hospitals were incentivized by published information about their performance in relation to the target not only to meet targets but perform well in relation to their closest competitors. The incentive to compete around these targets is particularly strong where the information is available to GPs/patients who exercise choice.

6.183 We also considered whether non-regulatory factors incentivize a hospital to offer good quality services: for example, the interests of consultants and managers in protecting and enhancing their professional reputations as well as the desire to provide good services to patients. However, similar considerations are not uncommon in other industries and we do not consider that we can rely on these softer factors to prevent any lessening of competition from having an effect on outcomes. In this context, we note that while RBCH and PH appear to have high quality standards, hospitals vary significantly in quality, which indicates that there is still an ability for hospitals to differentiate themselves on quality, and this may be a factor on which they promote themselves.

- *Conclusion on quality regulation*

6.184 We concluded that despite the fact that regulation played an important role in ensuring minimum standards of quality in the provision of elective services, it did not lead to all hospitals providing the same levels of quality and did not remove the incentive for hospitals to compete on quality.

- *Conclusion on incentives to compete*

6.185 We found that government policy implies that the parties should have incentives to compete. However, we considered a number of factors that could remove these incentives. We found that expansion of elective services appeared to be profitable at the margin, subject to capacity issues. We found that sharing of consultants did not remove these incentives. We found that despite existing capacity constraints there is a level of flexibility around capacity, which meant that the parties could expand to some extent within specialties (particularly if hospitals try to expand more profitable specialties or procedures at the expense of less profitable ones). We found that in general we expected commissioners to pay for genuine increases in activity, and so these relationships did not entirely remove the trusts' incentives to compete (although they may soften them or make the link between activity and income less direct). Finally, we found that quality regulation did not remove the role for competition in pursuing higher quality. On this basis, we concluded that the parties have incentives to compete.

### *Closeness of competition*

6.186 We considered the extent to which parties overlapped in the provision of services in paragraphs 6.24 to 6.54 above. In this section, we consider the extent to which they are close competitors compared with other hospitals in and around the wider Dorset area. First, we consider the relevant results from our patient survey. To further test the closeness of competition between RBCH and PH, we then looked at what GP referral patterns show regarding closeness of competition between the parties.

- *Patient survey*

6.187 When asked which hospitals patients had discussed with their GP:

- 96 per cent of RBCH respondents said that they had discussed RBCH. The next most frequently-mentioned hospital was PH (37 per cent), followed by University Hospital Southampton (26 per cent); Salisbury District Hospital (11 per cent); Lymington (7 per cent); Yeovil District Hospital (4 per cent); and DHUFT Wimborne/Victoria (4 per cent).
- 89 per cent of PH respondents said that they had discussed PH. The next most frequently-mentioned hospital was RBCH (37 per cent) followed by Dorset County Hospital (15 per cent); Yeovil District Hospital (11 per cent); and DHUFT Wimborne/Victoria (11 per cent). Salisbury District Hospital, DHUFT Swanage and DHUFT Weymouth were also cited by 4 per cent of PH respondents.

6.188 In order to understand the strength of quality competition between the parties and against other hospitals, we asked patients how they would alter their choice of hospital if a quality decrease were to occur: this provided a diversion ratio motivated by a quality, rather than price, change. The results showed that:

- (a) Of the 78 PH patients who indicated how much longer they would be prepared to wait before switching, 51 per cent said that they would switch to RBCH, 12 per cent said they would switch to DHUFT Wimborne/Victoria; 9 per cent said they would switch to Dorset County Hospital; 4 per cent said they would switch to DHUFT Weymouth; and 3 per cent said they would switch to Salisbury District Hospital (no other hospital was mentioned by more than 2 per cent of respondents).
- (b) Of the 73 RBCH patients who indicated how much longer they would be prepared to wait before switching, 52 per cent said that they would switch to PH; 14 per cent said they would switch to University Hospital Southampton; and 8 per cent said they would switch to Salisbury District Hospital (no other hospital was mentioned by more than 2 per cent of respondents).

6.189 These results suggested that, where the parties' patients would switch as a result of quality changes, they are by far the closest alternatives to one another. However, 81 per cent of those PH patients who said they would have switched to RBCH said they would strongly prefer PH, and 74 per cent of those RBCH patients who said they would divert to PH said that they would have strongly preferred RBCH. This might suggest that a large proportion of those patients who told us that they would switch would be reluctant to do so in the face of the sorts of marginal (but significant) changes in waiting time and other aspects of clinical quality that we may be concerned about.

6.190 Respondents who indicated that they would switch between the parties were also asked what they would do if waiting times increased further or their treatment was

unavailable at their second-choice hospital (ie the other merging party). In both cases, a high proportion of respondents said that they did not know what they would do. This might suggest that, for many patients, there are not obvious alternatives to the parties given the distances they are prepared to travel for treatment. Conversely, some 41 per cent of RBCH patients who did express an alternative and 33 per cent of PH patients said that there would be no difference between their third and second choice.<sup>220</sup> The parties suggested that this meant that a significant proportion of patients would be willing to travel longer distances to other providers. However, we found that the great majority of these patients had already indicated that their second choice was substantially less preferred than the hospital they actually used, and hence for almost all patients the third choice was noticeably less preferred than their first choice.<sup>221</sup> Hence we did not think that many patients would be willing to travel long distances in the event of a reduction in quality of their preferred hospital.

- 6.191 The parties suggested that most patients were unlikely to be highly responsive to changes in quality, and hence that RBCH and PH were not close competitors. The survey evidence supports the view that many patients are currently not highly responsive to changes in quality, although some patients are, and RBCH and PH are, at least, each other's closest competitors. The parties also said that marginal patients who were responsive to such changes in service quality were likely to be willing to travel significantly further than 20 to 30 minutes' drive.
- 6.192 The parties' two comments together imply that patients can be divided into two groups: those who are insensitive to quality and those who are highly sensitive to quality, with nothing in between. This would be contrary to normal expectations about consumer preferences, and indeed our patient survey suggested that sensitivity to quality varied, with some being insensitive, some being highly sensitive, but also others with varying degrees of sensitivity in between.
- 6.193 Some patients do travel long distances (further than the 80<sup>th</sup> percentile figures) but this may be simply because they live a long way from any hospital, or because their treatment is not available from their nearest hospital, and therefore this did not demonstrate anything about willingness to trade off distance and quality. If patients live between a third party hospital and one of RBCH or PH, they might be more willing to change from the nearer of RBCH/PH to that third hospital than patients who live in the Poole/Bournemouth area. However, as noted above, there were very few patients whose second choice hospital was either PH or RBCH but whose third choice hospital was not significantly less preferred than their first choice, suggesting that they would have to be highly sensitive to quality to switch to a third party hospital.
- 6.194 In summary, the survey evidence supported the view that where patients are choosing or asked to choose between hospitals, the parties are close alternatives, as demonstrated by the high diversion ratios between them (see paragraph 6.189) and

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<sup>220</sup> We noted that the figures of 41 and 33 per cent were based on the subset of patients who named a third-choice hospital if the other merging hospital did not offer the treatment they needed (57 per cent at RBCH and 43 per cent at PH). Of the patients who would be willing to switch to the other merging party in response to a fall in quality, only around a half were able to name another hospital as their third choice, which suggests that (a) many people did not know what they would do if the parties' services declined in quality, and (b) only 23 per cent of RBCH's patients (ie 57 per cent of 41 per cent), and 14 per cent of PH's patients (ie 43 per cent of 33 per cent), actually appeared to be indifferent between switching to the other merging party or to a third hospital.

<sup>221</sup> Out of 61 patients who answered both questions, only five patients (8 per cent) said both that there was no difference between first and second choice (some of these expressed this as saying they would not have waited any longer before switching hospital) and that there was no difference between second and third choice. Forty patients (66 per cent) expressed a strong preference for either first over second choice or second over third (here we interpret a strong preference as those who would have waited more than two extra weeks to go to their preferred hospital).

the low level of mentions of alternative hospitals that patients said they might attend instead.

- *Analysis of GP referral patterns*

- 6.195 Our market definition analysis showed that the merging trusts attracted 80 per cent of their patients from within a drive-time of approximately 20 minutes. We considered the constraints posed on the parties by rivals located outside these isochrones.
- 6.196 We looked at the share of referrals 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 patient would be likely to go to in response to a change in the quality of services at either of the parties. Our detailed analysis is set out in Appendix K.
- 6.197 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 above and Appendix H). It also seemed consistent with RBCH's analysis of its share of referrals with GP practices.<sup>222</sup>
- 6.198 We considered 132 GP surgeries: all GP surgeries in the Dorset CCG area and GP surgeries in certain parts of the West Hampshire CCG area.<sup>223</sup> 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. 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) is the favoured alternative for a GP practice if it decided to switch patients away from a hospital.
- 6.199 We found that RBCH was the best ranked alternative to PH 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 each). 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, 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).
- 6.200 In relation to RBCH, we found that PH was the best alternative option to RBCH for 51 per cent of GP practices from which RBCH drew referrals (64 GP practices), followed by Dorset County Hospital (26 per cent) and University Hospital Southampton (10 per cent). RBCH drew 85 per cent of its activities from the GP practices where PH was the best alternative. The practices for which Salisbury District Hospital and Yeovil District Hospital were the next best option by weighted

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<sup>222</sup> See paragraph 6.205 and Appendix K, paragraphs 30–32.

<sup>223</sup> 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 RBCH receives patients.

volume represented 6 and 3 per cent respectively 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.

- *Exposure to competition*

6.201 As a further assessment of the substitutability between hospitals, we considered the extent to which hospitals overlapped (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). Our exposure analysis is detailed in Appendix K. This analysis was also consistent with a relatively small proportion of the referrals received by RBCH and PH being exposed to competition from providers other than each other.

- *Marginal GP practices*

6.202 Building on the exposure analysis, we carried out an analysis of the extent to which the merger might affect 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). We considered which GP practices might be 'marginal' or contestable to each of the parties. We defined a GP practice as marginal (ie liable to change its referral patterns in response to changes in quality) where the rival hospitals' combined share exceeds 50 per cent.<sup>224</sup> We then analysed how many of these practices would still be marginal post-merger. (See further Appendix K.)

6.203 Based on the data provided by the Dorset and West Hampshire CCGs, and focusing on the revenue related to elective inpatient and outpatient services, we found that, using a definition of marginal GP practices as practices which referred 50 per cent or less of their referrals to the respective hospital:

- PH's share was 50 per cent or below in 120 out of the 130 GP practices from which it drew referrals and it generated approximately 69 per cent of its SUS revenue in these marginal practices.
- RBCH's share 50 per cent or lower in 84 out of 130 GP practices from which it drew referrals and it generated approximately 29 per cent of its SUS revenue in these marginal practices.

6.204 The parties' combined market share 50 per cent or below in 58 GP practices. From PH's perspective this would imply a net reduction in the number of marginal GP practices of 62 GP practices compared with the pre-merger scenario, and of 26 GP practices from RBCH's perspective. In terms of revenue:

- the proportion of income generated by PH in the GP practices that would be marginal from the perspective of the merged entity would be around 7 per cent, implying a reduction in the 'exposed to competition' revenue (the internalization effect) of more than 62 percentage points.

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<sup>224</sup> The shares are calculated in terms of the SUS revenue related to inpatient elective and outpatient services for the period April 2010–November 2012.

- The same figure for RBCH would be around 6 per cent with reduction in the 'exposed to competition' revenue of 23 percentage points compared with the pre-merger scenario.

6.205 As a sensitivity check we considered RBCH's identification of marginal GP practices in its 'Marketing & Communication Plan – Putting Patients First (2007–2008)'. 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 to us 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. We found that all of the 17 GP practices identified by RBCH as marginal in 2007/08 would also be marginal according to our definition. The proportion of RBCH's revenue generated from the GP practices which would no longer be marginal post-merger (ie the potential internalization effect) would be approximately [X] per cent. (See further Appendix K.)

6.206 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.

- *Conclusion on closeness of competition*

6.207 In summary, we found that:

- (a) There is little overlap between the catchment areas of the parties and those of any other acute hospital. However, the parties' catchment areas overlapped with each other and that area of overlap was outside the catchment area of any other acute hospital.
- (b) Distances are important in patients' choice of hospitals, which implied that the parties could be expected to be each other's closest competitor and other competitors to exert significantly less constraint.
- (c) For patients attending each party, our survey found that the other merging party was the most likely to be discussed with GPs and the most likely second choice (although not always a close second); that a large proportion of patients did not know where else they would go, and of those who did, a majority strongly preferred the other merging party to a third-choice hospital.
- (d) Looking at GP referral patterns, the parties were the best ranked alternative to each other at the majority of GP practices from which they drew patients, and more so at practices from which they drew the bulk of their referrals.
- (e) The merger would reduce the number of 'marginal GP practices' at which the parties might perceive significant competition for referrals.

6.208 This analysis consistently showed that the parties were each other's closest competitor and that they were likely to face limited constraints from other healthcare providers in the area for the bulk of their services.

*Evidence of competitive behaviour between RBCH and PH in provision of elective services*

6.209 On the basis that RBCH and PH are each other's closest competitors and have incentives to compete for elective services (albeit slightly weakened due to the factors outlined above), we next considered the evidence we had received of RBCH and PH competing.

- *Parties' views*

6.210 When asked whether the parties were competing at the time of the proposed merger, PH told us that it did not think that there was explicit competition between it and RBCH. PH said that in many cases they offered complementary services but even where their services overlapped, there was not currently explicit competition between it and RBCH. PH said that the drive to maintain good-quality elective services was driven not just by regulation but by clinical pride and clinical excellence.

6.211 However, PH also told us that over the years it had introduced new services 'in order to be more efficient, provide a better service and probably outsmart its neighbours a little bit', and cited the introduction of the one-stop rectal bleeding clinic as an example. This indicated to us that it had made some improvements to its services in response to competitive pressures, albeit other factors may also have been relevant. PH told us that this comment was made in the context of the discussion about the natural competitiveness between individual consultants (many of whom provided services across both trusts) rather than any belief that such new services would lead to significant changes in long-term referral patterns across the trusts.

6.212 RBCH told us that where there was extra business to be won, some surety about being paid and provided it could cover its costs, then it would compete. It cited AQP services within the community for endoscopy and dermatology services as examples of where it did compete, noting that AQP was bringing in up to eight new providers in Dorset. RBCH said that there might be instances where it would be prepared to offer a service as a loss leader because there would be other advantages in attracting a greater amount of work as a consequence. When asked whether RBCH specifically competed with PH, RBCH told us that it would not see the relationship as competitive to the degree that perhaps others would but that it did compete in the sense that it did not want to see its market share diminished and that where it could safely and appropriately grow its market share it would want to.

6.213 Regarding shared consultant arrangements, RBCH told us that:

... there were obvious spin off benefits for the hospital who employs the consultant in the first instance because often that is the inpatient base for the work and a hospital's geographic coverage is much wider because you have consultants in outlying clinics too. So you are expanding your catchment population and your market share as a consequence.

It therefore appears that these arrangements are in part a tool to enhance market share and attract patients from new areas.

- *Third parties' views*

6.214 We received submissions<sup>225</sup> on the merger from a number of third parties, mainly members of the public. Many of these submissions discussed benefits and disadvantages of the merger but were not relevant to a competition analysis of the merger. We did, however, receive the following comments on the merger:

(a) A hospital provider ([REDACTED]) told us that in respect of competition within the market, it believed that each of RBCH and PH were clearly each other's closest competitors and that NHS activity within the local market would therefore be adversely affected should the trusts merge.

(b) A member of the public told us that without knowledge of the likely reconfigurations of hospital services that might be produced should the trusts merge, loss of convenience to patients would seem to be a real risk, and that existing competition to some extent currently offset that risk but would be lost if the merger was approved without safeguards.

(c) A member of the public raised concern about the possible closure of Christchurch Hospital and another noted that the merger would 'remove any semblance of competition between the two main hospitals'.

(d) West Hampshire CCG told us that:

There was significant sharing of services between the two hospitals and some degree of competition. ... There was competition between the two hospitals in some high volume specialty areas—dermatology, ENT, rheumatology. RBCH and PH also competed on some acute services. West Hampshire CCG saw some potential disadvantages if the merger did not go ahead because of the lack of stability that might have on RBCH. However, West Hampshire CCG's patients had a significant amount of choice and whilst 30 per cent of patients from the west New Forest area go to RBCH, if there was a significant change and services were moved to PH, there would be other good quality options for those patients. This was relatively unusual for a rural population. Similarly, as much of this population would not travel to PH there was currently no significant benefit from competition between the two hospitals. However, more generally having competition across two hospitals could drive up patient quality, leading hospitals to think more about patient experience (including factors which matter to patients such as car parking). So as a commissioner, West Hampshire CCG did want to see choice.

6.215 As noted in paragraphs 6.114 to 6.123 above and Appendix H, we received evidence in the parties' internal documents which indicated that they undertook marketing and promotional activity with the aim of attracting additional patients. Some of RBCH's documents indicated that it had (or believed it had) the incentive and ability to affect referral patterns and the number of patients it treated, and that it competed with other healthcare providers (including PH, other hospitals in the wider area, and providers in the community for certain services). The parties' post-merger plans showed their awareness of the role of competition and provided some examples of the benefits of competition.

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<sup>225</sup> [www.competition-commission.org.uk/our-work/directory-of-all-inquiries/royal-bournemouth-and-christchurch-poole/evidence/initial-submissions](http://www.competition-commission.org.uk/our-work/directory-of-all-inquiries/royal-bournemouth-and-christchurch-poole/evidence/initial-submissions).

- *Conclusion on evidence of RBCH and PH competing*

6.216 In summary, we received evidence that the parties competed with each other prior to the decision to merge, in so far as they engaged in marketing and strategic behaviour to some degree. The evidence we reviewed suggested that competitive considerations tended to have been reflected more in RBCH's behaviour than in PH's.

#### *Outpatient services*

6.217 As discussed above in paragraphs 6.82 to 6.83, patient choices often involved a pathway of elective services and associated outpatient services and so our analysis generally looked at them together. This includes both outpatient services which follow on from elective inpatient episodes, and outpatient consultations and diagnostic tests which form the start of elective pathways, but not outpatient services that follow on from non-elective episodes, as discussed in paragraph 5.38. Follow-on services will generally be provided by the same provider as the inpatient service and would therefore be an extra source of revenue and profit (since we found that outpatient services are generally profitable). However, hospitals typically also offered initial consultations in specialties where they did not provide inpatient services and therefore the scope for competition could be broader in outpatient services than inpatient services.

6.218 The parties submitted that the dynamics of competition for outpatient services were markedly different to those for elective inpatient services, and that low barriers to entry will ensure that the market for outpatient services is highly contestable post-merger. We consider the arguments made in relation to low barriers to entry and expansion in Section 7.

6.219 We observed that some outpatient services were currently provided in the community by providers other than acute hospitals but the extent of this was small: in our data on patients in the wider Dorset area, only 12 per cent of outpatient services by volume and 7 per cent by value were provided by a community provider. The parties told us that patients generally receive precursors or follow-ups to elective treatment integrated with their inpatient activity from the same provider, and expressed the view that they could be regarded as part of the relevant inpatient market.<sup>226</sup>

6.220 The parties also provided us with a list of their consultants' current outpatient activity taking place under the control of community providers (ie where an entity other than an acute hospital was commissioned and paid for the work carried out, and the parties were in turn paid by that entity for their consultants' time). This was confined to a few specialties, and most clinics were infrequent and made up a small proportion of the consultants' time:

(a) RBCH had SLAs for its consultants to carry out community-based clinics in anaesthetics, orthopaedics, urology, rheumatology, eye unit and elderly medicine. This amounted in total to 7.75 PAs<sup>227</sup> per week (or 31 hours), and between 4 and 15 per cent of each consultant's contracted PA time. This equates to less than 80 per cent of one consultant's weekly contracted hours.

(b) PH had SLAs for its consultants to carry out community-based clinics in 16 specialties (including all those on RBCH's list except urology), amounting to 34.6 PAs per week or 138 hours. This made up, on average, 10 per cent of each

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<sup>226</sup> Joint main party initial submission, paragraph 202.

<sup>227</sup> PAs are programmed activities, or 4 hours of work within the normal working week Monday to Friday.

relevant consultant's contracted PA time, and was equivalent to the weekly hours of around 3.5 consultants in total.

- 6.221 The parties combined supply less than the equivalent of 4.5 consultants in total across only 17 specialties to community providers, and although other acute hospitals may also supply consultants, we did not see any evidence to suggest that this would significantly affect the overall scale. Therefore community providers only seem currently able to supply consultations to a small proportion of patients.
- 6.222 This, together with the other analysis we have reported in our competitive effects analysis, and particularly the small degree of switching to community providers in our patient survey,<sup>228</sup> suggests that any constraint provided by community providers is currently weak.

#### *Competition in the foreseeable future*

- 6.223 We then considered whether the parties' past competitive behaviour is likely to change in the foreseeable future, such that pre-merger evidence of competition is unlikely to be the most suitable guide for the level of competitive behaviour between the parties going forward, if the merger did not occur.
- 6.224 There were a number of reasons why the parties may not have been competing as strongly as they might be expected to given the NHS policy framework and we might expect them to compete more strongly in the foreseeable future because:
- (a) The merger has been in contemplation since at least 2011 by RBCH and since 2009/10 by PH, and possibly longer (see Section 4).
  - (b) One or both parties was internalizing the impact they have on the other already as a result of being part of the NHS.<sup>229</sup>
  - (c) Although the manner in which Dorset CCG commissions services from the parties does not remove their incentives to compete for activity, it has in our view dampened the manner in which they consider competing for activity (as shown by the change in RBCH's marketing strategies post-2009/10). The parties' perception that they may not be paid for genuine activity that is carried out over and above that agreed in their Indicative Activity Plan set out in their annual NHS Standard Contract was likely to have affected their competitive strategies. However, we considered that commissioners will increasingly not put in place contracts that do not correctly remunerate providers in accordance with the national tariff since these are not in line with NHS policy and the obligations imposed on commissioners by HSCA 2012, for the reasons set out in Appendix C, paragraphs 51, 52 and 72.
  - (d) Patients will become increasingly aware of their right to choose and information on quality in hospitals will become increasingly available and part of the decision-making process.
- 6.225 We took the view that for these reasons, absent the merger, the parties would be likely to compete more strongly in the foreseeable future.

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<sup>228</sup> No community provider was discussed with the GP by more than 7 per cent of RBCH patients or 11 per cent of PH patients. 12 per cent of PH patients said they would consider switching to Wimborne/Victoria if waiting times at PH increased, but no more than 2 per cent of RBCH patients mentioned a community provider. See paragraph 6.187 above.

