Anticipated merger between The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust and Poole Hospital NHS Foundation Trust

ME/5351/12

The OFT's decision on reference under section 33(1) given on 8 January 2013. Full text of decision published 7 February 2013.

Please note that the square brackets indicate figures or text which have been deleted or replaced in ranges at the request of the parties or third parties for reasons of commercial confidentiality.

PARTIES

1. **The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust** (**RBCH**) is an acute general hospital with 601 beds on two sites. It provides a wide range of hospital-based services including elective and non-elective, specialist/tertiary clinical services and community and outpatient services to patients in Bournemouth, Christchurch, East Dorset and part of the New Forest. Its income in 2011-12 was £239.8 million.

2. **Poole Hospital NHS Foundation Trust** (**PHFT**) is an acute general hospital with 606 beds located on two sites. It provides a wide range of hospital-based services including elective and non-elective, specialist/tertiary clinical services and community and outpatient services to patients in Poole, East Dorset and Purbeck. Its income in 2011-12 was £195.1 million.

TRANSACTION

3. On 29 November 2011, the merger parties announced their intention to merge subject to several conditions, including approval by Monitor and the Secretary of State for Health.

JURISDICTION AND TEST FOR REFERENCE

Jurisdiction

4. As a result of the proposed transaction, RBCH and PHFT will cease to be distinct. The Office of Fair Trading (OFT) considers that both RBCH and PHFT are 'enterprises'[1] for the purposes of the Enterprise Act 2002 (the Act) because:

   4.1. NHS foundation trusts provide clinical services for gain or reward. While those services are 'free for the patient at the point of delivery', the primary care trusts (and/or commissioning organisations) procure and pay a consideration for the provision of such services depending on the number of patients that are treated at the hospital. NHS foundation trusts have the incentive to re-invest such income to attract patients.

   4.2. NHS foundation trusts have been given a substantial amount of financial and corporate autonomy to manage their finances and have the ability to retain and benefit from surplus generated from the income they receive from primary care trusts (PCTs) and/or commissioning groups for the provision of clinical services.

   4.3. the NHS healthcare sector and its providers (such as foundation trusts) are subject to a greater or lesser extent to regulations.[2] This does not prevent those providers (either publicly or privately controlled) from maintaining sufficient scope of autonomy to make organisational, financial and other operational decisions with a substantial impact on the competitive structure of the sector.

5. Furthermore, section 79 of the Health and Social Care Act 2012 provides that for the purpose of UK merger control where the

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[1] See section 129 of the Act.

[2] Determining for example, borrowing limits, minimum quality parameters, notable data transparency, terms of authorisation to operate and restrictions on private income.

activities of two or more NHS foundation trusts cease to be distinct activities is to be treated as being (in so far as it would not otherwise be) a case in which two or more enterprises cease to be distinct enterprises.

6. The UK turnover test under the Act is satisfied since each of the merging parties achieves revenues above £70 million.[3]

7. The OFT therefore believes that it is or may be the case that arrangements are in progress or in contemplation, which, if carried into effect, will result in the creation of a relevant merger situation.

Test for reference

8. The OFT is required to make a reference to the Competition Commission where it believes that it is or may be the case that the creation of a relevant merger situation may be expected to result in a substantial lessening of competition (SLC) within any market or markets for goods or services in the United Kingdom.

BACKGROUND AND RATIONALE

Choice and competition in the NHS

9. The UK system of healthcare has undergone extensive reform since 2000. This has included the gradual introduction of patient choice, greater organisational freedom and independence for NHS service providers and greater competition between NHS healthcare service providers. The most recent changes are set out in the July 2010 White Paper *Equity and excellence: Liberating the NHS* leading to the enactment on 27 March 2012 of the Health and Social Care Act 2012.

10. Competition and choice can bring benefits to public healthcare markets. Effective patient choice can be a key source of competitive pressure on providers and drive the incentives for higher quality and

[3] See paragraphs 1and 2 above.

a more efficient provision of care.[4] NHS reforms have introduced competition and choice through organisational reforms and a regime enabling patients (and their clinicians) to make informed decisions about where to be treated or referred for further clinical consultation.

11. Competition in NHS healthcare may be either (i) competition *for* the market (mostly in the case of non-elective services); or (ii) competition *in* the market via policies such as 'Choose and Book'[5] and 'Any Qualified Provider'[6].

12. Organisational reforms have included the conversion of certain NHS organisations to NHS foundation trust status and the introduction of Clinical Commissioning Groups.

13. NHS foundation trusts have devolved decision-making and have greater freedom to decide their own strategy and how clinical services are run (subject to appropriate clinical safeguards and other regulatory provisions) than their predecessor organisations. They can

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[4] One example of the impact of patient choice reforms can be seen in research carried out in May 2012 by Walter Beckert, Mette Christensen and Kate Collier. It found that four out of 10 hip replacement patients now do not select their nearest hospital, choosing instead to be treated based on criteria other than proximity. As patients become more familiar with the possibility of selecting their provider, this proportion should increase and should, in turn, enhance the level of competition between providers. *Choice of NHS-funded Hospital services in England*, The Economic Journal 122 (May), 2012, pages 400-417.

[5] **Choose and Book** provides patients with the right to choose the hospital and/or consultant-led team for a first outpatient appointment for a consultant-led service. The expectation is that in most cases, the patient will continue treatment in that hospital and/or with the chosen consultant-led team. A range of transparency measures and tools intended to inform patient choice and/or commissioners on their behalf include the publication of performance against a range of criteria such as waiting times and mortality rates.

[6] Under the **Any Qualified Provider** (AQP) scheme, patients can select from any NHS or independent sector provider of acute elective care in England that is registered with the Care Quality Commission (CQC), has a local commissioner or nationally-led NHS Contract, and is willing to provide services at the NHS tariff.

also, for example, retain surpluses and borrow to invest in new and improved services.

14. Clinical Commissioning Groups are groups of GP practitioners that will, from April 2013, be responsible for designing local health services in England. They will do this by commissioning (buying) healthcare services such as GP services and acute hospital care.

Rationale for this merger

15. The merger parties state that this merger will produce a range of positive outcomes for patients and the local community. They submit it will enable them to provide better integrated and higher quality services.[7] They submit that, at present, they face clinical, income and staffing pressures.

THE COUNTERFACTUAL

16. The SLC test is a comparison of prospects for competition with and without the merger. The competitive situation without the merger is referred to as the 'counterfactual'. The OFT considers the effect of a merger compared with the most competitive counterfactual provided always that it considers that situation to be a realistic prospect. [8] In practice, the OFT generally adopts the prevailing conditions of competition as the counterfactual against which to assess the impact of the merger. However, the OFT will assess the merger against an alternative counterfactual where, based on the evidence available to it, it considers that the prospect of prevailing conditions continuing is not realistic.

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[7] See further paragraphs 141 and *ff* on suggested relevant customer benefits.

[8] See *Merger Assessment Guidelines*, a joint publication of the Competition Commission and the Office of Fair Trading, September 2010.

17. The parties did not submit that the OFT should assess the merger against an alternative counterfactual, stating that they would be most likely to remain independent if the merger did not take place. They did, however, submit that the OFT should take into account the sectoral context in which they operate.[9] Specifically, they note that, given the financial and operational pressures, absent the merger, each of them would need independently to work closely with their commissioners to establish how they can best achieve balanced budgets whilst causing the least detrimental impact to the delivery of patient services. They submit that this would be likely to lead to the reconfiguration of certain services and that they expect that it would result in a decline in quality and the 'breadth and depth' of the services available to patients.[10] In addition, they explain that they already plan and deliver services across East Dorset jointly (in several specialties provided by only one of them).

18. The OFT has assessed whether the merger (or aspects of the parties' services) should be assessed against an alternative counterfactual due to:

    18.1. compelling evidence of service reconfiguration or exit or

    18.2. the extent of pre-merger co-operation and its impact on competition.

Service reconfiguration or exit

19. The evidence available to the OFT indicates that some form of reorganisation of clinical services would be required absent the merger to address the financial and operational challenges faced by each party. This was confirmed by the relevant commissioner. However, detailed evidence on service reorganisation relating to particular clinical services or operational matters to enable the OFT to determine how such reorganisation would impact on competition

[9] See paragraphs 9 and *ff* above.

[10] See paragraphs 110 and 119 of the Submission.

between the merger parties was not provided by the parties or the commissioners. Therefore, insufficient evidence to depart from the prevailing conditions of competition as the counterfactual against which to assess the impact of the merger.

Pre-merger co-operation between the parties

20. The OFT's investigation has indicated that there has been a wide range of co-operation between PHFT and RCBH across a range of clinical services and sometimes staffing rotas. The OFT notes, however, that this level of co-operation is typically through arm's length commercial arrangements between two independent service providers. As such, as is discussed further below, the OFT considers that the existence of commercial agreements between the merger parties to provide clinical services jointly to the commissioners does not eliminate the scope for competition between them to provide such services. This point is discussed further in detail in paragraph 60.1 below. Therefore, the OFT has not altered its view on the counterfactual to assess this merger being the prevailing conditions of competition.

FRAME OF REFERENCE

21. The merger parties overlap in the provision of hospital-based elective and non-elective clinical services, specialist/tertiary care and community and outpatient services primarily to patients in Bournemouth, Christchurch, Poole, East Dorset and part of the New Forest. They provide these services from sites in the conurbations of Poole and Bournemouth within approximately seven miles of each other.

OFT's general approach to market definition

22. The examination of the competitive effects of a merger rests on identifying the appropriate frame of reference for analysing the immediate competitive constraints faced by the merged entity. This involves identifying the appropriate product and geographic scope affected by the merger.

Demand-side substitution

23. In the case of hospital mergers, the OFT's starting point is to consider the narrowest set of substitute clinical services from the demand-side (customer perspective) in which the merger parties overlap and then to consider the incentives of a hypothetical monopolist to raise prices, lower quality or reduce access. In the case of NHS hospital mergers, demand-side substitution may be by: (i) the patient or the GP making the referral to the secondary care provider (secondary care); (ii) the consultant/trust making a referral for a tertiary (or specialist) treatment (tertiary/specialist care); or (iii) the payer (the NHS commissioners).

Supply-side substitution

24. The OFT also examines the extent to which the frame of reference can be widened in its product or geographic scope from the supply-side. In NHS hospital mergers, this involves an examination of the extent to which a supplier of alternative clinical services would have the ability and incentive to switch in an easy and timely manner (typically within two years) into the provision of a service or procedure in response to a decrease in the quality of the services provided by a hypothetical monopolist supplier.

Product scope

25. The merger parties submit that the appropriate frame of reference for assessment in this case should differentiate between NHS funded and non-NHS funded services and within each of those, a further distinction by: each clinical specialty; distinct product markets for

elective and non-elective services;[11] and markets for outpatient services by specialty.

