In brief

The Health Foundation Inspiring Improvement

Mergers in the NHS

Lessons from the decision to block the proposed merger of hospitals in Bournemouth and Poole

Health Foundation summary and analysis

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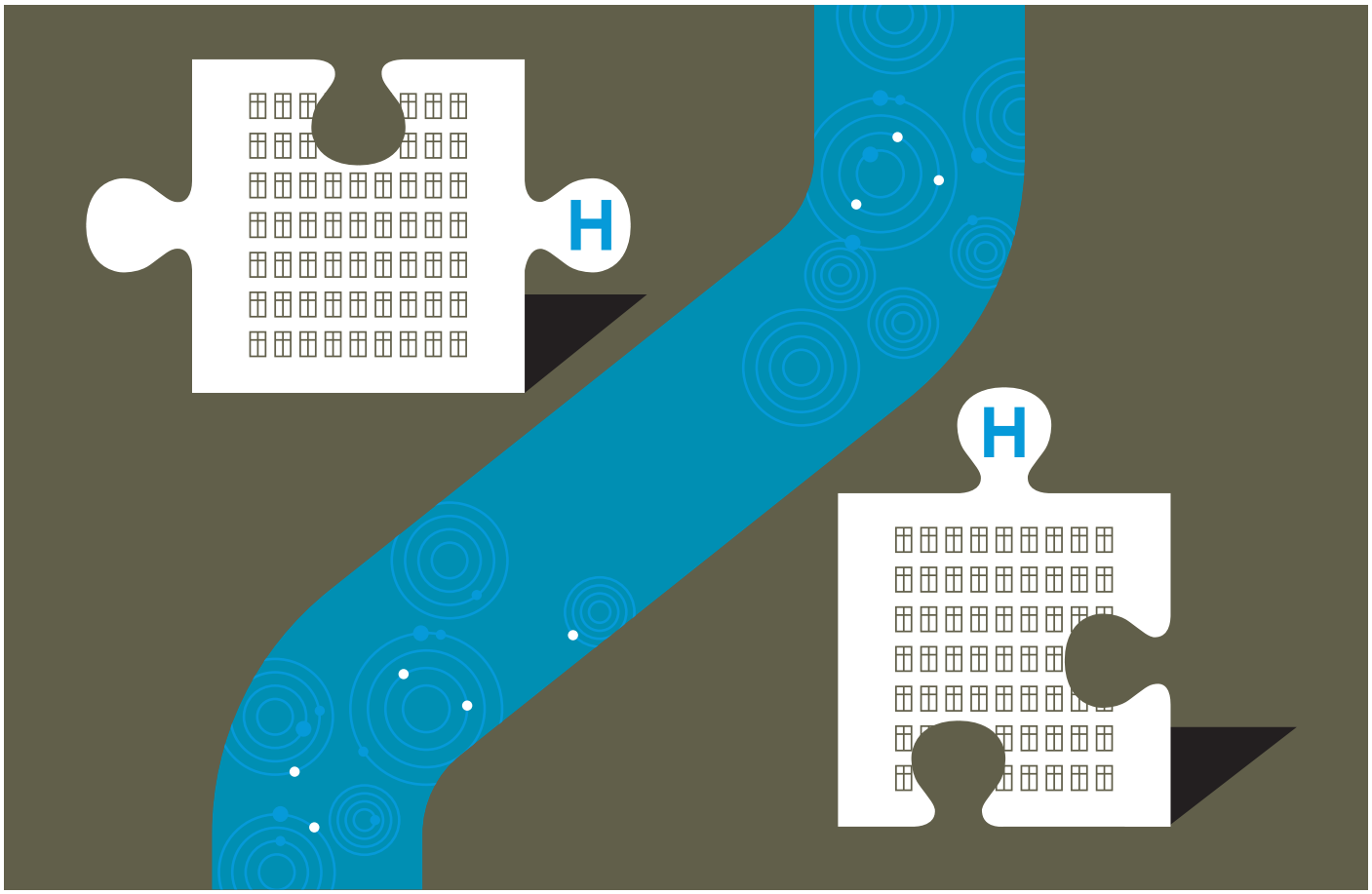

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www.health.org.uk/nhsmergers