<sup>229</sup> [REDACTED]

## Conclusion on the effect of the merger on actual competition in elective services

6.226 In summary, we found that:

- (a) The parties overlapped in relation to the provision of elective inpatient and outpatient services (within 19 specialties for elective inpatient services and 33 specialties for outpatient services that relate to elective services<sup>230</sup>). In accordance with our identification of upper and lower bounds described in paragraph 6.29 above we found that these services together accounted for approximately £[§] million for PH and £[§] million for RBCH at specialty level and £[§] million for PH and £[§] million for RBCH at treatment/diagnosis level (in FY 2011/12). Considering the overlaps at specialty level, these figures equated to [11–20] per cent and [21–30] per cent per cent, respectively, of PH's and RBCH's overall clinical income (£178.9 million for PH and £220.4 million for RBCH<sup>231</sup>) respectively.<sup>232</sup>
- (b) Choice is likely to be exercised by patients and/or GPs in relation to the majority of first consultant-led outpatient appointments that are made, and this choice will affect both outpatient and inpatient parts of the pathway.
- (c) Quality matters to patients and GPs and appears to be a factor in driving choice in many cases which generates scope for hospitals to compete with each other on quality in relation to services that they both provide. In principle we would therefore expect the parties to have incentives to compete with one another for patient referrals and that they would increase quality and flex capacity to do so.
- (d) The parties do have incentives to compete, albeit that uncertainties in relation to the degree to which the CCG will remunerate activity seem likely to have muted their incentives to attract additional patient referrals from one another to some degree. In coming to our overall conclusion, we also considered whether the parties' incentives to attract more referrals from one another were reduced (or altogether removed) by the nature of the shared consultancy arrangements in place; by capacity constraints because services were unprofitable; or because they would not expect to be remunerated in full by the CCG.
- (e) The parties are each other's closest competitors. Our analysis indicated that the merger would significantly reduce the proportion of the parties' revenue earned from referrals by GP practices where they currently face competition and therefore we expect the merger would significantly alter their competitive incentives.
- (f) The parties are aware of the role of competition and the importance of quality in maintaining or growing share of patient referrals.
- (g) There is some evidence of competition between the parties. We considered that the evidence indicated that the parties were competing with each other pre-merger, or at least prior to the point at which the decision was taken to merge.

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<sup>230</sup> We excluded from the 36 overlaps: maternity outpatient services, which we include within our assessment of maternity inpatient services below; and A&E and transient ischaemic attack outpatient services, both of which relate exclusively to non-elective services.

<sup>231</sup> [Joint main party initial submission](#), Tables 1 & 2.

<sup>232</sup> We noted that outpatient services could include both elective and non-elective elements and the parties were unable to provide us with data separating out those elements. Our understanding was that all outpatient overlap services, except A&E and maternity, involved elective overlaps (with these two exceptions, there were no specialties with an inpatient non-elective overlap but no inpatient elective overlap. The outpatient volume associated with these two specialties represented 5 per cent of PH's outpatient activity and 4 per cent of RBCH's outpatient activity).

(h) There are reasons why the parties would be likely to compete more strongly in the foreseeable future absent the merger.

6.227 We therefore concluded that the merger would be likely to lead to unilateral effects in the following markets:

(a) 19 elective inpatient services: general surgery, breast surgery, colorectal surgery, upper gastrointestinal surgery, pain management,<sup>233</sup> general medicine, gastroenterology, endocrinology, clinical haematology, hepatology, diabetic medicine, rehabilitation service, palliative medicine, cardiology, dermatology, respiratory medicine, rheumatology, geriatric medicine and gynaecology; and

(b) 33 outpatient services that relate to elective services:<sup>234</sup> general surgery, urology, breast surgery, colorectal surgery, hepatobiliary and pancreatic surgery, upper gastrointestinal surgery, vascular surgery, trauma and orthopaedics, ENT, ophthalmology, oral surgery, cardiothoracic surgery, anaesthetics, pain management, general medicine, gastroenterology, endocrinology, clinical haematology, hepatology, diabetic medicine, clinical genetics, rehabilitation service, palliative medicine, cardiology, dermatology, respiratory medicine, medical oncology, neurology, rheumatology, paediatrics, geriatric medicine, gynaecology and clinical oncology.

6.228 We expected that the loss of actual competition between the parties would result in less pressure to maintain and improve the quality of the services that they offer to patients. We found examples of the benefits of competition including focusing on waiting times, implementing best practice guidance, delivering innovative models of care, extending expertise and enhanced service provision and improving facilities to attract patients. We expected the loss of actual competition between the parties to manifest itself in a reduction (or lack of improvement) in quality in the overlap specialties in which competition would be removed. For the reasons set out in paragraph 6.31 above, we might also expect that the reduction in competition could manifest itself in a reduction in quality at the hospital level.

### *Potential competition in supply of elective services*

6.229 The *Merger Assessment Guidelines* set out two ways in which the removal of a potential entrant could lessen competition by weakening the competitive constraint on an incumbent supplier. The first way is where the merger involves a potential entrant that could have increased competition by entering. Such ‘actual potential competition’ is a constraint only if and when entry occurs. Second, the merger may remove an entity which is not in the market, but which nevertheless imposes an existing constraint because of the threat that it would enter if existing entities in the market raised their prices (or reduced the quality of their offering). A constraint from such ‘perceived potential competition’ may arise even though the Authorities do not believe that entry would actually occur absent a price increase. An entity is more likely to provide a constraint as a perceived potential competitor if its entry can take place without incurring any substantial sunk costs, and if it can happen within a year, though the Authorities’ assessment in any case will take account of the particular aspects of the market in question.<sup>235</sup>

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<sup>233</sup> In relation to services other than persistent pain management.

<sup>234</sup> We consider outpatient services that relate to non-elective services and to maternity services separately in the appropriate sections below.

<sup>235</sup> CC2, paragraphs 5.4.14–5.4.17.

- 6.230 We considered whether the RBCH/PH merger could in principle give rise to a loss of potential competition in relation to elective services because:
- (a) one of the parties is constrained in its behaviour pre-merger by the threat of entry by the other party (perceived potential competition); or
  - (b) one of the parties might, absent the merger, enter a new specialty in competition with the other merging party (actual potential competition).
- 6.231 In relation to (a), we had no specific evidence of perceived potential competition, ie that the behaviour of one of the parties was currently constrained by the threat that the other party might start supplying an elective service that it did not previously supply if quality of any service were to fall. In addition, we took into account the time-scales involved for the necessary investment and hiring of specialist staff in many specialties and the uncertainties on the revenue side associated with expanding into an activity that a hospital has not previously provided (see further paragraphs 5.24 and 5.25 and paragraphs 23 to 25 in Appendix F). Since this form of potential competition was likely to be a constraint only if the potential entrant could start serving customers before the incumbent could react, we are of the view that potential entry is unlikely to be a constraint. Therefore RBCH was unlikely to be currently constrained by the threat of expansion into new specialties by PH and vice versa, and therefore the merger has no impact in this regard.
- 6.232 We then considered whether the merger would be likely to lead to a loss of actual potential competition ((b) above). Actual potential competition provides a constraint only if entry occurs and to find a likelihood of unilateral effects under this theory we therefore need to believe that the entry by either party in respect of a service already provided by the other party would have been likely absent the merger.
- 6.233 PH told us that it had no specific plans for entry into new specialties in the absence of the merger since it did not have capacity and it would be difficult to recruit consultants of the requisite quality in competition with the established service nearby at RBCH. It said that the only area it believed it would be likely to expand was in neonatology (so that it could keep premature babies who are currently transferred to Southampton and beyond), which was unaffordable absent the merger. We note that in any event RBCH does not provide a neonatology service so even if PH had firm plans to begin to provide this service absent the merger, there would be no overlap with services provided by RBCH.
- 6.234 RBCH told us that, absent the merger, it was looking at expanding/entering into a [redacted] (which would be a subspecialty within [redacted]). More generally, RBCH said that due to the tight funding constraints, service expansion tended to be on the margins because grand service expansion was not affordable in the [redacted].
- 6.235 We also noted the following:
- (a) The Clinical Challenge Directorate Strategy Pack (which outlines quality and cost improvements for 2013/14 to 2015/16 on the assumption that the merger proceeds) discusses possible expansion in several areas including: [redacted]; [redacted] (at PH); [redacted]; [redacted]; [redacted] ([redacted] to PH); and [redacted] services.
  - (b) PH's Forward Plan Strategy Document for 2012/13 submitted to Monitor discusses key investments in infrastructure (including the investment in an MRI scanner to provide additional capacity), investment in additional and dedicated capacity to treat private inpatients separately, and increasing radiotherapy capacity if activity and commissioning intentions can justify investment (radiotherapy

was noted as one of the trust's key strategic services), all of which would be required absent the merger.

(c) RBCH's Forward Plan Strategy Document for 2012/13 submitted to Monitor noted that cost savings would be harder to achieve absent the merger and that these would need to come from other areas, such as reducing [redacted] services or reducing [redacted] and taking the service [redacted]. The document also discusses (i) an expanded [redacted] (with the agreement of an expanded cardiac primary percutaneous coronary intervention (PPCI) model for 24/7 care), (ii) investment in a further MRI scanner to increase capacity, (iii) agreement of a strategy across east Dorset for [redacted], and (iv) growth of endoscopy activity, especially bowel cancer screening.

6.236 On the basis of the information outlined above, assuming that the parties were to carry out the changes indicated in their Forward Plans, this would increase the scale of the overlap activity in specialties including clinical oncology and cardiology. The expansion of overlap activity (as opposed to new entry into a service not previously provided) would change the size of overlaps<sup>236</sup> but would not substantially alter our competitive effects analysis.

6.237 The parties told us that the entry outlined in paragraph 6.235(a) was merger dependent and therefore these changes were not outlined in their stand-alone plans. As such, we did not see evidence that the parties would be likely to carry them out in the counterfactual (such that they would be included in the overlap).

6.238 Furthermore, we did not receive any evidence from the parties or third parties that either RBCH or PH was planning to enter a new specialty. Overall, we therefore did not consider that entry by either party in relation to a new market was likely, and concluded that the merger would not lessen actual potential competition between the parties.

### ***Non-elective services***

6.239 We considered the effects of the merger on non-elective services (excluding maternity services, which we consider separately below). We considered whether the merger could result in unilateral effects in relation to non-elective services through a change to competition *in* the market (ie a quality reduction by the parties). We consider in a separate section of this report (starting at paragraph 6.315) whether there could be unilateral effects through a change to competition *for* the market (ie less competition in the event of a commissioner-led reconfiguration of or tendering of services).

### ***Parties' views***

6.240 The parties submitted that there was little, if any, competition 'in the market' for non-elective services because there was no patient choice (patients that were in urgent need of treatment were taken to the nearest clinically appropriate provider) and the pattern of service provision was driven by patient access requirements rather than a competitive process. When patients needed urgent treatment they would, in most cases, travel to the nearest hospital that provided this care, or the decision as to where they were taken would be made by an ambulance crew.<sup>237</sup> They told us that for there to be effective competition between them for non-elective services, patients would need to be able to choose their provider of non-elective services, thereby

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<sup>236</sup> See paragraphs 6.48–6.52.

<sup>237</sup> [Joint main party initial submission](#), paragraphs 61 & 62.

allowing them to ‘vote with their feet’ by electing to receive treatment at the hospital that they believed would best cater to their needs.<sup>238</sup>

### *Analysis of effect of merger on competition in the market for non-elective services*

6.241 To find an SLC in relation to competition in the market for non-elective services, we would have to establish that all of the following conditions apply:

- (a) the parties are close competitors;
- (b) patients and/or GPs have and exercise choice of provider;
- (c) quality influences patient choice; and
- (d) the parties have incentives to compete to attract patients.

6.242 We did not attempt to define exactly which aspects of quality are likely to be affected, but we assumed that similar considerations would be likely to apply as to elective services (see paragraphs 6.80 to 6.120 above). We also note that given possible entryways to non-elective treatment, one important parameter of choice may be the perceived quality of A&E departments.

6.243 Many non-elective services also included an outpatient element as a follow-up to an emergency treatment or attendance; patients would not generally have (and had no entitlement to) choice of provider for that follow-up. We therefore viewed this follow-up as part of the non-elective pathway (even though all outpatient services are technically regarded as elective services). Therefore if there was choice, it would be made at the initial non-elective stage and that, rather than the stage of the outpatient service, would likely be the main driver in any GP/patient choice. However, the revenue from follow-on outpatient services might still form part of a provider’s incentives to attract patients to its non-elective services (although it was small relative to non-elective income).

#### *Closeness of competition*

6.244 Our analysis found that there are areas of substantial overlap between the parties in provision of non-elective services: see paragraphs 6.24 to 6.54 above. Geographical considerations suggest that the merging trusts are likely to be each other’s closest competitors for many patients, given their close proximity and the distance to other providers. This is reflected in the results of our analysis of emergency patients’ attendances below.

6.245 The parties provided a submission to us analysing where their A&E patients would divert to in event of the hypothetical closure of one of their A&E departments.<sup>239</sup> The analysis showed that 90 per cent of patients would divert to the other trust.

#### *Extent of patient choice in relation to non-elective services*

6.246 The parties told us that there was no patient choice (patients that were in urgent need of treatment were taken to the nearest clinically-appropriate provider) and the pattern

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<sup>238</sup> *ibid.*, paragraph 228.

<sup>239</sup> *ibid.*

of service provision was driven by patient access requirements rather than a competitive process.<sup>240</sup>

6.247 We understand that there are a number of ways a patient can be classified as an emergency admission, which are summarized in Table 8. The second column shows the proportion of emergency admissions at RBCH and PH combined in 2012.

TABLE 8 Means of emergency admission

Means of admission	% of patients (RBCH & PH 2012)	Choice?
Via A&E	64	Not if via ambulance, otherwise yes
Via GP (emergency)	25	No right to patient choice; GP may exercise choice
Via outpatients clinic	2	No
Transfer	6	No
Other	3	No

Source: The parties.

6.248 We understand that patients being transported by ambulance will be taken to the hospital dictated by the ambulance service's protocols<sup>241</sup> and patients are unlikely to have any choice. Patients referred by an outpatient clinic at same hospital, or transferred for treatment not available at the hospital where they were first seen, are also unlikely to have choice. Patients referred by GPs might in theory be given a choice but do not have the right to choose, and we would expect the majority to be guided by their GP, who may in some cases exercise choice on their behalf where there are realistic alternatives.

6.249 However, patients making their own way to an A&E department without referral are 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 such patients go to their nearest A&E.<sup>242</sup> We examined this proposition. If a significant proportion of patients chose to go to 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.

6.250 We analysed data from the Dorset CCG on all emergency department attendees at RBCH and PH in 2011/12 and 2012/13 (up to end of January 2013) to determine the extent to which patients go to their nearest A&E. We found that the majority of attendees would have had a choice of hospital (with most of the remainder brought by ambulance).<sup>243</sup> We then analysed for each A&E attendee<sup>244</sup> which was their closest A&E department, based on their GP's location,<sup>245</sup> and whether they attended the nearest A&E. We removed those arriving by ambulance from the data (to restrict our analysis to those likely to have a choice). We found that 77 per cent of attendees

<sup>240</sup> *ibid*, paragraph 14.

<sup>241</sup> We have reviewed these protocols and they tend to be based on a combination of the urgency of the treatment, the type of treatment required, and the proximity of hospitals that can offer treatment. For example, patients with a heart attack within the RBCH/PH catchment area are transported to RBCH, and all children with burns to PH, [§<]. Patients with pre-existing conditions are, where possible, taken to the hospital of their treating consultant. We do not believe that there is any opportunity for patient choice in such situations. The only way in which trusts could influence the patient destination in the medium term is by increasing the range of services that they offer. Effects of the merger on the range of services offered are considered elsewhere in this report.

<sup>242</sup> [Joint main party initial submission](#), paragraph 61.

<sup>243</sup> We also noted that a high proportion of A&E attendees who went on to be admitted arrived by ambulance: 64 per cent of admissions at PH arrived by ambulance, with only 25 per cent self-referring. We thought this was a more reliable guide than the corresponding number for RBCH, where many ambulance arrivals bypass A&E.

<sup>244</sup> We could not identify those who were admitted and so it covers all A&E attendees.

<sup>245</sup> We excluded patients where the GP practice is not listed and patients attached to GP practices that are not in our data set (ie GPs who do not refer patients to the parties for elective services, so likely to be out-of-area GPs).

at PH and 78 per cent of attendees at RBCH were attending their nearest A&E department. 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.

- 6.251 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 were likely to have input from a healthcare practitioner which may help direct them to the most suitable provider. Of these patients we found that only 58 per cent at PH and 56 per cent at RBCH were likely to be attending their nearest A&E. 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 which hospitals are able or better suited to treat the patient's condition.
- 6.252 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; and (b) some patients will know that their nearest hospital's medical facilities are less well suited to them (eg if they have a recurring condition). Therefore we consider that a figure of approximately three-quarters indicates that most patients are likely to view proximity as an important factor in choice of provider in an emergency, although the reason for this may be that providers are perceived to be of similar quality.
- 6.253 Details of our analysis and other sensitivity checks carried out on the analysis are set out in Appendix H.
- 6.254 Overall, we found that there is some scope for choice by A&E attendees, and that some admitted patients were referred by GPs, who may in some cases be able to exercise choice on their behalf.<sup>246</sup>

#### *The influence of quality on choice*

- 6.255 We next considered whether quality influences choice in provision of non-elective services. We noted that the framework for patient choice (as set out in the AQP and PbR models and the surrounding regulation and guidance such as the NHS Standard Contract, the PbR Code of Conduct and Monitor guidance) is explicitly stated to apply to elective services and not to non-elective services. While some non-elective services have national tariffs and are therefore subject to a form of PbR, there is no guarantee of patient choice in relation to non-elective services. Perhaps because of this, limited information is publicly available to patients on which to compare the quality of non-elective services (with the exception of A&E departments where reviews are available on the NHS Choices website).
- 6.256 We also noted that in an emergency situation, patients are less likely to have time to research their various alternatives and will generally not have the benefit of GP guidance (which we found to be important to more than half of patients for elective services<sup>247</sup>). Whilst the number of patients attending their nearest hospital for non-elective services is similar to that for elective services, for attendances at RBCH and PH, we considered that this is likely to reflect different decision-making pathways in

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<sup>246</sup> Since the parties did not overlap in all services, not all A&E attendees or GPs would have been in a position to exercise choice between the parties.

<sup>247</sup> See paragraph 6.92 above.

relation to the different service types. That is, if the quality is similar for elective services between two hospitals, then location is likely to be a more influential factor in patient choice than when one hospital has markedly different quality. Whilst this will also be true for non-elective services, due to the emergency nature of A&E trips, location will sometimes of necessity override other factors relating to choice.

- 6.257 We therefore noted that whilst improving the quality of A&E departments could be expected to increase the volume of patients at the margins by appealing to those patients which have choice,<sup>248</sup> only some of even the limited group of A&E patients who have choice will be in a situation whereby they can exercise that choice on the basis of quality factors, rather than location, due to the time-critical nature of their problem and the lack of information available to them in that time.

#### *Incentives to compete pre-merger*

- 6.258 There are a number of further factors which may affect the parties' incentives to compete for non-elective patients pre-merger. Many of these are similar to those outlined above in relation to elective services (capacity, shared consultants, profitability, relationships with commissioners, quality regulation). In this section, we specifically consider two incentives which we think are of most relevance to an analysis of whether or not RBCH and PH are likely to be competing to attract additional non-elective patients. These are: the profitability of non-elective services; and the relationships with commissioners in relation to their procurement of non-elective services.
- 6.259 We also considered whether competition would give a provider an incentive to increase the quality of (a) particular non-elective treatments or (b) its A&E department. We thought the linkages were more indirect than in the case of elective services. We thought that (a) would have a limited influence on patient choice (given that in an emergency patients would not be in a good position to know what non-elective service they needed, or to consult with a GP or research it). We thought that (b) might attract more emergency patients in general but not necessarily patients that the provider wanted, eg they might be patients that would have to be transferred to another hospital, or patients in an unprofitable specialty. Therefore the parties are likely to have a lesser incentive to improve quality in order to attract additional patients, compared with elective services.

#### *Profitability*

- 6.260 We analysed the extent to which it might be profitable for a hospital to attract additional non-elective patients (ie they would make 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. We analysed the trusts' costs and revenues by specialty for the year 2011/12, taking into account the possible effects of the marginal rate tariff. Details of our methodology are set out in Appendix J.
- 6.261 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,<sup>249</sup> and

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<sup>248</sup> Or, equivalently, if quality reductions could be expected to lead to a loss of patients.

<sup>249</sup> There is some ability to adjust the baseline to reflect service reconfiguration since 2008/09 but 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.

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 was to incentivize providers to support the shift of care out of hospital settings and keep the number of emergency admissions to a minimum.<sup>250</sup> We noted that Monitor is reviewing the impact of this marginal tariff. However, the timing for any change to the marginal tariff rate and how it may change is insufficiently foreseeable for us to take account of in this report.

- 6.262 Currently PH was operating close to, but below, its threshold—it believed that the 30 per cent marginal tariff would start applying if it grew its revenue by [redacted] ([redacted] per cent) before incurring the marginal tariff on further relevant activity.<sup>251</sup> RBCH told us that it was operating at around 30 per cent above its threshold.<sup>252,253</sup>
- 6.263 We found that for RBCH, including the full nominal revenues (ie ignoring the marginal rate tariff), all non-elective services earned a contribution for the marginal patient when [redacted] were taken into account, and more than [redacted] earned a contribution even if [redacted] were also taken into account. Those that earned a negative contribution accounted for [redacted] per cent of non-elective income. However, applying the 30 per cent marginal rate tariff changed this outlook. Including only 30 per cent of revenues, [redacted] service lines become unprofitable at a variable cost level ([redacted]). If [redacted] were also taken into account, only [redacted] service lines out of 26 earned a [redacted].
- 6.264 Since RBCH was already exceeding its marginal rate baseline, and was likely to continue to do so, then—at 2011/12 prices and costs (and we have noted that prices can vary substantially)—RBCH would have an incentive to attract additional non-elective patients at the margin in most specialties, but that incentive would disappear if it attracted enough patients to trigger a change in semi-fixed costs.
- 6.265 Therefore it appeared likely that it would only have an incentive to attract patients if it could do so in a controlled way, ie targeting particular specialties and limiting the volume of additional patients. This is likely to be difficult in practice because (a) RBCH would have to be able to attract patients only in profitable specialties, whereas its major tools to attract patients (such as the perceived quality of its A&E department) may attract a wider range of patients; and (b) some relevant measures of quality may be difficult to adjust in a way that attracts a small number of patients without attracting so many that further costs would be incurred (for additional consultants, beds etc). If it were only able to attract patients across the board, the effect of the marginal rate tariff would be to make that unprofitable.
- 6.266 We found that for PH, including the full nominal revenues (ie ignoring the marginal rate tariff), [redacted] non-elective services earned a contribution for the marginal patient when only variable costs were taken into account, and [redacted] lines (accounting for [redacted] per cent of non-elective income) earned a contribution even if semi-fixed costs were also taken into account. Applying the 30 per cent marginal rate tariff would change this outlook. Including only 30 per cent of revenues, [redacted] service lines become unprofitable at a variable cost level (notably [redacted]). If semi-fixed costs were also taken into account, [redacted] service lines [redacted] earned a positive contribution.

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<sup>250</sup> 'Payment by Results Guidance for 2013-14', [www.wp.dh.gov.uk/publications/files/2013/02/Payment-by-Results-Guidance-for-2013-14.pdf](http://www.wp.dh.gov.uk/publications/files/2013/02/Payment-by-Results-Guidance-for-2013-14.pdf) (paragraph 89ff). The marginal rate emergency tariff does not apply to: activity outside the scope of PbR; non-contract activity; activity covered by the best practice tariffs, with the exception of the best practice tariffs which promote same-day emergency care; A&E attendances (although treatment resulting from an attendance does apply); outpatient appointments; or contracts with commissioners in the devolved administrations.