NHS funded and non-NHS funded services

26. The OFT has not found it necessary to conclude on this distinction since no competition concerns arise in relation to the provision of non-NHS funded services. The OFT did not receive any evidence indicating that this merger would raise competition concerns with regard to non-NHS funded services and no third party raised any substantiated concerns in relation to these services. The OFT has therefore focused its identification of the relevant markets on NHS funded services only.

Clinical specialties

27. The OFT considers that individual services including medical assessments and tests, treatments or interventions are not substitutable for a patient, GP, consultant or commissioner seeking a service. As such, the starting point for market definition is one of narrowly delineated product markets of each service. From the perspective of the supplier of services, the consultants and doctors who provide treatments are ordinarily trained to perform a range of different routine treatments within a given specialty. This applies to each specialty (for example, urology, cardiology, gastroenterology, dermatology, oral surgery, and so forth). The OFT therefore considers that it is reasonable to widen the narrow demand-side individual service markets to encompass all treatments and services within a given specialty.

28. In summary, the OFT has adopted an appropriate product frame of reference comprising each clinical specialty as a separate candidate product market. However, for the purpose of assessing the merger, specialties which face similar constraints and which are provided by

[11] **Inpatient** are those patients who must remain in hospital (overnight) for treatment as opposed to those patients who attend hospital for consultation, intervention or treatment that do not require overnight stay (day-case and outpatients).

the same set of competitors are analysed together in clusters.[12] This is similar to the approach taken by the Co-operation and Competition Panel (CCP) in recent cases.[13]

Elective and non-elective care

29. Generally, healthcare providers make a distinction between elective and non-elective services. From a demand-side perspective, in general terms:

    29.1. routine elective clinical care can be planned and typically requires a referral from a GP or an allied healthcare professional. These services include both surgical procedures (for example, neurosurgery) and diagnostic scans and test (for example, X-Rays)

    29.2. non-elective clinical care is provided in unplanned or urgent circumstances. These services include accident and emergency (A&E), as well as supporting services such as emergency surgery, maternity and critical care services.

30. The merger parties submit that elective and non-elective care are in separate markets since there is a limited ability of a supplier of elective services to switch to supply non-elective services within a given specialty. They state that the features of non-elective care include additional capacity (full-time purposed clinicians) and facilities (beds, purposed operating theatres and treatment rooms) and that these are not ordinarily associated with the provision of routine elective care. In light of these barriers to switching, the parties conclude that it is not possible to widen the market, from a supply-side viewpoint, from elective to non-elective care.

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[12] See paragraph 35 below.

[13] See, for example, Report by the Co-operation and Competition Panel on the merger of Dartford and Gravesham NHS Trust with Medway NHS Foundation Trust, 10 October 2012, paragraphs 56 and 57.

31. The merger parties further consider that there are limited incentives to switch from elective to non-elective care because of the greater cost of non-elective care and the need to hold capacity to meet uncertain demand.

32. In contrast, the merger parties acknowledge that there are fewer barriers to switching from non-elective to elective because elective care can be provided with the same staff and equipment as non-elective care, without the need for capacity to deal with short-run uncertain demand. However, the merger parties disagree that non-elective care asymmetrically constrains elective care. They argue that:

    32.1. switching from non-elective care to elective care for some services can require long-term investments in staff and facilities

    32.2. the minimum number of patients required to maintain services means that the parties and other trusts will have limited ability in the future to 'pick and choose' the services that they provide

    32.3. providers can specialise in elective or non-elective care without automatically providing both. The merger parties also note a distinction between routine services and tertiary services.[14]

33. Third parties generally confirm that consultants can and do switch between providing non-elective and elective care within their own specialty.

34. The OFT notes that skills and equipment required to provide elective and non-elective care are very similar. This raises the question of whether both types of care are part of the same relevant market. Hospitals other than the merger parties explained to the OFT that the cost of switching to supply non-elective care for an elective care

[14] See paragraph 44 below.

provider is substantially higher and may not be financially feasible. As a result, non-elective care providers are more likely to have the ability and incentive to switch to start providing elective care than vice-versa. This results in, at most, the existence of an asymmetric constraint from non-elective care to routine elective care but not a single relevant market comprising both types of services. For example, a general surgeon performing non-elective abdominal interventions can provide routine elective general surgery.

35. The OFT considers that a reasonable starting point for its assessment on a cautious basis is to focus on two different clusters of services across each and every specialty:

    35.1. elective (hospital-based) care (that is, considering the competition between hospitals for GP/patient referrals for routine secondary services)

    35.2. non-elective care (that is the competition for the allocation of non-elective secondary clinical services).

Outpatient and community services

36. Outpatient services form an important part of patient care. Outpatient services 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 a hospital. The OFT considers that it is appropriate to make a distinction between two types of outpatient services:

    36.1. The first group includes services which may lead to a hospital admission such that they form part of the 'admitted care pathway' and should therefore be considered in conjunction with the relevant elective care with which it is provided. These may, for example, include pre-operative assessments or post-operative follow-up appointments. The OFT notes, for example, that the NHS Choice website stresses the importance of choosing the hospital at which a patient is first seen by a consultant since that hospital will

probably also be the one where the patient receives treatment if it is required.[15]

36.2. The second group includes services typically provided in an outpatient setting with no requirement to admit the patient. This second type of service would not generally form part of an admitted patient pathway.

37. The OFT notes that the above distinction is also followed by the CCP in its decisional practice. [16]

38. The merger parties submitted that there are distinct product markets for outpatient services by specialty and that, due to the scope for supply-side substitution, these product markets include both (i) providers of inpatient clinical services; and, (ii) providers of community-based clinical services.

39. In the parties' view, those providers supplying inpatient services can easily supply or start supplying outpatient services because:

39.1. all inpatient providers of a specialty will also provide outpatient services

39.2. the facilities required to provide outpatient activity are less than those required to provide inpatient care.

40. With regard to the second group of outpatient services as described in paragraph 36.2 above, the OFT has not found any evidence to depart from the findings in earlier CCP's hospital cases.[17] As a result,

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[15] www.nhs.uk/choiceintheNHS/Yourchoices/hospitalchoice/Pages/Choosingahospital.aspx

[16] See Report by the Co-operation and Competition Panel on the merger of Dartford and Gravesham NHS Trust with Medway NHS Foundation Trust, 10 October 2012, Appendix 4, paragraph 37.

[17] See further Report by the Co-operation and Competition Panel on the merger of Dartford and Gravesham NHS Trust with Medway NHS Foundation Trust, 10 October 2012, Appendix 4, footnote 16. CCP noted in that case that the market for inpatient

the OFT considers that it is appropriate to include providers of elective and non-elective care and given the wider set of providers within this second group, the OFT is confident that there is likely to be more competition in the second group than is the first group of outpatient services as described in paragraph 36.1 and 36.2 above.

Other community services

41. With regard to those community services in the second group, they are provided by a range of NHS, private and voluntary sector providers.

42. The OFT notes that decisional practice in this area has identified a community service provider will often provide a range of community services. For example, they include those services aiming to assist the population to stop smoking, to promote healthy living, nutritional assessment, vaccinations, health child programmes, etc. Specifically, the CCP noted in its *Dartford* decision[18] for the provision of each of these community services, providers will face broadly the same set of competitors. CCP also notes the relatively low barriers to entry at least for providers of other healthcare service providers.

43. There are a range of community service providers in the Poole and Bournemouth area. Most notably, Dorset HealthCare University NHS Foundation Trust (DCH) operates 16 community hospitals in the relevant area. The OFT has therefore not identified any competition concerns in relation to the provision of community care services resulting from this merger. The commissioners confirmed these views and the OFT has received no complaints from any third parties in relation to community services. Therefore, there has been no need to conclude on market definition in relation to community care and community care is not addressed any further in this decision.

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elective services is more local, there are little or no barriers to any form of acute provider entering into the provision of outpatient services.

[18]Report by the Co-operation and Competition Panel on the merger of Dartford and Gravesham NHS Trust with Medway NHS Foundation Trust, 10 October 2012, paragraph 33.

Primary, secondary and tertiary services

44. The pathway for the provision of patient care can be divided into primary, secondary and tertiary services. This segmentation has relevance to market definition given that there are often different types of services, in terms of actual care provided and the level of complexity. There are also different suppliers providing such services at each stage of the pathway for a given specialty. A simple way to describe this segmentation is by reference to the suppliers/parties involved at each stage of the provision of a clinical service to a patient:

    44.1. primary care where a patient presents to a GP with a medical problem (patient and GP)

    44.2. secondary care, when the patient is referred from a GP to a consultant (patient, GP or other healthcare professionals and consultant) and

    44.3. tertiary (or specialist) care, when the patient is referred from a consultant to a specialist consultant (patient, consultant and specialist consultant).

45. Tertiary services address more complex clinical situations than 'routine' clinical conditions and may be purchased by specialised commissioning groups. These are distinct from the commissioners of primary and secondary services for their local and/or regional areas.

Geographic scope

46. The merger parties submitted that the appropriate geographic frame for an assessment of this merger is at least a 40 to 60 minutes' drive-time isochrone centred on the merger parties' hospital sites. In their view, patients will be willing to travel further if the quality of clinical service in a local hospital were to decline. They have provided a map showing the GP practices from where PHFT received referrals from in 2011-12 and noted those which had referred five or more patients. The contention is that the OFT should draw a catchment area including all those practices (regardless of the volume of patients coming from them) and this would present a

drive-time isochrone of at least 40 to 60 minutes. In addition, the parties submitted the 'SSNIP test' is not best suited to determine the geographic scope in hospital cases.[19]

47. A common approach used by the OFT to analyse the geographic area in which a business derives a large percentage of their business is to identify an appropriately bounded catchment area. The OFT uses a variety of evidence to identify the catchment area. The OFT has used this approach in past hospital mergers.[20] It is also one of the approaches suggested in the report prepared by Oxera for the OFT's Private Healthcare Market study[21] and is suggested as a potential approach in the CCP's Merger Assessment Guidelines.[22]

48. In this specific case, the OFT has identified the catchment area by analysing the area over which [80-90] per cent of patients referred to the parties are located. This analysis showed that that [80-90] per cent of the GP referrals to the merger parties' hospitals originated within a [10-20] minutes' drive time (in the case of RBCH) and [20-30] minutes' drive-time (in the case of PHFT).

49. To ensure that the results were robust, the OFT also conducted a sensitivity check.[23] The OFT reviewed the GP referral data by each specialty and carried out [70-80] and [90-100] per cent catchment

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[19] They based some of their arguments on this topic on the content of the analysis of the economic literature produced by Oxera for the OFT's market study on the Private Healthcare sector. See *Techniques for defining markets for private healthcare in the UK. Literature review*. Page v. November 2011 (Oxera report).

[20] See OFT's decision on the completed acquisition by General Healthcare Group of four Abbey Hospitals and Transform Holdings Limited, 14 September 2010, paragraphs 23 and *ff.*

[21] *Techniques for defining markets for private healthcare in the UK. Literature review*. November 2011.

