31 March 2015

CMA Phase 2 review: anticipated merger of Ashford and St Peter's NHS FT and Royal Surrey County Hospital NHS FT

NHS Providers' submission

ABOUT NHS PROVIDERS

NHS Providers is the membership organisation and trade association for the NHS acute, ambulance, community and mental health services that treat patients and service users in the NHS. We help those NHS foundation trusts and trusts to deliver high quality, patient focused, care by enabling them to learn from each other, acting as their public voice and helping shape the system in which they operate.

NHS Providers has 226 members – 94 per cent of all NHS foundation trusts and aspirant trusts – who collectively account for £65 billion of annual expenditure and employ more than 928,000 staff.

INTRODUCTION

NHS Providers welcomes the opportunity to provide its views on the anticipated merger of Ashford and St Peter's Hospitals NHS Foundation Trust (ASP) and Royal Surrey County NHS Foundation Trust (RSC), to assist the Competition and Markets Authority (CMA) in its understanding of the market in the NHS. Both ASP and RSC are members of NHS Providers.

This submission will deliberately focus on the system wide implications of the UK merger control regime as it operates within the context of the NHS, particularly given the policy priorities set nationally for the health service, and the nature of the financial and quality challenges facing NHS providers. We will explore what this means for mergers of this kind in the NHS and the importance of the CMA taking these issues fully into account, within the existing legal framework, when undertaking any Phase 2 review. We do not aim to repeat the detail of the case the two trusts have already made for their proposed merger however we will allude to the specifics of the ASP and RSC proposals when we feel they illustrate a wider point with ramifications for the operation of the merger control regime within the NHS as a whole.

CURRENT CONTEXT AND SYSTEMIC ISSUES FACING THE NHS

National policy priorities

As colleagues in the CMA will be aware, there has been a recent shift in the national rhetoric and the policy framework within which the NHS operates, with a renewed focus on integration and collaboration as a means of moving towards more financial and clinical sustainable models of care.

The *Five Year Forward View* (5YFV), published in October 2014, sets out the strategic vision for the NHS and presented a compelling case for change based on the need to move away from 'short term expedients' to preserve services and standards and focus on a longer term strategy. The vision promotes a health and care system focussed on prevention with more integrated and flexible models of service delivery, operating with maximum efficiency and presented a number of care models to achieve these changes. This vision was developed by the six arms-length bodies in the NHS (Monitor, NHS Trust Development Authority, Care Quality Commission, Health Education England and Public Health England), presenting, for the

first time since the restructure of the health service, a fully unified policy direction for NHS providers, commissioners and other partners. The 5YFV was also welcomed by all the political parties, as well as policy commentators, and the current government has committed to a 'four pillar plan' to support the implementation of the vision[1].

The 5YFV importantly identifies three widening gaps which will compromise the long term sustainability of the NHS, all of which should, in our view, be pertinent in the CMA's considerations of the counterfactual and patient benefits within merger reviews:

1. The health and wellbeing gap: without a focus on prevention, health inequalities will widen.
2. The care and quality gap: without reshaping care, the changing needs of patients will go unmet.
3. The funding and efficiency gap: without matching funding levels with system efficiencies, we will see worse services, fewer staff, more deficits and restrictions on new treatments.

Since the publication of the 5YFV, 29 sites across England have been selected as 'vanguards' and will be supported by the arms-length bodies to develop new care models, further demonstrating the commitment of the centre and the sector to pursuing new approaches. Importantly all local health economies, and NHS providers have been strongly encouraged to consider a range of means for collaborating and moving to new care models with Simon Stevens, Chief Executive of NHS England, stating that "in some places mergers and reconfigurations will of course be needed[2]".