<sup>251</sup> [Joint main party initial submission](#), Table 1 & fn 24.

<sup>252</sup> *ibid*, paragraph 197 & fn 24.

<sup>253</sup> The parties told us that they expected the merged trust to have a single baseline based on the sum of the baseline at the two individual trusts, possibly with some small adjustments (for example, to exclude spells where patients were admitted to both sites, to avoid double counting).

6.267 PH was not currently exceeding its marginal rate baseline, but was close to it (it estimated that it was within £[redacted] million of it, or [redacted] per cent of its emergency activity). Therefore it would have more incentive than RBCH to increase its non-elective activity, even if doing so increased the level of semi-fixed costs, but within limits; and it may have wanted to retain a margin of error given the unpredictability of volume of emergency treatments, rather than trying to attract patients up to the benchmark. Therefore it appears likely that it would only have an incentive to attract patients if it could do so in a controlled way, ie targeting particular specialties and limiting the volume of additional patients. This is likely to be difficult in practice for the reasons discussed in paragraph 6.264 above. However, it would still have an incentive to compete in order not to lose profitable patients, ie there was a possible asymmetry for PH: it may have had an incentive not to lose patients, but no incentive to gain extra patients.

#### *Relationships with commissioners*

6.268 As noted in paragraph 6.155 above, we assessed the impact of the relationships between the parties and the local CCGs on RBCH and/or PH's incentives to compete. Our detailed analysis of these contracts in relation to non-elective services is set out in Appendix J. Our analysis was similar for non-elective services as for elective services above. However, Dorset CCG told us that it considered that it had a greater obligation to remunerate providers for their non-elective activities than for elective because providers had less ability to restrain their non-elective activities.

6.269 In theory, since RBCH exceeds its baseline for emergency activity, it should be reimbursed at 30 per cent for marginal activity above that baseline. We found that in practice, it has been reimbursed at between [redacted] and [redacted] per cent for non-elective activity above its agreed level (which was largely emergency). This suggests that it has been reimbursed, on average, more than it would expect to be under the marginal rate tariff.

6.270 In relation to PH, we found that for non-elective services, [redacted] agreed activity level and in 2012/13 [redacted]. The Dorset PCT cluster's reimbursement for non-elective services was based on actual activity in 2010/11 and 2011/12; [redacted].<sup>254</sup> We noted that PH's non-elective activity was below its 2008/09 baseline in each of these years.

6.271 Therefore, based on our understanding of the parties' past activity levels and commissioner payments for activity, we were of the preliminary view that the contracts alone did not remove incentives to compete.

#### *Conclusion on competition in the market for non-elective services*

6.272 We found that there were areas of substantial overlap between the parties. We found that many patients do not have a choice of hospitals (because they are transported by emergency services according to ambulance protocols). For those that do, we noted that there is no guarantee of choice (unlike in relation to elective services). We also noted that the link between quality and choice was likely to be less clear than with elective services, because there is less opportunity for patients to make a choice based on quality (they will have less opportunity to research it when they need emergency treatment and will generally not have input from a GP). The parties, especially RBCH, were not strongly incentivized to attract additional patients, and in some specialties may have no incentive to do so at the margin, under the 30 per cent

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<sup>254</sup> See Appendix J, paragraph 66.

marginal tariff. The link between quality of A&E department and attracting patients to a particular non-elective specialty also appears weak. For these reasons, taken together, we found that the proposed merger was unlikely to result in an SLC in relation to non-elective services or in relation to outpatient services that follow on from non-elective episodes.

## **Maternity services**

- 6.273 Maternity services are classified as non-elective services but not as emergency services. The issues that arise are different from other non-elective services, notably in relation to choice and to tariffs, and therefore we have assessed them separately.
- 6.274 The parties distinguished between three types of maternity services: (a) high-risk obstetrics, (b) midwife-led hospital births and (c) home births. Midwife-led hospital births and home births involve midwives but do not require the involvement of consultants. Only low-risk expectant mothers are eligible for this type of birth and not all mothers are low risk (see below). The remainder of mothers and babies will require the presence of a consultant and in some cases longer hospital-based care, eg neonatal intensive care. Those expectant mothers who are eligible for midwife-led care may encounter complications during birth and require transfer to a high-risk obstetrics unit. As a result, expectant mothers may choose to give birth in a hospital that offers these facilities, even if they are not classed as high risk.
- 6.275 PH told us that the Department of Health figures suggested that at initial classification 65.5 per cent would be 'low risk' with the remainder being high risk, and its review of its internal figures gave a similar result of 65.3 per cent. RBCH told us that an internal study in October to December 2012 suggested that 78 per cent of all expectant mothers were categorized as low risk at the beginning of the pregnancy and the remaining 22 per cent were high risk.
- 6.276 Nationally, at least one in five women needs to be transferred from a midwife-led unit to an obstetrics unit mid-labour.<sup>255</sup> This rate is more than one in three for first-time mothers.<sup>256</sup> At RBCH in 2012/13, 28.6 per cent of planned deliveries at RBCH were transferred to PH (including a small number of post-natal transfers).<sup>257</sup>

## ***The parties' activities***

- 6.277 PH provides a full range of maternity services. RBCH offers a small midwife-led unit and hence is only suitable for low-risk births, for which not all expectant mothers would be eligible. Any expectant mothers presenting a risk that requires obstetric cover cannot be handled by RBCH. Four thousand five hundred patients currently give birth at PH each year. In 2012 (and in FY 2012/13) around 450 patients gave

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<sup>255</sup> NHS: Birthplace in England research programme, final report part 1 ([www.netscc.ac.uk/hsdr/files/project/SDO\\_FR1\\_08-1604-140\\_V02.pdf](http://www.netscc.ac.uk/hsdr/files/project/SDO_FR1_08-1604-140_V02.pdf)), found a transfer rate from freestanding midwifery units to be 21.9 per cent. However, it excluded those ladies found to no longer be low risk at the onset of labour.

<sup>256</sup> The Birthplace study (p27) found that 36 per cent of first-time mothers are transferred from a freestanding midwife-led maternity unit.

<sup>257</sup> [Joint main party relevant customer benefits submission](#), section B. RBCH told us that the 40 per cent of first-time mothers transferred from Bournemouth included women that were unbooked (eg tourists) and those who presented unannounced that were not clinically suitable for birth at Bournemouth (some women present in labour via A&E or because they did not think they would make it to Poole).

birth at RBCH. Their combined income from maternity services was £[redacted] million in 2011/12 (including both inpatient and outpatient services).<sup>258</sup>

6.278 RBCH and PH also offer 'interface services' in the community. These interface services include: antenatal booking and surveillance; antenatal day assessment service; home birth service; and postnatal care services.<sup>259</sup>

6.279 The parties told us that all of the services listed above were also provided by University Hospital Southampton, Salisbury District Hospital and Dorset County Hospital. These services were commissioned and reimbursed by Dorset CCG (for expectant mothers from the Dorset CCG area). Where services were provided to women from outside the area, individual organizations were cross-charged accordingly.

### *Choice of provider*

6.280 We understand that expectant mothers will make their choice of where to give birth in consultation with their GP.<sup>260</sup> At the time of their choice, expectant mothers will be advised whether they are high risk or low risk and informed of their choices accordingly. They will be sent for a midwife appointment with the hospital of their choice (although this may take place in a community setting rather than a hospital, it will still be conducted by a midwife associated with the relevant hospital). If they opt for a home birth, they will still be able to choose a hospital. Although they are not forced to choose a consultant-led unit, high-risk expectant mothers will be strongly advised to do so.

6.281 Once they have chosen their care provider, they will typically remain with that provider for the antenatal services, the birth and a limited postnatal period, and that provider will be paid for the care according to its contract with commissioners. A small minority of low-risk expectant mothers may be reassessed as being high risk (but not vice versa) during the pregnancy and this may affect their choice of where to give birth; and as noted above, a proportion of expectant mothers who have chosen a midwife-led environment (eg RBCH or home birth) will develop complications and be transferred to a consultant-led environment (eg PH). Dorset CCG told us that if a patient transferred provider during the pathway, each provider would be paid for its respective part of the pathway.

6.282 PH has a 95 per cent bed occupancy rate, which it said was one of the highest maternity unit occupancy rates in the country and hence claimed that it did not currently have the capacity to accommodate unexpected increases in demand. PH said that it was clearly capacity constrained in the provision of these services and did not have access to the financial resources necessary to undertake investment in a new maternity unit.<sup>261</sup> Its maternity unit is housed in a separate building to the rest of the hospital and we understand that hence it is not possible simply to reallocate beds from other functions. The parties submitted that PH could not compete with RBCH for

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<sup>258</sup> They also earned an additional combined approximately £[redacted] million from community midwifery which is not included in PbR services (see paragraph 6.309) and which we have not included in our overlap analysis since we do not have SUS data for it.

<sup>259</sup> Antenatal services include an initial booking by the midwife in the expectant mother's home, in a GP surgery or in a children's centre, and multiple surveillance appointments throughout pregnancy. This is provided for all pregnant women. For expectant mothers with high-risk pregnancies only, antenatal clinic appointments in hospitals are undertaken by obstetricians. We understand that for the most part these interface services will be bound up with the patient pathway and so the hospital selected by each patient will also receive income and costs associated with them.

<sup>260</sup> The NHS Choices website informs expectant mothers that 'Your midwife can help you decide which hospital feels right for you. If there is more than one hospital in your area you can choose which one to go to' and provides information about each hospital's maternity services: [www.nhs.uk/conditions/pregnancy-and-baby/pages/where-can-i-give-birth.aspx#close](http://www.nhs.uk/conditions/pregnancy-and-baby/pages/where-can-i-give-birth.aspx#close).

<sup>261</sup> Joint main party initial submission, paragraph 67.

additional maternity volumes because it was capacity constrained, and RBCH could not compete with PH because it offered only a midwife-led service.<sup>262</sup>

- 6.283 However, we understand that as part of PH's £4 million investment in maternity services which would occur absent the merger and will finish in June 2014, it will increase the capacity of its maternity unit sufficiently to accommodate all mothers who currently give birth at RBCH. PH said that ideally it would operate at 85 per cent capacity and was currently at 95 per cent or above; taking on [redacted] RBCH's patients would return it to the present level, which would not be ideal. However, the investment would clearly remove capacity constraints at the margin.
- 6.284 The parties told us that RBCH faced strong competition for its maternity service from the University Hospital Southampton. RBCH told us that it could not compete effectively to attract mothers away from University Hospital Southampton and considerable investment would be needed to do so.<sup>263</sup>
- 6.285 The parties sought to illustrate the non-substitutability of RBCH's services with an example. On the morning of 15 August 2012 the senior management team at PH determined that the maternity unit had reached full capacity with every bed in the building occupied. However, despite the unit accepting no further patients on that day, no maternity patients were referred from PH to RBCH during this period. They told us that one high-risk patient was referred to Salisbury District Hospital, while three low-risk women opted for home births rather than travelling to RBCH.<sup>264</sup> On this day, there were no births at RBCH after 4am, so there was capacity and a full complement of staffing. RBCH's board minutes also addressed the capacity issue in general terms: '... in the event of Poole's unit being unable to take patients who have elected to deliver at the Poole obstetric unit, patients will not [redacted]. Poole will inform patients that they must go to [redacted].'

### *Competitive assessment*

- 6.286 We assessed whether expectant mothers had a choice of provider between PH and RBCH; whether quality was a factor that affected their choices; whether the parties were close competitors; and whether they would have an incentive to compete for expectant mothers before or absent the merger.

#### *Choice of provider and the role of quality*

- 6.287 Although maternity services are classed as non-elective, patients do have choice and they also have the opportunity to research and make an informed choice, and maternity services appear similar to elective services in this way. Therefore quality appears likely to be more important in maternity than in other non-elective services. The parties appear to believe that quality plays a role in expectant mothers' choice of maternity unit. They told us that:

... once the proposed upgrade of the maternity service have been realised, the merged entity will provide a stronger competitor to University Hospital Southampton. This means that some mothers in Dorset who currently elect to travel to University Hospital Southampton but would consider travelling to PH if it delivered an improved service, will now have such a choice. The parties believe that once they have

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<sup>262</sup> [ibid](#), paragraph 67.

<sup>263</sup> [Relevant customer benefits submission](#), 12 February 2013, paragraph 31.

<sup>264</sup> [Joint main party initial submission](#), paragraphs 64–66.

built the new maternity facility at PH, they will also be able to attract some mothers who currently give birth in Dorset County Hospital. These mothers may not consider PH as an option at present due to its poor existing facilities, but may consider PH if these facilities improved.<sup>265</sup>

6.288 RBCH told us that: 'If you look at where mothers want to go, they very much look at the facilities ... where I have worked in other organisations you can actively market that and invite women in to come and have a look around your unit in competition with other hospitals.'

6.289 PH said that in the context of maternity, 'patients understandably place quite a lot of emphasis on the environment, and Poole, as you have seen, is not a very pleasing environment and we think we lose business because of this'.

6.290 We also note that many reviews of RBCH and PH on the NHS Choices focus on maternity services. Therefore it appears that at least some patients do make an active choice of provider and that quality has a role in that choice; and that RBCH and PH are aware of this relationship and the role of quality in competition.

#### *Closeness of competition*

6.291 Table 9 sets out the number of births in the Dorset CCG region last year. It shows that PH was the provider for the majority of births with RBCH accounting for only 5 per cent and Dorset County Hospital accounting for approximately a quarter. It is not possible to identify the shares of low-risk births, although we know that all expectant mothers giving birth at RBCH will have been classified as low risk and hence RBCH's share of low-risk births will be higher than its share of all births.

TABLE 9 Number of births in Dorset CCG region, 2012/13

<i>Hospital</i>	<i>Births</i>	<i>Share %</i>
Dorset County Hospital	1,770	26
PH	4,051	61
Salisbury District Hospital	304	5
University Hospital Southampton	65	1
RBCH	359	5
Yeovil District Hospital	<u>121</u>	<u>2</u>
Total	6,679	100

Source: Dorset CCG data, CC analysis.

6.292 Based on the nature of RBCH's maternity unit, we expected that high-risk mothers would not have a choice between the two hospitals and that for some of the others, the ability to handle complications (if only as a fall-back) may be a more important factor than other aspects of quality for which the parties may compete.

6.293 However, the fact that some patients do choose to give birth at RBCH indicates that it is an acceptable provider for some patients and therefore that there may be a degree of competition between the parties for (some) low-risk mothers.

6.294 We also calculated the shares of births in the areas around each of RBCH and PH, using isochrones of different sizes (based on drive-times) and the results are shown in Tables 10 and 11.

<sup>265</sup> [Relevant customer benefits submission](#), paragraphs 31 & 32.

TABLE 10 Shares of births around RBCH

<i>Isochrone in minutes</i>	<i>PHFT share %</i>	<i>RBCHFT share %</i>	<i>Dorset County share %</i>	<i>Salisbury share %</i>	<i>Southampton share %</i>	<i>Number of births</i>
10	82.5	<b>15.9</b>	0.5	0.4	0.7	6,155
15	84.0	<b>14.1</b>	0.6	0.4	1.0	8,658
20	85.3	<b>10.0</b>	0.8	1.8	2.2	12,624

Source: Hospitals' SUS data, CC analysis.

TABLE 11 Shares of births around PH

<i>Isochrone in minutes</i>	<i>PHFT share %</i>	<i>RBCHFT share %</i>	<i>Dorset County share %</i>	<i>Salisbury share %</i>	<i>Southampton share %</i>	<i>Number of births</i>
10	<b>97.0</b>	1.4	1.2	0.3	0.0	5,965
15	<b>92.9</b>	5.5	1.1	0.2	0.4	9,564
20	<b>90.3</b>	7.9	1.1	0.3	0.4	12,761

Source: Hospitals' SUS data, CC analysis.

- 6.295 Table 10 shows that RBCH is a small provider compared with PH, since it attracts less than a fifth of mothers who live very close to it. (We note that around two-thirds of mothers are classified as low risk, and although some low-risk mothers choosing RBCH may need to be transferred and so would be likely to appear as a PH birth, RBCH should still be able to compete for half of all births.) Very few expectant mothers in the RBCH area go anywhere other than the parties' hospitals.
- 6.296 Table 11 suggests that PH faces very little competition in its local area, with around 90 per cent of all expectant mothers in its catchment area giving birth at PH. However, RBCH appears to be the strongest competitor in this area (for low-risk mothers); it would have a larger share among low-risk mothers. Very few expectant mothers in the PH area go anywhere other than the parties' hospitals.
- 6.297 To assess the total value of maternity services using SUS data, we noted that certain activities common to the parties (including births) were classified as obstetrics by PH and as midwifery by RBCH. We therefore combined these two specialties to give a total figure for maternity (including both inpatient and outpatient services). On that basis the combined value of maternity services (upper bound) was £14.6 million, and the overlap at treatment level was worth £6.6 million.
- 6.298 The parties submitted that if the quality of care at PH were to decline, the primary risk that it would face would be that more mothers would choose to travel to other units in the region that offered obstetric cover (eg University Hospital Southampton Dorset County Hospital), rather than to RBCH. We did not see any evidence to support this proposition. In particular, we noted that PH already claimed that its unit was capacity constrained and did not meet modern specifications for care. Given that, if there were good substitutes, we would expect that some mothers in the Poole and Bournemouth areas would *already* be choosing to give birth in another unit; but, as the tables above demonstrate, the only other unit that mothers in the area chose, to any significant degree, was RBCH.

### *Incentives to compete*

- 6.299 The parties told us that the maternity service was loss-making for RBCH ([REDACTED]).<sup>266,267</sup> According to RBCH's SLR reporting, its midwife specialty is loss-making as a whole. However, its revenue [REDACTED], suggesting that it is likely to be [REDACTED], ie [REDACTED] makes a contribution to overheads, and RBCH would have an incentive to compete for maternity patients. When its semi-fixed costs are taken into account, the service [REDACTED], suggesting that it would not be profitable for RBCH to [REDACTED].
- 6.300 PH's obstetrics specialty is (slightly) unprofitable as a whole, taking into account contribution to overheads. However, excluding that contribution to overheads, it is profitable, indicating that PH does have an incentive to compete for maternity patients. PH told us that [REDACTED]. This also suggests that, subject to capacity constraints, PH would have an incentive to compete for maternity patients absent the merger.
- 6.301 We understand that PH's maternity unit operates at close to full capacity while RBCH's unit is often under-utilized. This also suggests that RBCH is not actively (or successfully) competing for patients in maternity.
- 6.302 We asked RBCH why it would not hire obstetricians and operate a full maternity unit that would be able to accept high-risk births. It told us that it did not have the necessary facilities (such as dedicated obstetric theatres) and would need a large number of obstetricians and a large number of supporting junior staff, and a neonatal unit; these would involve considerable investment.
- 6.303 We considered that there may be an asymmetry in the competitive constraint. It is possible that RBCH is not actively attempting to attract maternity patients (as suggested by its less than full maternity capacity utilization), and that PH's presence does not affect RBCH's behaviour. However, RBCH would still be a significant constraint on PH and influencing PH's behaviour if a deterioration in PH's maternity services would lead to patients switching to RBCH. In other words, capacity constraints may remove PH's incentive to attract more expectant mothers (until its capacity increases), but they do not remove its incentive to maintain quality to avoid a reduction in demand for its maternity services. Pre-merger, a reduction in quality might see some (low-risk) expectant mothers divert to RBCH; post-merger, it would no longer have any significant competitors (based on current share of births in the local area in Tables 10 and 11) and we would expect that its incentives to maintain quality would be reduced.

### *Conclusion on maternity services*

- 6.304 We found that patients had choice between maternity services providers and aspects of quality appeared important to their choices. RBCH attracted a significantly smaller number of mothers compared with PH (and all would have been low-risk births), but it nevertheless appeared to be the only provider other than PH with a substantial number of births in the parties' catchment areas. We therefore thought it was likely to be the strongest constraint on PH. We considered that there may be an asymmetry in the competitive constraint and that RBCH may not have strong incentives to compete. However, RBCH would still be a significant constraint on PH and influencing PH's behaviour if a deterioration in PH's maternity services would lead to patients switching to RBCH. Finally, we found that PH, at least, had incentives to compete for expectant mothers, and those incentives were likely to increase once PH's capacity

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<sup>266</sup> The 30 per cent marginal rate emergency tariff does not apply to maternity services.

<sup>267</sup> [Joint main party initial submission](#), paragraph 138; [relevant customer benefits submission](#), 12 February 2013, paragraph 17.

had increased (which would happen absent the merger through the current refurbishment). Therefore we found that the merger could be expected to lead to unilateral effects in maternity services (both inpatient and outpatient services).

## Community services

- 6.305 We considered whether the merger may be expected to result in unilateral effects in the provision of community services supplied by both parties.
- 6.306 RBCH and PH both provide some community services. PH's total income from community services in 2010/11 was £[redacted] million, while RBCH's total income from community services in the same year was £[redacted] million. RBCH and PH told us that their community services were therefore dwarfed by comparison with other providers in the region, most notably DHUFT, which operates 16 community hospitals.<sup>268</sup>
- 6.307 We considered the degree of overlap between the parties in terms of competition 'in the market' in provision of community services and also the possible effects of the merger on competition 'for the market' (ie the possibility that the merger may lead to less competition in tenders for community services or in event of a commissioner-led reconfiguration and so worse outcomes for commissioners) (see further paragraphs 6.315 to 6.320).
- 6.308 RBCH and PH told us that they did not provide any community services under the NHS Standard Contract for Community Services. Under their NHS acute contracts they provide some interface services linking their hospital-based acute services and primary/community services in the surrounding area, within the Dorset CCG catchment. These are pulmonary rehabilitation and community neuro team (RBCH), community paediatrics (PH) and community midwifery<sup>269</sup> and discharge support services (both). They also provide some community services in the Dorset area that were funded under non-PbR arrangements with local commissioners. Table 12 sets out the community services provided by the parties in the year to March 2011.

TABLE 12 Value of community services provided by the parties, 2011/12

<i>PH</i>		<i>RBCH</i>	
Community Midwives—births	[redacted]	Community Midwives	[redacted]
Community Midwives—ante-natal visits	[redacted]		
Community Midwives—post-natal visits	[redacted]		
Community Nursing for Children	[redacted]		
Community Paediatrician Services	[redacted]		
Looked after children	[redacted]		
		Rehabilitation—OPAL (Older Persons Assessment and Liaison)	[redacted]
		Rehabilitation—CART (Community Assessment and Rehabilitation Team)	[redacted]
		REDS (Respiratory Early Discharge Scheme) overheads*	[redacted]
		Integrated Community Equipment Service	[redacted]
Total	[redacted]	Total	[redacted]

Source: RBCH and PH data.

\*REDS removed for 2012/13 pending review.

Note: The parties also both provide a general dermatology outpatient service. This is captured within our analysis of outpatient services and not included here.

<sup>268</sup> Joint main party initial submission, paragraph 18.