[22] Co-operation and Competition Panel *Merger Guidelines*, 25 October 2010, page 25.

[23] This is one of the recommendations of the Oxera report for the assessment of hospital merger cases. *Techniques for defining markets for private healthcare in the UK. Literature review*. November 2011. Page 31.

area sensitivity checks. The results did not change substantially by specialty or using a higher proportion of patients (that is over [80-90] per cent) to determine the catchment areas.

50. The OFT noted that for certain specialties these average drive-times can be wider or narrower.[24] For RBCH, the OFT notes that [90-100] per cent of all patients referred come from a catchment area of [20-30] minutes' drive-time.[25] In the case of PHFT, the catchment area for dermatology, neurology, oral surgery and rehabilitation are between [30-40] and [40-50] minutes' drive-time; for ENT, general practice, gynaecology, paediatrics, pain management, and trauma and orthopaedics the [90-100] per cent catchment area is within [30-40] minutes' drive time. However, the overall drive-time is around [25-35] minutes' for PHFT which draws [80-90] per cent of its patients from a catchment area within [20-30] minutes' drive-time.

51. The OFT notes that other evidence corroborates the catchment area analysis set out above. The merger parties' internal documents and the Care and Quality Commission's review refer to the parties providing healthcare to the populations of Bournemouth, Christchurch, Poole, East Dorset, New Forest and Purbeck. This is consistent with the proposed governance structure and the local authorities which will be eligible to nominate governors to the

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[24] This is consistent with the findings of the Co-operation and Competition Panel in recent cases. See further Report by the Co-operation and Competition Panel on the merger of Dartford and Gravesham NHS Trust with Medway NHS Foundation Trust, 10 October 2012; Report by the Co-operation and Competition Panel on the merger of Barts and The London NHS Trust, Newham University Hospital NHS Trust and Whipps Cross University Hospital NHS Trust, 15 December 2011; and, Report by the Co-operation and Competition Panel on the merger of Ealing Hospital NHS Trust and North-West London Hospitals NHS Trust, 13 June 2012; Report by the Co-operation and Competition Panel on the merger of the Royal National Throat, Nose and Ear Hospital of the Royal Free Hampstead NHS Trust with University College London Hospitals NHS Foundation Trust, 14 March 2012.

[25] The OFT did not have sufficient data to assess one specialty: allergy (with 486 referrals and data only up to 80 per cent of the patients). In the case of clinical immunology, the OFT notes that PHFT attended only four cases. The catchment area in those four cases of clinical immunology is 60 minutes' drive-time.

merged trust, which are expected to come from Bournemouth Borough Council, Borough of Poole, Dorset County Council and New Forest District Council.

52. In addition, the OFT has asked local patients' groups, commissioners and other hospitals to list alternative providers which could constrain the merger parties' ability to reduce the quality of their services following this merger. The competitive assessment contains the most significant competitive alternatives available to the patients (and commissioners) of the merger parties, as identified by third parties whether or not the alternative provider is present in the isochrones.

53. In response to the Issues Paper, the merger parties put forward evidence which they submit supports a wider geographic scope. This included the fact that referrals emanate from a much wider geographic region than the catchment area analysis above. The OFT must take a cautious approach to geographic scope. In this case, the OFT notes that it has adopted an established methodology to assessing the appropriate geographic frame. This, alongside a range of qualitative information, indicates a narrower geographic scope than that put forward by the parties. In those circumstances, it would be odd, taking a cautious approach, for the OFT to rely on a few examples of patients in rural or semi-rural locations being referred to the parties' hospitals given that they account for a very small proportion of income for the parties. Thus, the OFT does not consider that this evidence is sufficiently compelling to widen the geographic scope. However, the OFT notes that market definition is only a starting point for a competitive assessment and, to the extent that, there are constraints from outside of the market which can be shown to provide a constraint post-merger to the merging parties then these will be taken into account in the competitive assessment.

Conclusion on frame of reference[26]

54. For the reasons set out above, the OFT has assessed the merger on the basis of the following clusters:

    54.1. the provision of routine elective (hospital-based) care (that is, considering the competition between hospitals for GP /patient referrals for routine secondary services) and

    54.2. the provision of non-elective care (that is, consider the competition between hospitals for the allocation of non-elective secondary clinical services).

55. The OFT considers that the relevant geographic scope for routine elective care is between 20 and 30 minutes' drive-time respectively centred at each of the merger parties' hospital sites but noting that some clinical specialties might warrant a wider catchment area.

56. As the OFT did not have market share data based on 20 and 30 minutes' drive-time, for its substantive assessment, it has used data at PCT[27] level. It has used data based on the Cluster Dorset PCT (comprising Bournemouth and Poole PCT and Dorset PCT). Since the PCT geographic area is slightly larger than a catchment area of 20 or 30 minutes' drive-time centred at the hospitals' sites, this data is expected to be more favourable to the merger parties when compared with the drive time suggested by the OFT's candidate geographic market. In addition, as noted above, the OFT has taken

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[26] As stated by the UK Merger Assessment Guidelines, market definition is a useful tool, but not an end in itself, and identifying the relevant market involves an element of judgment. The boundaries of the market do not determine the outcome of the OFT's analysis of the competitive effects of the merger in any mechanistic way. In assessing whether a merger my give rise to a substantial lessening of competition, the OFT may take into account constraints outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others. See further *Merger Assessment Guidelines*, a joint publication of the Competition Commission and the Office of Fair Trading, September 2010, paragraph 5.2.2.

[27] It has used data based on GP referrals for the Bournemouth and Poole PCT and Dorset PCT.

into account the competitive constraint conferred by other hospitals identified by third parties regardless of whether they are inside or just outside this candidate geographic scope.[28]

COMPETITIVE EFFECTS: INTRODUCTION AND BACKGROUND

57. The OFT has assessed whether the merger would be likely to reduce the extent of competition between providers of elective and non-elective care respectively in Bournemouth, Poole and other areas of Dorset. In particular, the OFT has assessed whether the merger is likely to lead to a reduction in the merged organisation's incentives to maintain access, and maintain and improve the quality and/or efficiency of their clinical services.

58. Competition between hospital providers contributes to the delivery of efficient and effective service for the benefit of patients and the taxpayer since hospitals will seek to achieve income from serving patients across a range of specialty areas in order to ensure the long-term sustainability of their operations. Before the merger, when making expenditure decisions, each provider would take account of the revenue it would lose if GPs, patients and/or commissioners decided to stop (or reduce) procuring clinical services from it. A merger could remove that uncertainty and, as a result, the merged party may not be prepared to incur the same level of expenditure and/or maintain the same level of quality above, for example, CQC or any other minimum regulatory standards.[29]

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[28] Paragraph 52 above.

[29] In recent cases, the CCP has noted that '[p]roviders have the ability to take into account of the impact on their income from customers (patients, GPs and commissioners) switching to alternative providers. The potential impact can influence how much they decide to invest in maintaining and improving the quality of the services at their hospital sites. Evidence suggests that a greater degree of competition in the provision of elective care (under the current fixed price regime) has led to improvements in clinical performance. Where a merger materially reduces the competitive constraint a hospital site faces, the merged organisation would face significantly less risk that customers would choose to switch provider if the quality of care provided were to deteriorate. As a result the provider would have less of an incentive to make investments so as to maintain and improve quality and efficiency and this might have a material adverse effect on patients and taxpayers.' See Report by the Co-operation and

59. The parties submitted that their activities in the provision of (hospital-based) elective and non-elective care are complementary. They accept that there is some degree of overlap in certain clinical specialties but that the extent of such competition between them is limited. They further submitted that, absent the merger, any competition between them would be further limited and/or reduced due to the challenges facing the NHS sector. Specifically they contend that:

    59.1. they focus on different specialist services within the same specialty

    59.2. while the merger parties may provide similar medical procedures, these take place under different circumstances (such as elective and non-elective care) or by different types of clinicians (for example under the supervision of a specialist consultant or general practitioner with a particular clinical interest)

    59.3. PHFT is the main non-elective provider and RBCH is the main provider of elective care

    59.4. they already cooperate substantially, for example by sharing consultants and other resources in the provision of routine elective services

    59.5. national guidance[30] will recommend that there is only one provider of certain clinical services in the future for populations of the size affected by this merger and

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Competition Panel on the merger of Ealing Hospital NHS Trust and North-West London Hospitals NHS Trust, 13 June 2012; paragraph 51.

[30] For example, the merger parties submit that the Improving Outcome Guidance for cancer care recommends catchments which in this case, would imply that a single, integrated hospital network should provide these services across Bournemouth, Poole and much of Dorset.

59.6. some elective (hospital based) and outpatient services that are offered at the merger parties' hospitals are in fact supplied by a contracted third party. This is the case for:

59.6.1. hepatobiliary and pancreatic surgery and cardiothoracic surgery services, which are provided by University Hospital Southampton NHS Foundation Trust

59.6.2. nephrology services, which are part of a regional service provision network involving Dorset County Hospital and

59.6.3. vascular surgery services, which part of a regional service provision network involving Salisbury District Hospital.

60. The OFT considers that the parties do compete across a wide range of clinical services and that their above arguments underplay the extent of competition between them for the following reasons:

60.1. On existing co-operation between the parties, the sharing of consultants does not remove the scope for competition between the hospitals. This is because the merger parties earn income based on the number of patients referred to that foundation trust in line with the general rule that 'money follows the patient'.[31] They are therefore incentivised to compete for patient income across all areas of activity and must undertake investment or action to attract patients to a particular hospital (such as shorter waiting times, cleanliness and better auxiliary services). The NHS publishes data on some of those criteria to inform patients' choice.

[31] For example, with regard to sharing consultants (or having visiting consultants from the other merger party), the merger parties told the OFT that the hospital 'lending' a consultant to a 'host' trust receives a fixed fee and the host trust receives the fee per activity for the GP referral.

60.2. As the merger parties had submitted, when addressing the market definition assessment, supply side substitution within specialties is relatively easy. This suggests that consultants may switch the treatments or services they supply at each site.

60.3. Rivalry between NHS hospitals to attract patients and procurement from the Commissioning Groups should increase given the ongoing legislative and practice changes in this sector.

Theories of harm

61. The OFT considers this case raises two theories of harm as a result of horizontal unilateral effects in the supply of:

61.1. routine elective (hospital based) care (competition to win GP referrals) and

61.2. non-elective care (competition **for** the market).

HORIZONTAL EFFECTS

Unilateral effects in the supply of routine elective (hospital based) care

62. In the case of routine elective (hospital-based) care, the OFT has looked at three criteria to assess the competitive impact of this merger:

62.1. GP referral patterns to gain an insight into the relative importance of the competitive constraints that alternative providers impose on a particular hospital trust

62.2. the level of closeness of competition between the parties and relative to other hospitals and

62.3. the competitive strength of the remaining constraints on the merger parties including, where appropriate, those outside the geographic frame of reference.