Key points

- Poole Hospital NHS Foundation Trust (PHFT) and Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT) decided to pursue a merger in November 2011. After a long, tortuous, unclear and costly process the merger was finally rejected by the Competition Commission (CC) in October 2013. The two trusts were required to sign undertakings that for ten years they would not seek to apply or implement a merger without the explicit permission of the competition authorities.
- The regulatory process to be followed was not clear to the two trusts at the outset. This was largely because the merger was pursued during a time of particularly significant flux in the NHS – during the passage through parliament of the Health and Social Care Bill and the comprehensive reorganisation it resulted in. However, the regulatory framework has its roots in the Enterprise Act 2002 – the 2012 Act did not create a new merger control regime.
- Had the process been clearer, the significant cost and effort involved in pursuing the failed merger bid by the trusts could have been avoided. Guidance published subsequently by Monitor and the Competition and Markets Authority (CMA) (formed in April 2014 after a merger between the Office of Fair Trading and the CC) has clearly spelt out the process to be followed and the level of evidence required. In the future, NHS foundation trusts will receive significantly more support from Monitor prior to a review by the CMA.
- The CC rejected the proposed merger because it was expected to result in a substantial lessening of competition (SLC) and the patient benefits put forward by the trusts as mitigation were not found to be relevant customer benefits under the Enterprise Act 2002. This left the CC with no choice but to prohibit the merger.
- If there is one main lesson from this case study it is that those pursuing merger or major reconfiguration must produce adequate evidence of patient benefit of their proposals at the outset. This is the case even if the desired or most appropriate path is to 'merge first, reconfigure later'.
- The guidance on demonstrating benefits to patients subsequently set out by Monitor and the CMA will help, but trusts, commissioners and other parties pursuing a merger or major reconfiguration may need more tailored support. Given the pace and scale of transformation needed in the NHS over the next few years, it is worth considering whether it will be more cost effective for the NHS to set up and offer a pool of experts, either in-house or through a set of preferred expert providers, rather than relying on individual localities to source expertise.
- Currently one of the CMA's key tests is whether (at phase 1) it is or may be the case that a merger has resulted or may be expected to result in a SLC and (at phase 2) whether a relevant merger has resulted or may be expected to result in a SLC. The underlying assumption is that a SLC would not be in patients' best interests. The empirical evidence to support or refute this assumption is as yet weak, and needs to be analysed much further by the regulatory authorities.
- We think it is right that there is some external scrutiny of merger decisions and accept that competition should be part of that process. However, a broader test which explicitly considers a range of factors (including competition) and makes specific reference to the views of commissioners as well as the sector regulator might be an improvement on the current process.
- Commissioners of services from Bournemouth and Poole are in the process of conducting a clinical services review across Dorset. If the outcome of that review is that a merger would indeed be in the best interests of the local population, the two trusts should have another opportunity to put their case forward.
- At the heart of the Bournemouth and Poole story is a fundamental question. Are foundation trusts part of a larger NHS 'chain' (to be supported as appropriate) or are they really standalone independent organisations (to compete as appropriate)? This is not an academic question but is at the heart of how the NHS should be managed and regulated in practice.

Mergers in the NHS: Lessons from the decision to block the proposed merger of hospitals in Bournemouth and Poole

1. Introduction

In October 2013, the Competition Commission (CC) prohibited the proposed merger of Poole Hospital NHS Foundation Trust (PHFT) and the Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT). This was the first merger between two NHS foundation trusts (FTs) to be examined by the competition authorities following the Health and Social Care Act 2012 which confirmed their role in assessing the competition aspects of mergers involving FTs. While the case itself is old news, the merger decision process is still often referred to in the NHS as a barrier to needed and major service change.

Because of this, and since there has not been an independent case study, the Health Foundation carried out an analysis of the proposed merger. Our aim was to draw out some lessons that would be useful for the NHS in the future, especially since major service reconfiguration may well be needed in some areas. The full analysis is published in the report, *Mergers in the NHS: Lessons from the decision to block the proposed merger of hospitals in Bournemouth and Poole.*[*] This *In brief* summarises the findings of the full report.