<sup>269</sup> The midwifery services fall under the scope of our analysis of maternity services; see paragraph 6.278.

- 6.309 Of the income received by each party, a significant proportion related to midwifery services, which was the only overlap between their services. The income related to midwifery was £[redacted] million for PH and £[redacted] million for RBCH. We consider the effect of these midwifery services separately in paragraphs 6.273 to 6.304 above.
- 6.310 The parties also provide services relating to offsite clinics. In almost all cases,<sup>270</sup> the income associated with these clinics is included within the main contracts under outpatient PbR activity. These services are effectively outpatient clinics which could be held within the RBCH and PH's hospitals and therefore we regard them as within the scope of our analysis of outpatient activity, rather than community services.
- 6.311 We understand that there is an intention to move more services out of an acute setting and into the community, a process which has already begun (including persistent pain and AQP contracts for dermatology, endoscopy and psychological therapy, as described above). This raises the question of whether there will be more community services where there might be competition in or for the market, and in particular whether RBCH and PH would, absent the merger, be likely to compete to provide such services.
- 6.312 We also considered whether entry into supply of community services was likely, which could counteract any potential adverse effects of the merger.
- 6.313 The parties told us that the Department of Health's strategy document, 'The NHS 2010-2015: from good to great – preventative, people-centred, productive', envisaged that other types of provider would be able to enter the market for community services relatively easily, following the move of community services to an AQP framework.<sup>271</sup> The CCP noted in its *Dartford* decision<sup>272</sup> that for the provision of each of these community services, providers would face broadly the same set of competitors and there were relatively low barriers to entry, at least for providers of other healthcare services. Dorset CCG told us that community services were easier markets to enter compared with large acute services which required acute support and back-up services. We understand that in particular there are many entities already involved with the supply of healthcare services to the wider Dorset area which could expand into new areas.

#### *Conclusion on community services*

- 6.314 With the exception of certain maternity services (which we considered separately in paragraphs 6.273 to 6.304 above), and a general dermatology outpatient service (which is captured within the scope of our outpatient analysis), there was no overlap between the parties' activities in the supply of community services. Therefore the merger would not reduce competition in the market, although it is possible that in the future more services will move into a community setting, and that there could be less competition in provision of these services as a result of the merger. However, we did not find that there were any such services that both parties would indeed be likely to supply in the counterfactual; and we considered that the relative ease of entry would be likely to offset any unilateral effects. We consider competition for the market in community services below.

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<sup>270</sup> The exception to this is a community skin cancer activity run by RBCH staff and paid for within a separate SLA, and which ceased in April 2013.

<sup>271</sup> [Joint main party initial submission](#), paragraph 44.

<sup>272</sup> [Report by the CCP on the merger of Dartford and Gravesham NHS Trust with Medway NHS Foundation Trust](#), 10 October 2012, paragraph 33.

## Competition for the market

6.315 In this section, we considered whether the merger would be likely to lead to reduced competition in relation to services which commissioners may consider procuring via a competitive process, because the merger will, in principle, reduce the number of suppliers that might compete to be a provider. 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). We refer to competition for services as a 'competitive tender', but in this we include any competitive process by which providers will be selected, which may or may not be a formal tender process.

6.316 There are generally two concerns in a merger when competition is 'for the market':

(a) in the event of a competitive tender there may be worse outcomes than pre-merger because there are fewer bidders (which may be reflected in commissioners receiving reduced value for money, including lower quality or, if prices are not set at national rates, higher prices); and

(b) suppliers on existing contracts may provide lower-quality services, knowing that commissioners have fewer options to replace them than pre-merger.

6.317 In this case we did not think that (b) was likely. As we discuss below and in Appendix L, commissioners told us that they would be reluctant to procure services via competitive processes to increase quality, noting the potential for destabilizing suppliers.<sup>273</sup> If an existing supplier was providing services at an acceptable level, commissioners would not be likely to use the potential for change of supplier as a tool to improve quality further. If quality fell below an acceptable level, they would initially work with the supplier to try to resolve this. If they had to reconfigure to address quality concerns, it would be a last resort and it would be unlikely that the incumbent supplier would be in a good position to win the tender.<sup>274</sup> Therefore we did not think that the level of quality at which services would be opened up to competition, or the chances of retaining the service post-reconfiguration,<sup>275</sup> would be significantly affected by the merger, and so the constraint on quality would also be unchanged. Therefore in this report we focused on (a).

6.318 We considered whether new guidance on service procurement might lead to a different process for service configuration (eg if more tenders would be required) but concluded that this was unlikely.

6.319 We separately considered whether the merger would be likely to substantially lessen competition for the market for (a) elective and non-elective services, (b) community services, and (c) specialised services. In each case we considered the history of competitive tendering; comments from the commissioners as to their intentions for procuring on a competition-for-the-market basis; and detailed evidence relating to the

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<sup>273</sup> See Appendix L, paragraphs 12 & 13.

<sup>274</sup> Monitor regulations require commissioners to evaluate the performance of existing providers on an ongoing basis and to consider using the mechanisms included in the contract to address any underperformance. If underperformance continues and it appears that the provider is no longer best placed to provide the services, it may be appropriate to consider terminating the arrangement where this is possible (Monitor, [Substantive guidance on the Procurement, Patient Choice and Competition Regulations](#), 20 May 2013, p15). However, this does not require commissioners to intervene to increase quality when a supplier is not underperforming.

<sup>275</sup> 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.

procurement of specific services, such as, for example, haematology. For details of our analysis please see Appendix L.

- 6.320 We did not find that the merger would be likely to give rise to SLCs in relation to competition for the market for any of the services mentioned above. Our reasoning for this was:
- (a) in relation to elective and non-elective services, the award of contracts in competitive situations has occurred rarely 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;
  - (b) in relation to community services, past tenders showed a range of bidders and that PH and RBCH have not been close competitors; and Dorset CCG, as the largest potential customer for these services, was not concerned by the merger; and
  - (c) in relation to specialised services, based on the stated position of the relevant specialised commissioner that it has no plans for the award of contracts in competitive situations, and the uncertainty about the way in which any such changes 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.

### ***Private healthcare services***

- 6.321 We considered whether the merger would be likely to give rise to unilateral effects in relation to provision of acute services to private (fee-paying) patients. With regard to private services, our concern was that the merger may lead to either an increase in prices paid (by self-pay patients or insurers), a reduction in quality, or both.

### ***Background***

- 6.322 The defining characteristic of these services is their source of funding: patients or their insurers pay directly for the provision of these services as opposed to NHS commissioning groups. These activities are not publicly funded through the NHS, and private healthcare providers—as well as NHS providers of services to private patients—have flexibility in choosing the services and specialties they wish to offer and in negotiating prices. We understand that services offered to fee-paying patients are likely to be routine elective services that are typically planned in advance and often follow a referral from a GP or another consultant. These services may be offered as outpatient, inpatient or day-case activities (see paragraph 5.27 for a description of the different type of services).
- 6.323 We analysed the extent to which the parties overlapped in the provision of private-patient activities and the extent to which other providers represented a competitive constraint in the provision of these services.
- 6.324 PH and RBCH provide a range of elective secondary care services to private patients and in that context offer both inpatient (including day-case) and outpatient services. The parties offer these services from their PPUs. Data submitted by the parties indicated that non-NHS services accounted only for a very small proportion of their clinical income (0.9 per cent for PH and 1.1 per cent for RBCH in 2011/12). The parties further argued that they provided a very small share of the total private activities offered in Bournemouth, Poole and in Dorset more generally. The parties

also told us that they ‘focus primarily on different private sector services. For example, only RBCH offers cardiac interventions and specialist radiology using the latest scanners, whereas only PH offers radiotherapy and complex cancer care.’<sup>276</sup>

- 6.325 In the last few years, the parties have both expanded their private patient services. As noted above, about three years ago RBCH established a cardiac unit that attracted patients and consultants to its private patient centre. Spire Southampton told us that, following the opening of a new specialist cardiology lab in RBCH, a number of its consultants moved their private cardiology work to RBCH. In September 2012 PH opened a new private inpatient unit and expanded its capacity by adding six new beds.

### *Third parties’ views*

- 6.326 When private insurers were asked by the OFT whether they had any concerns regarding the impact of the merger on the provision of private healthcare services, they indicated that they did not. AXA said ‘we do not consider the trusts to be in close competition with each other from a private patient perspective’. Aviva said that both RBCH and PH were listed to provide MRI and CT diagnostic treatments (scanning) to it. It went on to state that it had limited spend with these providers, and that other providers in the area were BMI Harbour Hospital and Nuffield Health Bournemouth Hospital, which most of its customers used. Aviva did not consider NHS hospitals, either separately or merged, as valid competition to the Nuffield and BMI hospitals. Bupa, another private insurance provider, said that ‘the trusts specialise in different areas i.e. Poole – oncology and Bournemouth – cardiology’. PruHealth said that NHS providers did not compete in the provision of private services as fee-paying patients tended to prefer dedicated private facilities, and that the merger would therefore have no impact on the range and cost of the activities offered.
- 6.327 We asked a number of private providers whether the parties provided private services that were not offered by any other provider in the area and if not, if there were any reasons to think this might happen in the future.
- 6.328 [redacted] told us that the parties did not offer any private services that were not offered by other providers in the area, and it was unaware of any reason to believe that this might change in the future. Spire Southampton supported this view, stating that ‘the merging parties do not provide any services that are exclusive to their sites only’. Nuffield Health Bournemouth Hospital said that, although RBCH and PH offered a full range of private services, it could offer most of the same specialties. In addition, it submitted that the RBCH private clinic was initially set up to provide activities not offered within the area but it had now expanded to provide a full range of private services. Spire Southampton and [redacted] told us that they believed themselves to be in direct competition with the parties for the provision of non-NHS funded activities.

### *Competitive assessment*

- 6.329 As described in Section 5, our starting point for analysis was that private services are in a separate product market from NHS services. We did not rule out the possibility that NHS services could provide some level of constraint, but note that in this case the nearest NHS competitors to the parties were situated a considerable distance away and unlikely to impose a significant constraint. We used data on activity (revenue) submitted by the parties to identify the specialties where one or both of the

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<sup>276</sup> [Joint main party initial submission](#), paragraph 287.

parties offered services to private patients. We looked separately at inpatient (including day-case) services and outpatient services.

### *Inpatient services*

6.330 Table 13 shows that one or both of the parties supplied inpatient services to private patients in 19 specialties in 2011/12. We noted that the majority of these specialties were also provided to private patients by a number of private competitors in the wider area.

TABLE 13 Value of private inpatient services provided by one or both of the parties and selected other private providers in 2011/12

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<i>Treatment specialty</i>	<i>PH</i>	<i>RBCH</i>	<i>Nuffield</i>	<i>BMI Harbour</i>	<i>Spire</i>	<i>BMI Winterbourne</i>
General surgery	[X]	[X]	[X]	[X]	[X]	[X]
Urology	[X]	[X]	[X]	[X]	[X]	[X]
Colorectal surgery	[X]	[X]	[X]	[X]	[X]	[X]
Vascular surgery	[X]	[X]	[X]	[X]	[X]	[X]
Trauma & orthopaedics	[X]	[X]	[X]	[X]	[X]	[X]
Ophthalmology	[X]	[X]	[X]	[X]	[X]	[X]
Oral surgery	[X]	[X]	[X]	[X]	[X]	[X]
General medicine	[X]	[X]	[X]	[X]	[X]	[X]
Gastroenterology	[X]	[X]	[X]	[X]	[X]	[X]
Clinical haematology	[X]	[X]	[X]	[X]	[X]	[X]
Cardiology	[X]	[X]	[X]	[X]	[X]	[X]
Dermatology	[X]	[X]	[X]	[X]	[X]	[X]
Respiratory medicine	[X]	[X]	[X]	[X]	[X]	[X]
Medical oncology	[X]	[X]	[X]	[X]	[X]	[X]
Gynaecology	[X]	[X]	[X]	[X]	[X]	[X]
ENT	[X]	[X]	[X]	[X]	[X]	[X]
Neurology	[X]	[X]	[X]	[X]	[X]	[X]
Obstetrics	[X]	[X]	[X]	[X]	[X]	[X]
Clinical oncology	[X]	[X]	[X]	[X]	[X]	[X]

Source: Data submitted by the parties and third parties, CC analysis.

\*The data provided by PH showed that it treated one patient in dermatology, but we understand that it was related to a non-elective procedure for an overseas patient and not to private healthcare activity.

**Notes:**

1. RBCH data relates to the value of all private patient activity (ie inpatient and outpatient). Data submitted by PH and third parties relates only to inpatient activity. The only exception is trauma & orthopaedics where PH value figure includes both inpatient and outpatient activity.
2. PH is the only provider that offers trauma orthopaedics. Spire includes only orthopaedic surgery. Spire does haematology, not clinical haematology. Spire, BMI and Nuffield do general oncology. Spire does gynaecology and obstetrics. In general medicine Nuffield includes gastroenterology, pain management and endoscopy.
3. Value data submitted by Nuffield and Spire covers the calendar year 2012. Value data submitted by the parties and the other third parties—BMI Harbour and BMI Winterbourne—covers the financial year 2011/12.

6.331 Consistent with our analysis of NHS services, we thought that Spire and BMI Winterbourne were unlikely to impose a significant constraint on the parties since they were located 27.9 and 24.8 miles respectively from the nearer of the parties. However, Nuffield is located in Bournemouth, 3.5 miles from RBCH, and BMI Harbour is in Poole, 0.2 miles from PH, and therefore we expected them to be able to impose a strong competitive constraint when offering the same services as the parties.

6.332 We calculated the shares of supply of the parties and the two other local private providers in the local area in the six specialties where PH and RBCH overlapped in the provision of inpatient services to private patients—see Table 14.

TABLE 14 Shares of supply of private inpatient services—value, 2011/12

Treatment specialty	per cent			
	PH	RBCH	Nuffield	BMI Harbour
General surgery	[0–10]	[20–30]	[<]	[<]
Trauma and orthopaedics	[0–10]	[0–10]	[<]	[<]
General medicine	[0–10]	[0–10]	[<]	[<]
Gastroenterology	[0–10]	[0–10]	[<]	[<]
Cardiology	[0–10]	[90–100]	[<]	[<]
Medical oncology	[0–10]	[0–10]	[<]	[<]

Source: CC analysis.

Note: We noted that RBCH's shares of supply are likely to be slightly overestimated as they include both inpatient and outpatient activity. However, this overestimation is likely to be minimal as inpatient activity is likely to be significantly more expensive than outpatient services; and where necessary we investigate further below using volume data.

6.333 In five of these specialties, general surgery, trauma and orthopaedics, general medicine, gastroenterology and medical oncology, the parties had a relatively small combined share of supply and a small increment and we therefore thought it unlikely that the merger would create unilateral effects in relation to these specialties. We noted that both PH and RBCH had plans to increase the scale of their private offering,<sup>277</sup> but we thought it unlikely that this would be on a scale that would change our conclusions, given the scale of Nuffield and BMI Harbour's operations. We investigated cardiology in more detail.

- *Cardiology*

6.334 The parties told us that they focused on different sub-specialties within cardiology—only RBCH provided interventional cardiology—and that they adopted different coding practices, particularly in relation to general surgery and general medicine, some of which would be more accurately captured under other specialties (as with NHS services).

6.335 To address the latter issue, we reallocated activities within general medicine and general surgery across specialties (see Appendix G for a description of the reallocation methodology). We performed the adjusted overlap analysis using volume data provided by the parties as the SUS data does not record the revenues generated by services offered to private patients.<sup>278</sup>

6.336 To obtain a better sense of the scale of treatment overlap, we considered only those activities where RBCH provided non-interventional cardiology to private patients.<sup>279</sup> We understand that PH, Nuffield and BMI Harbour do not offer interventional cardiology. Table 15 shows the extent to which the parties overlapped following our adjustments.

<sup>277</sup> See Section 4 above.

<sup>278</sup> We noted that the revenue data was coded as either missing or equal to zero in the majority of episodes in the parties' SUS data.

<sup>279</sup> The adjustment performed on cardiology can be described as follows:

- We defined as non-interventional cardiology the procedures provided by PH.
- We defined as non-interventional cardiology the same procedures carried out by RBCH.
- We defined as interventional cardiology the procedures that only RBCH provided.
- We looked at the split of RBCH's private patients between interventional and non-interventional procedures and considered only non-interventional activities.

TABLE 15 Inpatient adjusted overlaps—volume, 2011/12

Treatment speciality	Overlap analysis		Adjusted overlap analysis		Competitors	
	PH	RBCH	PH	RBCH	Nuffield	BMI Harbour
Cardiology (all treatments)	[£]	[£]	[£]	[£]	[£]	[£]
Cardiology (non-interventional only)	[£]	[£]	[£]	[£]	[£]	[£]

Source: Data submitted by the parties, CC analysis.

Note: PH data includes overseas patients. Nuffield and BMI Harbour data includes inpatient and day-case patients.

6.337 RBCH was the main provider of private inpatient cardiology services in the local area. A small fraction of RBCH’s cardiology was non-interventional and this accounted for about 7 per cent of its cardiology volume (we estimated that it may account for around £[£] of income).<sup>280</sup> PH was the second largest provider by value; it only offers non-interventional services, but even at this level the parties are the largest providers in the area: PH and RBCH’s shares of supply of non-interventional cardiology in the wider Dorset area would be about [40–50] and [40–50] per cent respectively, by value. The two local private hospitals earned relatively small amounts of revenue from activity in this area, with PH’s revenue being several times larger. Although Nuffield’s volume of activity was larger than PH’s, it was low-value activity, and we understand that neither Nuffield nor BMI Harbour offers the procedures performed by PH (implantation of pacemakers and of electrocardiography loop recorders<sup>281</sup>), which RBCH also provides. Therefore we thought it likely that PH exerted the main constraint on RBCH and that other local hospitals would not be able to replicate that constraint post-merger.

6.338 Consistent with our approach to NHS services, we primarily investigated the impact of the merger at the specialty level, and considered whether supply-side substitution would justify that or whether the market may be narrower. On a wide basis, we noted that RBCH was the largest supplier in the wider Dorset area, followed (on a value basis) by PH, with other providers having low revenue. However, even if we looked at a narrower segment of private inpatient cardiology (eg non-interventional cardiology, or at specific treatments such as the implantation of pacemakers and of electrocardiography loop recorders), the same conclusions would apply. Hence we found that the merger would be likely to result in unilateral effects in relation to private inpatient cardiology services in the wider Dorset area.

#### Outpatient services

6.339 We performed the same analysis for outpatient services. As RBCH was unable to provide a breakdown of its income across services—ie inpatient, day-case and outpatient—we used volume data submitted by the parties to identify the specialties that one or both merging parties provided to outpatients.<sup>282</sup>

6.340 Table 16 shows that there were 13 specialties offered as outpatient activities by one or both the merging parties to private patients in 2011/12. As for inpatient services,

<sup>280</sup> We calculated the percentage of RBCH’s non-interventional treatments on its 2011/12 volumes and assumed that the same percentage would apply to its income. However, we note that interventional cardiology is likely to be more expensive and therefore RBCH’s non-interventional income is likely to be overestimated. On this basis, Nuffield’s share of non-interventional cardiology would be about [£] per cent and BMI Harbour Hospital’s about [£] per cent.

<sup>281</sup> Both of these are designated as non-interventional services.

<sup>282</sup> Where available, volume data was broadly in line with value data for outpatient services.

the majority of these specialties are also offered by other private providers in the area.

TABLE 16 Private outpatient services provided by one or both the merging parties in 2011/12—volume

<i>Treatment speciality</i>	<i>PH</i>	<i>RBCH</i>	<i>Nuffield</i>	<i>BMI Harbour</i>	<i>Spire</i>	<i>BMI Winterbourne</i>
General surgery	[X]	[X]	[X]	[X]	[X]	[X]
Trauma & orthopaedics	[X]	[X]	[X]	[X]	[X]	[X]
ENT	[X]	[X]	[X]	[X]	[X]	[X]
A&E	[X]	[X]	[X]	[X]	[X]	[X]
Clinical haematology	[X]	[X]	[X]	[X]	[X]	[X]
Cardiology	[X]	[X]	[X]	[X]	[X]	[X]
Obstetrics	[X]	[X]	[X]	[X]	[X]	[X]
Clinical oncology	[X]	[X]	[X]	[X]	[X]	[X]
Urology	[X]	[X]	[X]	[X]	[X]	[X]
Ophthalmology	[X]	[X]	[X]	[X]	[X]	[X]
Respiratory medicine	[X]	[X]	[X]	[X]	[X]	[X]
Physiotherapy	[X]	[X]	[X]	[X]	[X]	[X]
Dietetics	[X]	[X]	[X]	[X]	[X]	[X]

Source: Data submitted by the parties and third parties, CC analysis.

Notes:

1. PH data includes overseas patients.
2. Volume data submitted by Nuffield and Spire covers the calendar year 2012. Volume data submitted by the parties and the other third parties—BMI Harbour and BMI Winterbourne—covers the financial year 2011/12.

6.341 Table 17 shows the volumes and the relative shares of supply of the parties and other private providers in the local area in the three specialties where PH and RBCH overlap in the provision of services to outpatients.

TABLE 17 Shares of supply of private outpatient services—volume, 2011/12

<i>Treatment speciality</i>	<i>PH</i>	<i>RBCH</i>	<i>per cent</i>	
			<i>Nuffield</i>	<i>BMI Harbour</i>
Trauma & orthopaedics	0.6	0.0	[X]	[X]
ENT	1.1	0.6	[X]	[X]
Cardiology	0.7	0.7		[X]

Source: CC analysis.

6.342 Table 17 shows that PH and RBCH had very small shares and both Nuffield and BMI Harbour provided significantly greater volumes than either of the parties for each of these outpatient services. Therefore, in our view it was unlikely that the merger would give rise to unilateral effects in relation to private outpatient services.

*Entry and expansion*

6.343 University Hospital Southampton stated that it had a very small PPU that generated less than 1 per cent of its clinical income, and that it would require a substantial capital investment to be able to compete in this market, and that Spire Southampton Hospital, located about 180 metres away, would be an important competitor. Dorset County Hospital told us that it did not have a private unit at the moment but it was considering establishing a small unit. However, consistent with our view on NHS services, we did not think that either would be geographically close enough to replicate the constraint removed by the merger. Among private providers, [X] told us that it was looking to increase activities in vascular surgery and in other specialties it currently provided. Spire Southampton, a more geographically distant competitor, said that, although it was not planning to expand its facility in the next year, it would start providing new medical treatments in addition to or in substitution for its current

treatments. In addition, when asked the extent to which it was easy to expand capacity, it told us that ‘the ease and cost of these measures varies according to the type of expansion. For example, Spire Southampton Hospital could increase the number of patient beds by six reasonably quickly and without significant expenditure.’

- 6.344 However, we did not find that entry or expansion by hospitals in the local area would be likely to replicate the constraint removed by the merger within an appropriate timescale.

### *Conclusion on private healthcare services*

- 6.345 We found that the parties overlapped in provision of a number of private services. In relation to most of these services we considered that the parties were likely to be constrained by competing providers of private services, which offered the same services in larger volumes than the parties and in close proximity to the parties. We found that there were no major alternative competing providers of inpatient private cardiology services in the relevant area which would be likely to constrain the merged entity. We therefore found that the merger would be likely to give rise to unilateral effects in relation to the supply of private inpatient cardiology services.