Analysis of GP referral patterns

63. The OFT considers that the level of concentration in a market can, in certain circumstances, indicate the level of competitive pressure within such market. In broad terms, the higher the level of concentration in a market, the weaker the competitive constraints on the merging firms. As stated in the UK Merger Assessment Guidelines, market shares of firms in the market, both in absolute terms and relative to each other, can give an indication of the potential extent of a firm's market power. The combined market shares of the merger firms, when compared with their respective pre-merger market shares, can provide an indication of the change in market power resulting from a merger.[32] The OFT also notes that its assessment takes place in the context of a time-constrained first phase merger control review.

64. In this case, the OFT measured the extent of concentration in the supply of routine elective care by assessing GP referral data produced by Dr Foster. It used this data to calculate market share on the basis of the volume of patient referrals from GPs to each party within the Bournemouth and Poole and Dorset PCT cluster.[33] The merger parties submitted comparative data for the last three years.

65. Before setting out the market share information, it should be noted that the merger parties put forward several observations on the use of this dataset, including:

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[32] See *Merger Assessment Guidelines*, a joint publication of the Competition Commission and the Office of Fair Trading, September 2010, paragraph 5.3.4 (first bullet point).

[33] This area represents the closest approximation to the drive times highlighted by the catchment area analysis. Dr Foster is a commercial data provider which supplies GP referral data which can be analysed under multiple criteria.

65.1. Dr Foster data is not representative of the extent of competition between them because they consider that there is no link between hospital-based care and competition to win outpatient GP referrals. In particular the parties stated that the outpatient data does not distinguish between outpatient and inpatient care.

65.2. Dr Foster data excludes independent service treatment centres (ISTCs) and community centres.

66. The OFT considers that the Dr Foster data is sufficiently representative of the number of hospital service providers across routine elective services which compete to win referrals from GPs. The OFT believes that the point at which GPs and patients choose their secondary service provider is a good proxy to assess the market structure and constraints from different providers in these markets.[34] In addition, the OFT has also considered third party representations on the level of constraints imposed by ISTCs regardless of whether they are included in the relevant frame of reference.[35]

67. Furthermore, the OFT has also considered arguments made by the merger parties, where appropriate and as set out in later paragraphs. Table 1 shows the outcome of the merger parties' own analysis of their inpatient data, which the OFT carefully considered. It includes the merger parties' estimated market shares by volume for themselves and their competitors for the past three years.

[34] See further paragraph 36.1 above

[35] See paragraphs 52, 102 and 104.

Table 1: Market shares by volume based on outpatient GP referrals[36]

	2010*		2011*		2012*	
Trusts	**Number of referrals**	%	**Number of referrals**	%	**Number of referrals**	%
PH	188,599	22.5	195,764	21.1	174,513	23.2
RBCH	265,817	31.7	271,404	29.3	254,072	33.8
Combined	**454,416**	**54.2**	**467,168**	**50.5**	**428,585**	**57.0**
University Hospital Southampton NHS Foundation Trust	12,753	1.5	13,317	1.4	8,661	1.2
Yeovil District Hospital NHS	22,432	2.7	23,757	2.6	20,812	2.8
Dorset County Hospital NHS Foundation Trust	246,206	29.3	272,587	29.4	203,614	27.1
Basingstoke NHS	203	0.0	165	0.0	262	0.0
Salisbury NHS	53,381	6.4	56,390	6.1	30,046	4.0
Southern Health NHS	79	0.0	182	0.0	467	0.1
Others	49,503	5.9	92,236	10.0	60,003	8.0
Total	838,973	100.0	925,802	100.0	752,450	100.0

Source: OFT based on Dr Foster GP referral data submitted by the merger parties.

* Financial years ending 30 March.

[36] See paragraph 36 above.

68. The market share information indicates that the merger will create the largest provider of NHS routine elective care in the Cluster Dorset PCT (by number of referrals). The merger will lead to a total market share of 57 per cent with an increment of 23 per cent. The nearest provider to the parties post-merger would be Dorset County Hospital NHS Foundation Trust (DCH) with a share of around 27 per cent. This indicates a high degree of concentration in the area in the supply of routine elective services overall. In addition, there will be a significant difference between the combined merger parties and the next nearest competitor (DCH).

Competition assessment by clinical specialty

69. In addition to the above overall assessment, the OFT's analysis based on GP referral patterns by clinical specialty in routine elective care is presented in Annex I. This analysis shows the following:

    69.1. there are 26 overlapping specialties for which the merger parties have a combined market share greater than 40 per cent

    69.2. 17 of those specialties involve increments close to or greater than 10 per cent and

    69.3. in 10 of those specialties, combined market shares are above 60 per cent.

70. The levels of market share and increment in those 17 clinical specialties give rise to competition concerns given the overall level of market concentration in each clinical specialty.

71. The merger parties, in response to the Issues Paper, submitted that they do not compete to any material extent across the majority of clinical specialties. They submitted that at an aggregate level of all clinical activity and by specialty, the level of concentration overstated the actual level of competition in individual specialties which they claim are complementary with one provider strong in routine elective care and another strong in non-elective care, for example. In order to assess whether the parties' claims concerning the complementary nature of their activities within individual

specialties should be given weight, the OFT analysed the extent of overlap at the detailed Healthcare Resources Group (HRG) service level.[37] This provided further support to the notion that the parties overlap across a range of individual specialties, including the 17 where the OFT has competition concerns based on the market concentration levels.

Set against this, the merger parties indicated that the NHS's HRG categories also overstate the limited level of competition between them prior to the merger. They submitted that these overlapping procedures within the HRG data are not competitive since they are performed either by clinicians of different qualifications (specialist consultants or generalists); and/or in different environments (specialists centres as opposed to general wards); and/or different medical conditions (that is while in some cases the medical procedures is the main medical condition of the patient, in others, it is an additional treatment to other medical conditions). The OFT considers that, overall, the parties would seek to compete within an individual specialty to provide a range of services and that the data from Dr Foster and HRG both support an extensive level of competition between the parties across a range of clinical specialties.

[37] Within the NHS, a Healthcare Resource Group (HRG) is a grouping consisting of patient events that have been judged to consume a similar level of resources. For example, there are several knee-related procedures that all required similar levels of resource, and they may all be assigned to one HRG. Each HRG would refer to specific medical procedures which becomes also relevant for tariffication purposes. Annex II includes the table stating the OFT's findings of those treatments and interventions which are performed by both merger parties with regard to the 17 specialties raising concerns.

Table 2: Specialties raising competition concerns (by volume of GP referrals)

	Specialties	Merger parties' views	PHFT %	RBCH %	Combined %	3rd largest %	Trust
Group A	Rheumatology	Some overlaps between the merger parties (but only limited activity relates to elective inpatient)	[30-40]	[30-40]	[70-80]	[10-20]	DCH
	Rehabilitation		[30-40]	[10-20]	[40-50]	[40-50]	Salisbury NHS FT
	General Medicine		[50-60]	[10-20]	[70-80]	[10-20]	DCH
	General Surgery		[40-50]	[0-10]	[50-60]	[10-20]	DCH
	Geriatric Medicine		[30-40]	[30-40]	[60-70]	[20-30]	DCH
Group B	Clinical haematology	The merger parties focus on different sub-specialties	[10-20]	[30-40]	[50-60]	[20-30]	DCH
	Dermatology		[30-340]	[30-40]	[70-80]	[10-20]	DCH
Group C	Palliative Medicine	The merger parties sharing or have visiting consultants. There is little or no scope for competition.	[10-20]	[80-90]	[90-100]	[less than 5]	SUH
	Cardiology		[20-30]	[30-40]	[50-60]	[20-30]	DCH
	Oral Surgery		[60-70]	[10-20]	[80-90]	[0-10]	Salisbury NHS FT
Group D	Medical Oncology	The merger parties offer complementary rather than competing services for these specialties. Their services might differ substantially from one another – inpatient/outpatient care; elective/non-elective; basic/complex care.	[20-30]	[50-60]	[70-80]	[0-10]	DCH
	Gynaecology		[20-30]	[30-40]	[50-60]	[20-30]	DCH
	Vascular surgery		[15-25]	[70-80]	[80-90]	[0-10]	Salisbury NHS FT
	Neurology		[40-50]	[10-20]	[60-70]	[20-30]	DCH
	Ear, Nose and Throat (ENT)		[40-50]	[10-20]	[50-60]	[20-30]	DCH
	Trauma & Orthopaedics		[15-25]	[20-30]	[40-50]	[20-30]	DCH
Group E	**Cardiothoracic Surgery**	**The services are provided by a third party**	**[70-80]**	**[10-20]**	**[80-90]**	**[10-20]**	**Others**

72. Table 2 above sets out a summary of the merger parties' submission on the 17 specialties in which their combined market share exceeds 40 per cent with an increment above 10 per cent. This section sets out the competitive assessment of those 17 clinical specialties for which the OFT has competition concerns. In response to the OFT's Issues paper, the merger parties grouped those clinical specialties into five categories depending on the main reason why, in their view, the OFT should not conclude that its duty to refer is not triggered. The OFT assesses each of these groups, and where relevant, individual specialties within those groupings below.

Group A specialties

73. The merger parties acknowledge that there is some competition between them in this group of specialties but consider that the loss of competition occasioned by the merger is limited because only limited activity relates to elective inpatients.

74. As noted above, the OFT believes that assessing the market share by volume of GP referrals for secondary care is a reasonable proxy to assess the level of concentration and the competition impact of this merger in those clinical specialties.

75. On this basis, the level of market concentration in each specialty is high. The merger leads to a reduction in the number of sizeable providers of routine elective care to NHS patients in each specialty from 3-to-2[38] or 4-to-3.[39] The combined merger parties will be the largest hospital provider (by number of GP referrals) by a significant margin with a limited number of effective constraints remaining post-merger across these individual specialties.

76. As a result of the above, the OFT has competition concerns with regard to these specialties.

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[38] This is the case of elective services of rheumatology, general medicine, general surgery and geriatric medicine.

[39] This is the case of elective services of rehabilitation.

Group B specialties

77. In both dermatology and clinical haematology, this merger leads to a duopoly with DCH remaining as the second alternative. The merger parties will also have substantial combined market shares (50-60 and [70-80] per cent in clinical haematology and dermatology respectively) after sizeable increments ([10-20] and [30-40] per cent respectively). This high level of market concentration combined with a lack of material post-merger constraint from other hospital providers raises competition concerns over unilateral effects.[40]

78. The merger parties submit that competition to supply the services in the Group B is limited or non-existent since they offer a different focus on sub-specialties within each broader individual clinical specialty. By way of example, the parties noted that certain specialist Mohs surgery takes place solely at RBCH. With regard to clinical haematology, the merger parties state that RBCH has developed sub-specialisation in transplantation, myeloma, myelodysplasia, chronic lymphocytic leukaemia and some lymphomas.