[*] To download or order the report, visit: www.health.org.uk/nhsmergers

2. A brief history of competition policy in the NHS

Ever since it was founded in 1948, the NHS has effectively been a large monopoly, albeit with national contracts to general practices as independent providers of primary care. Reforms implemented by the Conservative government in 1990 split purchasing and providing functions by establishing NHS hospitals as self-governing trusts and set up health authorities and newly introduced GP fundholders as commissioners of NHS-funded care.[1] The rationale was in part to generate competition between hospitals in a 'quasi- (NHS) market'.

The publication, by the Labour administration, of the *NHS Plan* in 2000[2] marked a significant step in increasing the role of the private sector in the provision of NHS-funded services. Choice of provider for patients was expanded over the next decade enabling patients to have a choice of outpatient and inpatient care. These policies were underpinned by developments to the way in which hospitals were paid (moving from block contracts to payments for activity), which boosted the financial incentives for hospitals to compete for patients. The *NHS Plan* also outlined proposals to give clinicians and managers greater freedom to run local services. FTs were established under the Health and Social Care (Community Health and Standards) Act 2003. Unlike NHS

trusts, FTs were independent organisations and were given greater freedoms, including no longer being subject to direction from the Secretary of State for Health. The legislation provided for an independent regulator (later known as Monitor) to monitor the performance of FTs.[3]

In 2007 the Department of Health published the Principles and Rules for Cooperation and Competition (PRCC).[4] The PRCC were intended as guidance on the expected behaviours and rules governing cooperation and competition. As well as outlining plans to develop an independent competition panel,* the PRCC set out 10 principles that would apply from April 2008. Key provisions included a requirement that commissioners should contract with the provider best able to meet the needs of their local population, and that both commissioners and providers were required to foster patient choice. The guidance stated that mergers and acquisitions were acceptable when in the best interest of patients and taxpayers, as long as sufficient choice and competition remained to ensure high quality services.

* The Co-operation and Competition Panel was established on 30 January 2009

The 2010 white paper, *Equity and Excellence: Liberating the NHS* outlined widespread structural changes to the NHS including the creation of the NHS Commissioning Board (later renamed NHS England), the abolition of strategic health authorities (SHAs) and primary care trusts (PCTs), the transfer of public health functions to local authorities, and the establishment of GP consortia (later clinical commissioning groups (CCGs)).[5] The white paper made it clear that diversity of supply of clinical care was a key objective. The government aimed to allow 'any willing' (later 'any qualified') provider to provide clinical services, with the aim of giving patients greater choice and stimulating innovation and improvement through greater competition. The white paper also outlined the government's intention to amend the role of Monitor (the regulator of FTs) to become an 'economic regulator', with responsibility for promoting competition, regulating prices and safeguarding the continuity of services.[5] The Department of Health updated the PRCC in 2010 following the publication of *Equity and Excellence*. While the 10 principles remained similar to those published in 2007, the role of choice and competition within the NHS was strengthened.[6] The principles contained within the PRCC were later formalised in the National Health Service (Procurement, Patient Choice and Competition) (No.2) Regulations 2013 (the Section 75 regulations), amid much controversy and political debate.[7]

The Health and Social Care Act 2012 gave effect to the policies outlined in *Equity and Excellence.* Part 3 of the Act (relating to the regulation of health and adult care services) had been subject to a number of amendments since the Bill was introduced on 19 January 2011. There were no longer references to 'economic regulation' and the focus was on 'sector regulation'.

The Act defined the role of the sector regulator (Monitor) and outlined that Monitor's overriding duty would be to protect and promote the interests of patients by promoting economy, efficiency and effectiveness in the provision of health care, while maintaining or improving quality. Monitor was given concurrent powers with the Office of Fair Trading (OFT) to apply the Competition Act 1998 (allowing Monitor to investigate anti-competitive practices) and the Enterprise Act 2002 (in relation to market investigation references). The Health and Social Care Act 2012 provided the Secretary of State with delegated powers to make regulations that placed requirements

on commissioners relating to procurement, patient choice, anti-competitive conduct and conflicts of interest. The Co-operation and Competition Panel (CCP), which investigated breaches of competition, became part of Monitor on 1 April 2013.[8]

3. Merger control in the NHS

The Health and Social Care Act 2012 did not establish a system of merger control but instead sought to confirm the legal position in the NHS relating to the application of existing merger control legislation set out in the Enterprise Act 2002.