## **7. Competitive constraints which might offset effects of the merger**

### ***Buyer power***

- 7.1 We considered the extent to which the unilateral effects outlined in Section 6 in relation to elective services, outpatient services, maternity services and private cardiology services could be offset by buyer power.
- 7.2 In the provision of these services there is a split between those exercising choice and the commissioners that pay for the services. On the former, we did not consider that GPs and patients are likely to have sufficient buyer power to offset any potential quality decrease caused by the merger, as no GP/practice or patient is likely to account for a substantial proportion on an ongoing basis of either trust’s income in relation to any specific market (ie even at the level of inpatient elective services provided in a particular specialty, it is unlikely that a GP or practice would persistently account for a significant proportion of those services). As such, we considered that they would be unlikely in the majority of cases to have negotiating strength sufficient to require the merged entity to maintain quality levels.
- 7.3 We next considered whether the commissioners would be likely to have the ability to prevent the merged entity from dropping quality in respect of those specialties where it was no longer constrained by a competitor. We considered whether in these circumstances the commissioner would be able to easily switch (or threaten to switch) its demand to another hospital or otherwise constrain the merged entity. We note that we have already considered the effect of quality regulation as a constraint on decreases in quality in our competitive effects analysis. As such, we are considering here whether the commissioners could act to prevent a decrease in quality at the margins, in particular in an area where, for example, the parties both provided services of a high quality, levels over and above key regulatory requirements or in areas where the merged entity would not consider a decrease in quality such that it lost CQUIN payments or fell below a quality regulatory threshold to be a significant issue.
- 7.4 We discussed above in our consideration of competition for the market (see paragraphs 6.315 to 6.320) the extent to which commissioners had the ability and incentive to procure services using competitive processes. We noted that commissioners

could not generally remove AQP services (subject to providers meeting minimum criteria); and that for other services commissioners would be reluctant to do so given the scale, complexity and time involved with conducting such processes and the destabilizing effect on providers. Dorset CCG told us that it would be unlikely to consider reconfiguration as a way of improving quality (subject to acceptable standards being met).<sup>283</sup>

- 7.5 In our conclusion, we did not find that the commissioners would be likely to have countervailing buyer power to outweigh any unilateral effects created by the merger.

### **Market entry/expansion**

- 7.6 We considered the extent to which market entry or expansion was likely to occur in relation to the services described in Section 6 and whether such entry or expansion would be likely to mitigate any unilateral effects described in Section 6.

### **Parties' view**

- 7.7 The parties submitted that barriers to entry in the provision of outpatient and routine elective services were generally low in terms of equipment, expertise and governance requirements, reflecting the 'stand-alone' nature of many of these services.
- 7.8 They further submitted that the dynamics of competition for outpatient services were markedly different to those for elective inpatient services, and that low barriers to entry would ensure that the market for outpatient services was highly contestable post-merger. They said that a range of other providers would have both the ability and the incentive to establish their own competing outpatient services in the local area, either community hospitals, other acute providers renting space in community hospital or GP premises, or (in some cases) existing private providers. They said that all these providers would have ready access to the expertise, equipment and facilities required. They said that other providers would have a financial incentive to enter the market or step up their existing provision in response to a reduction in the quality of outpatient care at RBCH and PH.
- 7.9 They told us that this meant competition could be rapidly set up (less than a year) and covered community hospital and GP practices as potential (and actual) providers within Dorset currently opening up significant choice for patients.<sup>284</sup> In relation to governance requirements, they told us that the AQP model meant that as provider choice was most likely to arise for high-volume services with low fixed costs, barriers to entry for services covered by the AQP model were low. They noted that: 'The low barriers to entry for these services are underlined by recent policy initiatives to shift a range of outpatient services and some routine elective care from an acute setting into a community setting.'<sup>285</sup>
- 7.10 They submitted that it was therefore possible that any reduction in the quality of service provision in the Dorset area would act to spur the entry of new local providers.<sup>286</sup>

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<sup>283</sup> 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.

<sup>284</sup> [Joint main party initial submission](#), paragraph 180(c).

<sup>285</sup> *ibid*, paragraph 44.

<sup>286</sup> *ibid*, paragraph 283.

- 7.11 They also told us that new entry into NHS services by the private healthcare provider Circle was likely in Poole and that it had purchased a site in the city for a new hospital.<sup>287</sup> Circle told us that it had had an option on land in the Bournemouth area but this had lapsed in 2012. It did not plan to build a new hospital in Poole.

### *Analysis of entry and expansion*

- 7.12 In our view, based on the more detailed information provided by the parties and third parties regarding sunk costs of entry<sup>288</sup> and the views set out above, entry into inpatient services by anyone other than an existing acute hospital was not likely. Many outpatient services are linked to inpatient services through the care pathway, which would prevent another provider from offering a comparable constraint into this part of the pathway. In our view, any entry by other acute hospitals into new services was possible but unlikely to replicate the pre-merger constraint (consistent with our analysis of actual existing competition where we found that other acute hospitals already providing the same services as the parties would not effectively constrain the merged trust).
- 7.13 We separately considered whether entry or expansion by community providers into provision of outpatient services would occur in a manner which would be timely, likely and sufficient to address the substantial lessening of competition identified in relation to selected outpatient services.
- 7.14 In order for entry to be a constraint post-merger, it is necessary that (a) other providers can profitably begin or expand activity in response to a reduction in quality by RBCH and PH, and (b) patients would be willing to switch to those providers in sufficient numbers to make the quality reduction unprofitable.
- 7.15 As we discussed in Section 5, the requirements for outpatient services vary and are in many cases less demanding than for inpatient services. Some require complex diagnostic equipment only likely to be found in an acute setting, but many are consultations that require only the presence of a consultant. In particular, first consultations account for 31 per cent of outpatient episodes by volume and 44 per cent by value. However, our understanding is that the minimum requirement to offer outpatient services is access to consultant expertise. Given the large number of types of outpatient services we were unable to consider the competitor sets and costs of entry and expansion for each of these separately.
- 7.16 We thought that there was some scope for competition with respect to first outpatient appointments, but less scope in relation to outpatient treatments and diagnostics (which require specialised equipment and resources rather than just a consultant) and in relation to follow-ups to inpatient treatment. We thought that supply-side substitution was likely to be to some extent asymmetric (ie it would be straightforward to expand from treatment/diagnostics into consultations, but more difficult to expand in the opposite direction). Therefore, we concluded that it was unlikely that non-acute providers would be able to start providing more specialised outpatient services (primarily treatments and diagnostics) in response to a reduction in quality (relative to the counterfactual) by a merged PH and RBCH. We therefore would not expect entry to remove the SLCs we have identified.
- 7.17 We nonetheless considered whether entry was possible in relation to those outpatient services which did not require specialised equipment and resources, primarily

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<sup>287</sup> *ibid*, paragraph 284.

<sup>288</sup> Appendix F, paragraphs 23–25.

consultations. The main obstacle to entry or expansion would be access to consultants. We understand that it is unlikely that consultants will wish to work entirely for community hospitals, because they will want to be exposed to a wide range of challenging cases that principally arise in acute settings, but some consultants are willing to have clinics in community settings either during their contracted hours (for which their acute employer will be reimbursed for the time at cost) or outside contracted hours. We thought there would be some scope for community hospitals to attract additional consultants but this would be limited by consultants' other activity. The parties told us that community providers would have to negotiate strongly to get consultants unless it was to the benefit of the associated acute hospital.

- 7.18 The parties told us that outpatient services were generally profitable, as supported by their SLA data, and there was no reason to believe that they would be less profitable in a community setting. However, the parties also told us that consultants provided under SLAs would have to give up clinics or surgeries at the acute hospital in order to work in community clinics. They also said that this could be less efficient use of their time because (a) travel time was also involved (and usually billed for); and (b) community clinics were usually lower volume because Choose & Book did not work as well. The latter reflects the fact that fewer slots are available because community clinics worry about overbooking, especially when they have infrequent clinics; do not take fasttrack referrals; and can slow down the 18 week pathway. If consultant time is the main cost of provision, it seemed to us that services provided in the community were likely to be less efficient and therefore less profitable, which would limit the extent to which they would be attractive to community providers and the ability for such providers to agree terms with acute hospitals for use of their consultants.
- 7.19 On the second point, patient willingness to switch, we thought that this was not well-supported by the evidence we had seen. For example, our survey showed very little willingness to switch to community providers. No community provider was discussed with the GP by more than 7 per cent of RBCH patients or 11 per cent of PH patients. 12 per cent of PH patients said they would consider switching to Wimborne/Victoria if waiting times at PH increased, but no more than 2 per cent of RBCH patients mentioned a community provider.<sup>289</sup>

### *Conclusion on entry and expansion*

- 7.20 We therefore concluded that the unilateral effects outlined above were unlikely to be mitigated by entry.

### **Efficiencies**

- 7.21 Depending on likely size of efficiencies, we may examine arguments made as to efficiency gains from the merger, such as synergies from manufacturing and procurement. To form a view that the claimed efficiencies will enhance rivalry so that the merger does not result in an SLC, the CC must expect that the following criteria will be met: (a) the efficiencies must be timely, likely and sufficient to prevent an SLC from arising (having regard to the effect on rivalry that would otherwise result from the merger); and (b) the efficiencies must be merger specific, ie a direct consequence of the merger, judged relative to what would happen without it.<sup>290</sup>

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<sup>289</sup> See paragraph 6.188 above.

<sup>290</sup> CC2, paragraph 5.7.4.

- 7.22 The parties did not put forward any arguments in relation to efficiencies.
- 7.23 There is no evidence of any possible efficiencies that would be sufficiently rivalry enhancing to counteract any adverse impacts on the market resulting from the merger. As set out in Section 6, the parties constrain each other in relation to supply of overlap elective, outpatient, maternity and private cardiology services listed in paragraph 8.1 below and if this constraint were removed we would expect quality to decrease as a result of this loss of rivalry.
- 7.24 We separately consider the RCBs put forward to us by the parties as likely to arise from the merger in Section 9 of our report.

## Summary

- 7.25 In summary, we have found that the proposed merger would be likely to create unilateral effects in relation to some elective services and some outpatient services (the full list of specialties in which we found that unilateral effects would be likely is set out in paragraph 8.1 below) and in relation to maternity services (inpatient and outpatient) and to inpatient cardiology services to private patients. We found that the affected specialties together accounted for approximately [21–30] per cent (£[redacted] million) of PH's total clinical income (£178.9 million) and [21–30] per cent (£[redacted] million) of RBCH's total clinical income (£220.4 million).<sup>291</sup> In the context of quality competition, we noted that unilateral effects meant effects not only on clinical quality but other factors which patients and GPs took account of when coming to a decision on choice of provider (eg provider environment, waiting times, location of services). We found that commissioners would be unable to constrain the merged entity from decreasing quality and that entry was unlikely to occur in a timely and sufficient manner to counteract the unilateral effects identified in relation to the various specialties. We did not find efficiencies that would be sufficiently rivalry-enhancing to counteract any adverse merger impacts. We noted that the parties had put forward RCBs in relation to the merger and we consider whether these outweigh the SLCs we have identified in Section 9 of our report.

## 8. Conclusions on the SLC test

- 8.1 We have concluded that the proposed merger may be expected to result in an SLC in the Dorset area in the supply of the following services:
- (a) 19 elective inpatient services: general surgery, breast surgery, colorectal surgery, upper gastrointestinal surgery, pain management,<sup>292</sup> general medicine, gastroenterology, endocrinology, clinical haematology, hepatology, diabetic medicine, rehabilitation service, palliative medicine, cardiology, dermatology, respiratory medicine, rheumatology, geriatric medicine and gynaecology;
- (b) 34 outpatient services: general surgery, urology, breast surgery, colorectal surgery, hepatobiliary and pancreatic surgery, upper gastrointestinal surgery, vascular surgery, trauma and orthopaedics, ENT, ophthalmology, oral surgery, cardiothoracic surgery, anaesthetics, pain management, general medicine, gastroenterology, endocrinology, clinical haematology, hepatology, diabetic medicine, clinical genetics, rehabilitation service, palliative medicine, cardiology, dermatology, respiratory medicine, medical oncology, neurology, rheumatology, paediatrics, geriatric medicine, gynaecology, clinical oncology and maternity;

<sup>291</sup> Joint main party initial submission, Tables 1 and 2.

<sup>292</sup> In relation to services other than persistent pain management.

(c) one non-elective inpatient service: maternity; and

(d) one private inpatient service: cardiology.

## 9. Relevant customer benefits and remedies

### *Introduction*

- 9.1 We found that the merger may be expected to result in an SLC in 55 services. This section considers possible remedies to the SLC and resulting adverse effects that are described in Section 8.
- 9.2 We considered whether the merger would be likely to give rise to RCBs and whether any action should be taken to remedy, mitigate or prevent the SLC or any adverse effect arising from it.
- 9.3 We observed that in the case of mergers of foundation trusts, benefits accrue to patients, rather than shareholders; foundation trusts, as public benefit corporations, have as their principal purpose the delivery health services in England.<sup>293</sup> Patient benefits, and the assessment of them, are therefore important in such mergers. Monitor's statutory role in advising the OFT on patient benefits at phase one of the merger control process is a reflection of this.<sup>294</sup> Monitor's advice to the OFT on patient benefits, as well as the informed views of clinicians and local commissioners on the specific benefits proposed by the parties (and the plans for implementation of these locally) will carry significant weight when we consider the first element of the test for RCBs: namely whether or not the proposed benefits will be 'benefits' within the statutory definition of RCBs.
- 9.4 In this case Monitor provided advice to the OFT which we have taken into account in our assessment of benefits. However, we noted there had been changes in the parties' proposals since Monitor prepared its advice (see paragraph 9.46).
- 9.5 RBCH and PH discussed some aspects of changes that they wished to make after the merger (which were part of the RCBs that they asked us to consider) with local commissioners, some local councillors, MPs, staff and governors. As noted above, we recognize the relevance of these views to our assessment of patient benefits. However, we also noted that in many instances, the parties had presented only high-level views of possible changes and had not shared any specific details of the proposals. For example, there was a lack of clarity about the location of particular services (maternity, haematology, A&E) and there was generally a lack of detail surrounding local implementation and knock-on effects of changes on other services and patients. It was because the proposals were at a preliminary stage of analysis and planning that the local commissioners told us that whilst they had considered the principle of the changes proposed, the assessment of specific proposals could not be undertaken until after the merger when more information was available (see 'third party views' below).
- 9.6 The parties proposed to us that the merger would result in RCBs in five clinical areas: maternity; cardiology; haematology; A&E; and emergency surgery. In addition we considered the following benefits: other clinical benefits; financial savings; merger-avoided costs; merger-enabled investments; and balanced portfolio of services.
- 9.7 This section is structured as follows:
- framework for the analysis of remedies and RCBs;

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<sup>293</sup> See section 43 of the NHS Act 2006.

<sup>294</sup> [Monitor's advice to the OFT under section 79\(5\) of the Health and Social Care Act 2012](#), 11 February 2013.

- consideration of general benefits of hospital mergers;
- consideration of the effect of consultant cover;
- consideration of specific patient benefits; and
- consideration of appropriate remedies.

9.8 In the context of this aspect of our review of the merger, we took into account:

- submissions and evidence from the merger parties and commissioners;
- the views of experts, including [✂];
- submissions from third parties, including members of the general public who wrote to us or provided views at the drop-in session that was held on 5 September 2013 in the Bournemouth/Poole area;
- Monitor's advice to the OFT of 7 December 2012 (published 11 February 2013); and
- publicly available information and studies, for example studies evaluating the general benefits of hospital mergers.

### ***Framework for analysis of remedies and relevant customer benefits***

9.9 Having decided that the merger is expected to result in an SLC, we are required to consider whether remedies are appropriate. The questions we must answer are, in summary:

- (a) Should the CC itself take action to remedy, mitigate or prevent the SLC or any adverse effect which may be expected to result from it?
- (b) Should the CC recommend the taking of action by others, for example Government, regulators or public authorities, to remedy, mitigate or prevent the SLC or any adverse effect which may be expected to result from it?
- (c) In either case, what action should be taken and what is to be remedied, mitigated or prevented?<sup>295</sup>

9.10 The Act requires that, when considering possible remedial actions, we shall 'in particular, have regard to the need to achieve as comprehensive a solution as is reasonable and practicable to the SLC and any adverse effects resulting from it'.<sup>296</sup> Our guidance on merger remedies explains that to fulfil this requirement, we will seek remedies that are effective in addressing the SLC and its resulting adverse effects and will then select the least costly and intrusive remedy that we consider to be effective. We will also seek to ensure that no remedy is disproportionate to the SLC and its adverse effects.<sup>297</sup>

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<sup>295</sup> Section 36(2) of the Act.

<sup>296</sup> Section 36(3) of the Act.

<sup>297</sup> CC8, *Merger Remedies: Competition Commission Guidelines*, November 2008, paragraphs 1.7 & 1.9.

- 9.11 When answering the questions outlined in paragraph 9.9 above, we will also have regard to the effect of any action on any RCBs arising from the merger.<sup>298</sup> RCBs are defined in the Act and are benefits to relevant customers<sup>299</sup> in the form of lower prices, higher quality or greater choice of goods or services in any market in the UK, or greater innovation in relation to such goods or services.<sup>300</sup>
- 9.12 Additionally, to fall within the definition of RCBs, the Act requires that the CC believes that:
- (a) the benefit may be expected to accrue within a reasonable period as a result of the creation of the relevant merger situation concerned; and
  - (b) the benefit is unlikely to accrue without the creation of that situation or a similar lessening of competition.<sup>301</sup>
- 9.13 What is a reasonable period will vary on a case-by-case basis, depending for example on the nature of the proposed benefit and the circumstances of its implementation. For example, a large-scale building project may reasonably require a longer implementation period—with benefits not accruing to patients for a number of years—than a small project.
- 9.14 Remedies are conventionally classified as either structural or behavioural. Structural remedies, such as divestiture or prohibition, are generally one-off measures that seek to restore or maintain the competitive structure of the market; they address the reduction in rivalry that results from the merger at source.<sup>302</sup> Behavioural remedies are generally measures that aim to control the adverse effects expected from a merger rather than addressing the source of the SLC; they may require ongoing monitoring.<sup>303</sup>
- 9.15 The CC’s merger remedies guidance explains that in merger inquiries, we will generally prefer structural remedies to behavioural remedies because:
- (a) structural remedies are likely to deal with an SLC and its resulting adverse effects directly and comprehensively at source by restoring rivalry;
  - (b) behavioural remedies may not be effective and may create significant costly distortions in market outcomes; and
  - (c) structural remedies do not normally require monitoring and enforcement once implemented.<sup>304</sup>
- 9.16 We note in our merger remedies guidance that the CC will generally only use behavioural remedies as the primary source of remedial action where structural remedies are not feasible, or where the SLC is expected to have a short duration, or behavioural measures will preserve substantial RCBs that would largely be removed by structural measures.<sup>305</sup> We also note that this class of remedy is only likely to be

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<sup>298</sup> Section 36(4) of the Act.

<sup>299</sup> Relevant customers are defined in section 30(4) of the Act.

<sup>300</sup> Section 30(1)(a)(i) and (ii) of the Act.

<sup>301</sup> Section 30 (3)(a) and (b) of the Act.

<sup>302</sup> CC8, paragraphs 2.5 & 2.6.

<sup>303</sup> CC8, paragraph 2.11.

<sup>304</sup> CC8, paragraph 2.14.

<sup>305</sup> CC8, paragraph 4.1.

used on a temporary basis unless there is no alternative to a continuing regulatory solution.<sup>306</sup>

- 9.17 As explained in paragraph 9.11, the Act permits the CC to have regard to the impact of remedies on any benefits that are RCBs within the meaning of the Act. In line with the Act, our merger remedies guidance explains that we will take RCBs into account once we have decided on the existence of an SLC by considering the extent to which alternative remedies may preserve such benefits. We may modify a remedy to ensure retention of RCBs or may decide to implement a different remedy, or, in rare cases, may decide that no remedy is appropriate.<sup>307</sup> In the context of the CC's preference for structural remedies over behavioural remedies (see paragraphs 9.15 and 9.16), the merger remedies guidance explains that behavioural measures might be selected on the basis that they will preserve RCBs that would largely be removed by structural measures.<sup>308</sup>
- 9.18 We have considered remedies from paragraph 9.158 onwards below.
- 9.19 RCBs were considered by the OFT as part of its merger review, taking into account the advice on benefits provided by Monitor.<sup>309</sup> At that stage, the OFT was not satisfied that the RCBs would outweigh the identified SLC. The parties have continued to claim that benefits—which differed in some respects from those put forward to Monitor—will result from this merger and that these are RCBs within the meaning of the Act. It is open to the merging parties or third parties to identify possible RCBs. In reaching our decision as to whether any claimed benefits fall within the statutory definition, we have regard to the evidence provided to support any such claims. Our merger remedies guidance states: 'The merger parties will be expected to provide convincing evidence regarding the nature and scale of relevant customer benefits that they claim to result from the merger and to demonstrate that these fall within the Act's definition of such benefits.'<sup>310</sup>
- 9.20 In the following sections, we address whether there are possible benefits from the merger and whether they meet the statutory test for RCBs (see paragraphs 9.11 and 9.12 above); we then consider the statutory remedy questions. However, before doing so, we first consider evidence of benefits of hospital mergers in general.

### ***Consideration of general benefits of hospital mergers***

- 9.21 There has been some public comment to the effect that any prohibition of a merger of NHS hospitals would be disproportionate (see further below—views of third parties), on the basis that competition is not a significant quality driver in the NHS. We have considered the evidence regarding competition as a quality driver in Section 6 and Appendix H. We found examples of the benefits of competition including focusing on waiting times, implementing best practice guidance, delivering innovative models of care, extending expertise and enhanced service provision and improving facilities to attract patients. We expected the loss of actual competition between the parties to manifest itself in a reduction (or lack of improvement) in quality in the overlap specialties in which competition would be removed. We also expected that the reduction in competition could manifest itself in a reduction in quality at the hospital level.

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<sup>306</sup> CC8, [paragraph 4.31](#).

<sup>307</sup> CC8, [paragraph 1.15](#).

<sup>308</sup> CC8, [paragraph 4.1](#).

<sup>309</sup> Pursuant to [section 79\(5\)](#) of HSCA 2012, Monitor is required to provide advice to the OFT on the effect of the merger on any RCB claims as well as such other matters as Monitor considers appropriate. In this case, Monitor provided advice to the OFT on 7 December 2012 that was published on 11 February 2013.

<sup>310</sup> CC8, [paragraph 1.17](#).

Before turning to consider any specific benefits of the merger, we first considered whether a merger in the NHS should necessarily be regarded as beneficial for patients; in that context we reviewed empirical literature on the impact of hospital size and of mergers on clinical quality and efficiency in England and the USA. This is not intended to be a comprehensive review, nor would that be possible in the time available to us. For this reason we have given particular attention to survey articles rather than individual studies.