79. The OFT acknowledges that certain sub-specialist procedures take place solely at one hospital. However, the evidence available to the OFT indicates that within these specialties there are a range of procedures in which the parties are currently competing and where they would remain competitive absent a merger.

80. As a result of the above, the OFT has competition concerns with regard to these specialties.

Group C specialties

81. The OFT notes that the merger will lead to a near monopoly share of referrals of palliative medicine in the Cluster Dorset PCT area. In oral and maxillofacial surgery, the merger will lead to very significant shares of approximately [80-90] per cent with an increment of [10-

[40] See paragraphs 107 and *ff* below.

20] percent. In cardiology, the merger will lead to significant overlap of around [50-60] per cent with an increment of around [20-30] per cent. The parties will face limited constraints from other NHS providers in relation to these three services.

82. The merger parties submitted that there was extensive collaboration in the area of palliative medicine noting that they share 'on-call' rotas. In their view, this indicates that competition between them in the provision of palliative medicine is muted. The OFT does not agree with this logic. It considers that sharing rotas does not prevent each party altering the aspects of their services (aside from consultant or junior doctor service provision). In particular, given that palliative medicine consists of providing patients with relief from a range of symptoms, pain and stress of a serious illness, the hospital environment including cleanliness and quality of services is likely to be of great importance to such patients.

83. In the case of cardiology and oral and maxillofacial surgery, the merger parties submit that they share consultants (or visiting consultants from the other Trust). They also submit that while there is overlapping general service provision at both Trusts, certain sub-specialist or specialist services are only available at one of the hospitals.[41] They argue that given the presence of sub-specialists of differing natures at each Trust this severely limits the ability for them to compete in these individual specialties. In particular, they argue amongst these areas and in relation to other areas where there are sub-specialist services, that consultants must obtain a certain accreditation in a sub-specialist area by undertaking a certain number of treatments over a given period. They submit that this places a certain amount of pressure on consultant capacity/availability which reduces the ability of consultant sub-specialists to compete with another Trust's general services within the same specialty. The OFT

[41] For example, in the case of cardiology, cardiac intervention or specialist procedures, only takes place at RBCH. Interventional cardiology is the term used to describe a number of procedures performed by cardiology specialists in a cardiac catheter laboratory. Procedures such as removal of blood clots from the arteries of the heart, or the use of balloons or stents to widen narrowed coronary arteries are carried out using catheterisation techniques under x-ray visualisation.

was not provided with sufficient evidence to support the contention that for each and every specialty each consultant who provided sub-specialist services would not provide any routine services within that speciality.

84. Therefore, the OFT considers, on the basis of the available evidence, the merger raises competition concerns in relation to these specialties.

Group D specialties

85. The combined market shares in each of these specialties range from [40-50] to [80-90] per cent with notable increments of around [15-25] per cent in both cases.

86. The merger will lead to reductions in the number of providers from four-to-three[42] and three-to-two[43] in these specialties with DCH remaining the third largest provider in all but one specialty.

87. The merger parties submitted that they do not overlap in any of these specialties. They submit that that their clinical services differ substantially from one another either in their focus or type of care (that is inpatient/outpatient, elective/non-elective and routine/complex). To assess this statement the OFT pursued a suggestion by the merger parties and reviewed the level of direct overlap at HRG level in each of the specialties in Group D and those which the merger parties have described as 'providing complementary rather than competing services'.[44] The result of that review is attached in Annex II. It shows that the merger parties overlap in performing 197 out of 463 HRG procedures.

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[42] Medical oncology, Gynaecology, Neurology and Trauma and Orthopaedics.

[43] Vascular surgery and ENT.

[44] These included all the specialties that the merger parties have included in the Amber Group in its response to the OFT's Issues paper.

88. Presented with this data, the merger parties considered that it does not accurately represent the level of competition between them. They argued that the same routine procedure can be performed in different circumstances and/or by different clinicians (such as specialist consultant or GP with a particular interest) and the merger parties should not be deemed to be competing or considered potential competitors in these medical specialties. They also submit that in all these specialties consultants are also either shared by the merger parties or visiting the other party hospital as part of ongoing co-operation between the merger parties.

89. The OFT acknowledges that some clinical services of some of these specialties may only be provided at one of the hospitals. However, the OFT has not been provided with sufficient evidence to conclude definitively that the parties' respective routine elective services do not overlap at any stage of the clinical pathway and that this merger will not substantially reduce patients' existing choices and lessen existing competition between the merger parties for GP referrals in routine elective care.

90. Also, for similar reasons to those stated above,[45] the OFT does not believe that in this case, schemes of sharing or visiting consultants exclude fully the possibility of some scope for competition between the merger parties.

91. In summary, across all areas within Group D, the data and evidence supplied have been mixed. On the one hand, the level of market concentration and lack of rivals across most clinical specialties is a strong indicator giving rise to competition concerns. However, the parties have sought to put forward information to demonstrate that they have a different focus in each of these areas or that collaboration is extensive and mutes the level of competition. Overall, the OFT considers that, on a 'may be the case' basis, this merger raises competition concerns in each of these services included in Group D since there is insufficient evidence to support

[45] See paragraph 60.1 above.

the parties' contention that they do not compete at any level of the clinical pathway.

Group E specialty

92. Cardiothoracic surgery services are provided by a third party (University Hospital Southampton NHS Foundation Trust) on behalf of the merger parties. Based on the GP referral data supplied to the OFT, the merger parties' combined market shares is estimated to be [80-90] per cent (with an increment of [10-20] per cent). This merger will remove the choice of those patients which would choose one of the hospitals over the other merger party's hospitals based on criteria other than the consultants which will be the same in both hospitals.

93. Such removal of the incentive of the merger parties to compete with each other to attract patients to their own hospitals (to the detriment of the other) gives rise to competition concerns in this specialty.

Analysis of the closeness of competition between the parties

94. In general, the level of competition loss resulting from the merger of two competitors depends, in part, on the closeness of the competition between them.

95. As set out above, the OFT has competition concerns across a range of clinical specialties for elective hospital-based care. The OFT also considers that the expected competitive impact of this merger is likely to be more significant based on six further considerations:

    95.1. the merger parties' hospitals are each other's closest competitors in terms of physical location

    95.2. they operate the only two District General Hospitals in Bournemouth and Poole

    95.3. the breadth and depth of clinical services they offer is extensive and this merger will create the largest provider in the vicinity in a large proportion of clinical specialties. Most of other nearby hospitals are substantially smaller in terms of

number of beds, income and, more importantly, they are all a significant distance away from the merger parties' sites

95.4. both parties' hospitals have received many recognised awards for some of their clinical services, patient care and productivity. Also, both merger parties were rated as 'excellent' in the 2008-09 Care Quality Commission's overall score (the last made available to the OFT). They were also both rated 'excellent' in financial management 2009-10. The parties' strong performance is indicative that they are strong constraints on one another in the provision of routine elective care, rather than presenting a weak party 'losing patients', for example due to a poor track record

95.5. as part of the parties' merger due diligence, McKinsey, the parties' advisors, assessed the financial implications if the merger parties were to cease providing certain routine elective services at one of their sites and moved the capacity to the other merger parties' site. This exercise was conducted for several services. The parties' advisors conducted a ward-by-ward analysis of where patients would travel to receive treatment following the proposed service cessations. An important assumption made by McKinsey in the modelling work was that all patients receiving routine elective care would, following service cessation at one of the merger parties' sites, switch to the other merger parties' sites. This forecasted high level of diversion is indicative that the merger parties are very close competitors and that they would have substantial incentives to cease providing services post merger and

95.6. third party views largely stated that the merger parties are close competitors. They also confirmed that few, if any, of other existing NHS and private hospitals in the vicinity were close competitors to either of the merging parties in any given specialty.

96. Set against this, the merger parties do not consider that they are close competitors. They accept that they are geographically close but do not consider this equates to closeness given that they submit

they consider that they provide a range of complementary services given the extensive level of pre-merger collaboration and co-operation between them. They also dispute the OFT's analysis of the McKinsey paper which they submit was produced for a different purpose than assessing the anticipated level of switching between the parties post-merger.

97. Overall, the OFT considers that the parties are each other's closest competitor and they are the next best alternative for a wide range of clinical services for GPs, patients and other service users.

Strength of the remaining constraints on the merger parties

98. The assessment of each of the individual clinical specialties has noted the presence of any material provider of that specialty in the Cluster Dorset PCT area.[46]

99. The OFT notes, however, that it is important to consider the likely reaction of rivals post-merger, even those which may not presently represent a significant constraint on the parties' activities. This may depend on the willingness of patients to travel in response, for example, to a reduction in quality of the service provided. This may, in turn, depend on factors such as, private car usage and availability of public transport options, age and mobility of the local population, service levels at other hospitals in the vicinity and actions of other actors in the local healthcare economy such as, GPs and clinical commissioning groups.

100. The merger parties submitted that post-merger they will be constrained by Dorset County Hospital NHS Foundation Trust, Hampshire Hospitals NHS Foundation Trust, Lymington New Forest Hospital, Salisbury NHS Foundation Trust, University Hospital Southampton NHS Foundation Trust, and Yeovil District Hospital NHS Foundation Trust. The parties add that they will be constrained in non-complex elective treatments by independent sector treatment centres.

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[46] See paragraphs 52, 56 and footnote 26.

101. The parties submitted analysis showing the percentage of patients within 40 minutes' drive-time of each of the merger parties' sites who are also within 40 minutes' drive-time of other healthcare providers. As discussed in the geographic scope section, the OFT believes that 40 minutes' drive-time is too wide for many clinical services. Also, this analysis was not supported by evidence that patients would switch to those rival trusts or any private healthcare provider following a cessation of a particular specialty or a decrease in quality. Moreover, it appears to be inconsistent with the evidence in the McKinsey report produced to inform the merger parties' management decision on the appropriateness of this merger which shows that most of the diversion will be captured by the other merger party rather than a third party.

102. The OFT notes that a range of private and public-owned hospitals can potentially compete against the merger parties in the provision of several clinical services. It therefore posed detailed questions to hospitals and the relevant commissioners on the relative constraints posed by other hospitals in the area. The results show that other hospitals are not deemed to be 'moderate' or 'strong' competitors to the merger parties across a significant proportion of clinical services. In light of these views, the OFT cannot consider that the competitive constraint exerted by any of these hospitals individually, or all of them collectively, would be sufficient to constrain the merged entity going forward.

103. The views collected by the OFT on two possible competitors are set out below:

    103.1. Southampton University Hospital (SUH) is regarded by some third parties as a strong competitor of the merger parties for several clinical services. In particular, one commissioner highlighted SUH's cardiac and paediatric services. In contrast, some other third parties listed SUH as a weak competitor to PHFT and a moderate competitor to RBCH. Another third party includes other services and notes that SUH might compete with PHFT for the provision of neonatal,

obstetrics and cancer haematology and with RBCH for the provision of orthopaedics, cardiology and gastroenterology.[47] The foregoing indicates that SUH may constrain RBCH and PHFT for certain treatments for a subset of patients within the parties' catchment areas. However, the actual extent of those patients for whom SUH might represent a viable alternative to the merger parties in those services post-merger is uncertain.