One of the objectives of the Health and Social Care Act 2012 was to clarify the role of the OFT in examining mergers involving NHS FTs. Previously, 'applicable mergers'* were reviewed by the CCP in a non-legislative arrangement, rather than the OFT.[9] The CCP was formally established in January 2009 and its role was to investigate potential breaches of the PRCC, review proposed mergers and advise on the wider development of cooperation, patient choice and competition within the NHS. In practice, the CCP expected that mergers involving NHS FTs and NHS trusts would be primarily examined by the CCP and mergers between independent sector providers of services to the NHS would be examined initially by the OFT, which would refer cases on to the CC as appropriate.[10] The relationship between the OFT and the CC with regards merger control was established through the Enterprise Act 2002.

The Health and Social Care Act ultimately provided for a single system of merger control for NHS FTs. Under the Act, the OFT was required to notify Monitor (which would later incorporate the CCP) of a merger situation involving one or more FTs, and Monitor was required to advise the OFT on the likely benefits (as defined by the Enterprise Act 2002) to patients. Monitor could advise on other matters relevant to the merger, although the Act did not specifically mention the 'substantial lessening of competition' (the key criterion used by the OFT and CC to assess mergers) as one of them. As part of its general public duties, the OFT was obliged to consider the advice provided by Monitor.[11]

Chapter 3 of *Mergers in the NHS* looks in detail at the functions of the then OFT and the CC, as these were the relevant regulatory bodies in the Bournemouth and Poole case. Their functions have since been merged as part of the new Competition and Markets Authority (CMA), which was established on 1 April 2014.

When undertaking a competitive assessment the CMA has to decide the following:

At phase 1 (previously OFT):

- Does it believe that it is or may be the case that a relevant merger situation has been created or will be created?
- If so, has the creation of that situation resulted or may be expected to result, in an SLC?
- If so, do any relevant customer benefits outweigh the SLC concerned and any adverse effects of the SLC?†

* Guidance issued by the CCP in 2010 suggested that a merger would come under its remit if the revenue of a combined entity exceeded the applicable threshold (primary care - £15 million, community services- £35 million and £70 million in the case of acute and mental health trusts).

† The CMA only weighs benefits against the SLC at phase 1. In phase 2, benefits are relevant to the selection of an appropriate remedy.

At phase 2 (previously CC):

- Has a relevant merger situation been created or will be created?
- If so, would that merger result, or be expected to result, in a SLC?
- If it is found that there is an anticompetitive outcome, the CMA must decide whether action should be taken to remedy, mitigate or prevent the SLC or any adverse effect that has or could be expected to result from the SLC. If action is to be taken, the CMA has to decide what action should be taken and what is to be remedied, mitigated or prevented. It is at this point that the CMA would consider relevant customer benefits.[12]

Mergers between two NHS trusts are not considered to be a relevant merger situation under the Enterprise Act 2002. This is because the secretary of state is considered to be ultimately in control of both organisations – NHS trusts being part of a national system – so a merger is not seen as resulting in two distinct enterprises coming under common control. In contrast, a merger involving a NHS FT (a public benefit corporation with income generating powers and viewed as an independent body) is seen as creating a situation where two or more enterprises cease to be distinct. Mergers arising from service reconfigurations can also be subject to merger control, for example if the total annual turnover of the relevant services reaches £70m or the enterprises together supply or acquire at least 25% of all those particular goods or services supplied in the UK or in a substantial part of it.[13]

The decision-making process for the competition authorities is provided for by the Enterprise Act 2002 and is complex. The factors the CMA is required to consider are generic in that they apply across a range of industries and sectors.

4. The Bournemouth and Poole case

Poole Hospital NHS Foundation Trust (PHFT) is a 635-bed acute general hospital, operating on one site. The trust mainly serves people living in Poole, East Dorset and Purbeck. It is the trauma unit for East Dorset and provides a broad range of general hospital care and services, such as paediatrics and maternity, for a wider catchment area. The trust also provides specialist services across Dorset, such as cancer care.[14]

The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust (RBCHFT) is a 601-bed trust operating across two sites covering people living in Bournemouth, Christchurch, East Dorset and part of the New Forest in Hampshire. Some specialist services are provided for a wider catchment area, covering Poole, the Purbecks and South Wiltshire.[15]

The primary commissioner for both providers is Dorset Clinical Commissioning Group. In 2011/12 RBCHFT's total income was £239.8m and PHFT's total income was £195m.[16] West Hampshire Clinical Commissioning Group also has an interest and commissions approximately £22m of services from Bournemouth and £3-4m from Poole.[17]

The two trusts are approximately eight miles apart. The Royal Bournemouth Hospital was built in 1989 (ie before the purchaser-provider split reforms of 1990) and was in part designed to complement the services available at PHFT for the population of East Dorset. The two trusts' potential local competitors are spread across a wide area.