### *Effect of size*

- 9.22 A 2010 study by the CCP looked at data from 73 qualitative and quantitative studies published between 2000 and 2009 to establish whether a relationship between volume of hospital procedures and patient outcomes exists and, if so, the nature of this relationship—ie positive or negative.<sup>311</sup> The study reported some evidence that lower mortality rates are associated with higher volumes, but not sufficient to conclude that higher hospital and consultant procedure volumes cause better outcomes. It also found that the literature does not identify a minimum volume of treatments or consistent definitions of high volumes.
- 9.23 In 2012 Monitor concluded, following a literature review, that economies of scale exist in hospitals with fewer than 200 beds, and unit costs then remain constant up to approximately 400 beds.<sup>312</sup> However, above a certain size,<sup>313</sup> diseconomies of scale begin to appear because larger units or case mix in larger hospitals are more difficult to manage. In line with these findings, another recent evidence review by the Nuffield Trust found that costs remain fairly constant until approximately 600 beds, above which diseconomies of scale set in.<sup>314</sup>
- 9.24 However, a review of the evidence base for guidance on (a) which services are required to be co-located with A&E and (b) the minimum scale of those services found there was a 'dearth of cited evidence in documents produced by a wide range of organisations suggesting there may not a large amount of evidence, especially economic evaluations, available to cite'.<sup>315</sup>

### *Effect of mergers*

- 9.25 We also considered literature on the impact of mergers on hospital performance. An empirical study of the effect of mergers in the NHS was published in 2012.<sup>316,317</sup> The authors looked at the wave of hospital mergers in England between 1997 and 2006 and examined the extent to which performance of hospitals that merged changed

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<sup>311</sup> CCP, *The impact of hospital treatment volumes on patient outcomes*, Working Paper Series, Volume 1, Number 1.

<sup>312</sup> A study investigating the extent to which there are economies of scale and scope in healthcare markets and how these can be measured by Monitor, Frontier, August 2012: [www.monitor-nhsft.gov.uk/economiesofscaleandscope](http://www.monitor-nhsft.gov.uk/economiesofscaleandscope).

<sup>313</sup> Different studies find different thresholds. Monitor's paper concluded that the literature did not identify a consistent size above which diseconomies of scale come into play.

<sup>314</sup> Smith and Dixon, *Can NHS hospitals do more with less?*, Nuffield Trust, January 2012.

<sup>315</sup> Goudie R, Goddard M, *Review of evidence on what drives economies of scope and scale in the provision of NHS services, focusing on A&E and associated hospital services*, 2011, Centre for Health Economics, University of York.

<sup>316</sup> Gaynor, Laudicella and Propper, 'Can governments do it better? Merger mania and hospital outcomes in the English NHS', The Centre for Market and Public Organisation, working paper no 12/281, January 2012.

<sup>317</sup> The authors used a complex methodological approach to deal with a number of issues related to the nature of hospital mergers. They used an event study design that considers merged hospitals (the 'treated group') and identifies the effect of the merger (the 'treatment') on hospital performance compared to those of hospitals that did not merge (the 'control group'). As the effect of the 'treatment' can be identified only if the control group is appropriately selected, the authors used also a difference-in-differences matching approach. This procedure was used to identify the closest matches for each merged hospital taking into account hospital and geographic characteristics. Overall, this methodological approach allows the authors to control for a number of issues: (i) merged hospitals are likely to have different characteristics from non-merged hospitals; (ii) beneficial mergers are likely to be pushed forward before less beneficial mergers; (iii) there may be an anticipation effect of the merger that affect hospitals' performance before the event; and (iv) hospital mergers may be subject to political influence.

compared to those of stand-alone organizations. This study focused on performance in the period before the most recent NHS reforms, which affects the extent to which we can draw any inferences in relation to the current situation.

- 9.26 The authors matched hospitals according to a range of characteristics and compared the change in performance of those hospitals that merged with those that did not, looking at performance two years before the merger to four years after. The authors examined activity, staffing, financial performance and a large number of measures of clinical quality.
- 9.27 They found that mergers bring about a reduction in capacity but had very little systematic positive impact on productivity and clinical quality.<sup>318</sup> They also found that financial performance tends to deteriorate and waiting time to increase post-merger, relative to unmerged organizations.
- 9.28 This study incorporates data from a large number of hospital mergers in the NHS, some of which have characteristics similar to the merging parties, eg acute trusts, mergers within multiple hospitals in urban areas. However, we interpret the findings of this study with some caution as they are based on the average performance of post-merger hospitals and are therefore the results of a balancing exercise between mergers that have a positive impact and those that have a negative impact on productivity and/or clinical quality. The conclusion we draw is that we cannot assume that mergers will necessarily bring benefits.
- 9.29 Harrison (2011)<sup>319</sup> examined whether economies of scale exist for merging hospitals and then whether they capitalize on these potential cost savings post-merger, focusing specifically on cost savings due to scale economies. She used estimates of the expected costs for each merging hospital before the merger and of the expected costs for the merged entity to estimate the expected cost savings as the difference between the two. This estimation exercise was carried out under the assumption that hospitals maintained their pre-merger output mix and simply merged operations, to give a measure of potential economies of scale from the merger. She found that economies of scale are present for merging hospitals, and they realize these cost savings immediately following a merger. However, over time, cost savings from the merger decrease and the proportion of hospitals experiencing positive cost savings declines. In the first year after the merger, the average hospital reduced its costs by about \$3.5 million or about 5 per cent; but in years 2 and 3, post-merger costs were not statistically lower than pre-merger costs. This study uses data on American hospitals in the period 1984 to 1998, primarily non-profit, non-teaching hospitals. However, we interpret the findings of this study with some caution as US hospitals tend to be smaller than their UK counterparts.<sup>320</sup>
- 9.30 Another study, published in 2002, looked at the impact of mergers on service delivery, management structure, staff recruitment and retention.<sup>321</sup> The authors carried out a cross-sectional study involving nine trust mergers and reconfigurations that took place in London between 1998 and 1999. They also studied four mergers—one involving acute trusts, one involving mental health trusts and two involving community NHS providers. They collected data from the second and third year

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<sup>318</sup> Clinical quality is broadly defined to include length of stay, waiting time, readmission rate and mortality rate for different health problems (eg fracture proximal femur, stroke).

<sup>319</sup> Harrison, TD, 'Do mergers really reduce costs? Evidence from hospitals', *Economic Inquiry*, Volume 49, Issue 4, October 2011, pp1054–1069.

<sup>320</sup> Gaynor, Laudicella and Propper, 'Can governments do it better? Merger mania and hospital outcomes in the English NHS', *op cit*.

<sup>321</sup> Fulop et al, 'Process and impact of mergers of NHS trusts: multicentre case study and management cost analysis', *BMJ*, 2002, 325(7358), August 2002.

following the mergers, carried out 96 interviews with informants and analysed a number of public consultation documents.

- 9.31 The authors found that, overall, mergers had a negative impact on service delivery and that planned service developments were often delayed by at least 18 months. The study also showed that mergers brought about tensions between staff and between clinical staff and management of the two organizations. No positive effect was found on the ability of the merged entities to improve staff recruitment and/or retention. However, the study found that staff benefited from the mergers through improved clinical supervision, more training and opportunities for career development and more coherent professional management.

### *Summary*

- 9.32 Overall the surveys that we reviewed provided no convincing evidence that mergers in the hospital sector in general are beneficial. Whether a merger will be beneficial to patients will depend, for example, on the precise service changes proposed and the local characteristics of the merger.

### ***Consideration of the effect of consultant cover***

- 9.33 We next considered the effect of the level of consultant cover on clinical outcomes.
- 9.34 There is some evidence in support of the proposition that improved consultant cover can result in better outcomes. A large study of emergency admissions to all public acute hospitals in England for 2005/06 found that the overall adjusted mortality rate for all emergency admissions was 10 per cent higher in those patients admitted at the weekend compared with patients admitted during a weekday.<sup>322</sup> This, it said, was consistent with previous North American studies.<sup>323</sup> In England, 77 per cent of responding UK A&E departments reported that they had at least one emergency medicine consultant present in the A&E department over 12 hours on weekdays, but only 17 per cent reported such presence for 16 hours, and at weekends the number of A&E departments with consultant 'shop-floor' cover for at least 12 hours each day was just 30 per cent.<sup>324</sup> NHS England estimated that 4,400 lives in England could be saved every year if the mortality rate for patients admitted at the weekend was the same as for those admitted on a weekday.<sup>325</sup>
- 9.35 A literature review by the Academy of Royal Colleges found that there is a body of evidence that case-mix-adjusted mortality rates are higher for patients admitted electively or as emergencies to hospital 'out-of-hours', with most research focusing on weekends. However, it found that not all studies report a positive association. It said that contrary to expectations, elective hospital admissions may be more susceptible to error than emergency admissions, and that elective admissions at weekends may have a higher case-mix-adjusted mortality rate than emergency admissions. It concluded that the weekend effect is very likely attributable to deficiencies in care processes linked to the absence of skilled and empowered senior

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<sup>322</sup> Aylin P, Yunus A, Bottle A, Majeed A, Bell D, ['Weekend mortality for emergency admissions. A large, multicentre study'](#), *Qual Saf Health Care*. 2010 Jun; 19(3): 213–7.

<sup>323</sup> It cited Bell CM, Redelmeier DA, 'Mortality among patients admitted to hospital on weekends as compared with weekdays', *N Engl J Med*, 2001; 345:663–668 and Kostis WJ, Demissie K, Marcella SW, et al, 'Weekend versus weekday admission and mortality from myocardial infarction', *N Engl J Med*, 2007; 356:1099–1109.

<sup>324</sup> NHS England, 2013, [High quality care for all, now and for future generations: Transforming urgent and emergency care services in England. The Evidence Base from the Urgent and Emergency Care Review](#), p51.

<sup>325</sup> *ibid*, p15.

staff in a system which is not configured to provide full diagnostic and support services seven days a week.<sup>326</sup>

9.36 We have therefore found that increased consultant cover leads to better outcomes.

### **Consideration of specific patient benefits**

9.37 As noted in paragraph 9.19, patient benefits identified by the merger parties were considered by the OFT and Monitor as part of the phase one merger review process. Under the UK merger regime, the OFT may decide not to refer a merger to the CC if it believes, first, that the benefits put forward by the parties are RCBs within the meaning of the Act and, secondly, that they outweigh the SLC and any adverse effects of the SLC in all affected markets.<sup>327</sup> At the OFT stage, the clinical benefits identified by the parties related to five areas, namely: maternity, cardiology, haematology, A&E and emergency surgery. The parties also identified the following benefits: financial savings, other clinical benefits (eg 24/7 cover, increased scale), balanced service portfolio and merger-enabled investments. Monitor provided advice to the OFT on possible benefits in these areas having regard to the statutory definition of RCBs, and this advice was published on 11 February 2013.

9.38 Monitor advised the OFT that some benefits might accrue to patients in the form of higher-quality maternity and cardiology services. As explained further in paragraph 9.46 below, during our investigation the parties indicated that they no longer intended to reconfigure maternity services in the way they had originally proposed and which Monitor had found to be a benefit to patients. Monitor advised the OFT that it was not appropriate to treat some of the other claimed benefits as RCBs for the purposes of the OFT's assessment of the merger. Monitor found that some of those submitted benefits would not give rise to clinical benefits for patients, or were likely to accrue without the merger (for example, in relation to haematology, A&E and emergency surgery) and found that part of the benefits submitted regarding cardiology may be an RCB but would be time limited.<sup>328</sup>

9.39 In relation to A&E services and the benefit that the parties had put forward in terms of closer supervision of junior doctors and savings, Monitor noted that the parties had not provided detail such as numbers of middle grade doctors likely to be shared between the trusts, or the quantity of savings that would be delivered. Accordingly, Monitor did not accept that these would be RCBs for the OFT's assessment.

9.40 Similarly, in relation to emergency surgery and the benefits that the parties had submitted regarding combining trainee surgeons on to a single rota, the parties had not provided detail such as the numbers of trainees likely to be shared between trusts, or the clinical evidence of the benefits of a shared trainee rota. In the absence of further detail Monitor considered that there was insufficient evidence to accept this as an RCB.

9.41 In the case of other possible benefits put forward by the parties (for example, benefits in terms of financial savings, the ability to raise additional capital and benefits in terms of improved quality of services other than the five services addressed specifically in the merger parties' submission on benefits), Monitor noted in its advice

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<sup>326</sup> Academy of Medical Royal Colleges, *Seven Day Consultant Present Care*, December 2012, Appendix B.

<sup>327</sup> Section 33(2)(c) of the Act; OFT 1122 – *Mergers: Exceptions to the duty to refer*, December 2010, paragraph 4.4.

<sup>328</sup> OFT decision dated 8 January 2013 (ME/5351/12), paragraphs 146–148.

<sup>32</sup> *Monitor's advice to the OFT under section 79(5) of the Health and Social Care Act 2012*, 11 February 2013, paragraph 78.

<sup>33</sup> *ibid*, paragraph 93.

<sup>34</sup> *ibid*, paragraph 116.

to the OFT that it was not satisfied that the merger parties had submitted sufficient detailed evidence to support their arguments.

- 9.42 We have further detailed Monitor's conclusions in the relevant section of each benefit we have considered below.
- 9.43 Recognizing the potential significance of RCBs in this merger, we engaged with the parties on their benefits case at an early stage, sending them detailed questions based on Monitor's advice to the OFT and the parties' benefits submission prior to our provisional findings. Our starting point was to ask the parties for the further evidence which Monitor had indicated it would have required in order to find an RCB. In formulating our information requests, we also looked to Monitor's draft guidance on merger benefits, which further explains the types of information which might be used to show a benefit.<sup>329</sup> We repeated some of our requests for this evidence in a further set of detailed questions after publishing our Notice of possible remedies. We continued to request clarifications and supporting evidence from the parties and commissioners throughout the second stage of our analysis.
- 9.44 The parties have proposed to us RCBs in five clinical areas: maternity; cardiology; haematology; A&E and emergency surgery.
- 9.45 These areas are broadly consistent with the clinical benefits the parties submitted to the OFT and Monitor but, as noted in paragraph 9.46 below the parties amended their benefits case in some respects. In addition, we have considered the following benefits:
- other clinical benefits;
  - financial savings;
  - merger-avoided costs;
  - merger-enabled investments; and
  - balanced portfolio of services.
- 9.46 In the course of our inquiry the parties have made various submissions in respect of RCBs. The five clinical areas in respect of which the merger parties claimed RCBs have been constant, but there are aspects of the parties' claims that have altered. For example, the parties' claim that the reconfiguration of maternity services would involve the [X] was withdrawn. This was part of the benefit proposed to the OFT and Monitor by the parties and was included in the initial RCBs submission the parties made to the CC on 12 February 2013. It was accepted as a benefit by Monitor.
- 9.47 The parties had originally submitted to the CC that the five clinical services would be reconfigured in a particular way, for example a new maternity unit would be built at PH and haematology services would be consolidated at PH.<sup>330</sup> The CC invited comments on these benefits in its Notice of possible remedies dated 11 July 2013. Following publication of this notice, the parties submitted a revised statement of benefits. For each of maternity, haematology, A&E and emergency surgery, the parties identified benefits by reference to a number of mutually exclusive options.

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<sup>329</sup> [Consultation on draft Monitor guidance on merger benefits](#), 27 March 2013.

<sup>330</sup> The parties stated that all such changes were 'subject to any and all necessary legally compliant clinical, stakeholder and public engagement and consultation on service change'.

The CC invited views on this in the Supplementary Notice of possible remedies published on 12 July 2013.

- 9.48 The implication of the revised statement of benefits was that for each of these clinical services, the parties included an additional option of ‘no change’. For example, in respect of the proposed maternity benefit, the Supplementary Notice of possible remedies identified as an option ‘maintaining the current configuration of an obstetric and midwife delivered service at PH and a midwife delivered service at RBCH’. We found that the option of ‘no change’ would not be an RCB within the meaning of the Act in this case because we found in the counterfactual that the pre-merger situation—in terms of the quality and range of services—would be likely to be maintained absent the merger (see Section 4).
- 9.49 In relation to the benefits where the parties have included alternative reconfiguration proposals (for example, in the case of the haematology benefit, whether inpatient services would be consolidated at RBCH or PH), we have taken into account the likelihood of either being implemented (ie accruing). For a number of the relevant services the parties do have a preferred option (for example, the preferred site for the consolidated haematology inpatient services is PH). The parties have emphasized to us that any such reconfigurations are ‘subject to any and all necessary legally compliant clinical, stakeholder and public engagement and consultation on service change’ and that this applies to statements they have made regarding preferred options for reconfiguration.
- 9.50 Where the parties have put forward alternative locations for services (maternity, haematology, A&E and emergency surgery), as a starting point we would expect that the benefit would be similar regardless of location. We recognize that there may be some differences, for example, some of the costs of implementation may vary depending on the location, and there may be benefits in terms of co-location with other clinical services, or a higher number of patients may have to travel further.
- 9.51 We note also that the parties’ proposals relating to possible benefits, at least in some respects, are not well developed.<sup>331</sup> This affected the parties’ ability to specify the precise patient benefits, the commissioners’ ability to comment on the specific benefits and our ability to assess them.
- 9.52 We did not expect the parties to have: (a) publicly consulted on the benefits (in respect of changes where consultation would be required for reconfiguration, see 9.57); (b) to have taken a firm decision to proceed with them; or (c) to have implemented them at this stage. However, we did expect that for each benefit the parties would have taken a number of steps as outlined below:
- Determined what the preferred proposal was (we determined this based on our review of the parties’ internal documents) and provided evidence for the need for change.
  - Established the groups necessary to evaluate the benefit, including, for example, a clinical advisory group, programme board, commissioner review group and any other commissioner decision making bodies.

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<sup>331</sup> This is consistent with the parties’ public consultation on the merger and the proposed governance arrangements for the merged entity (see paragraph 3.3) which noted that ‘Future service developments will be led by local commissioners and will be fully consulted upon at the time any proposed change is being considered and before any decisions are made’. See [www.rbch.nhs.uk/assets/templates/rbch/documents/about\\_the\\_trust/public\\_consultations/healthy\\_future/merger\\_doc.pdf](http://www.rbch.nhs.uk/assets/templates/rbch/documents/about_the_trust/public_consultations/healthy_future/merger_doc.pdf).

- Developed a model of care in consultation with the relevant groups set out above as appropriate.
  - Produced an assessment of the clinical benefits (and any disbenefits) as well as a robust assessment of the financial or economic viability of the plans.
- 9.53 We understand that the above are the first in a series of steps which NHS providers and their commissioners will take for significant service reconfigurations (see further the section below on consultation requirements).
- 9.54 We note that the steps set out in paragraph 9.52 are not a prescriptive list which we applied to each benefit. Rather, it is indicative of the type of information we expected to see for some of the more extensive benefit proposals (eg A&E and emergency surgery reconfiguration). The level of information required to demonstrate a benefit will vary on a case-by-case basis.

### *The effect of consultation requirements on RCBs*

- 9.55 We are required to decide whether benefits that have been proposed would be unlikely to accrue without the merger or a similar lessening of competition.<sup>332</sup> We considered to what extent requirements to consult on substantial service developments/ variation<sup>333</sup> would impact on the likelihood that benefits put forward by the parties would accrue, and would do so within a reasonable time from the merger.<sup>334</sup>
- 9.56 Service reconfiguration involves a number of steps. The first is to determine what options for service configuration there are and to gather evidence for change; this includes a listening exercise with stakeholders and the public. A programme board, which is likely to include commissioners, will then be established, as well as advisory groups of patients and clinicians. This may be followed by a pre-engagement consultation with the public on models of care, and, where appropriate, a review by the National Clinical Advisory Team and a consultation with the Health Overview and Scrutiny Committee. There may be informal engagement with the Independent Reconfiguration Panel (IRP). This may then be followed with a formal consultation (where the proposed change is substantial), together with public events to discuss and obtain feedback. Finally, feedback will be analysed and a recommendation will be drawn up by the programme board. Providers will then give a view on the recommendations and a decision will be taken by the commissioners.
- 9.57 In general the fact that merger parties have not conducted a public consultation may not be an insurmountable obstacle to a finding that a proposed benefit would be likely to accrue. However, the merger parties will need to provide a robust clinical evidence base in support of the relevant reconfiguration. In this case, the parties' proposed benefits in haematology, cardiology, A&E and emergency surgery all include reconfiguration. We found that these services were not RCBs for reasons unrelated to consultation requirements, and therefore we do not set out in our analysis any views as to whether consultation would or would not impact on the likelihood of these proposed benefits accruing.

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<sup>332</sup> Section 30(3)(b) of the Act.

<sup>333</sup> Section 244 of the NHS Act 2006. There are also more general requirements to involve the public in the planning of healthcare services (NHS Constitution and section 242 of the NHS Act 2006).

<sup>334</sup> Section 30(3)(a) of the Act.

- 9.58 Further detail on our consideration of the effects of consultation requirements on RCBs is set out in Appendix M (see paragraph 326 onwards).

### *Third party views on benefits*

- 9.59 During the course of our inquiry we sought and received comments from a large number of third parties on the potential benefits and disbenefits of the merger and the proposed service changes. This evidence came from a wide range of sources including the general public, governors and staff of the two foundation trusts, local commissioners, MPs, and others. We also held a drop-in session in the Bournemouth/Poole area on 5 September 2013 to gather views on the merger.
- 9.60 We held hearings with the commissioners, who all believed that the merger would provide benefits. However, although the commissioners supported the merger in general, they had not been provided with details of the benefits to patients of the proposed service reconfigurations and therefore could not provide evidence on whether the specifics of any proposals put forward by the parties would be a benefit. The commissioners generally emphasized that they considered that the loss of competition was small, particularly when compared with the detrimental impact for local people if the merger did not proceed.
- 9.61 Dorset CCG told us that it could not be sure that the specific benefits that were put to us would be the ones that would occur. It told us that the benefit it saw was of the two organizations coming together and that any changes that the parties wished to make would be subject to public consultation and the CCG may or may not agree with what it was saying. Dorset CCG told us that at this stage the parties had not shared detailed business plans with it but that Dorset CCG would become involved if the parties created a detailed plan. It told us that:

As commissioners we are looking increasingly at integrated service provision, clinical outcomes, and cost effective solutions, we are less concerned about the level of competition purely for competition sake and we see the outcomes for the patient as more important. If anything, multiple organisations can lead to increased risks and complexities around patients falling through the 'gaps' in service provision between different organisations. The reality is that it would be incredibly difficult for the CCG as a Commissioner to push everything through via 'market forces' and tendering, due to the complexities and interdependencies that already exist between the Trusts and the specialties within them. The theoretical world of a pure market would simply not match the reality of what could be achieved within a reasonable timescale. The merger would provide a strong foundation from which the CCG as Commissioners, can implement our local improvement plans. Whilst competition has a part to play in any Commissioners 'tool kit' the use of cooperation must also play its part, and for the services that are the focus of the merger benefits case, we would see cooperation through the merger leading to a better solution for the patients than a purely competitive process.