103.2. Salisbury NHS Foundation Trust is listed by third parties as a competitor to the parties for certain patients but, based on the overall evidence before the OFT, it cannot be considered a strong competitor in the parties' main catchment area. It is perceived as a strong competitor for patients in West Hampshire and North and East Dorset and a moderate competitor of PHFT in South West and East Dorset because of geographic proximity. The OFT did not receive any evidence suggesting that patients from outside those areas were expected to switch from other hospitals and start using Salisbury NHS Foundation Trust in any significant numbers.

104. Respondents to the OFT's market testing did not identify any ISTCs as being a moderate or strong constraint on the merger parties.

105. The OFT does not consider that it has been presented with sufficient evidence, to conclude that the merged entity would face sufficient constraints across the full range of clinical services for the vast majority of patients in the catchment area post-merger.

[47] The competition impact of this merger on these services has been assessed above.

Unilateral effects in the supply of non-elective care

106. The OFT believes that competition with regard to non-elective services is primarily a case of competition **for** the market usually taking place by way of public tenders or negotiations with the commissioners. Patients rarely choose the hospital they are attending in unplanned visits to the hospital.

107. Against this background, as noted above, the OFT assesses the impact of this merger, in the case of non-elective care, largely focused on the choices for commissioners. That is whether the merger would be likely to reduce the extent of competition between providers of non-elective services in Bournemouth, Poole and East Dorset. In particular the OFT assesses whether the merger is likely to lead to a reduction in the merged organisation's incentives to maintain and improve the quality and/or efficiency of the non-elective services provided at each of its hospital sites. The OFT has also considers the impact of this merger on the options open to the commissioners when considering the possible reconfiguration of non-elective services.

108. The OFT notes, at the outset, that it has received a significant number of unsolicited third party complaints relating to maternity and accident and emergency services in the local area, all of which relate to this theory of harm.

109. The merger parties submit that they do not generally compete in non-elective NHS services. The OFT notes that their income from emergency and non-elective NHS services accounted for 42.1 per cent of their overall income in the 2010-11 financial year.[48] The parties submit that: (i) patients of non-elective services do not choose between hospitals for unplanned emergency treatments and (ii) it is unlikely that local commissioners will initiate competition *for* the market for these services.

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[48] Spreadsheet titled *Q14 McKinsey- model for clinical reconfigurations* submitted by the merger parties.

110. The merger parties believe that the current offering of non-elective services reflects the commissioners' views on the most appropriate services to cover the local needs for non-elective clinical services. They add that it is unrealistic to expect that the commissioners will invite tenders for the exclusive right to provide these services in their entirety.

111. The merger parties submitted that:

    111.1. there is no reasonable prospect of them competing *for* this market in the foreseeable future and

    111.2. there is very limited overlap between the non-elective services that each of them offers as shown in Table 3.

112. In order to assess the effect of the merger on competition between providers of non-elective care, the OFT has considered:

    112.1. whether it is realistic that the commissioners would reconfigure non-elective services between existing providers (in particular the merger parties' sites but also involving other third parties) in the foreseeable future and

    112.2. the proportion of revenue the merger parties could expect to gain if one or both of them lost their existing contracts to provide non-elective services from their various hospitals sites.

Table 3: Non-elective services supplied by one of the merger parties only

Non-elective services offered at PHFT, but not at RBCH	**Non-elective services offered at RBCH, but not at PHFT**
Trauma	Vascular
ENT	Urology
Paediatrics	Ophthalmology
Gynaecology	Cardiology (heart attacks)
Obstetrics	

Source: the merger parties (Slide 25 of the Response to the Issues paper dated 10 December 2012)

113. The commissioner for Cluster Dorset PCT (comprising Bournemouth and Poole PCT and Dorset PCT) informed the OFT that it intends to launch a review of Urgent Care in Dorset. This review would be likely to result in the reconfiguration of A&E and maternity services but any proposed reconfiguration would be subject to statutory public consultation. The OFT considers that this creates an uncertainty and raises the prospect of competition for the provision of maternity and A&E services in Dorset (to a greater or lesser extent) absent the merger. This merger removes the opportunity for commissioners to receive two separate proposals from the merger parties in terms of possible re-configuration of non-elective services.

114. McKinsey provided an indication in their advice to the parties on the merger that closing a non-elective service (such as A&E and maternity) at either of the parties' sites would result in the vast majority of patients switching to the other merger party. This is based on the assumption that distance is the main criterion for choice. The OFT considers that this may indicate that one merger party would capture the majority of the revenue were the other merger party to cease providing non-elective services.

115. On August 15 and 16, 2012 PHFT's maternity services closed temporarily. The parties submitted that, during this period, no patients switched to RBCH for maternity services. Set against this, PHFT's internal review of the closure suggested that RBCH should be the appropriate place to refer Low Risk mothers. The documents also note discussions with RBCH prioritising postnatal beds to receive clinically stable delivered women from PHFT. This information tends to indicate that PHFT would expect at least some switching to RBCH. Moreover, the closure of PHFT's maternity service does not provide information about the strength of the constraint of PHFT on RBCH, which the OFT believes could be considerable based on the merger parties' own internal merger documents (such as the McKinsey report).

116. The main ambulance trust serving the parties advised that there are some services for which the constraints from one of the merger parties may not be particularly strong as most (if not all) procedures are referred directly to one of the merger parties' hospital. For

example, heart attack patients are generally transported to RBCH and burn trauma patients are transported to PHFT.

117. While the extent, breadth and scope of such reorganisation is uncertain, there is no question that this merger will lead to some reduction in the alternatives open to commissioners. This reduction in competition might also have an impact on the merger parties' incentives to continue to invest in maintaining and improving the quality, range and efficiency of non-elective services above any minimum standard required by regulation.

118. The OFT sought the views of third parties regarding the provision of non-elective services. Members of Parliament of the relevant geographic areas expressed concerns regarding the transaction. In particular some MPs were concerned about i) the reduction of choice for maternity services in case of closure of the midwife-led maternity service at RBCH, ii) the impact of the merger on the incentives to innovate, iii) the loss of bargaining power of the commissioners towards the merged entity, iv) the possibility that a merger involving A&E services may result in delivering worse quality services to critically ill patients.

119. Borough Councils were concerned about i) the closure of elderly services run at Christchurch site that would oblige elder people to travel to Poole, which is not easy to reach; ii) the possibility that Christchurch site may become obsolete and services run there may close down; iii) lessening of patient choice.

120. While some individual members of a local patient association were positive about the benefits that could accrue as a result of this merger, the overall view of local patient associations and private individuals were concerned about i) the possibility that A&E service at Poole may be closed down and patients would be obliged to travel to RBCH; ii) the closure of the midwife-led maternity service at RBCH.

121. In light of the above, the OFT considers that the choices offered to commissioners and, where appropriate, patients in non-elective services will be reduced by the merger. Such concerns are not allayed by the prospect of new entry. As a result, the OFT believes

that in relation to the provision of non-elective care in the relevant geographic area, this merger gives rise to the realistic prospect of a SLC on a 'may be the case' standard.

BARRIERS TO ENTRY AND EXPANSION

122. The UK Merger Assessment Guidelines state that, where a merger gives rise to competition concerns, these may be allayed by the prospect of entry where that entry is timely, likely and sufficient.[49]

123. In this case, the OFT has not received any evidence which could lead the OFT to conclude that it can expect new entry at such scale that it could restore the competition lost by this merger for those routine elective and non-elective services raising competition concerns.

CONCLUSION ON THE ASSESSMENT OF THE SUBSTANTIAL LESSENING OF COMPETITION

124. In light of the above assessment, the OFT finds an SLC with regard to the provision of the following routine elective (hospital-based) care specialties as a result of unilateral horizontal effects: rheumatology, rehabilitation, general medicine, general surgery, geriatric medicine, dermatology, clinical haematology, oral and maxillofacial surgery, cardiology, palliative medicine and cardiothoracic surgery (those listed in Groups A, B, C and E).

125. With regard to those specialties included in Group D (medical oncology, gynaecology, vascular surgery, neurology, ENT and trauma and orthopaedics) and non-elective services, the evidence indicates that the merger may also lead to a SLC on a 'may be the case' standard.

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[49] See *Merger Assessment Guidelines*, a joint publication of the Competition Commission and the Office of Fair Trading, September 2010, paragraph 5.8.3.

126. The OFT is concerned that this merger might reduce the hospitals' incentives to undertake investment or actions (for example to continue to enhance the quality of those services over the minimum required standards), to compete for patient income by not undertaking the same level of investment, or actions which attract patients to a particular hospital (such as shorter waiting times and better auxiliary services).

ASSESSMENT

127. The merger parties overlap in the provision of hospital-based elective and non-elective clinical services, specialist/tertiary care and community and outpatient services primarily to patients in Bournemouth, Christchurch, Poole, East Dorset and part of the New Forest. They provide these services from sites in the conurbations of Poole and Bournemouth within approximately seven miles of each other.

128. The OFT has adopted an appropriate product frame of reference comprising each clinical specialty as a separate candidate product market. However, for the purpose of assessing the merger, specialties which face similar constraints and which are provided by the same set of competitors are analysed together in clusters. As a result, the OFT has assessed this merger on the basis of the following frame of reference and has addressed individually only those specialties raising competition concerns:

    128.1. the provision of routine elective (hospital-based) care (that is, considering the competition between hospitals for GP /patient referrals for routine secondary services) and

    128.2. the provision of non-elective care (that is, consider the competition between hospitals for the allocation of non-elective secondary clinical services);.

129. The OFT considers that the relevant geographic scope for routine elective care is between 20 and 30 minutes' drive-time respectively centred at each of the merger parties hospital sites but noting that some clinical specialties might warrant a wider catchment area.

130. As the OFT did not have market share data based on 20 and 30 minutes' drive-time, for its substantive assessment, the OFT has used data at PCT[50] level. It has used data based on the Cluster Dorset PCT (comprising Bournemouth and Poole PCT and Dorset PCT). Since the PCT geographic area is slightly larger than a catchment area of 20 or 30 minutes' drive-time centred at the hospitals' sites, this data is expected to be more favourable to the merger parties when compared with the drive time suggested by the OFT's candidate geographic market. In addition, as noted above, the OFT has taken into account the competitive constraint conferred by other hospitals identified by third parties regardless of whether they are inside or just outside this candidate geographic scope.

131. The OFT considers this case raises two theories of harm as a result of horizontal unilateral effects in the supply of:

    131.1. routine elective (hospital based) care (competition to win GP referrals) and

    131.2. non-elective care (competition **for** the market).