On 29 November 2011, the boards of PHFT and RBCHFT announced their intention to merge on the basis that a merger would provide the trusts with the best opportunity to be financially sustainable and offer higher quality clinical services for patients. The trusts believed there was a clear lack of financial sustainability at Poole, and clear risks to the quality of clinical care. The decision was taken at a time when the Health and Social Care Bill was mid-way through its parliamentary passage and it was not certain exactly what provisions on competition and sector regulation would be passed into legislation. Furthermore, the local commissioning system was in a state of flux due to the likely abolition of the existing commissioning bodies – PCTs.

In their initial submission to the CC the trusts suggested that the merger would deliver the following:

- Improved access, safety and quality of care in five clinical areas: cardiology, acute general surgery, emergency department (A&E), haematology and maternity.
- Financial savings through economies of scale estimated at generating up to £20m of savings.
- Enhanced sustainability of services as it would be easier to recruit and train key clinical staff and support the provision of 24/7 services and appropriate staff rotas in a larger (merged) entity.
- Improved ability to support provision of health care through unlocking capital resources and facilitating a more efficient allocation of capital investment across both sites.[16]

The broad position of both trusts was that they needed to merge because of a clear lack of financial sustainability at Poole, and clear risks to the quality of clinical care. They also felt, following advice from a consultancy firm, that it would be more appropriate (financially, clinically and with regard to local consultation) to develop the necessarily detailed plans for reconfiguration across a wide set of services, and thus identify associated benefits, only after the trusts had merged. The initial decision by the trusts to 'merge first, reconfigure later' was not, as it later transpired, necessarily conducive to providing the level of evidence on patient benefit that was required by the regulators to support the merger. However, this does not mean that the 'merge first, reconfigure later' model may not be appropriate in the future, but parties do need to be in a position to provide robust evidence on benefits where merger raises competition concerns.

After subsequent referral to the CC, the trusts suggested that a decision on whether a merger would result in a SLC should be taken on the basis that without the merger PHFT would exit the market through financial failure (alongside other arguments about the degree of overlapping services and cooperation between the trusts).[16] The CC rejected this 'counterfactual' (ie what would happen absent the merger) on the basis that Monitor would be unlikely to place the trust into special administration. The CC cited the length of time that it took to place Mid Staffordshire NHS Foundation Trust into special administration (despite significant failings). It was also noted that other trusts had been able to run up large deficits over time without being placed into special administration. Put simply, the CC did not believe that PHFT was about to fail (or 'exit') on current evidence. This view was subsequently confirmed in April 2014 by Monitor's decision to close its investigation into Poole's financial

sustainability and governance.[18] Furthermore the CC did consider the size, case mix and financial forecast of PHFT in its final report and the CMA can take the future performance of trusts into account in its analysis of competition even if the trusts do not meet the specific 'exiting firm' test.

The CC found that the proposed merger might be expected to result in a SLC in the wider Dorset area in the supply of services in 19 elective inpatient services, 34 outpatient services, one non-elective inpatient service (maternity) and one private service (cardiology).[19]

The CC then considered whether the merger would be likely to give rise to 'relevant customer benefits'* and whether any action should be taken to remedy, mitigate or prevent the SLC or any other adverse effects resulting from the SLC. By this stage, the two trusts had supplemented their initial evidence supplied to Monitor and OFT on patient benefit, and included supporting statements from the key local commissioners and other stakeholders (although in the case of the maternity proposal, the plans for reconfiguration included at an earlier stage were dropped). Nevertheless the CC was not convinced by these or subsequently the proposed remedies to the SLC suggested by the trusts, and concluded that the merger would not result in relevant customer benefits in all of the five clinical areas proposed. Likewise, the CC was not convinced that broader clinical benefits, financial savings, merger-avoided costs, merger-enabled investments, the creation of a more balance portfolio of services and cost savings to commissioners constituted relevant customer benefits. The CC therefore prohibited the proposed merger in October 2013.