- 9.62 In its letter to the CC dated 24 July 2013, Dorset CCG stated that:

prior to any significant service change, the merged trust must make arrangements for users (whether directly or through representatives) to be involved in planning of services and how they are provided. This needs to give due regard to any changes in accessibility of service, the impact of the proposal on the patients and wider community, and

methods of service delivery. Given that any service reconfiguration would need to go through this process, it is our view that the merger itself would not directly affect the current services or choices available to the patients. Even though the merged trust may have **plans** to reconfigure services, the above process would still need to be undertaken, in exactly the same way as it would for the two trusts as they stand now. [and]

We believe that patient interests are best served if the question as to whether or not there is any significant impact on choice and competition is asked as part of the consultation process associated with an individual service reconfiguration, rather than at the point of the merger. We see the merger as being part of the supporting management and organisational infrastructure that enables any service offer to be made to the parties, and that the removal of some of this current infrastructure would be of benefit to the tax payer.

- 9.63 Dorset CCG also told the CC that the consultation process with the merger would be a quicker and easier process. It stated that if the merger took place, it would feel confident that this would smooth the process of getting the proposed reconfigurations through the consultation processes. If Dorset CCG were dealing with two separate trusts, it expected that the trusts would compete with each other and challenge the process, and this would make it much more difficult for it to achieve what it wanted for patients.
- 9.64 It further noted that for the parties to incur significant costs at this stage without there being a reasonable chance of implementing such proposals would be a waste of taxpayer funds—the parties should not have undertaken the level of detailed work the CC was requesting on the proposed schemes without having detailed discussions with the commissioners and wider stakeholder consultation. It noted that each one of the benefit cases was a sizeable task in its own right.
- 9.65 NHS England (Wessex) told us that no concrete plans had been shared with NHS England for any of the proposed service reconfigurations put forward in the parties' benefits case, and that if the merger went ahead it was not a foregone conclusion that any service reconfiguration would happen. NHS England (Wessex) also noted that some of the service reconfiguration could happen irrespective of the merger.
- 9.66 The NHS Commissioning Board (South of England) submitted that,

In our assurance role of the quality and outcomes which CCGs are able to secure from their local providers we believe that there are substantial quality improvements to be gained from the proposed merger. These include benefits in maternity care, urgent care, and in specialities such as clinical haematology and cardiac care. In the latter two benefits ascribe to the increase of multidisciplinary working achieved through integration, higher volumes of patients being treated, and in the development of single protocols adopted across the patient pathways. Ability to attract and retain clinical expertise will also be enhanced across a larger service base, thus securing improved quality, resilience and outcomes for patients.

These benefits are more safely delivered through a single organisation rather than through two organisations working together. This is because multiple clinical governance systems (i.e. accountability back to two organisational boards through executive processes) can create

confusion and add risk into healthcare. This would also be a reduction in the bureaucracy of service level agreements operating across organisations which require monitoring and accountability systems/processes and reduces risks around teams trying to work together to provide a single seamless service for the patient whilst working for different organisations with different cultures, protocols and reporting arrangements. These patient benefits are significant in terms of experience of care and absolute measurable quality indicators. In terms of urgent care and maternity care where patient risk is at its highest, there are absolute benefits of integration as opposed to competition.

- 9.67 West Hampshire CCG noted that in terms of consultation, it did not think the merger would make the consultation process easier. However, it also said that a reorganization of services within an organization would be easier than with two, from an organizational point of view. In response to a question whether in the absence of the merger, doctors may not support reconfiguration, West Hampshire CCG responded that there had already been substantial changes in services provided between RBCH and PH over the years, and effectively a significant number of reconfigurations had already occurred in terms of services being delivered at PH compared with RBCH.
- 9.68 West Hampshire CCG said that in its view, where there was clear evidence that a particular reconfiguration had clinical benefits, there was an expectation that clinicians would act ethically and not be opposed to it based on their allegiance to a particular organization.
- 9.69 Several parties told us that RBCH and PH could best achieve the efficiency gains needed within the NHS through the merger, and that this could provide opportunities for significant cash savings. Some parties believed that without merger both PH and RBCH would face financial difficulties in the near future.
- 9.70 However, several parties expressed concerns about the different ethos of the two hospitals (for example, some parties mentioned that RBCH currently had a higher rate of intervention in chest pain clinics than PH) and that the merger could therefore have a negative effect on patient choice. This was especially the case as the merger was seen by some as being a takeover of PH by RBCH (some of these respondents also mentioned their concern at the lack of involvement and possible closure of Christchurch Hospital).
- 9.71 In addition, some parties expressed concerns about increased travel times, specifically in relation to A&E and maternity. The Poole Local Involvement Network (LINK) received several responses expressing concern at the possible closure of A&E services at PH and the possible closure of maternity services at RBCH.
- 9.72 The FTN provided us with a detailed paper in response to our provisional findings, stating that the benefits of the merger outweighed the effects of competition. The FTN referred to evidence of the need to reconfigure services to meet the challenges facing the NHS and also to continue to provide safe and effective healthcare. The FTN referred to the financial challenges facing PH and stated that the current configuration of services was not clinically or financially viable in the longer term. The FTN supported change in each of the areas proposed as an RCB by the parties.
- 9.73 The governors of both RBCH and PH who wrote to us generally supported the merger, stating that the merger was needed to implement the changes needed to meet Royal Colleges' best practice guidelines; that any service quality issues would be addressed by the commissioners and regulators; and that any reduction in

competition must not take precedence over the sustainability of safe health services. The governors of PH noted that without the merger PH would not be able to afford to build the new maternity unit. The RBCH governors stated that increased consultant cover could only be achieved through merger and that merger would lead to greater financial security, greater ability to manage capital developments and achieve the necessary cost savings.

- 9.74 A number of clinical staff at PH also wrote a joint letter to us expressing their support for the merger: in their view fewer, larger trusts was the correct response to the increasing complexity of medical treatment and was the only option to meet the requirements of the medical colleges to deliver consultant-led acute services. This letter supported each of the proposed areas of benefit and stated that these benefits outweighed the perceived reduction in choice.
- 9.75 We have set out on our [website](#) summaries of the hearings we have held as well as the written evidence submitted by third parties.

### *Consideration of specific patient benefits proposed*

- 9.76 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. 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, as noted in paragraph 9.46, there are some aspects of the parties' proposals that have altered since Monitor undertook its review. 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.
- 9.77 We have set out our assessment of the evidence and then considered whether the proposal could give rise to a benefit to patients and assessed whether the proposal meets the statutory test to be considered a RCB. Summaries of each proposed benefit and our conclusions regarding those benefits are set out in this section; the evidence and our assessment of the evidence is set out in more detail in Appendix M.

### *Maternity*

- 9.78 Both RBCH and PH provide maternity services, as outlined in Section 6 and Appendix M, paragraphs 4 and 5). The parties told us that PH's existing maternity unit was no longer fit for purpose and needed refurbishment. PH was carrying out an interim refurbishment, to be completed in April 2014, which would allow the unit to continue in its current form for approximately five years (ie until 2018/19), although the parties noted that this was a sub-optimal solution.
- 9.79 The parties have put to us that the merger will allow significant investment (of approximately £[31–40] million, although the exact costs have yet to be determined) to build a new maternity unit at PH. They have told us that the new maternity unit will improve the patient environment due to en-suite delivery rooms, adequate heating, improved security and other factors. There is general acknowledgment in the Dorset community that PH's maternity unit could be improved and PH has been planning a new maternity unit for decades. Due to PH's lack of funds and the lack of an

incentive for RBCH to provide the funds to PH absent a merger, they have stated that this is a benefit which would not accrue absent the merger. Moreover, the parties told us that building a new unit at RBCH had not been considered sufficiently plausible.

- 9.80 The parties have also claimed that the merger will allow benefits in the form of a single managed maternity service. The parties told us that a single managed maternity service would allow sharing of staff and professional links, a shared and enhanced home birth service, and an improved midwifery ratio. However, the parties did not explain how a single managed maternity rota would be a benefit to patients and did not provide an implementation plan for this reconfiguration. We therefore did not find that a single managed maternity rota would be a benefit to patients.
- 9.81 The parties initially put forward that the merger would allow [REDACTED]. Monitor found in its report to the OFT that this would be an RCB. However, in August 2013 the parties explained to the CC that they were no longer proposing this as a benefit of the merger as any decision to [REDACTED] would be one for the new board of the merged entity.
- 9.82 We considered evidence from the parties as to the benefit proposed and the views of local commissioners and Monitor (see further Appendix M, paragraphs 9 to 38). The parties submitted to Monitor that the merger would deliver the following benefits to patients: eliminate patient transfers [REDACTED], reducing the risks to mortality and morbidity of both mother and baby that are associated with transfer; and enable the parties to combine their midwife rotas to provide increased cover in accordance with Royal Colleges' guidance. The parties submitted that these benefits would be delivered by [REDACTED], and refurbishing and expanding [REDACTED]'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. Monitor did not separately assess investment in [REDACTED]'s maternity unit as a potential benefit.
- 9.83 We found that a new maternity unit would be a benefit to patients in the form of higher quality services (see Appendix M, paragraphs 12 to 14 and 41). Having found that a new maternity unit would be a benefit to patients, we then considered whether it would be unlikely to accrue absent the merger and whether that benefit would be expected to accrue within a reasonable period as a result of the merger (see Appendix M, paragraphs 9 to 38 and 42 to 54).
- 9.84 The parties told us that, based on a merger in April 2014, the build of a new maternity unit would commence in 2016/17 with the new unit opening in 2018. 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 referred to in the Act. Given PH's financial position (as discussed in Section 4 above and Appendix B), we did not consider that, absent the merger, PH would obtain the amount of money required to finance the new unit; nor was it likely that a new unit would be built at RBCH. We therefore found that this benefit was unlikely to accrue absent the merger.
- 9.85 We next considered the evidence that the benefit would be likely to accrue within that period in the event that the merger proceeds.
- 9.86 There is commitment by the current management of both hospitals to build a new maternity unit (see Appendix M, paragraph 46). However, the parties' description of the likely maternity benefit has changed during the course of Monitor's and our investigations (see further Appendix M, paragraph 47).
- 9.87 The parties have not, at this stage, prepared their analysis of the proposed investment setting out the supporting financial projections, how the project would be

implemented and considering clinical interdependencies of any services that will need to be co-located with the new unit. The parties have also not yet decided at which of the possible sites this new unit would be built (see Appendix M, paragraphs 16 and 19).

- 9.88 We noted that the board of the merged entity would be unable to properly consider the investment decision until the analysis described above has been completed and that the required investment decision will not need to be taken immediately by the board of the merged entity. See further Appendix M, paragraphs 48 to 52.
- 9.89 We also noted 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. See further Appendix M, paragraph 51.
- 9.90 Our conclusion on whether it was likely that, in the event the merger proceeds, the new maternity unit would be built within a reasonable period is based on the considerations set out above and in Appendix M, in particular the following key considerations:
- 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 Appendix M, paragraph 52(c)). 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 Appendix M, paragraphs 16, 19 and 48). We would expect the plans to consider the configuration of maternity services across the whole area (see paragraph 9.89 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 Appendix M, paragraph 52(e) and (f)).
  - The current investment in the refurbishment of the existing maternity unit at PH (see paragraph 9.78 above) means that a new maternity unit is not required immediately and, as noted in paragraph 9.87, 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.
- 9.91 Although we found that five years would be a reasonable period within which to realize a project of this scale, based on the factors outlined above, we did not find that, in the event that the merger proceeds, it was likely that the new maternity unit would be built within that period.

### *Cardiology*

- 9.92 The parties told us that following the merger: (a) a single dedicated rota of cardiologists would span the two sites; and (b) acute cardiac inpatient admissions would be consolidated at RBCH. The details of their benefits proposal are described in Appendix M, paragraphs 63 to 67 and 72.

- 9.93 The creation of a single cardiology rota would allow out-of-hours cardiology cover to be extended to the PH site at weekends, which may result in better outcomes for cardiology patients treated at these times. This would be achieved by reorganizing the general medical rotas of both parties to allow PH cardiologists to be released from the PH general medical rota to provide weekend cardiology cover, with the remainder of the weekend cardiology cover being provided by RBCH cardiologists. This would involve changing the working times of 50 medical staff across the merged entity. For PH to increase its cardiology cover as a stand-alone trust would cost approximately £0.5 million, which it could not fund absent the merger, and it would need to backfill its general medical rota.
- 9.94 The second cardiology benefit put forward—consolidating acute cardiac inpatient admissions—would mean that 400 more patients are treated at RBCH and this would reduce transfers between the two sites (as only RBCH provides interventional cardiology).
- 9.95 We considered evidence from the parties as to the benefits proposed and the views of local commissioners and Monitor as well as the views of third parties who wrote to us on this subject. See further Appendix M paragraphs 68 to 99.
- 9.96 We found evidence (see Appendix M, paragraphs 67 and 100) that improving cardiology cover would be a benefit to patients in the form of higher quality services. We asked the parties to clarify how many patients they expected to benefit, but this information was not provided to us.
- 9.97 We considered that the proposed timescale for reconfiguring the rota (within a year of the merger) would result in benefits accruing within a reasonable period. We also found that the benefit would be likely to accrue within that period because of financial incentives to implement the proposed changes (see Appendix M, paragraphs 103 and 104).
- 9.98 We then considered the likelihood that this benefit could be implemented without the merger. The parties told us that they already shared rotas in other areas (see Appendix M, paragraph 89) and we requested, but they did not provide, worked examples to explain why sharing cardiology rotas should be so complex. We also noted that the parties already share consultants in a large number of services (see paragraph 6.133). Given the small scale of the cost of implementing the proposed changes absent the merger (see Appendix M, paragraphs 91 and 104 to 106 and the fact that other rotas had been reconfigured without a merger, we did not find that the reconfiguration of cardiology rotas would be unlikely to accrue absent the merger.
- 9.99 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 Appendix M, paragraph 85). We therefore did not find that the proposed consolidation of acute cardiac inpatient admissions would be unlikely to accrue absent the merger.
- 9.100 We therefore did not find the proposed cardiology benefits to be RCBs.

### *Haematology*

- 9.101 The parties told us that a merger benefit would be reconfiguration of level 2 and level 3 haematology services, with the preferred option being to consolidate inpatient services at PH with an outpatient ‘spoke’ at RBCH. The details of their benefits proposal are described in Appendix M, paragraphs 115 to 124.

- 9.102 We received evidence that the specialist commissioner of these services, together with the local PCT, had been considering reconfiguration of level 3 haematology services in the Dorset area for some time, including developing a business case for reconfiguration in June 2012 (see Appendix M, paragraph 124). We understood that the reconfiguration had not occurred as RBCH and PH had been unable to agree to the structure for reconfiguration and commissioners had considered tendering these services. However, in 2013 the commissioner for these services changed and the new commissioner, NHS England (Wessex), told us that the parties had both recently self-assessed themselves as meeting the relevant standards for level 3 haematology and therefore, as its commissioner it had no immediate plans to reconfigure or tender these services (see Appendix M, paragraph 128). The parties also provided evidence which indicated that this reconfiguration might be seen as of lesser importance given the small number of patients affected (see Appendix M, paragraph 138).
- 9.103 We considered evidence from the parties as to the benefit proposed and the views of local commissioners and Monitor. See further Appendix M, paragraphs 115 to 145.
- 9.104 We did not have sufficient confidence that the parties would proceed with the reconfiguration of these services for the reasons set out in Appendix M, paragraphs 146 to 153, which further describe the evidence mentioned in paragraph 9.102 above. We therefore did not find it likely that the benefits would accrue in the event that the merger proceeds and concluded that the proposed haematology benefits were not RCBs.

#### A&E

- 9.105 The parties told us that the merger would lead to a reconfiguration of A&E services which would result in better A&E consultant cover. This would be achieved by reconfiguring the two A&E units of PH and RBCH to a major injury A&E and a minor injury A&E, with the minor injury A&E being staffed primarily with nurses with input from GPs and remote oversight by A&E consultants situated at the major injury A&E unit.
- 9.106 There was uncertainty as to which site the major injury A&E unit would be located at. We considered the parties' internal documents and noted that the preferred option, for a variety of reasons including costs, was [REDACTED].
- 9.107 We considered evidence from the parties as to the benefit proposed and the views of local commissioners and Monitor. See further Appendix M, paragraphs 157 to 205.
- 9.108 The parties provided us with a number of studies considering the benefits of A&E reconfiguration on a national basis (see Appendix M, paragraphs 167 to 171). However, we noted that whether such a reconfiguration would result in benefits in the Dorset area would depend on a careful weighing of the benefits and disbenefits on a local basis (see paragraphs 9.60 to 9.62 and Appendix M, paragraphs 180 and 181). As Monitor noted in its report to the OFT, any benefit of the proposed reconfiguration must be balanced against the potential adverse impact for patients of having reduced access to emergency care at the minor injury A&E unit (see Appendix M, paragraph 202). 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. As this detailed clinical analysis of the effects of, for example, lower mortality as a result of better consultant cover against the effects of increased travel times for patients, would need to be done on a local basis, and this analysis had not yet been initiated with

commissioners, commissioners were unable to support the specific reconfiguration proposal, although they supported the principle of an A&E reconfiguration (see paragraphs 9.60 to 9.62 and Appendix M, paragraph 208).

- 9.109 We also noted that a significant reconfiguration of this type would include moving interrelated services (eg if RBCH were selected as the major injury A&E, then gynaecology, paediatrics and trauma would need to move from PH to RBCH and if PH were selected as the major injury A&E, vascular surgery and urology surgery would have to move to PH from RBCH), see Appendix M, paragraph 165. The information provided to us by the parties did not include detailed costings or benefits analysis of re-siting these interrelated services (see Appendix M, paragraph 198).
- 9.110 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 dependent services are located. This assessment of benefits and disbenefits had not yet been undertaken and without this assessment we therefore did not find that the proposal was an overall benefit to patients.
- 9.111 We therefore did not find that the A&E benefit proposed by the parties was an RCB.

#### *Emergency surgery*

- 9.112 The parties told us that if A&E were reconfigured, then emergency surgery would be consolidated on the major injury A&E site. This would allow that site to have a dedicated emergency theatre 24/7.
- 9.113 We considered evidence from the parties as to the benefit proposed and the views of local commissioners and Monitor. See further Appendix M, paragraphs 211 to 239. We noted that the parties had changed their benefits case from that which Monitor reviewed and were no longer claiming that the emergency surgery reconfiguration would occur before the A&E reconfiguration (see Appendix M, paragraph 241).
- 9.114 Our findings on emergency surgery were similar to those for A&E. Although we found that, in theory, if planned and implemented effectively, the proposed reconfiguration of emergency surgery may be a benefit to patients, we found that 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. This assessment of benefits and disbenefits had not yet been undertaken and without this assessment we therefore did not find that the proposal to reconfigure emergency services was an overall benefit to patients (see Appendix M, paragraph 241 to 244).
- 9.115 We therefore concluded that the emergency surgery benefit is not an RCB.

#### *Other clinical benefits*

- 9.116 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. The parties also told us 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 undesirably low patient volumes. According to the parties, this would deliver significant clinical benefits. See further Appendix M, paragraphs 245 to 248.

- 9.117 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. We have assessed these in relation to the specific benefit proposals detailed above. The parties did not provide details of other services where there are plans to improve consultant cover and increase specialisation of medical staff.
- 9.118 We did not find that the proposed benefit would be a benefit to patients and therefore did not find that this proposal was an RCB.

#### *Financial savings*

- 9.119 The parties told us that the merger would achieve cost savings by releasing important synergies and efficiencies. They 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.
- 9.120 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 £13.3 million.
- 9.121 We considered the parties' evidence on financial savings in our analysis of the counterfactual (see Appendix B, paragraphs 41 to 46) and set out further information on this in Appendix M (see paragraphs 254 to 262).
- 9.122 We looked at the various savings to determine how they might be an RCB (as set out in Appendix M, paragraphs 269 to 283).
- 9.123 We noted that some of the proposed clinical savings may be a disbenefit to some groups of patients, for example, the rationalization of services. The parties have not yet undertaken quality impact assessments for each proposed clinical saving which will allow any potential impacts on quality to be understood and assessed.
- 9.124 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 is 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.
- 9.125 We therefore saw insufficient evidence to determine whether the benefits of financial savings outweigh any disbenefits. We therefore did not find that financial savings would be a benefit to patients.
- 9.126 As it was not clear what form some of the proposed savings would take and we had not seen detailed implementation plans or business cases for all proposed savings, we therefore, in line with Monitor's views (see Appendix M, paragraphs 263 to 268), did not find that the financial savings benefit may be expected to accrue within a reasonable period as a result of the merger.
- 9.127 In addition, we found that some of the claimed financial savings would accrue absent the merger (see Appendix M, paragraphs 281 to 283).
- 9.128 For the reasons explained in paragraphs 9.123 to 9.127 above (and in Appendix M, paragraphs 269 to 283) we therefore did not find that the financial savings benefit proposed to us was an RCB.

### *Merger-avoided costs*

- 9.129 The parties initially told us that they would be able to avoid costs as a result of the merger as they would be able to put in place more efficient rota systems using fewer consultants and midwives.
- 9.130 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.
- 9.131 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 would be an overall benefit to patients.
- 9.132 The parties have indicated that they would not incur these costs absent the merger (see Appendix M, paragraphs 289 to 291). As a result we consider that these costs are likely to be avoided absent the merger.
- 9.133 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*

- 9.134 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 told us 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 (see Appendix M, paragraphs 297 and 298).
- 9.135 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. 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.
- 9.136 The parties have provided limited detail of the other capital projects and resulting benefits to patients which would be enabled by the merger.
- 9.137 The merged entity will need to consider the relative merits and opportunity costs of different capital projects and prioritize its capital spend accordingly. Based on the available evidence, it was not clear to us how the merged entity intends to prioritize capital spend to ensure that there is an overall benefit to patients.
- 9.138 We therefore did not find that merger-enabled investments would be a benefit to patients and concluded that the merger-enabled investments proposed to us were not RCBs.

### *Balanced portfolio of services*

- 9.139 The parties told us that a large part of their income was based on centrally set PbR tariffs. 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 trust provides services across the main tariff categories, it should be able to remain resilient to the swings. However, both the parties and third parties told us that due to PH's service mix it was less resilient to such swings.
- 9.140 As set out in our counterfactual analysis in Section 4, 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. The parties have not explained the specific quality deteriorations that would be expected at PH absent the merger.
- 9.141 Further, there is a risk that, in the event the merger proceeds, the quality of services at PH is maintained or improved by the merged entity at the expense of potential improvements in quality of services at RBCH. We therefore did not find that the benefits of subsidizing services at PH outweigh the potential disbenefits of reducing investment in services at RBCH.
- 9.142 On the basis of the available evidence we therefore did not find that this would be an overall benefit to patients and concluded that a balanced portfolio of services was not an RCB.