132. In the case of routine elective (hospital-based) care, the OFT has looked at three criteria to assess the competitive impact of this merger:

    132.1. GP referral patterns to gain an insight into the relative importance of the competitive constraints that alternative providers impose on a particular hospital trust

    132.2. the level of closeness of competition between the parties and relative to other hospitals and

[50] It has used data based on GP referrals for the Bournemouth and Poole PCT and Dorset PCT.

132.3. the competitive strength of the remaining constraints on the merger parties including, where appropriate, those outside the geographic frame of reference.

133. The market share information at overall level indicates that the merger will create the largest provider of NHS routine elective care in the Cluster Dorset PCT (by number of referrals). The merger will lead to a total market share of 57 per cent with an increment of 23 per cent. The nearest provider to the parties post-merger would be Dorset County Hospital NHS Foundation Trust (DCH) with a share of around 27 per cent. This indicates a high degree of concentration in the area in the supply of routine elective services overall. In addition, there will be a significant difference between the combined merger parties and the next nearest competitor (DCH). As to a detailed assessment of those specialties raising competition concerns, the OFT notes that there are 17 specialties in which the merger parties will have combined market shares exceeding 40 per cent with an increment above 10 per cent. The OFT has competition concerns regarding these 17 specialties.

134. In addition, the evidence available to the OFT indicates that the merger parties compete closely in the provision to patients of routine elective care in several specialities and in competition for the market in non-elective care. This evidence includes third parties' responses to the OFT's investigation, the McKinsey due diligence report produced on behalf of the parties, OFT analysis of GP referral patterns, and the parties' geographic proximity.

135. Given these concerns, the OFT considered the prospects for the remaining competitive constraints on the merger parties. The OFT's analysis of the GP referral patterns and third parties' views did not highlight other NHS or private hospitals as being strong competitors to the merger parties across a significant proportion of clinical services. In light of these views, the OFT could not consider that the competitive constraint exerted by any of these hospitals individually, or all of them collectively, would be sufficient to constrain the merged entity going forward.

136. On non-elective services, the OFT found that the choices offered to commissioners and patients will be reduced as a result of this merger. Such concerns were not allayed by the prospect of new entry.

137. In light of the above assessment, the OFT finds an SLC with regard to the provision of the following routine elective (hospital-based) care specialties as a result of unilateral horizontal effects: rheumatology, rehabilitation, general medicine, general surgery, geriatric medicine, dermatology, clinical haematology, oral and maxillofacial surgery, cardiology, palliative medicine and cardiothoracic surgery.

138. With regard to medical oncology, gynaecology, vascular surgery, neurology, ENT and trauma and orthopaedics and non-elective services, the evidence available to the OFT indicates that this merger may lead to a SLC on a 'may be the case' standard.

139. The OFT is concerned that this merger might reduce the hospitals' incentives to undertake investment or actions (for example to continue to enhance the quality of those services over the minimum required standards), to compete for patient income by not undertaking the same level of investment, or actions which attract patients to a particular hospital (such as shorter waiting times and better auxiliary services).

140. Consequently, the OFT believes that it is or may be the case that the merger may be expected to result in a substantial lessening of competition within a market or markets in the United Kingdom.

EXCEPTIONS TO THE DUTY TO REFER

Relevant customer benefits

Legal test and the role of the OFT

141. Under section 33(2)(c) of the Act, the OFT may decide not to refer a merger to the Competition Commission where the relevant customers benefits (RCBs) in relation to the creation of the relevant

merger situation concerned outweigh the SLC concerned and any adverse effects of such SLC.[51]

142. The OFT is tasked with undertaking the assessment of whether RCBs outweigh the SLC it has identified as a result of its merger assessment.

Role of Monitor

143. In cases of mergers involving NHS foundation trusts, the Health and Social Care Act 2012 requires that Monitor provide the OFT with specific advice on RCBs.[52] Monitor provided its advice to the OFT on 10 December 2012 (Monitor's advice).[53]

OFT's approach to relevant customer benefits

144. In order to constitute RCBs under the Act, the benefits must be merger specific. That is, they must be unlikely to accrue without the creation of the merger or a similar lessening of competition.[54] In addition, such RCBs must be clear and the evidence in support of them must be compelling.

145. In general, the merger parties must be able to produce detailed and verifiable evidence of the RCBs that allows the OFT assess both the magnitude of the RCBs and the probability of them occurring and that they will be pass on to patients, commissioners and other customers. The OFT sets the magnitude and probability of the RCBs against the scale and probability of the identified anti-competitive

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[51] The OFT has also issued guidance on this matter. See OFT's, *Mergers – Exceptions to the duty to refer and undertakings in lieu of reference guidance*, December 2010, OFT1122, Chapter 4.

[52] Section 79(5) of the Health and Social Care Act 2012.

[53] A non-confidential version of such advice will be published on Monitor and the OFT's websites at the same time as the non-confidential version of this decision.

[54] See OFT's Exceptions to the duty to refer and undertakings in lieu of reference guidance paragraph 4.7.

effects.[55] In the event that the evidence supporting the RCBs is clear and compelling, the RCBs in one market can offset the effects of an SLC in another.

Assessment of possible relevant customer benefits in this case

146. The merger parties submitted that this merger will give rise to significant RCBs that could not be achieved without it. The merger parties categorise these RCBs under four themes:

146.1. improved quality and safety of services

146.2. delivery of financial savings through economies of scale

146.3. improved scope of services

146.4. enhanced ability to raise capital

147. The merger parties propose to reconfigure five services (maternity, haematology, emergency department, acute general surgery and cardiology) which they submitted will improve the quality of those services. They stress that the proposed reconfiguration of these services will be subject to consultation requirements under the National Health Service Act 2006 and approvals by the commissioners and Monitor.

148. Monitor has advised that some benefits may accrue to patients in the form of higher quality maternity and cardiology services. However, Monitor advises that it is not appropriate to treat the other claimed benefits as [RCBs] for the purposes of the [OFT's] assessment under [the Act].'[56] Specifically, Monitor advises that:

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[55] See OFT's, *Mergers – Exceptions to the duty to refer and undertakings in lieu of reference guidance*, December 2010, OFT1122, paragraphs 4.9-10.

[56] See Monitor's advice, page 3.

148.1. RCBs only arise from the merger in relation to the provision of maternity services and (to a lesser and temporary extent) in cardiology services

148.2. other benefits the merger parties have put forward as possible RCBs do not amount to such for different reasons. These reasons are detailed in Monitor's advice.

149. In summary, Monitor questions whether some of the remaining suggested benefits meet all the criteria to be accepted as RCBs. It raises some doubts that some of those benefits can only accrue as a result of the merger and/or will effectively accrue (for example in relation to haematology, A&E and general surgery). In the case of other possible benefits, Monitor is not satisfied that the merger parties have submitted sufficient detailed evidence to support their arguments (for example with regard to financial savings, the ability to raise additional capital and benefits on services other than those specifically addressed in the merger parties' submission on benefits and in Monitor's advice).

150. Given Monitor's sectoral expertise and statutory advisory role, the OFT has taken due account of its advice. The OFT has also considered additional evidence submitted by the merger parties on this issue. It does not believe that this additional evidence undermines Monitor's advice in any significant respect. In addition, the OFT has sought to consider the views of third parties, in particular, the commissioners, against the above criteria.[57]

151. Responses from third parties relating to RCBs were mixed. While they acknowledged that some benefits for patients could arise from this merger, there were equal concerns about the closures of certain services, most notably A&E and maternity, as well as an overall loss of choice.

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[57] See paragraphs 144 *ff* above and most generally, OFT's *Mergers – Exceptions to the duty to refer and undertakings in lieu of reference guidance*, December 2010, OFT1122, Chapter 4.

152. The commissioners provided support for the merger's ability to generate certain RCBs. They were not specific as to the precise RCBs which would accrue but did anticipate that the merger would facilitate the delivery of the wider commissioning intentions in Dorset through providing an entity which can meet their intentions in a clinically and financially sound manner.

153. In applying its discretion the legislation requires the OFT to be satisfied that the RCBs outweigh the competition loss. In this case, the OFT cannot be satisfied that they are sufficient to outweigh the competition concerns it has identified.

154. The OFT considers that the test for reference is or may be met in relation to the supply of routine elective (hospital-based) care across a range of clinical specialties and non-elective care. This would mean that the potential adverse effects of the loss of competition in the form of a reduction in quality of service for patients would extend significantly beyond the two areas (maternity and cardiology services) in which Monitor considers RCBs may arise. It would also raise competition concerns across a wider range of areas than those specified by commissioners in their submissions to the OFT as to the benefits which could be realised by the merger.

155. The OFT is also conscious of concerns raised by Monitor about the lack of evidence to substantiate some of the arguments presented by the merger parties on this matter.

156. Overall based on the evidence available to it, the OFT is not satisfied that the RCBs would outweigh the identified SLC. In reaching this conclusion, the OFT has considered in the round the financial and non-financial (including clinical) aspects which were detailed in Monitor's advice.

DECISION

157. The merger will therefore be referred to the Competition Commission pursuant to section 33(1) of the Act.

End Note 1- In relation to paragraph 51 of this decision, following the announcement of the decision, the merger parties told the OFT that the merged trust has not included an Appointed Governor for New Forest District Council although the New Forest will be part of the public constituency. This minor factual adjustment does not materially change the substance of this decision.

Annex I- Elective (hospital based) care

Specialties	Poole	Poole - %	Bournemouth	Bournemouth - %	PH + RBCH - %	Southampton University Hospital - %	Yeovil District Hospital NHS FT - %	Dorset County Hospital NHS FT - %	Basingstoke NHS - %	Salisbury NHS FT - %	Southern Health NHS FT - %	Others - %	Total
Allergy	0	0.0%	584	86.5%	86.5%	10.4%	0.0%	0.0%	0.0%	0.0%	0.0%	3.1%	675
Anaesthetics	208	1.7%	11,575	93.1%	94.7%	0.0%	0.7%	3.2%	0.1%	0.0%	0.0%	1.3%	12,436
Anticoagulant Service	431	75.7%	0	0.0%	75.7%	0.0%	0.0%	0.0%	0.0%	17.6%	0.0%	6.7%	569
Breast Surgery	0	0.0%	5,609	54.4%	54.4%	0.5%	0.0%	35.1%	0.0%	8.1%	0.0%	1.9%	10,308
CARDIOLOGY	7,535	20.4%	14,450	39.1%	59.5%	1.6%	6.1%	23.3%	0.0%	2.6%	0.0%	6.9%	36,965
CARDIOTHORACIC SURGERY	101	72.1%	25	17.9%	90.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	10.0%	140
CLINICAL HAEMATOLOGY	4,945	19.6%	9,914	39.3%	58.9%	1.4%	1.1%	29.5%	0.0%	2.8%	0.0%	6.4%	25,244
CLINICAL IMMUNOLOGY	0	0.0%	64	55.2%	55.2%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	44.8%	116
CLINICAL IMMUNOLOGY and ALLERGY	0	0.0%	42	10.5%	10.5%	84.5%	0.0%	0.0%	0.0%	0.0%	0.0%	5.0%	401