In addition, Sir David Dalton's review of organisational forms *'Examining new options and opportunities for providers of NHS care'*, published in December 2014, offered a range of organisational forms, covering collaborative, contractual and consolidation approaches, which could be used to practically support the delivery of the care models described in the 5YFV. These models included full scale acquisitions or mergers, joint ventures, group structures, service level chains and management contracts. The Dalton review was commissioned by the Health Secretary and made several recommendations to national bodies and leaders across the NHS, these recommendations covered five themes, which if addressed would accelerate the transformational change required to overcome the challenges facing the NHS. One of these key themes was the need for quicker transformational and transactional change, specifically referencing competition as a perceived barrier to this. The government welcomed the Dalton review and its recommendations, the Health Secretary encouraged all those working in or with the NHS to consider the review's recommendations in their own work[3].

It is our view that while competition can be one driver of quality and service improvement in the NHS, it must be applied carefully and appropriately to the ultimate benefit of patients. It is essential that the application of competition law and the UK merger regime do not prevent the NHS sector from moving towards new patterns of service delivery and developing the care models set out in the 5YFV and the organisational forms presented within the Dalton review.

The 5YFV and the Dalton review send a strong message to the sector that more integrated care models, including horizontal and structural integration are increasingly supported and encouraged by national policy makers. New care models are essential to better integrate services for the benefit of patients and equally, to ensure the clinical and financial sustainability of NHS services. It is therefore essential that the CMA takes the longer-term strategy for the NHS as a whole into account in undertaking a merger review involving NHS organisations.

Growing financial and operational pressures

The operational and financial challenges facing the NHS are unprecedented. Demand is continuing to increase across all services within the health and care system at a rate far above the long run average for the NHS, for example attendances to type 1 A&E departments had increased by 5.4% in quarter 3 of 2014/15, compared to the same period in 2013/14[4] . In addition, NHS providers report increasing complexity of need as demography changes and we seek to support an ageing population with an increase in the prevalence of co-morbidities and long term conditions.

[1] http://www.publications.parliament.uk/pa/cm201415/cmhansrd/cm141201/debtext/141201-0002.htm#1412014000003 [accessed 27 March 2015]
[2] https://www.england.nhs.uk/2014/06/04/simon-stevens-nhs-confed/ [accessed 30 March 2015]
[3] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/384126/Dalton_Review.pdf [accessed 31 March 2015]
[4] NHS Providers analysis of NHS England A&E Weekly SitRep data. Type 1 A&E attendances only.

As demand grows, the financial context for the NHS provider sector has deteriorated sharply. Despite the welcome focus on closing the funding and efficiency gap set out in the 5YFV, the sector is still being challenged to deliver record levels of efficiencies, of £22bn by 2020/21 (based on existing levels of productivity) which still leaves an £8 billion funding gap facing the NHS by 2020/21[5]. The recent debates about the national tariff demonstrate that the historic national focus on driving efficiencies through the national payment system for NHS providers is no longer tenable, nor is holding flat NHS staff pay indefinitely in attempts to control trusts' greatest outlay.

The provider sector is now expected to end 2014/15 over £850 million in deficit, rising to a projected deficit of £2.5 billion at the end of 2015/16. In the hospital sector alone, we are expecting 80% of acute trusts to end the year in financial deficit. Monitor also reports a slowing of efficiency savings delivered through individual providers' cost improvement plans and more and more providers are looking outwardly to their partners to realise the transformation in financial and clinical sustainability required to safeguard services for the future.

In fact, as Ashford and St Peters and Royal Surrey have indicated, the financial pressures are rising at such a pace that even those NHS providers which have historically been high performing with well managed finances are now facing unprecedented financial challenge with many reporting deficits for the first time with the medium term outlook over the five years, becoming particularly financially challenging

Operationally, at a national level, the pressures of growing demand, and flat funding, can be seen in national level breaches of constitutional performance targets including referral to treatment times and waiting times for accident and emergency care – which have come under unprecedented pressure over the past couple of years.[6]

In short, the financial pressures, along with the growing focus on transforming services to maintain modern, high quality care, is increasing an impetus for change. Providers of NHS services are therefore exploring all their strategic options and in some cases this will result in the pursuit of a merger with another organisation, or another transaction that be considered a relevant merger situation by the CMA, in order to maintain the sustainability of their organisation and continue to safely deliver essential services to patients. The context in which NHS providers are operating has significantly altered over recent years, and we would encourage the CMA to carefully consider this during the Phase 2 review of the anticipated merger of ASP and RSC.