* For a benefit to be considered a relevant customer benefit it must be in the form of lower prices, high quality, greater choice or greater innovation. The benefit also has to meet a time test – the benefit needs to be expected to accrue within a reasonable period as a result of the merger and would be unlikely to take place without the merger (Enterprise Act 2002).

Following this decision, the trusts were required to sign undertakings that for 10 years they would not seek to apply or implement a merger or acquisition unless they had the written permission of the relevant competition authority.

Table A below gives a high level outline of the timescales of the merger decision-making process. Chapter 4 of the full report explores the process and rationale for the merger in more detail.

Table A: High level timeline of the RBCHFT and PHFT merger process:

29 June 2011	Minutes from the board meeting of PHFT held on 29 June 2011 explain the chairman and the chief executive had met with their counterparts at RBCHFT to discuss joint working.
29 November 2011	RBCHFT and PHFT's boards announce their intention to pursue a merger.
March 2012	The parties start producing their case for the OFT (according to feedback from interviewees).
22 June 2012	OFT notifies Monitor that it has decided to carry out an investigation under Part 3 of the Enterprise Act 2002.
22 October 2012	OFT announces that it was reviewing the proposed merger.
7 December 2012	Monitor provides advice to the OFT on potential benefits to patients of a merger.
8 January 2013	OFT decide to refer to CC.
11 February 2013	Monitor's advice to the OFT published.
22 March 2013	OFT publishes further advice on its role in NHS mergers.
11 July 2013	Provisional findings from the CC.
17 October 2013	Final report from the CC, blocking the proposed merger.
17 October 2013	Joint statement from the OFT, CC and Monitor.

5. Discussion

It was unique and unfortunate timing that RBCHFT and PHFT pursued their proposal to merge at a time of considerable uncertainty and organisational instability in the NHS. Not only were all levels of the NHS's administrative structure in flux, but the role of Monitor was also changing. In the Bournemouth and Poole case, this seems likely to have resulted in an overlong, tortuous and unclear process, large financial cost, and a huge burden on the parties to supply information, all of which could have been avoided or appropriately aborted at an earlier stage. Monitor and the CMA have subsequently set out guidance to clarify the process for FTs contemplating a merger, and the type of evidence needed to support claims of relevant benefits to patients.[12,20]

The route pursued by Bournemouth and Poole was to 'merge first, reconfigure later'. However, the ultimate rejection of the merger proposal does not mean that a model of 'merge first, reconfigure later' could not be successful in Bournemouth and Poole or elsewhere in future. The main point is that the rationale and expected benefits of the proposals need to be thought through to the detail required by Monitor and the CMA (as now set out).

Furthermore the case for the merger needs to be fully transparent to gain needed public and commissioner support for the changes. In the Bournemouth and Poole case, the decision to pursue the merger was initially taken by the two trusts. But arguably it is the local commissioners that may be best placed to lead, or have a large role in taking forward, merger proposals because they view services from the perspective of the needs of the geographical population, not the needs of the local providers. It may help to amend current legislation to give the views of local commissioners additional weighting in the regulatory process for mergers involving FTs.

The case highlights dissonance between the commonly held belief by NHS management that merger is often an effective solution to achieve financial and clinical sustainability and the role of the CMA which is required in legislation to act to protect consumers from mergers which cause a SLC. Empirical evidence in health care, such as it is, does not necessarily support either perspective – empirical evidence on the benefits of mergers or competition in health care is still weak.[21,22]

If a merger proposal does reach the competition authorities, as in the Bournemouth and Poole case, currently one of the main tests (assuming a relevant merger situation) is 'would the proposed changes result or may be expected to result in an SLC?' But the empirical evidence on a causative link between competition and quality of care is still too weak to draw any firm conclusions. Six months after the CC's decision on Bournemouth and Poole, the OFT published a review of the theoretical and empirical literature on the relationship between quality and competition. This review suggested that the empirical literature is '*recent and still relatively sparse* ' and '*it is probably too early to draw any general lessons from this*'. However, the report noted that, for health care, empirical studies suggest that competition leads to improvements in some measures of quality when prices are regulated.[22]

We suggest a much more probing analysis of the impact of competition relative to other factors now needs to be carried out by Monitor or an independent organisation with considerable expertise in the sector. Such a review should consider the impact of competition relative to a full range of extrinsic incentives that can affect quality in the NHS (such as targets, regulation, commissioning and payment mechanisms) or intrinsic incentives (for example better availability of data on performance), and whether the relationship between competition and quality outcomes in the existing literature is causative or merely associative.