### *Consideration of benefits to commissioners*

- 9.143 We considered if there were any benefits to third parties which could be RCBs that should be taken into account in our decision on how to remedy the adverse effects of the merger. We took the view that if commissioners and trusts were able to provide the same services (and the same quality of services) to patients at a lower cost as a result of the merger, this could be a benefit to patients.
- 9.144 Having already obtained the views of commissioners on patient benefits, we separately asked Dorset CCG if it considered that the merger would lead to cost savings for Dorset CCG. It responded that initially it would make very few direct savings as a result of the merger as it would still be paying for activity at the national tariff rate for the majority of services. However, where the provider makes savings, this should reduce the cost base of the provider which would, over time via the reference cost submission, filter into a lower tariff price nationally. More immediately, the lower cost base should lead to a lower non-tariff cost or at least a contract negotiation; this would be difficult to quantify. Dorset CCG also said that increased financial stability of the merged organization could result in financial savings for it and ultimately the taxpayer.
- 9.145 In terms of the merged entity's reduced cost base and the possible impact on tariff reductions, we noted in our earlier analysis of financial savings (see paragraph 9.126) that we had concerns about whether cost savings were likely to accrue if the merger proceeded.
- 9.146 In any event, we considered that any cost savings are unlikely to have a significant impact by way of tariff reductions because national tariff rates are set by reference to the cost bases of a large number of hospitals; a cost saving of one provider is therefore unlikely to impact on this significantly, in particular if that cost saving is small. We therefore did not find that this would be an RCB.

- 9.147 We noted Dorset CCG's view that it might be able to negotiate lower non-tariff prices due to the merged entity's lower cost base. As outlined above, in our earlier analysis of financial savings (see paragraph 9.126) we stated that we had concerns about whether cost savings were likely to accrue if the merger proceeded. We also took into account the fact that the reduction in the number of local providers would impact negatively on the CCG's ability to negotiate, and that the CCG had not explained how it expected this would work to its advantage. In addition, we noted Dorset CCG's view that this benefit would be difficult to quantify.
- 9.148 We therefore did not consider that this would be an RCB.
- 9.149 Dorset CCG also stated that where the CCG was currently charged for transfers of patients between the two providers there would be a direct saving in the region of £[~~£~~], although this was an estimate and that the figure was difficult to quantify as in very few cases was it simply a case of paying for one instead of two spells of care.
- 9.150 Dorset CCG explained that a double payment arose, for example, when a patient was admitted to PH via A&E, the patient was stabilized at PH but then transferred to RBCH for treatment. The CCG was currently charged twice for this, namely: (a) as a complete spell at PH (with an admission and discharge); and (b) as a complete spell at RBCH. In the event that RBCH and PH merge, a transfer of a patient between sites will be charged as a ward transfer, instead of as two separate complete spells.
- 9.151 Dorset CCG noted that under PbR, payment was for the dominant procedure in a spell (ie the most complex and hence most expensive treatment within the spell). In the example above, while not much may happen by way of treatment at PH when the patient is admitted, stabilized and waiting to be transferred to RBCH, the PbR code (and associated payment) reflects the patient's condition and co-morbidities. Following the merger, Dorset CCG would not need to pay for the less dominant procedure performed at the Poole site.
- 9.152 According to Dorset CCG, the most likely scenario where this occurs was where there was one main centre and one non-main centre, for example for cardiology and orthopaedics (main centre at RBCH) and for paediatrics, maternity and cancer (main centre at PH).
- 9.153 Dorset CCG subsequently noted that [~~£~~].
- 9.154 We noted that any savings to commissioners due to reduced transfer costs would be offset by a reduction in income at the merged entity. In the circumstances of this case it was, in our view, relevant to take into account two factors, namely: (a) commissioners are not 'customers' in the normal commercial sense in that their remit is to commission services for patients in the local area using the funds available to them; and (b) as noted above (see paragraph 9.3), foundation trusts are public benefit corporations that according to their constitution have as their principal purpose the provision of goods and services for the purpose of the health service in England. The fact that the cost saving to the CCG would represent lost income to the merged entity indicates that patients in the Dorset area are not better off overall and there is no net saving in terms of healthcare funding in the Dorset area. We therefore concluded that this is not a benefit to patients and therefore is not an RCB.

### *Conclusion on relevant customer benefits*

- 9.155 As set out above, we did not find that the merger would give rise to any RCBs.

- 9.156 We note that it was put to us by the FTN that the extent of the detriment to patients arising from the loss in choice and competition had not been quantified, making it impossible to measure trade-offs between different groups of patients.
- 9.157 As we did not find that the merger would be likely to give rise to RCBs there was no need to measure such benefits against the adverse effects of the SLCs we identified.

### ***Consideration of appropriate remedies***

- 9.158 In this section we set out the various remedies options that we have considered.
- 9.159 In the Notice of possible remedies, we invited views on prohibition of the merger as an appropriate remedy for the expected SLC in this case. At that stage, we did not outline other remedies for discussion because we had concerns about the effectiveness of other options.<sup>335</sup>
- 9.160 In response to our Notice of possible remedies, the parties proposed a behavioural remedy based on the NHS Friends and Family test (FFT).<sup>336</sup> No other remedies were proposed by any parties.
- 9.161 In this section we consider the effectiveness of the behavioural remedy proposed by the parties and then consider the effectiveness and proportionality of structural remedies.

### ***Proposed behavioural remedy***

- 9.162 The parties noted that the SLCs we had found affected quality in numerous different ways, including potentially in ways which could not be measured or monitored individually. They told us that they had therefore sought to identify metrics which reflected quality as a whole. The metric they proposed was the FFT score, a new standard of measurement within the NHS.
- 9.163 The parties explained that the FFT was implemented in April 2013 and that the first results for NHS providers were published in July 2013. The FFT asks patients: ‘How likely are you to recommend our [ward/day case unit/clinic/service] to friends and family if they needed similar care or treatment?’ The possible responses fall into six categories: (1) extremely likely; (2) likely; (3) neither likely nor unlikely; (4) unlikely; (5) extremely unlikely; (6) don’t know.
- 9.164 The parties summarized their proposed remedy as one which:
- (a) required them to measure the FFT scores on a quarterly basis in each of the overlap areas;
  - (b) required those scores to be an average of 1 or 2 in each overlap area; and
  - (c) had escalation arrangements in the event of failure to meet them, including:
    - discussions with the relevant commissioners to determine appropriate remedial action, ultimately leading to an inspection, and
    - tendering by commissioners of the relevant services.

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<sup>57</sup> Notice of possible remedies, 11 July 2013, paragraphs 5 & 6.

<sup>336</sup> Joint main party response to the remedies notice, 9 August 2013.

- 9.165 The parties submitted that the ultimate sanction was a viable one because they reasonably believed that alternative providers would be interested in tendering for areas of activity identified in the provisional findings as giving rise to an SLC, and this approach had been adopted before by the CCP as a model in principle.
- 9.166 The parties accepted that the proposed remedy did not replicate competition but stated that it would ensure that the merger would not adversely affect patients and that patients would still obtain the benefits which would be lost if the merger was prohibited.
- 9.167 The parties referred to the CC's merger remedies guidance, and specifically paragraph 2.16 which states:

In general, one or more of the following conditions will normally apply in the unusual circumstances where the CC selects behavioural remedies as the primary source of remedial action in a merger inquiry:

(a) ...

(b) ...

(c) Relevant customer benefits are likely to be substantial compared with the adverse effects of the merger and these benefits would be largely preserved by behavioural remedies but not by structural remedies.

- 9.168 The parties also noted a CC report on past merger remedies which stated that:

Behavioural remedies ... can operate satisfactorily in limited circumstances, especially where the company operates in a regulated environment and where there are expert monitors.

Our case studies have highlighted two main lessons for monitoring and enforcement: (a) the benefit of behavioural remedies being implemented in a regulated environment, and (b) the involvement of either the industry regulator or a third party monitor.<sup>337</sup>

- 9.169 The parties referred us to the CCP's practice on behavioural remedies in the context of hospital mergers that the CCP had reviewed. We first consider the relevance and likely effectiveness of the CCP's behavioural remedies, and then whether the specific behavioural remedy proposed by the parties would be effective in addressing the SLC in this case.

### *CCP behavioural remedies*

- 9.170 The parties referred to the behavioural undertakings in the following mergers that the CCP reviewed:

(a) The merger of Barts/Newham/Whipps Cross to create Barts Health. The parties stated that in this case the CCP recommended that the merger be allowed on the basis that the parties delivered on the promised benefits of the merger and that the quality of care was kept high. Safeguards were agreed with merger parties and the local commissioners, who were empowered to find alternative providers

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<sup>337</sup> CC, [Understanding past merger remedies: report on case study research](#), Updated September 2012, pp2, 14 & 15.

to operate from the Newham site if services deteriorated after the merger. The CCP's recommendations were accepted by the Secretary of State in March 2012.

- (b) Merger of Dartford/Medway. The parties stated that the CCP recommended that this merger be cleared after the trusts and commissioners agreed to put in place quality safeguards for standard non-cancer elective urology and endocrinology patients (the areas where the CCP had found that the merger would adversely affect patient choice). The remedy included commitments by the parties to meet specific quality indicators, with commissioners having the power to swiftly intervene if quality deteriorated, including replacing the parties. If the parties were replaced, the parties would be required to allow the new provider access to its estate.
- (c) Merger of the community services provider arms of South Birmingham PCT/ Birmingham East and North PCT/Heart of Birmingham PCT. The parties stated that the CCP recommended the introduction of behavioural remedies to safeguard the GP gatekeeper function. In our view this remedy is of limited relevance to the merger of RBCH and PH as it does not involve acute trusts, and we therefore do not consider it further.

- 9.171 In respect of the remedy in Barts/Newham/Whipps Cross, we observe that the recommendation of the remedy was not unanimous. Two CCP panel members were of the view that the removal of Newham University Hospital NHS Trust from the merger was the only fully effective remedy.<sup>338</sup> Second, we note that the remedy was considerably more detailed than the one proposed by the parties in this case, covering mortality rates, patient safety measures, satisfaction measures, various efficiency indicators, waiting times and others; it also included a commitment to achieve the benefits that the parties said would arise from the merger.<sup>339</sup> The remedy included extensive reporting requirements and mechanisms for monitoring the quality outcomes and indicators. The relevant commissioners committed to certain actions including the tendering of services where quality declined to unacceptable levels; in that event the merged organization would facilitate the provision of services by a competing provider on the Newham Hospital site on fair, reasonable and non-discriminatory terms.<sup>340</sup>
- 9.172 We discussed the behavioural remedy in Barts/Whipps Cross/Newham with Monitor.<sup>341</sup> Monitor told us that for the first three quarters following the transaction the reporting requirements of the remedy had not been fully met. Monitor is in discussions with the parties concerned about the effectiveness of this remedy.
- 9.173 We noted that Barts Health was identified by the CQC as one of the six highest-risk trusts and in August 2013 Whipps Cross Hospital (part of Barts Health) was found to have a number of serious failings following unannounced inspections by the CQC.
- 9.174 In our view, there is insufficient evidence that this type of behavioural remedy would effectively address a wide-ranging SLC finding. Although we did not think that the fact that Barts Health is facing clinical and financial challenges is *in itself* an indication that the behavioural remedy is not effective, we found it likely that in those circumstances the hospitals and commissioners would have difficulty in prioritizing reporting on and monitoring the quality and outcome indicators set out in the remedy. This

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<sup>338</sup> CCP, [Merger of Barts and the London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust, Recommendation on Remedies](#) (7 February 2012), paragraph 10.

<sup>339</sup> *ibid*, paragraph 48 & 49.

<sup>340</sup> *ibid*, paragraphs 50–53.

<sup>341</sup> The CCP became a directorate of Monitor from 1 April 2013.

accords with the information provided by Monitor that the merged entity is struggling to meet the reporting requirements of the behavioural remedy.

- 9.175 In this case the parties proposed far less-extensive quality and outcome indicators than the remedy required in the Barts Health case, and did not offer to provide access to facilities on fair, reasonable and non-discriminatory terms in the event of a tender by commissioners to address unacceptable quality standards. These two factors are considered in more detail below.
- 9.176 In respect of the merger of Dartford and Medway, we noted that Medway's plans to integrate with Dartford had been paused, following Medway being named as one of 14 trusts subject to Sir Bruce Keogh's review of Hospital Standardised Mortality Ratios (HSMR). In September 2013 a statement was issued by the two trusts that they had both agreed it was not in their interests to proceed with the proposals.<sup>342</sup> As the merger was not completed, the remedy did not come into effect. Monitor was therefore unable to provide us with views on the effectiveness of the remedy in maintaining quality in that case.
- 9.177 We noted that even if the remedy was effective in that case, the parallels between Dartford/Medway and RBCH/PH are limited because in Dartford/Medway, the CCP found adverse effects in only two clinical services whereas we have found SLCs in a far wider range of services. This is considered in more detail below.

### *Friends and Family Test*

- 9.178 The FFT is a new measure being introduced to the NHS. Since April 2013, patients have been asked whether they would recommend hospital wards and A&E departments to their friends and family if they needed similar care or treatment (see also paragraph 9.163). Currently the test is only applied to A&E and inpatient services. It will be applied to maternity from October 2013. The full range of NHS-funded services will not be covered until March 2015. The first results were published in July 2013 for the three months to June 2013.
- 9.179 Foundation trusts are required to implement the FFT in any event. The parties have told us that the additional benefit provided by the remedy is that action would be taken in the event that the score is not sufficiently high (an average of 1 or 2, according to the proposed remedy).
- 9.180 The FFT is relatively new, and the national results have been criticized because of the low response rates both at ward and trust level. Criticisms include that hundreds of wards had no responses and were therefore excluded from the results; for many other wards the result was based on a single response.<sup>343</sup> The parties told us that PH and RBCH had response rates of 10.8 and 15.3 per cent for the three months to June 2013 across all wards/specialties surveyed.

### *Views of third parties on the proposed behavioural remedy*

- 9.181 We sought the views of commissioners and the CQC regarding the likely effectiveness of the proposed remedy; we also asked their views on implementation issues which would arise and if the remedy could be modified to make it more effective.

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<sup>342</sup> [www.bbc.co.uk/news/uk-england-kent-24102217](http://www.bbc.co.uk/news/uk-england-kent-24102217).

<sup>343</sup> See, for example, [www.hsj.co.uk/opinion/the-friends-and-family-test-is-a-foe-to-the-nhs/5061906.article](http://www.hsj.co.uk/opinion/the-friends-and-family-test-is-a-foe-to-the-nhs/5061906.article).

- 9.182 The CQC responded that it was responsible for registering and inspecting healthcare providers. The range of services available within an area falls outside its remit; therefore it was unable to comment on whether this remedy would be effective in addressing concerns regarding reduction in choice that the CC identified.
- 9.183 The CQC noted that the parties had stated that they would welcome a targeted inspection by CQC should their scores for the FFT fall below the agreed level for two consecutive quarters. The CQC stated that it considered the full range of information received, and it could not confirm that these shortfalls alone would result in an inspection. The CQC told us that it would continue to monitor information received regarding both trusts, and would take regulatory action as necessary, in accordance with its framework.
- 9.184 Dorset CCG responded that what the parties had proposed would be a useful way of gauging whether there had been a drop in quality, but that it also looked at a wide range of other metrics. Dorset CCG also noted that it already had a range of routes for it to address reductions in quality and so the remedy, although helpful, would not in practice add to the CCG's ability to deal with quality issues.
- 9.185 West Hampshire CCG told us that it was not sure that the FFT would give any more assurance than what was currently in place as the FFT was only one indicator.
- 9.186 NHS England (Wessex) told us that the remedy proposed by the parties was feasible and would be a reasonable way of assessing the impact on quality if the merger went ahead. NHS England (Wessex) noted that the FFT was one of a number of quality indicators and checks currently used by commissioners and that levers already existed within contracts to address deteriorations in quality.

### *Assessment of the proposed remedy*

- 9.187 As noted above, the CC generally prefers structural remedies (divestiture or prohibition) over behavioural remedies, and in practice the CC has selected structural remedies in the great majority of merger inquiries that have required remedies under the Enterprise Act regime.
- 9.188 There are two broad categories of behavioural remedies: those that enable competition (for example, by providing access to products or facilities of the merged entity) and those that control the adverse effects expected from the merger (for example, price caps or quality standards, such as those proposed by the parties to this merger).<sup>344</sup> The CC has a preference for those that enable competition as these are more likely to lead to ongoing competition. Remedies that attempt to control the adverse effects of a merger are subject to several significant disadvantages, including vulnerability to circumvention risks; and the cost of monitoring and enforcement.
- 9.189 We considered the effectiveness of the proposed remedy, taking into account how various elements of the proposal might be modified to make it more effective, for example by including more extensive quality indicators or including provision for access to the merged entity's facilities in the event of a competitive tender by commissioners.

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<sup>344</sup> CC8, paragraph 2.17.

- 9.190 First we noted that the proposed remedy—even if fully effective—would by its nature only remedy, mitigate or prevent the adverse effects of the SLCs; it would not address the SLCs at source by restoring competition.
- 9.191 Secondly, the proposed remedy is reactive: it responds to a fall in quality and then tries to address this. The result is that by the time that the fall in quality is addressed, harm has already occurred. This is not in the best interests of patients.
- 9.192 Third, as noted in Section 2, the parties are subject to significant quality regulation but the existence of such regulation does not mean that competition does not drive quality; to the contrary, we expect that competition drives continuous improvements in quality in ways that minimum quality standards do not. Under the proposed remedy, even if the merged entity is able to maintain current quality and meet the FFT standards, we consider that there would have been the potential for even greater improvements in quality in a competitive environment.
- 9.193 We are also concerned that poor FFT results would not necessarily identify where the quality issue is, only that patients perceive there to be a quality issue. Commissioners and providers would then need to evaluate the situation in order to understand where the issues are and agree appropriate actions to address them.
- 9.194 The parties told us that the benefit of the FFT was that it naturally became harder to achieve a high score as patients' expectations increase over time. In this way it could replicate the dynamic improvements that competition would lead to. However, we consider that it is impossible for us to determine how patients' expectations may change, or that they would necessarily increase over time, because that would depend entirely on the benchmark they are using. We would not expect patients in this region to be widely exposed to quality at other hospitals (in particular in respect of the services where we found an SLC), and therefore we do not consider that the FFT would be as effective as competition in driving continuous improvement.
- 9.195 We expect that competition will drive hospitals to improve quality in a way that will appeal to GPs and other medical professionals as well as patients. A remedy that only captures the patient experience would only replicate one aspect of competition. We would not want hospitals to focus solely on the patient experience at the expense of other aspects of quality valued by medical professionals.
- 9.196 In order to address all of the SLCs which we found, the FFT would need to cover all of the relevant services. Currently the FTT is not expected to be implemented across all NHS services until 2015 and we note that there are currently no proposals for the FFT to cover private patient services. The parties could fast-track the implementation of the FFT across all of the affected services. However, even if the FTT is extended in this way, its effectiveness depends to a large degree on the parties collecting the required data accurately, impartially and in a timely manner and providing this to the commissioners promptly. We recognized that there is a risk of circumvention. In addition, the required response rate would need to be agreed in advance so that the results would be meaningful and, where relevant, would provide a credible basis for commissioner intervention, but the response rate may in fact be outside the parties' control.
- 9.197 The proposed remedy would require careful and ongoing monitoring (and, where relevant, enforcement) by commissioners of how the parties: (a) carried out the FTT; (b) assimilated the scores; (c) performed over time; and (d) complied with any quality improvement measures imposed by commissioners. Generally, monitoring of this type is likely to entail significant third party costs. However, since commissioners already review the quality of services and intervene when standards fall, the

incremental cost is unlikely to be significant in this case. On the other hand, this reflects the views of Dorset CCG and the CQC that the FTT, although useful, is just one quality standard among many that they are monitoring and enforcing in any event.

- 9.198 Importantly, the effectiveness of the remedy depends on the willingness of commissioners (and the CQC) to intervene at the appropriate time, and there must ultimately be a credible threat that services will be put out to tender in the event that quality declines. The responses from the CQC and commissioners did not provide us with any confidence that they would intervene solely on the basis of scores below an average of 1 and 2 obtained in the FTT, or that this remedy materially improves the range of measures that are available to commissioners to respond to a deterioration in quality.
- 9.199 In considering whether or not putting services out to tender would be a credible threat, we also took into account the fact that commissioners have told us in the context of our competitive assessment that they have no plans to hold any tenders and that this would only be relevant once contractual mechanisms for quality improvements have been exhausted.
- 9.200 We also noted that (re)tendering services could be problematic in terms of actual or perceived challenges relating to: (a) co-location of the tendered service with other services, in particular in circumstances where the remedy does not involve an access provision; (b) risks that the merged entity would in some way be 'destabilized' if it no longer provided certain services; (c) the fact that tendering may result in services being located elsewhere which is likely to involve a public consultation exercise; (d) many services are likely to be part of the AQP regime which means that any qualified provider may provide them so a competitive process may not be appropriate; and (v) there may be a limited number of credible bidders for some services.

### ***Conclusion on the behavioural remedy***

- 9.201 We therefore found that the proposed remedy would not be an effective remedy to the SLCs we have identified. We do not consider that it can be modified to make it effective, for example by extending the FTT to cover all services affected by SLCs.

### ***Structural remedies***

- 9.202 In our Notice of possible remedies we stated that we believed that prohibition would be an effective remedy to the SLCs we had identified. In response to this Notice, we received no responses that suggested that prohibition would not be effective.
- 9.203 Prohibition would prevent an SLC from arising in any of the areas we have identified and would therefore be a comprehensive, timely and durable solution to the SLCs. It is practical to implement, monitor and enforce and has a low risk profile.<sup>345</sup>
- 9.204 We considered whether there were structural remedies other than prohibiting the merger that would be likely to be effective in addressing the SLCs. For example, in some merger situations a partial divestiture might provide a comprehensive and effective solution to address an SLC in a local area.

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<sup>345</sup> CC8, [paragraph 1.8](#).

- 9.205 We did not receive any proposals from the parties or third parties that other structural remedies could be an effective solution to the SLCs we had provisionally identified.
- 9.206 We found SLCs in 55 different clinical areas. Each of these would need to be addressed by any remedy. The services affected by the SLCs are not easily divisible from the rest of the merged parties' operations and it would be impossible to separate all of these services from the rest in order, for example, to divest them while allowing the remaining services to be merged.
- 9.207 We therefore did not find that there were remedies other than prohibition that would be effective.

### ***Proportionality of prohibition***

- 9.208 Where there is more than one effective remedy, we will select the least costly and intrusive remedy that we consider to be effective.<sup>346</sup> However, in this case we found that only prohibition would be effective; there were no other effective remedies.
- 9.209 In exceptional circumstances, even the least costly but effective remedy might be expected to incur costs that are disproportionate to the scale of the SLC and its adverse effects. In these exceptional circumstances, the CC would not pursue the remedy.<sup>347</sup> If remedies extinguish RCBs then the benefits foregone may be considered to be a cost of the merger.<sup>348</sup> However, in this case we did not find that any of the patient benefits put forward by the parties were RCBs within the meaning of the Act.
- 9.210 We note that in this case we did not find that the merger would be likely to give rise to RCBs which would render a prohibition disproportionate, therefore, there was no need to measure such patient benefits against the adverse effects of the SLCs we identified.

## **10. Conclusion**

- 10.1 We therefore concluded that prohibition of the merger was the only remedy that would address the SLCs and adverse effects that we found, and that it was proportionate to the SLCs.

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<sup>346</sup> CC8, paragraph 1.7.

<sup>347</sup> CC8, paragraph 1.12.

<sup>348</sup> CC8, paragraph 1.11.