Our concerns are that if NHS organisations are not able to pursue longer-term strategic options, they will inevitably fall further into financial difficulty with a direct impact on quality and access to services, and the consequent burden and expense of additional regulatory scrutiny, or intervention. If the challenges are still not fully resolved and an organisation is no longer able to deliver safe services due to on-going financial and/or clinical unsustainability it may then potentially enter a costly and lengthy special administration process, most likely leading to the dissolution of the organisation and a reconfiguration of services. In each instance, our preference would always be for proactive, NHS providers to work with their local health and social care economy partners to propose and pursue the best solution to ensure the clinical and financial sustainability of their services for local patient populations, and the taxpayer.

It is therefore essential that the CMA takes the rapidly worsening financial context within the NHS, and for the NHS provider sector specifically, into account when assessing proposed mergers. This should include full consideration of the long term financial sustainability of the organisations involved when considering the counterfactual *and* when assessing the benefit to patients, and to taxpayers. While we accept that a merger will not be the right option for all trusts, we are concerned that the mounting financial challenge facing trusts has been underplayed within the counterfactual in some cases to date, and remains of central importance in the case of ASPH and RSCH. We also consider safeguarding the long-term financial and clinical viability of services as being central to the relevant patient benefits of any proposal.

Increased regulatory scrutiny and the impact of rising quality standards

Quality of care has rightly risen up the agenda following some major failings in care in recent years and the publication of the Francis Inquiry, the Berwick review into patient safety and the Keogh mortality review, resulting in a strengthened role for quality regulation. We have welcomed this recent focus on quality and support the operation of an effective, risk-based regulatory

[5] Five Year Forward View
[6] http://www.nuffieldtrust.org.uk/sites/files/nuffield/publication/policy-briefing-4-hospital-access-targets-web-version.pdf

regime that promotes public confidence in the NHS and ensures quality of care retains parity with financial scrutiny. However, it is important to note that because of this NHS providers are now required to meet additional standards, such as minimum staffing numbers needed to deliver safe services, which require additional investment and expenditure. There has also been an increased focus on the NHS moving towards consultant led seven day services, a priority of NHS England since 2013.

In the current context, many providers simply cannot afford to meet new quality requirements, or seek to continually improve their services, without working in different ways, including through structural mergers with others. There is clear evidence that meeting the necessary quality improvements can result in providers facing increased financial challenges. For instance, The King's Fund recently reported that following 12 months in 'special measures', Basildon and Thurrock University Hospitals NHS Foundation Trust, moved from forecasting a £0.1million surplus to reporting an actual deficit of £9 million in 2013/14. The King's Fund suggested that this was primarily due to an increased investment in quality and the recruitment of an additional 200 nurses[7].

Many organisations, such as ASP and RSC, will take a decision to pool their resources and collaborate in order to meet additional quality standards and deliver integrated services seven days a week, in a financially sustainable way. For instance, in this case ASP and RSC have submitted that a key patient benefit of their proposed merger is extended seven-day consultant-led or nurse-led care across a number of core services.

The CMA should place significant weight on patient benefits that will assist providers to meet required national quality standards, such as minimum staffing levels and seven day services. The CMA should factor into the counterfactual the consequences of providers failing to deliver services to the required standards, and of the financial implications of resourcing new quality standards as standalone organisations.

COMPETITION IN THE NHS

The CMA is expert in assessing the impact of mergers on competition in a number of sectors and has made considerable efforts to develop its knowledge and understanding of the NHS and the unique challenges it presents when applying market principles. We have particularly welcomed the sector-specific guidance the CMA has produced in collaboration with Monitor and have been encouraged to see a number of NHS transactions approved by the CMA over the past two years at a Phase 1 review. However, we would like to cover some issues that arise when mergers in the NHS are considered through a purist competition lens. We would encourage the CMA to consider these points in full as part of its Phase 2 review of the proposed ASP and RSC merger.