Since the Bournemouth and Poole case a number of other NHS organisations have gone through the CMA (or the OFT/CC) process. In particular the acquisition of Heatherwood and Wexham Park Hospitals NHS Foundation Trust by Frimley Park Hospital NHS Foundation Trust[23] and service-level reconfigurations between the Royal Free London NHS Foundation Trust and University College London Hospitals NHS Foundation Trust.[24,25] The CMA is currently investigating the anticipated acquisition by Chelsea and Westminster Hospital NHS Foundation Trust of West Middlesex University Hospital NHS Trust.[26] All of these cases will provide additional learning and we understand that NHS Providers* is undertaking some work to provide a practical briefing on the merger assessment process for its members.

* NHS Providers is a membership organisation for NHS public provider trusts (formerly known as the Foundation Trust Network)

6. Conclusions

The two trusts in Bournemouth and Poole pursued their merger proposal at a time of considerable uncertainty and flux in the NHS, when the process to achieve the merger was unclear. The competition authorities robustly assessed the case in line with a legislative framework designed to protect consumers from the negative effects of merger. Ultimately, the CC found that merger would result in a SLC and was required to act to remedy that lessening of competition. The two trusts were not able to provide a sufficiently robust case on the benefits to enable the CC to allow the merger to proceed.

Had the process been clearer from the start to the trusts pursuing the merger, it is likely that the costs and burden to the two trusts could have been avoided. Monitor and the CMA have subsequently set out the merger control process much more clearly, which is to be welcomed.

The two trusts were required to sign undertakings prohibiting merger for a decade (unless there is explicit permission by the competition authorities). Given the unfortunate timing of the first proposal to merge outlined in this case study, we suggest the competition authorities should view any further proposals for merger or reconfiguration with flexibility if the outcome of the clinical services review, currently being conducted by local commissioners, suggests that merger would indeed be in the best interest of the local population.

Currently one of the CMA's primary tests of a merger is whether the proposals would result in or be expected to result in a SLC (however the CMA does take into account relevant 'customer benefits' if there is expected to be a SLC). The underlying assumption is that a lessening of competition would not be in the patients' best interests. The empirical evidence base to support or refute this assumption in health care is as yet weak, and needs to be analysed further by the regulatory authorities.

If there is one main lesson from this case study it is that those pursuing merger or major reconfiguration must produce adequate evidence of patient benefit of their proposals at the outset. This is the case even if the desired or most appropriate path is to 'merge first, reconfigure later'.

The guidance on demonstrating benefits to patients subsequently set out by Monitor and the CMA will help, but trusts, commissioners and other parties may need more tailored support. Given the transformation needed in the NHS over the next few years, it is worth considering whether it will be more cost effective for the NHS to set up and offer a pool of experts, either in-house or through a set of preferred expert providers, rather than rely on individual localities to source expertise.

We think it is right that there is some external scrutiny of merger decisions and accept that assessment of the impact on competition should be part of that process. However, a broader test which explicitly considers a range of factors (including competition) and makes specific reference to the views of commissioners as well as the sector regulator might be an improvement on the current process which was conceived in the early 2000s and not with the NHS in mind. There is scope to refine the process within the current legislative framework rather than through more radical change.

However, at the heart of the Bournemouth and Poole story is a fundamental question. Are FTs part of a larger NHS 'chain' (to be supported as appropriate) or are they really standalone independent organisations (to compete as appropriate)? This is not an academic question but instead is at the heart of how the NHS should be managed and regulated in practice. Clarity on this question would help as the NHS faces a period of necessary reconfiguration, and new opportunities for mergers to take place.

The recent review by Sir David Dalton[27] advocates in some cases the buddying or acquisition of poorly performing NHS providers by high performing, ambitious NHS FTs, to step up performance in the former. Both arrangements will need carefully thinking through with reference to the issues raised by the Bournemouth and Poole case.

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