Specialties	Poole	Poole - %	Bournemouth	Bournemouth - %	PH + RBCH - %	Southampton University Hospital - %	Yeovil District Hospital NHS FT - %	Dorset County Hospital NHS FT - %	Basingstoke NHS - %	Salisbury NHS FT - %	Southern Health NHS FT - %	Others - %	Total
CLINICAL ONCOLOGY (previously RADIOTHERAPY)	12,729	66.6%	55	0.3%	66.9%	0.8%	0.4%	19.1%	0.0%	1.2%	0.0%	11.6%	19,107
COLORECTAL SURGERY	0	0.0%	4,540	44.2%	44.2%	0.0%	0.0%	47.6%	0.0%	7.0%	0.0%	1.1%	10,278
DERMATOLOGY	16,206	34.1%	17,446	36.7%	70.9%	0.1%	1.5%	16.1%	0.0%	5.7%	0.1%	5.8%	47,490
DIABETIC MEDICINE	0	0.0%	8,016	54.9%	54.9%	0.0%	0.0%	42.6%	0.0%	1.7%	0.0%	0.7%	14,590
DIETETICS	3	0.1%	2,090	96.4%	96.5%	0.6%	0.4%	0.0%	0.0%	0.0%	0.0%	2.5%	2,168
ENDOCRINOLOGY	0	0.0%	2,196	82.1%	82.1%	1.3%	0.0%	0.0%	0.1%	8.5%	0.0%	7.9%	2,674
ENT	12,151	40.8%	4,258	14.3%	55.1%	1.4%	1.6%	26.4%	0.1%	6.4%	0.2%	8.9%	29,799
GASTROENTEROLOGY	344	2.7%	5,343	42.7%	45.5%	0.8%	3.6%	40.6%	0.1%	3.1%	0.2%	6.1%	12,510
GENERAL MEDICINE	17,839	58.8%	4,237	14.0%	72.7%	0.1%	2.1%	19.8%	0.0%	2.0%	0.1%	3.3%	30,352
GENERAL SURGERY	10,485	43.3%	2,341	9.7%	52.9%	1.2%	8.7%	16.2%	0.2%	4.6%	0.1%	16.1%	24,231

Specialties	Poole	Poole - %	Bournemouth	Bournemouth - %	PH + RBCH - %	Southampton University Hospital - %	Yeovil District Hospital NHS FT - %	Dorset County Hospital NHS FT - %	Basingstoke NHS - %	Salisbury NHS FT - %	Southern Health NHS FT - %	Others - %	Total
GERIATRIC MEDICINE	3,075	32.2%	3,413	35.7%	67.9%	0.0%	2.2%	20.1%	0.0%	0.8%	0.0%	9.0%	9,550
GYNAECOLOGICAL ONCOLOGY	478	80.1%	0	0.0%	80.1%	0.0%	0.0%	0.0%	0.0%	10.2%	0.0%	9.7%	597
GYNAECOLOGY	8,472	25.1%	11,456	34.0%	59.1%	1.3%	3.4%	27.8%	0.0%	2.4%	0.0%	5.8%	33,700
HEPATOBILIARY & PANCREATIC SURGERY	0	0.0%	271	79.5%	79.5%	0.0%	0.0%	0.0%	6.5%	0.0%	0.0%	14.1%	341
HEPATOLOGY	0	0.0%	2,980	88.0%	88.0%	3.1%	2.2%	0.0%	0.0%	1.2%	0.0%	5.5%	3,386
INTERVENTIONAL RADIOLOGY	0	0.0%	56	24.2%	24.2%	0.4%	0.0%	0.0%	0.0%	51.1%	0.0%	24.2%	231
MEDICAL ONCOLOGY	2,351	21.6%	5,984	55.1%	76.7%	2.5%	5.3%	6.9%	0.2%	4.6%	0.0%	3.8%	10,870
NEUROLOGY	3,845	48.1%	1,196	15.0%	63.1%	6.0%	2.1%	20.9%	0.0%	0.0%	0.0%	8.0%	7,994
NEUROSURGERY	89	5.0%	0	0.0%	5.0%	84.4%	0.0%	0.0%	0.0%	0.0%	0.1%	10.5%	1,782
OBSTETRICS	7,090	22.5%	3,701	11.7%	34.2%	0.1%	2.8%	60.1%	0.0%	2.2%	0.0%	0.5%	31,532

Specialties	Poole	Poole - %	Bournemouth	Bournemouth - %	PH + RBCH - %	Southampton University Hospital - %	Yeovil District Hospital NHS FT - %	Dorset County Hospital NHS FT - %	Basingstoke NHS - %	Salisbury NHS FT - %	Southern Health NHS FT - %	Others - %	Total
OPHTHALMOLOGY	2,631	3.5%	39,359	52.9%	56.5%	1.0%	2.3%	29.6%	0.0%	4.3%	0.1%	6.2%	74,375
ORAL SURGERY	11,957	69.3%	2,937	17.0%	86.3%	0.2%	2.5%	0.0%	0.0%	7.1%	0.2%	3.6%	17,249
ORTHODONTICS	0	0.0%	9,610	39.3%	39.3%	0.0%	2.4%	54.5%	0.0%	1.9%	0.0%	1.8%	24,455
ORTHOPTICS	0	0.0%	6,763	91.3%	91.3%	0.0%	2.4%	0.0%	0.0%	5.2%	0.0%	1.1%	7,409
PAEDIATRIC CARDIOLOGY	303	20.3%	0	0.0%	20.3%	60.4%	0.0%	13.4%	0.0%	0.0%	0.0%	5.9%	1,492
PAEDIATRIC DIABETIC MEDICINE	658	64.3%	0	0.0%	64.3%	0.0%	0.0%	30.2%	0.0%	5.2%	0.0%	0.4%	1,024
PAEDIATRIC MEDICAL ONCOLOGY	357	79.9%	0	0.0%	79.9%	0.9%	0.0%	8.3%	0.0%	1.8%	0.0%	9.2%	447
PAEDIATRIC RESPIRATORY MEDICINE	95	29.8%	0	0.0%	29.8%	48.0%	0.0%	16.6%	0.0%	1.9%	0.0%	3.8%	319
PAEDIATRIC SURGERY	356	32.0%	0	0.0%	32.0%	34.7%	0.0%	29.6%	0.0%	0.0%	0.0%	3.7%	1,113
PAEDIATRICS	8,993	52.8%	867	5.1%	57.9%	0.6%	5.4%	28.3%	0.1%	5.9%	0.1%	1.9%	17,027

Specialties	Poole	Poole - %	Bournemouth	Bournemouth - %	PH + RBCH - %	Southampton University Hospital - %	Yeovil District Hospital NHS FT - %	Dorset County Hospital NHS FT - %	Basingstoke NHS - %	Salisbury NHS FT - %	Southern Health NHS FT - %	Others - %	Total
PAIN MANAGEMENT	3,669	35.2%	797	7.6%	42.9%	0.0%	0.1%	50.4%	0.0%	0.9%	0.1%	5.6%	10,422
PALLIATIVE MEDICINE	616	15.2%	3,372	83.1%	98.3%	1.7%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	4,057
PHYSIOTHERAPY	3	0.0%	0	0.0%	0.0%	0.4%	4.3%	87.6%	0.0%	6.4%	0.0%	1.3%	23,039
REHABILITATION	501	31.8%	174	11.1%	42.9%	0.0%	0.6%	11.9%	0.0%	41.8%	0.0%	2.8%	1,573
RESPIRATORY MEDICINE	10	0.1%	8,462	54.4%	54.4%	0.9%	3.3%	23.4%	0.0%	13.3%	0.0%	4.6%	15,567
RHEUMATOLOGY	10,100	34.7%	10,820	37.2%	71.8%	0.2%	2.6%	13.0%	0.0%	4.1%	0.2%	7.9%	29,123
TRANSIENT ISCHAEMIC ATTACK	0	0.0%	839	99.4%	99.4%	0.1%	0.0%	0.0%	0.0%	0.0%	0.0%	0.5%	844
TRAUMA & ORTHOPAEDICS	23,899	21.5%	30,837	27.8%	49.3%	0.5%	3.1%	21.1%	0.1%	3.4%	0.1%	22.5%	111,122
UPPER GASTROINTESTINAL SURGERY	0	0.0%	2,515	97.3%	97.3%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	2.7%	2,584
UROLOGY	1,439	5.6%	12,283	48.0%	53.6%	0.2%	4.2%	31.1%	0.1%	4.0%	0.1%	6.7%	25,600

Specialties	Poole	Poole - %	Bournemouth	Bournemouth - %	PH + RBCH - %	Southampton University Hospital - %	Yeovil District Hospital NHS FT - %	Dorset County Hospital NHS FT - %	Basingstoke NHS - %	Salisbury NHS FT - %	Southern Health NHS FT - %	Others - %	Total
VASCULAR SURGERY	549	15.4%	2,595	72.6%	88.0%	0.3%	0.0%	0.0%	0.0%	8.9%	0.2%	2.6%	3,573
Grand Total	**174,513**	**23.2%**	**254,072**	**33.8%**	**57.0%**	**1.2%**	**2.8%**	**27.1%**	**0.0%**	**4.0%**	**0.1%**	**8.0%**	**752,450**

Annex II- Inpatient (elective and non-elective) procedures by Healthcare Resource Groups

	NUMBER OF HRG					NUMBER OF TREATMENTS				
Secondary elective services	**Both**	**RBCH only**	**PH only**	**Neither**		**Both**		**RBCH only**	**PH only**	**Neither**
						RBCH	**PH**			
Neurology	[20-30]	[5-15]	[10-20]	[20-30]		[1000-1500]	[1000-1500]	[0-100]	[0-100]	0
Ophthalmology	[0-10]	[20-30]	[0-10]	[0-10]		[4000-4500]	[0-100]	[4500-5000]	[0-10]	0
ENT	[20-30]	[0-10]	[30-40]	[0-10]		[600-1000]	[2500-3000]	[0-10]	[500-1000]	0
Trauma	[10-20]	[0-10]	[30-40]	[10-20]		[0-100]	[100-600]	[0-10]	[500-1000]	0
Orthopaedics	[40-50]	[10-20]	[0-10]	[0-10]		[5500-6000]	[500-1000]	[2000-2500]	[0-10]	0
Paediatrics	[0-10]	[0-10]	[50-60]	[40-50]		[0-100]	[0-100]	[0-10]	[0-500]	0
Medical Oncology										0
Gynaecology	[30-40]	[0-10]	[10-20]	[10-20]		[1000-1500]	[2000-2500]	[0-10]	[0-100]	0
Vascular Surgery	[10-20]	[10-20]	[0-10]	[0-10]		[500-1000]	[0-200]	[500-1000]	[0-10]	0
Urology	[30-40]	[50-60]	[0-10]	[10-20]		[6500-7000]	[500-1000]	[2000-2500]0	[0-500]	0