Markets in the NHS

The CMA is fully aware that the market conditions in the NHS are different to those in other sectors, however we would like to take the opportunity to reiterate this point. The NHS market is complex and heterogeneous. Patients' experience of a 'market' within the NHS varies depending on the geographical location, the types of services provided, the demographic of the population and the needs of the population. Some patients elect to use the provisions of choice within the NHS, and others do not. The main distinction between the NHS market and those in other sectors is the degree of provider entry and exit, and the fact that competition in the NHS is theoretically, based on quality rather than price.

Market entry and exit in the NHS differs dependent on the service in question. While the barriers to entry for wholly new providers is very high in the NHS, the barriers to entry and expansion in offering routine elective services for some specialties can be quite low entry for providers already delivering services in other specialties – a point we understand that ASP and RSC have made with regard to their own submission.

Quality regulation within the NHS

While regulation does not drive quality improvement as such, it plays a key role in ensuring that providers of NHS services are delivering care to agreed quality standards. Whatever the final configuration of a provider of NHS services, the Care Quality Commission (CQC) will regulate it services to ensure agreed standards of care are met. As such, the role of the newly

[7] The King's Fund (2014) *'financial failure in the NHS'*. Available here: http://www.kingsfund.org.uk/publications/financial-failure-nhs [accessed 31 March 2015]

strengthened quality regulation to which NHS services are subject in the wake of the Francis report arguably plays a much more central role in ensuring quality standards are met, than the much more peripheral role of competition within the sector.

Quality levers in the NHS

The CMA refers to patient choice and the Payment by Results (PbR) system as the incentives for providers to make spending decisions that affect quality in a way that best reflects the factors that matter to patients and GPs[8]. However it is important to recognise that choice is just one driver of improvement, and alongside this there is much academic debate on whether genuine choice operates within the NHS and to what extent it leads to improved quality with some arguing the evidence for competition as a driver of quality within the NHS remains relatively weak and under developed. There are undoubtedly a number of additional levers in the NHS that are used to drive quality improvements, including regulatory compliance, standards and expectations provided by NICE, professional and sector specific guidance (issued by the Royal Colleges for example) and sector-led initiatives to share and develop good practice. Commissioners also play a central role in agreeing quality expectations with providers and monitoring them contractually.

Although one of the principles behind the design of PbR was to drive patient choice by incentivising providers to attract more 'customers' for their services, it was also designed to increase access and reduce waiting times for services. The system is deliberately aimed at improving productivity and output and it is widely recognised that other mechanisms, separate to the payment system, are intended to incentivise high quality services. In this context, we would would query whether the PbR system should be seen as anything more than a payment system. We also recognise that radical change to payment and funding systems is needed to better meet the needs of patients and a key consideration of this is recognising the limitations of what payment systems can achieve and being clear on what it's trying to achieve.

We would urge the CMA to fully consider the limitations of the 'market' within the NHS when ascertaining when a proposed merger could lead to a 'significant lessening of competition', and in weighing up patient benefits within its Phase 2 reviews. While we welcome the tailored guidance CMA has created with Monitor for the sector, in our view, too much reliance is still placed on 'competition' as a driver of quality given the complexity of the system, the range of challenges facing NHS providers, and the safeguards which remain in place (via regulation and other processes) to protect, monitor and sustain agreed quality standards..

When considering the impact that reduced choice could have on the quality of services, the CMA should also take into account the fact that a merged organisation would still be subject to regulation by CQC and therefore would continue to deliver services that meet the required quality standards. A reduction in choice would not inevitably lead to a reduction in the quality of services received by the patient.

Counterfactuals in the NHS

As described above, the financial stability of the NHS is worsening and an organisation's financial position can change dramatically quite quickly. Historically, when facing financial difficulty NHS providers have been propped up by 'bail outs' from the Department of Health (DH). The DH however wishes to move away from this approach[9], as it is now considered to be short-termist and a blunt incentive for efficiency.

While it may not be the case that organisations will exit the market in the near future (in fact very few do genuinely exit the market), it is essential to consider the long-term picture when considering the counterfactual for any NHS organisations exploring a merger or other significant transaction.

The financial challenge facing ASP and RSC reflects the national context described above. Despite both organisations historically maintaining a healthy financial position, and delivering significant cost improvements and efficiency savings over the past three to four years, their financial situation is worsening. Since the parties' initial submission to the CMA, both organisations are now forecasting a deficit much earlier than previously anticipated and this has been confirmed to the CMA by North West Surrey CCG.

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[8] CMA phase 1 decision (p. 2) https://www.gov.uk/cma-cases/ashford-st-peter-s-nhs-foundation-trust-royal-surrey-county-nhs-foundation-trust [accessed 27 March 2015]

[9] https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/365134/SofS_Finance_Guidance_under_Section_42A.pdf [accessed 31 March 2015]

The CMA should consider financial projections for at least the next five years when deciding on the counterfactual for any proposed merger. We would encourage the CMA to place considerable weight and fully consider this significant change in circumstances when considering the counterfactual during the Phase 2 review.

Benefits to patients and taxpayers

NHS providers will be pursuing various strategic options to remain clinically and financial sustainable both in the short and long term, while also driving change to achieve the vision set out in the 5YFV and meet other policy priorities such as seven day working, as described above.

All these initiatives will have a positive impact on the care delivered to patients and while in some cases the desired outcome may be achieved without a merger, if it makes strategic sense for organisations to merge in order to realise the benefits, and helps avoid severe financial difficulty further down the line, they should not be penalised for doing so.

In the NHS relevant customer benefits refers to benefits to patients and the tax payer. As described above, where organisations are unable to pursue strategic options for moving towards financially sustainable models of care, they are most likely to experience further financial difficulty. Strategic options, such as mergers and other transactions reviewable by the CMA may help avoid a costly and lengthy trust special administration regime, which should clearly be considered as a benefit to patients and the tax payer. Monitor has recently reported on the cost of the TSA regime in Mid Staffordshire, which was almost £19.5 million over 18 months. £15.25 million had originally been budgeted for the work and the timescale was extended twice firstly to ensure that local NHS bodies agreed to all the TSA recommendations and secondly to allow time to agree the funding needed to implement these recommendations.

The CMA should place significant weight on benefits that help achieve these wider policy priorities when reviewing proposed mergers within the NHS specifically. The CMA should fully consider the benefits to tax payers, where a proposed merger benefits includes a significant financial saving.

The role of Monitor and third party comments

It is right that the CMA gives due consideration and weight to the advice provided by Monitor in any merger review, as the specialist healthcare regulator. However we are concerned that in the case of the ASP and RSC proposed merger the role of Monitor is still not clear and we will be continuing our dialogue with them to explore whether we can collaboratively identify how we might contribute to making this clearer in the future. Particularly taking into account issues around the sustainability and viability of services, which we believe should be central to considerations both of the counterfactual and of any proposed patient benefits. We are also interested in the weight placed on comments made by commissioners, and other interested parties within a Phase 1 review.

In summary

We hope that this submission assists the CMA in its understanding of the current environment in which providers of NHS services are operating and the challenges which ASP and RSC are facing. This includes:

- The current policy drivers, including the move to more integrated models of care as set out within the widely accepted vision for the NHS.
- The current financial and operational context and the rapidly changing position of previously high performing and financially healthy organisations.

It is crucial that the NHS begins to transform its services and move to delivering new care models in order to secure its long-term sustainability. This is widely accepted by providers, commissioners, policy makers and politicians. It is essential that the application of competition law in the NHS does not prevent this.

We encourage the CMA to carefully consider the issues highlighted in this submission. We would be very happy to provide any supplementary information required for this submission of discuss anything raised in further detail, if it would be helpful.